Live healthy
Live happy
Birmingham and Solihull

Birmingham and Solihull Sustainability and Transformation Partnership

Long Term Plan

"Helping everyone in Birmingham and Solihull to live the healthiest and happiest lives possible"

15 November 2019

FINAL DRAFT v3.20

As at 2/1/20, this document is subject to change and approval by the STP Board.

Live healthy Live happy
Birmingham and Solihull

Birmingham and Solihull Sustainability and Transformation Partnership (STP) is made up of the following organisations:

GPS Healthcare
General Practice Solihull

SDSmyhealthcare

Our Health Partnership
OHP A healthy future for patients and practices

mmp
TAKING CARE
MIDLANDS MEDICAL PARTNERSHIP

Birmingham City Council

Solihull
METROPOLITAN BOROUGH COUNCIL
URBS IN RURE

NHS
Birmingham and Solihull
Clinical Commissioning Group

NHS
Birmingham Community Healthcare
NHS Foundation Trust

NHS
Birmingham and Solihull Mental Health
NHS Foundation Trust

NHS
University Hospitals Birmingham
NHS Foundation Trust

NHS
Birmingham Women's and Children's
NHS Foundation Trust

NHS
The Royal Orthopaedic Hospital
NHS Foundation Trust

About us

Our partnership represents a dynamic and diverse place at the centre of the nation. Birmingham is a vibrant city that is the most youthful core city in Europe and the UK's second biggest metro economy. Solihull is a leading driver of economic growth in the region and is ranked as one of the best places to live in the country, with a green, high-quality environment.

Together we are greater than the sum of our parts.

We attract talent from around the world, as well as developing our own. We are rich in creativity, connectivity and culture. We promote knowledge, knowhow and education, with six universities in one city. We have a legacy and a future in sporting excellence. We possess fast new transport links and technological possibilities. We led the way in the industrial age and will do so again in the digital era. We are innovative, inventive, international and a place for economic growth and social mobility.

We are a place of limitless ambition.

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Executive summary

Working together for Birmingham and Solihull

In May 2018, the Birmingham and Solihull Sustainability and Transformation Partnership (STP), a partnership of existing health and care organisations, agreed a draft strategy to focus collectively on the needs of local people. We agreed we can only reduce variation in outcomes and address inequalities by working as a system.

Our ambition is:

"Helping everyone in Birmingham and Solihull to live the healthiest and happiest lives possible."

There are five aspirations that we stand for:

1. **Independence and resilience** – we want to play an enabling role that helps individuals and families to live long, fulfilling and independent lives, taking personal responsibility for their health and wellbeing, and with the physical and emotional resilience to cope with the stresses and strains of life and to recover from setbacks. Public services need to complement individual and community efforts, rather than substitute for them.
2. **Equity, equality and inclusion** – overall gains in health and prosperity have not been shared evenly, so we want to reduce the unacceptable gap between the health and wellbeing of the most and the least advantaged. We want parity of esteem between mental and physical health. And we want to promote inclusive communities, reducing social isolation.
3. **Integration and simplification** – many of the problems of health and care exist at the misaligned joins between separate organisations, services or professionals. We want to integrate our services around the paths people want or need to take, making best use of technology and personal health budgets to do so, rather than expecting them to navigate a complex and disjointed offer for their health and care. They should not have to tell their story many times over because the system should be joined up and enabled by technology.
4. **Promoting prosperity** – better health and life outcomes are closely correlated to prosperity for individuals and communities. We want to make our contribution to economic growth and stable employment by supporting people and communities to be active and productive.
5. **Social value** – when we use our scale and act collectively, we have the potential to deliver social and economic benefits that are far broader than health and care alone. We recognise our vision and aspirations are complex and multi-faceted, and we cannot achieve them alone. But we can and will be role models who provide leadership in some important areas, such as how we affect and interact with our environment, how we care for our many staff, how we tackle inequalities and the impact we have on people's diet and activity. We will hold ourselves to high standards in terms of the social value we create collectively.

This plan outlines the steps to achieve this over the next five years. It is focused on what citizens need in the different stages of their lives and is based on an analysis of our local challenges,

complexities and opportunities. It also details how we will meet the national requirements set out in the **NHS Long Term Plan**, which sets out an ambitious ten-year plan for transforming health services.

From a partnership perspective, we recognise we cannot achieve our ambitions in isolation given the critical role of our local councils in improving outcomes and supporting the wellbeing of our population; creating healthy places for people to live, work and grow up. Equally, we have listened to people in our communities to understand what matters to them and engaged with our local voluntary and community sector, who play a vital role in service delivery and supporting communities to thrive.

Whilst we have made great strides in delivering a series of improvements to quality as a system, we need to do more given:

- **Our ageing society:** People are living longer, which is a great success, but it means we need a system that helps many more people to live well and independently in later life, and to meet their varied care needs.
- **A shifting burden of disease:** The last century has seen a major shift from death and illness being caused mainly by infectious diseases to non-infectious diseases, such as cancer, heart disease, diabetes, dementia and mental illness. This reduces somewhat the fear of sudden, catastrophic illness, but increases many-fold the chances of people living more years with ongoing, complex and expensive care needs.
- **Technological advances:** Science and digital technologies are transforming every facet of modern life. We can introduce new treatments and innovations to improve clinical care and quality of life, but, whilst some may be cost-saving, the net effect is to add to the cost of care, especially in the most specialised services.

Together, as a partnership, we have collaborated and prioritised opportunities to improve health and wellbeing outcomes. This involves a fundamental rethink in the way that care has been traditionally provided.

As demand grows for our services grow, we will work continuously to provide high-quality, responsive care to local people within available resources. For the most specialised services, it will often be the case that they are best delivered at scale to concentrate specialist clinical skills and equipment. Less specialised clinical or care services, however, can be delivered more locally to people and communities.

Our focus over the next five years, and beyond, is transforming the way we deliver health and care services through:

- **Health promotion** – a system that supports people to maintain their health and wellbeing can reduce substantially the costs of treating preventable diseases, such as Type 2 diabetes, lung cancer and many other conditions linked to unhealthy lifestyles. Benchmarking shows that if we achieved best practice in the NHS, we could save around 70 lives per year that are lost to cancer or respiratory illnesses. We could also save around 8% of the £46m we spend per year on treating respiratory conditions. There will also be

multiple wider benefits for economic productivity in supporting people to stay health and active.

- **Independence and work** – as the structure of society is changing, so is the dependency ratio, which is the number of people in work relative to those who require support from public services. We want to support people to maintain their health, independence and productivity for as long as possible. We will be active in supporting local skills and employment opportunities to tackle the anomaly that we have pockets of high unemployment in Birmingham and Solihull, whilst also having vacancies at most skill levels in our health and care organisations.
- **Right care, right place** – the current model of care too often defaults to hospitalisation. In many cases, more preventative care in the community, or swifter discharge from hospital supported by a package of community support or social care, would be better for patients and more economical. This is particularly relevant for the care of older people and for those at the end of their life. Analysis has shown that we could save around £40m per year locally by caring for older people in the most appropriate settings, with enablement support, and by reducing clinically unnecessary stays in hospital. There are also opportunities for stable patients to have more of their follow-up care in primary or community settings, rather than in hospital outpatients.
- **Reducing variation** – we want citizens to receive the best quality care wherever they live, but there is too much variation in care and outcomes. There is ample evidence that higher quality care, with fewer errors, is both better for patients and more cost effective. Benchmarking data shows that if we achieved best practice in the NHS, we could save each year £20-27m on non-elective admissions, £14-16m on elective admissions and £15m through more consistent primary care prescribing.
- **Harnessing technology** – whilst the net effect of technological advances in healthcare has been to increase costs, especially for new medicines and in specialised services, technology can also reduce costs in other ways, for example by delivering services virtually, removing inefficiencies and automating repetitive tasks. We will seek out the potential productivity gains from new technologies, so that they support, rather than threaten, the sustainability of high-quality care.
- **Economies of scale** – we can deliver substantial efficiencies by working together to merge some corporate and back office functions and use our considerable purchasing power to make procurement savings and deliver social value. This will be one of the major advantages of using our scale to work in partnership, as it will release significant savings to reinvest in direct care.
- Quality and equality impact assessments have been carried out against the overall impact of the ambitions and commitments contained within the plan. Overall both assessments scored **positively** against the impacts on residents. Further quality and equality impact assessments will be carried out on new services as part of this process to ensure inclusivity and full consideration of all impacts.

This is an exciting journey and we are united in our ambition to deliver this transformation over the next five years and beyond. We will continue to engage and share plans in detail to reflect the voices of our citizens, staff and communities. This will enable us to continually refine the delivery of high-quality services to improve outcomes and reduce inequalities in Birmingham and Solihull, in line with our financial commitments.

Introduction

Birmingham and Solihull's Long Term Plan

This is Birmingham and Solihull STP's Long Term Plan, which sets out an ambitious journey of transformation in health and care services over the next five years. It is the health care delivery element of our STP strategy and has been developed by STP partner organisations, working across boundaries in the STP. This has included the views of our local councils who will be key to supporting delivery of the plan as well as voluntary and community organisations and citizens following engagement with a range of diverse communities.

This plan is focused on what citizens need in the different stages of their lives and is based on an analysis of our local challenges and opportunities. It also details how we will meet the national requirements set out in the **NHS Long Term Plan**, which sets out an ambitious ten-year plan for transforming health services.

It also includes a detailed financial, activity, workforce and performance analysis for the next five years, which complements this part of the plan and can be found in the appendices.

In the **Introduction**, we describe our local context, including the specific challenges and opportunities for our area. Later, we describe the work to date and our rationale for change and priorities for action. This is supported by an analysis of how our plan delivers the STP's aspirations and a summary of how we will deliver the changes outlined. It also includes a section on how services will be different by 2023/24 so that our citizens and staff can clearly see our transformation journey ahead and the benefits this will bring.

A key section in this plan is our focus on the critical elements to enable our success. These are described in the **Transforming the way we work** section. This includes, for example, our approach to person-centred services, digital transformation and how we will recruit and attract the best possible staff to work in our services. It also includes a focus on how we will work together as an STP and evolve into an Integrated Care System (ICS) as well as how we will manage our finances. These elements are critical to the way we will deliver care in future as we will work together in partnership to plan and deliver health and care services in the future.

As part of transforming services in the **Taking a life course approach** section, we explain how services will be different based on different services at each stage of our lives, which is further supported by key underpinning services for all our communities. These encompass our focus on maternity, children and adolescence; adulthood and work; ageing and later life; and also all age services.

We also describe in the **Risks to delivery** section the key factors that could impinge upon delivery and the ways we will manage and mitigate these risks. We will also work together as a system to monitor progress, which is explained in the **How we will monitor the progress of this plan**. This will be key in measuring and monitoring successful delivery of the plan and demonstrating progress and improvement to our population and staff.

Finally, the **Quality and equality impact assessment** outlines the impacts of the proposed changes for our population.

There is also a detailed list of **appendices**, which align to sections where relevant.

Context

In May 2018, the Birmingham and Solihull Sustainability and Transformation Partnership (STP), a partnership of existing health and care organisations, agreed a draft strategy (Appendix 1) to focus collectively on the needs of local people. Our ambition is:

"Helping everyone in Birmingham and Solihull to live the healthiest and happiest lives possible".

This is supported by five aspirations:

1. **Independence and resilience** – we want to play an enabling role that helps individuals and families to live long, fulfilling and independent lives, taking personal responsibility for their health and wellbeing, with the physical and emotional resilience to cope with the stresses and strains of life and to recover from setbacks. Public services need to complement individual and community efforts, rather than substitute for them.
2. **Equity, equality and inclusion** – overall gains in health and prosperity have not been shared evenly, so we want to reduce the unacceptable gap between the health and wellbeing of the most and the least advantaged. We want parity of esteem between mental and physical health. And we want to promote inclusive communities, reducing social isolation.
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This plan explains how the Birmingham and Solihull STP will deliver these aspirations and outlines the changes for the next five years. It aligns with the **NHS Long Term Plan**, which is a ten-year programme aimed at:

- Improving health and care quality to enable people to live well

- Reducing local health inequalities and unnecessary variations in care
- Emphasise the importance of innovation to transform and modernise services to support the future of the NHS.

We have been proactive in collaborating together to develop this strategy and delivery plan across health and social care, and it has been driven with the focus of quality improvement. As a result, we are united in our ambition to deliver a range of transformational changes over the coming years, which will build on the exciting work we have already begun.

As we work towards delivering our aspirations, this plan will be a live document and will be subject to change based on need, our performance and our financial position. This is so we can be truly responsive to the needs of our population within our resources. Our plan has also been approved by all the STP partner organisations.

Our local area

Our population

We serve a large and diverse population. The Birmingham area has a population of c.1.3 million, making it the largest local council in the country, and Solihull has c.210,000 residents. Over 100 different languages are spoken in Birmingham and in some wards of the city up to 80% of residents are from Black, Asian and minority ethnic groups.

We are, at once, young and ageing. Birmingham is a growing city that has the youngest average age across the core cities of Europe, with almost half of the population under 30 years of age. Some 90% of the adult population owns a smartphone, which is the highest coverage in Europe. Conversely, Solihull has an older population, on average, with 21% aged over 65.

In common with other developed countries, the overall structure of society is changing as people live longer lives. In three decades, the number of people over 65-years-old is expected to increase by a third. The number over 85-years-old will double, as will the number living with cancer and dementia, and other diseases often associated with ageing. This will increase costs significantly because, on average, the health costs for someone over 65 is four times higher than for a working age adult. They are eight times higher for a person over 85.

Our partnership

The following map (Figure 1) shows our local health and care infrastructure. It includes all of Solihull Metropolitan Borough Council and much of Birmingham City Council. West Birmingham is included in the neighbouring Black Country and West Birmingham STP, who we work closely with. This is covered later in this section. Our partnership includes:

- 164 general practices, many of which are within one of four large GP organisations: Midlands Medical Partnership, SDS MyHealthcare, Our Health Partnership, and General Practice Solihull Healthcare
- Birmingham Community Healthcare NHS Foundation Trust
- Birmingham and Solihull Mental Health NHS Foundation Trust

- NHS Birmingham and Solihull Clinical Commissioning Group
- Birmingham Women and Children NHS Foundation Trust
- University Hospitals Birmingham NHS Foundation Trust
- The Royal Orthopaedic Hospital NHS Foundation Trust.

West Midlands Ambulance Service University NHS Foundation Trust is an associate member of our partnership. We also have close relationships with neighbouring areas, such as the Black Country, Staffordshire, and Coventry & Warwickshire, and in some cases provide services for each other's citizens.

Figure 1: Birmingham and Solihull local health and care infrastructure

West Birmingham

The part of west Birmingham which covers Ladywood and Perry Barr falls within the commissioning arrangements for NHS Sandwell and West Birmingham CCG.

As a result of the different boundaries, NHS Birmingham and Solihull CCG, NHS Sandwell and West Birmingham CCG and Birmingham City Council work closely together to ensure collaborative commissioning arrangements deliver city-wide services based on the best interests of people in west Birmingham and city-wide for the place of Birmingham. This is part of an ongoing partnership approach to develop the medium and long term health and wellbeing strategy for this area in partnership with the local Health and Wellbeing Board.

Collaborative working is strengthened further as both STPs are associate members of their respective neighbouring STP boards. NHS Sandwell & West Birmingham CCG is also a member of the Birmingham Better Care Fund and actively contributes to many of Birmingham's city-wide transformation programmes.

To ensure citizens in west Birmingham receive fair and equitable access to health and care, joint commissioning arrangements that involve NHS Sandwell and West Birmingham CCG are in place for a number of areas including:

- Maternity and children's services delivered through an integrated strategic commissioning plan for children's and young people's services across the city
- Birmingham Older People's Programme, which focuses on prevention, early intervention and ongoing personalised care supporting people to age well alongside end of life care
- Dementia services funded through the Better Care Fund to develop a Birmingham strategy which will deliver integrated services and support to dementia patients and their carers/families
- Mental health given these are commissioned for the whole of Birmingham by NHS Birmingham and Solihull CCG
- Learning disabilities focusing on earlier intervention and reducing the reliance on hospital-based and inpatient care and supporting the transformation of community services to build capacity and greater resilience.

As our two STPs develop their plans to evolve into Integrated Care Systems, we will be considering how local citizens can be better served through closer integration of our health and social care delivery, both for city-wide delivery and locality-based integrated delivery. Critical within this planning and way of working together is ensuring the design and delivery of local services fit with the wider systems redesign and that together we ensure the success of the new Midland Metropolitan Hospital in 2022 for local people.

The new Midland Metropolitan Hospital is strongly linked to the 'place-based' care agenda, which will include joint working to enable more preventative, primary and community-based care. This will be supported by greater personalisation and self-determination, particularly for children and families, babies and very young children, frail older people and those at the end of life. This aligns with the strategic and operational direction in both the Birmingham and Solihull STP Plan and the Black Country and West Birmingham STP Plan as part of the commitments to deliver the **NHS Long Term Plan**.

There will also be further opportunities to be realised over the coming years through the potential wider roll out of the Digital First approach across a larger area, which is a key strand of

transformation in Birmingham and Solihull. This is in addition to complementary approaches to health promotion which signal an overall Birmingham city-wide focus on smoking prevention, supported by additional place-based interventions to support people in west Birmingham to live healthier lifestyles through obesity management. Together these approaches will deliver better outcomes for people across the west Birmingham area.

Building blocks to success

When the STP was established in 2016 our priority was to stabilise performance, quality and outcomes in our health and care organisations. In reality, this involved organisations providing variable quality of care and, in some cases, expenditure on healthcare was far exceeding our income. We acknowledged that unless we could stabilise these organisations, we would not have firm foundations for our ambitious transformation plans.

We have addressed these challenges through successful mergers of Birmingham Women's and Children's hospitals, the three clinical commissioning groups (CCGs) into one commissioning organisation, and the merger by acquisition of Heart of England NHS Foundation Trust by University Hospitals Birmingham NHS Foundation Trust.

We have a very well-developed system with regard to offering general practice at scale, with a number of well-established large GP organisations. In addition, all practices across Birmingham and Solihull have a Universal Patient Offer. This provides a consistent range of additional services in each GP practice.

Birmingham Community Healthcare NHS Foundation Trust has begun to develop community services to care for people at home, including local integrated multi-disciplinary teams, a rapid response nursing service and, most recently, 'virtual beds' to provide extra support in the most pressurised winter period.

The Birmingham and Solihull United Maternity and Newborn Partnership was established in January 2017 to deliver an ambitious transformation programme. The programme has been clinically-led and co-produced with local women and the wider population. It has delivered a number of key achievements, including; the implementation of a Local Maternity System electronic patient record, the standardisation of care pathways and an agreed Local Maternity System-wide performance dashboard.

We have made significant progress in mental health. Reach Out offers a new model for secure care. The MERIT programme aligns partners providing urgent care. We have also transformed access to community services for perinatal mental health. We have the only mental health global digital exemplar in the UK. We are also making sure we look after the health and wellbeing of our employees by rolling out the Thrive programme (e.g. mental health first aid).

In Solihull, the health and local authority partnership, Solihull Together, is helping people to retain their independence through 'SupportUHome', which provides timely support for people leaving hospital. The partnership has achieved significant reductions in delayed transfers of care. In its efforts to sustain and improve services, Birmingham City Council has set out a new vision for adult social care and health, and the formation of a dedicated Birmingham Children's Trust to lead

services for some of our most vulnerable children. This is now rated as 'Requires Improvement' which is a major step forward after 12 years of being rated as "Inadequate".

In the first national ratings of STPs, Birmingham and Solihull was rated as 'Advanced', the second highest on a four-point scale. This progress has laid the foundations for this next stage of our transformational journey, which will lead us to becoming an Integrated Care System. This will enable us to continue to strengthen the way we work together to collectively plan and deliver services for local communities in a way that feels local, joined up and easy to navigate.

Our challenges and priorities

Whilst we have made great strides in delivering a series of improvements to quality, we need to do more as a system given:

- **Our ageing society:** People are living longer, which is a great success, but it means we need a system that helps many more people to live well and independently in later life, and to meet their varied care needs.
- **A shifting burden of disease:** The last century has seen a major shift from death and illness being caused mainly by infectious diseases to non-infectious diseases, such as cancer, heart disease, diabetes, dementia and mental illness. This reduces somewhat the fear of sudden, catastrophic illness, but increases many-fold the chances of people living more years with ongoing, complex and expensive care needs.
- **Technological advances:** Science and digital technologies are transforming every facet of modern life. We can introduce new treatments and innovations to improve clinical care and quality of life, but, whilst some may be cost-saving, the net effect is to add to the cost of care, especially in the most specialised services.

Drawing from our Joint Strategic Needs Assessment and other performance information, we also recognise that we have a number of other challenges:

Health inequalities

Both Birmingham and Solihull have stark inequalities in terms of health and wealth. In Birmingham, 440,000 people, or 46% of the population, live in the 10% of most deprived areas in England, which accounts for some very poor health outcomes. The city has a level of homelessness that is more than three times the national average; long-term unemployment is two-and-a-half times higher; one in three children live in poverty; and one in four people live with a mental health condition that started in childhood.

Solihull has sharp contrasts in wealth and deprivation across different areas, although on average is more affluent than England as a whole. In the most northerly part of the borough, around one in three children live in a household where the parents are not in work or are reliant on benefits. Whilst improving, there is also a relatively high rate of homelessness.

People born in the most affluent parts of Birmingham and Solihull will live, on average, nine years longer than those born in the most deprived wards.

Our health inequalities are in a number of areas:

- **Infant mortality:** Birmingham has one of the highest rates of deaths in infants under one-year-old in England. This equates to 7.7 deaths per 1,000 in Birmingham and 5.2 in Solihull, compared to 3.9 in other parts of England. The majority of infant deaths are due to immaturity-related conditions and congenital anomalies. However, there are some factors increasing the risk of infant death such as deprivation, smoking in pregnancy, poor maternal and infant nutrition, poor vaccination uptake and limited access to antenatal care. We are also working closely with system partners to explore and understand better the impacts from consanguinity learning from the research work that Sheffield University has undertaken in this field. We are working closely with system partners to strengthen our approach to pre-conception opportunities for intervention as well as improve maternity pathways of care. We are also working with Sheffield University to explore and understand better the impacts from consanguinity and opportunities to intervene at a population and patient level.
- **Childhood obesity:** Latest figures show that one in four Reception children in Birmingham are overweight or obese. In 2016/17, 24.7% of Birmingham's four-year-olds and 40.1% of 11-year-olds were overweight or clinically obese compared to 22.6% and 34.2% in England. In Solihull we know that 22% of Year 6 children in north Solihull are obese. We know the risk of obesity is greatest in our most deprived communities and more importantly, this gap has been widening over time.
- **Child poverty:** In addition, there is strong evidence linking poverty and socio-economic disadvantage with poor health outcomes. Multiple adverse experiences in childhood can result in significant adverse impacts in later stages of the life course. Research shows that groups of children who have had more of these adverse experiences will suffer from worse health and wellbeing.
- **Unhealthy lives**: In Birmingham the top three causes of early death are coronary heart disease, lung cancer and alcoholic liver disease. The risk of developing and dying from these conditions can be reduced by stopping smoking and living healthier lifestyles such as reducing alcohol intake and increasing physical activity. Less than two thirds of adults (aged 19+) meet the recommended levels of 150 minutes of physical activity per week.
- **Poor mental health in adults and young people:** One in ten mothers suffer mental health problems in the first years after giving birth and, as time progresses, this has an impact on both mothers and young people. We have seen referrals for our young people's mental health service increase by 45% between 2015/16 and 2018/19. There is also a high proportion of Employment Support Allowance claims for people with mental health conditions and only 6% of people on the Serious Mental Illness register are currently employed.
- **Cancer:** We have a higher proportion of people (45%) presenting with stage 3 and 4 cancer, which is affecting long term survival. We also have a low uptake for breast, bowel and cervical cancer screening and are seeing a strong relationship between cancer stage at diagnosis and deprivation, linked to the overall levels of poverty in our area.
- **Learning disabilities:** Despite our efforts, we have received poor or inadequate reviews for services for people with special education needs and disabilities which needs to change.

We have long waiting times for people to access assessments and packages of care for things like speech and language therapy. We also need to move away from a medicalised model of supporting people with learning disabilities and autism to provide high-quality community-based support.

- **Older people services:** Whilst we have made a number of improvements to support people to age well, we need further change to support people to reduce social isolation and loneliness, as well as improve support to carers given more than half of adult carers would like more social contact. We also need to improve access to service to provide more community-based approaches to reducing hospital admissions. This also includes providing enhanced healthcare support to residents in care homes.
- **Work and skills:** Despite a number of staff shortages, we need to tackle pockets of high unemployment across our area, which contributes to the overall prosperity of families and our communities.

Growth in demand for our services

In general, we are seeing greater illness as a result of non-infectious disease such as cancer, heart disease, diabetes, dementia and mental illness. This means people live more years with ongoing and complex care needs.

Like many other areas, our services have been built upon treating ill health in a reactive and crisis-response way rather than focusing on prevention and early intervention. We have seen challenges in the delivery of national targets in accident and emergency (A&E), cancer standards and referral to treatment times, including 18-week waiting times and the reduction in the overall waiting list.

A&E has continued to see an increasing volume of patients across Birmingham and Solihull, both people self-presenting and via ambulances, which is exceeding the physical A&E capacity. Challenges in recruiting staff have also contributed to the levels of performance and the time people are waiting, which is particularly the case in relation to cancer, which is contributing to the inability to meet performance standards.

As a result, we need to embrace transformational change to streamline the way we do things and integrate our services where possible. We have the opportunity to maximise the opportunities that digital interventions can offer our citizens and workforce. However, we are still using out-of-date systems where people have to tell their story more than once, which we know causes frustration.

Quality improvements

Our Joint Strategic Needs Assessment and performance indicates our focus for the Long Term Plan priorities, which are to:

- **Enable individuals and communities to be able to look after themselves** and understand the services available by providing them with the information, resources, skills and services to manage their own health and wellbeing as well as providing accessible information.

- **Transform how we deliver urgent care** to provide effective support when needed most and prevent unnecessary admissions and lengths of stay, supported by effective discharge planning and reablement services to help people return home safely.
- **Improve children's services** to support babies to be born well by supporting the most vulnerable mothers throughout and after their pregnancy through our Savings Babies Lives Bundle of care, supported by our Local Maternity System and improvements to prevention and early help for children and young people.
- **Invest in mental health services to keep people well**, focusing on early intervention to avoid crises wherever possible; support people to grow well and thrive at work; and support faster access to specialist services for vulnerable people.
- **Address waiting times and access to cancer treatment** to improve early detection of cancer and improve survival rates through improved screening; ongoing prevention support through services such as smoking cessation.
- **Improve the support to people with learning disabilities and autism** so that high-quality community-based care is delivered wherever possible.

Attracting and retaining staff

Our most important resource is, of course, our many thousands of staff. Their skills, expertise and commitment to public service are the lifeblood of high-quality health and care services. However, we have areas of workforce pressures, with vacancies which include over 1,100 nurses in our area. This is on top of shortages in diagnostic and therapeutic radiography, operating department practitioners, sonography and all healthcare professionals relating to mental health. In addition to this, we face challenges given we have an ageing workforce, as 17% of our workforce are aged 55 and over.

We need to tackle our challenges together as a whole partnership, working with national and regional organisations to create opportunities for new roles and skill mix changes, rotational opportunities and to support our workforce through educational and training reforms and wellbeing support. This will make Birmingham and Solihull a great place to live and work, support our staff to be healthy, happy and productive, and support the prosperity of our overall area.

Creating financial balance

We need to deliver services more efficiently to be able to release cash and invest in our priority services to rebalance investment and enable us to focus on prevention of ill health in the first place. This will support improvements in quality in some of our services. The efficiencies we need to address are to:

- Harness technology, such as virtual appointments
- Improve early intervention to prevent unnecessary hospital admissions and reduce unnecessary lengths of stay in hospitals, which includes transforming A&E
- Reduce unnecessary variation in services to target specific savings opportunities
- Improve clinical productivity and release more time for patient care

- Reduce empty space in our collective estate to support more community-based care
- Achieve procurement efficiencies by working together more effectively to buy services and products across our system, and not just individual organisations
- Reduce duplication and fragmentation.

Our approach

Our vision is to help everyone in Birmingham and Solihull live the healthiest and happiest lives possible.

As part of delivering our STP strategy and Long Term Plan commitments, we want to take a life course and person-centred approach. As a result, our approach is

Born well, grow well, live well, age well and die well

We know that people's social and economic circumstances substantially affect their health status and life chances, and that their course is often set very early in life, whether positively or negatively. We want babies to have the best start in life; to have a healthy and happy transition through childhood and adolescence; to live well through adulthood; to age well; and, when the time comes, to reach the end of their life in a manner that meets their wishes and preferences.

This is explained later in the plan where we look at how we will transform services in:

- Maternity, childhood and adolescence – a healthy start in life
- Adulthood and work – promoting health and wellbeing, and managing chronic disease
- Ageing and later life – ageing well and improving health and care services to older people creating a better experience at the end of life
- All age services.

For the changes to be effective in delivering our ambitions, we recognise the need to make material progress in how our system works. This plan therefore also defines a set of transformative enablers and how we will advance them over the next five years. These include:

- Supporting the development of general practice and the wider integration across communities
- Focusing on prevention
- Evolving from an STP into an Integrated Care System
- Developing person-centred care
- Transforming services using digital innovation
- Empowering our workforce
- Delivering best financial value
- Using our buildings to deliver change

- Research and innovation to drive future outcomes improvement
- Creating social impact.

Success will be measured against our five aspirations so that we are clear on the difference this will make to our citizens and workforce. Although our aspirations and ambitions in the STP strategy are wider than this plan alone, this delivery plan focuses on the Long Term Plan. This will connect with the wider STP Plan, which will be developed for April 2020.

As demand for our services grows, we will work continuously to provide high-quality, responsive care to local people within available resources. For the most specialised services, it will often be the case that they are best delivered at scale in order to concentrate specialist clinical skills and equipment. Less specialised clinical or care services, however, can be delivered more locally to people and communities.

We need to find the safest, most effective and compassionate ways to manage the health and care needs of our population within the available resources **to make high quality health and care sustainable now, and for future generations**. This will require action at national and local levels. We believe it is both essential and possible to do this whilst making things better for patients and citizens because higher quality care is more cost-effective than poor quality, inefficient care.

We seek a greater emphasis on the **promotion of health and wellbeing** to keep people active and productive for longer, with a particular focus on supporting the most disadvantaged in our communities; we want to continuously **improve the quality of care** that people experience; and we want to **maximise efficiency** in how we use public resources.

Listening to the views of our citizens

To listen to the views of local people, NHS England and NHS Improvement asked the national organisation, Healthwatch, to engage with local people to understand their priorities.

Healthwatch Birmingham and Healthwatch Solihull led this exercise for our area and asked over 694 people through questionnaires and surveys for their views on the wider **NHS Long Term Plan**. The 694 people who participated in this research also included a range of people from under-represented and seldom-heard groups such as the Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Plus community.

The key findings tell us that our citizens want:

- **To understand how health and care will improve communications** so that people are listened to, have the information they need to understand their condition as well as have the resources they need to manage their health and wellbeing. People have emphasised they want to be involved in decisions about their care and services available to them.
- **To be able to address individual and community skills gaps** in being able to look after themselves. This means our citizens want to be able and be empowered to have the skills and resources they need to look after their own health and wellbeing. This also means appraising the range of support available, understanding how they can be supported to reduce inequitable access and how local communities can be developed to address individual and community challenges.

- **Information that is easy for everyone to understand** – this is to reduce gaps in the Accessible Information Standard so that individual needs will be met to reduce inequality of access.
- **Understand the range of services available** with improvements to referral pathways, waiting lists/times and the distribution of services. This is to enable people to access support in a timely manner and avoid worsening health or crisis situation.
- **To be able to support individuals to self-care** when waiting times are unavoidable to prevent conditions getting worse and individuals entering crisis.
- **To understand how resources within communities** will be supported and developed, identifying and addressing gaps in Birmingham and Solihull. In practice, this means upskilling and resourcing peers and communities to support themselves.
- **To understand how we will reduce the stigma** of mental health, disabilities and other conditions to support people to live well and self-care.

A significant element going forward will be the dialogue we have together about change; so that we drive forward these improvements and identify how we can make this happen. By doing this, we will deliver on our collective aim of creating a more person-centred approach and a shared responsibility for health and wellbeing to support our citizens and the services we rely on today and in the future.

The full Healthwatch Birmingham and Healthwatch Solihull Report can be found in Appendix 2.

Transforming how we work

Understanding what makes us healthy

If we think about what makes us healthy and enjoy life, it is the things that enable us to live well, either directly or indirectly. It's about our own self-esteem or sense of purpose, our families and friends, and a feeling of belonging through our wider connections in our community, or through work, education or training. It's about how we look after ourselves, our social networks and the support we have around us when we need help and encouragement, no matter how young or old we are.

A new way of delivering services

Our aim is to transform services by working on the basis of 'right care, right place' rather than by 'institution'. It might sound obvious but this is not the way public services have traditionally been organised. Previously, each organisation has been funded separately and had its own priorities, which has created fragmentation for our citizens.

Going forward we need to understand how to reorganise our collective public and community services to better meet the needs of local people, in a much more co-ordinated way.

We aim to use 'Digital First' as an effective way to transform our services. We are technically-savvy and a 'Digital First' approach will give individuals and communities the essential tools they need to be able to care for themselves as well as provide faster access to care.

It will also support our local economy to have equal access to evolving digital technologies and enable a digital workforce for the future, supporting the digital literacy of our population. It will be driven by clinical engagement and public participation and together it will simplify the way citizens can access health and care in future. It will also provide faster access and support and tackle our long waiting lists for care as people will be encouraged to use the tools to prevent ill health. It will also help us address our workforce shortages and the efficiencies we need to make to support our sustainability.

In practice, this will mean:

- **Digital First primary care** providing access to GPs through virtual consultations, digital prescriptions
- **Digital First self-care and advice** with the aim of providing improved and rapid GP and primary care access, targeted assessments at the right time and place, which will in turn address primary care workforce pressures
- **Digital First early help and prevention** through advanced artificial intelligence and a symptom checker we will be able to identify early changes in risk factors so preventative steps and early help can be provided
- **Digital First urgent care** will give access to applications including an online symptom checker and remote video consultations when needed
- **Digital First apps and online resources** will enable positive decisions in knowing how to support yourself and also where to go

- **Digital First diagnosis, care and treatment** will connect you to the right support and access to the right professional. It will promote remote access in real time, with professional advice where appropriate
- **Digital First outpatient consultations** will deliver a substantial proportion of outpatient appointments remotely (currently c.2 million appointments across University Hospitals Birmingham NHS Foundation Trust, linking seamlessly with our electronic patient record. We are also exploring placing diagnostics, such as phlebotomy, in convenient community settings, which in turn would enable more patients to be monitored and seen virtually. It will reduce physical journeys having an impact on our environment and reduce travelling time to and from hospitals
- **Greater availability of digital consultation and clinical advice** as well as more out-of-hospital lifestyle support will provide effective assistance for people with continuing and lifelong conditions. We will use business change to explore and consolidate the number of apps and wearable devices across Birmingham and Solihull.

Whilst our approach embraces new technologies, we recognise our services are about people. It does not mean our citizens will not be able to see a GP or have a face-to-face dialogue with a health and care professional when they need to. It will mean health and care professionals can spend more time with our most vulnerable people. Any digital solutions are developed with clinical leadership and are patient-focused. They are designed to deliver greater value, increasing the quality of our services and better use of resources.

At the heart of our new way of working is the need to:

- **Create a shared responsibility for preventing ill health and improving health and wellbeing.** By focusing on keeping people healthy, and greater choice and control about the care they receive, we will enable people to manage their health and wellbeing by supporting them with information, resources and skills to manage their own conditions. This will also include support to access a wider range of services to complement health and care services, as well as to support them through their health and care journey. This may be as simple as directing them to a local volunteer-led walk or event in their local library. It also means delivering a personalised approach so that care is delivered based on what matters most to our citizens, rather than providing services convenient to organisations. We recognise that this evolution of the relationship between us and our patients is happening across the public sector and we will work closely with our local authority partners to support this as a system-wide rebalancing of relationships with individuals and communities.
- **Focus on early intervention.** By taking action earlier we will prevent and reduce serious illnesses. We can deliver this using risk stratification and population health management which will identify particular risk factors amongst communities and individuals in relation to their health and wellbeing. This will enable targeted support.
- **Provide care in the 'right place'.** This might be through integrated neighbourhood care where GPs will work in partnership with a wider multi-disciplinary team of social work teams, community health service providers, mental health services and the local voluntary and

community sector to deliver a fully integrated service offer. Equally, it might be through access to urgent treatment centres, so you only go to A&E when absolutely necessary.

- **Create a single care record**, a single care plan and consent information will prevent duplication and support choice and control when using health and care services.
- The Birmingham and Solihull care models were both created based on national and regional best practice evidence. The following diagrams were produced to help describe the two distinct places of Solihull and Birmingham. Whilst there are many similarities in these diagrams, they were each co-produced with partners to reflect both local need and local services which can differ.
- As mentioned earlier in this chapter, Birmingham and Solihull have very different demographics. Birmingham is a much younger city, has concentrated urban areas, with several large universities and an ethnically diverse population. Whereas Solihull has an older generation and some large geographical areas of rurality. These differences in demographics and also varying reasons for health inequalities require an appropriate model of care to cater for the needs of each group. In addition, Birmingham and Solihull are served by different local authorities and hospital trusts – this can be seen in different terminology and local campaigns between the two areas. These have been reflected in the models to ensure the right services are in place to meet local need, in a language common to the area. It is important that future planning considers population needs in each of these areas and considers the different infrastructure of community assets in each area.
- Whilst recognising the differences in geography and in populations, there are a number of important commonalities which underpin both models. They both aim to reflect the varying factors that make us healthy, rather than just services that respond to ill health, for example having meaningful employment and the role our families and friends have. Both models consider prevention of ill health, placing elements such as housing in the centre. The diagram also seeks to highlight the importance of intervening as early as possible and as locally as possible to stop problems escalating. The circles within the diagram outline the different geographical scales used for appropriate service delivery, services such as pharmacies supporting smaller populations right through to more specialist services which are delivered more centrally for the whole of the Birmingham and Solihull population. Both models have patient-centred care as their focus and deliver similar aspirations and goals, to ensure synergy between the two models and a seamless transfer of care between the two demographic areas where needed (Figure 2 and Figure 3).

The Birmingham Place

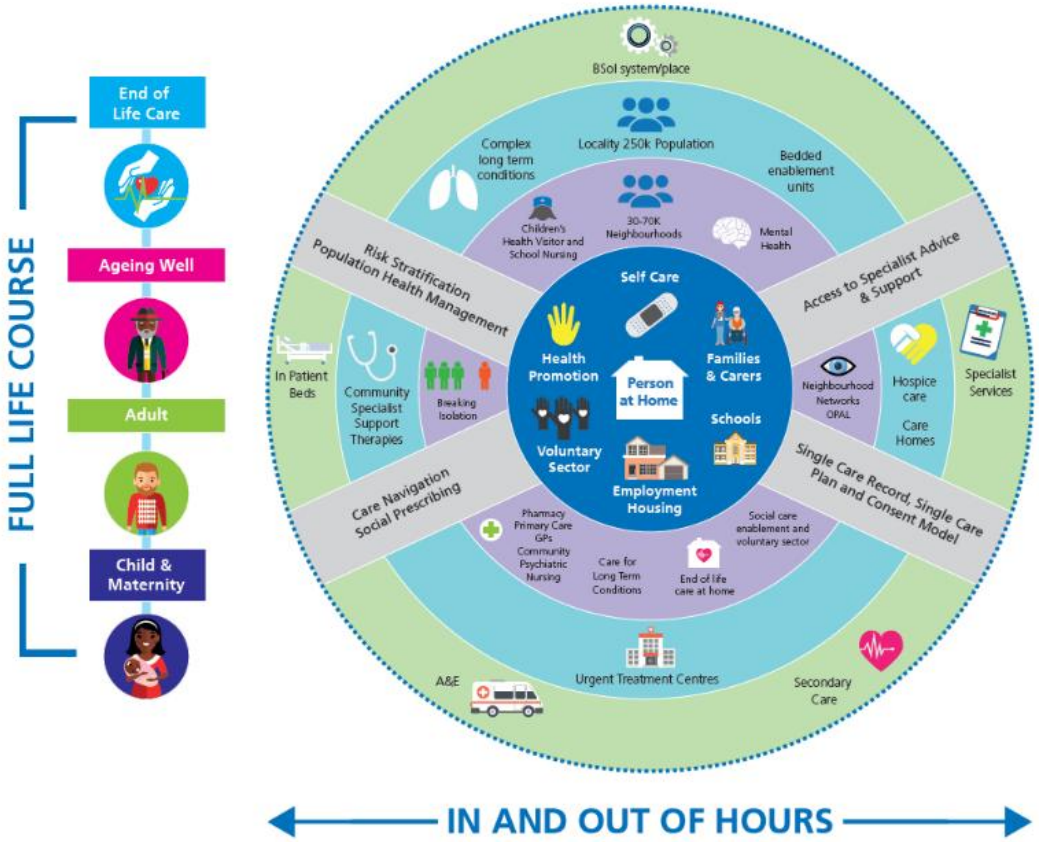

Figure 2: The Birmingham Place care model

The Solihull Place

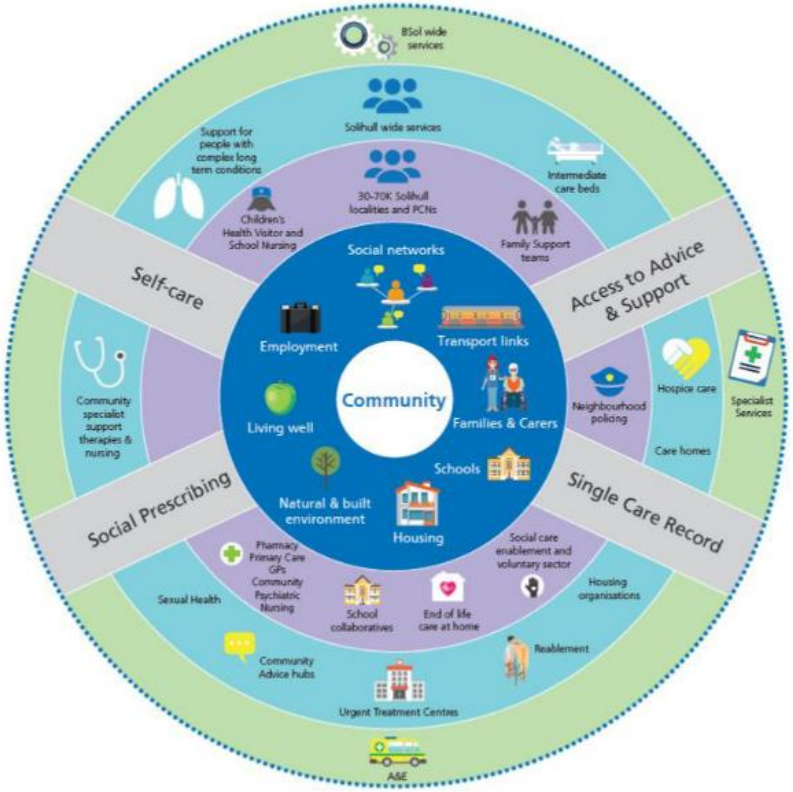

Figure 3: The Solihull Place care model

Primary care and Primary Care Networks

Providing 21st century high quality, accessible primary care, closer to people's homes through integrated primary and community services

We are committed to transforming primary care and we are already making significant and exciting progress in delivering this ambitious programme of transformation over the coming years. The key strands of this include:

- **A comprehensive practice** Universal Patient Offer – we have had 100% practice sign up to our primary care Universal Patient Offer Local Improvement Scheme in 2019/20. Working closely with our clinical leads, practices, GP provider organisations, the two local medical committees and other key stakeholders to ensure that citizens get the same high-quality additional primary care services wherever they live. Equally the offer has meant that for the first time in our area practices are able to deliver the same portfolio of work.
- **Primary care extended access** – the requirement for 100% coverage for primary care extended access was achieved again largely due to practices working together and the formation of hubs to share the workload. This has supported practices in working together, sharing data to support and improve services and access. We will look to continue to develop this through an improved response of urgent primary care and responding to the National Access Review.
- **Receiving the benefits of the GP Peer Support Team** – we have established and expanded the GP Peer Support Team. This team has worked to support not only resilience of primary care, but also to ensure quality improvement. Since the establishment and expansion of the team, we have seen 100% of our 164 practices achieve either "Outstanding" "Good" or "Needs Improvement", as rated by the Care Quality Commission. As a result of the peer support programme, there are no "Inadequate" practices and where improvements still need to be made, we are determined to deliver them. Our example of peer support has been highlighted as a **national exemplar** and we continue to receive positive feedback from practices benefitting from the support. The team is clinically-led; with professional leads from all areas of primary care supporting colleagues to be the very best.
- **Releasing Time for Care** – we have established a strong relationship with NHS England and NHS Improvement's Sustainable Improvement Team. The team has worked with us to deliver programmes to support the **General Practice Forward View** transformational schemes. This included the delivery of the Practice Quick Start Programme to a number of practice cohorts. We have now been successful in securing support for delivering a further work programme in 2019/20 with a focus on supporting practices as they transition into Primary Care Networks and collaborative working. We have a proposed delivery plan for two new cohorts of groups of practices to deliver the Productive General Practice: Collaborate programme.
- **Delivering the very best primary care service innovation for patients** – innovative work across groups of practices, together with integrated teams and social care, continues to deliver patient benefits. Pilot "place-based" schemes have included targeting frailty, diabetic

care, mental health, respiratory care, early detection of atrial fibrillation and end of life care. We continue to build on these examples looking to embed the learning from the pilots as permanent change to the way we deliver care.

Why do we want to change?

We are on an exciting journey to transform primary care but it is not without a number of challenges. Birmingham and Solihull faces severe GP and primary care team recruitment challenges as many of our GP partners and salaried GP vacancies remain unfilled, and an estimated 21% of our GPs are aged 55 years and above. There is also a trend of GPs retiring from the age of 55, which will increase further pressure on an already overstretched workforce. Our practice nurse workforce profile is equally challenging, with a third of nurses approaching retirement, while the number of nurses entering the primary care workforce is significantly less.

Against a backdrop of staff shortages, there is further pressure given that the demand on general practice continues to grow. This leads to an increasing gap between workforce demands and the GP practice workforce supply. These challenges present significant risks to the primary care and wider system.

Priorities for change

NHS England and NHS Improvement published the **General Practice Forward View** in May 2016, providing a road map to support the resilience and sustainability of general practice at a time of significant change. To date, we have worked with practices to successfully deliver the requirements of the **General Practice Forward View** whilst working to support the sustainability of general practice and maintaining high quality of care for our patients.

The **NHS Long Term Plan** includes specific objectives for primary care to further support sustainability and transformation of local GP services, primary care and community care closer to home. These objectives have formed the priorities of our primary care transformation programme and how these relate to the wider system ambitions of realising a fully integrated health and care system by 2023 based on:

- Investment and evolution
- Meeting the funding guarantees for primary care
- GP provider transformation
- Primary care development.

Investment and evolution

A five-year framework for GP contract reform to implement the **NHS Long Term Plan** included significant changes to the GP contract. This included, at its heart, the priority to establish Primary Care Networks, which is at the centre of integrated care system working.

In response to this, 32 Primary Care Networks (including six in west Birmingham) came into operation from July 2019 across Birmingham and Solihull with a mandate to deliver primary care transformation in their communities. These networks, working alongside the wider health and care system, will work to move care closer to people's homes by developing multi-disciplinary teams

and shaping accessible services that continue to improve health outcomes. Our Primary Care Strategy, developed in 2019 (see Appendix 14), sets out the vision for primary care, demonstrating how these ambitions will be achieved as we work to develop a fully Integrated Care System that ensures a seamless care pathway for patients. Although our Primary Care Networks vary in size, they adhere to the specification and criteria laid out in the national guidance and are working to the national entitlements under the 2019/20 network contracts.

Meeting the funding guarantees for primary care

We have constructed a financial plan for Primary Medical Care services, General Practice Information Technology and Primary Care Network support/development through to 2023/24.

Work is in progress to quantify the full impact of the workforce, estates and digital investments required to deliver the new models of care. This will also include any potential funding required to offset the cost of these where they cannot be contained within existing published allocations to 2023/24. Plans meet the funding requirements set out in the **NHS Long Term Plan**.

GP provider transformation

Collaboration and practices working at scale is not new to our area as we have some of the most celebrated GP provider organisations working across both Birmingham and Solihull, who share the benefits of their collaborative working models. The ‘at scale’ GP organisations have a seat at STP Board level and are active partners of the evolving Integrated Care System. They have established the Birmingham and Solihull GP Provider Transformation Group which forms part of the STP governance. The learning they are developing is not only being shared locally to improve practice resilience, but is also being shared nationally, demonstrating how the ambition of the **NHS Long Term Plan** can be delivered effectively with strong collaborative business models. These organisations are trailblazers in the areas of digital technology, workforce development and care redesign.

Our Primary Care Programme Board is responsible for ensuring Primary Care Networks are supported in their implementation, development and readiness for service delivery. Part of this means assessing where we are against the overall ambitions for delivery in the form of a Primary Care Network maturity matrix. The learning from this will used to construct a development programme for each Primary Care Network.

Primary care development

In consultation with our GP provider leaders and our Primary Care Network clinical directors, we have formed a Primary Care Network development plan focused on three components.

Figure 4: Primary Care Network development plan components

The development support provided to individual Primary Care Networks will be responsive to their relative level of maturity and will be framed to support the creation of successful Primary Care Networks which not only meet the requirements of the new Direct Enhanced Services network contract, but also enable the delivery of high-quality, relevant and responsive primary and community services at a neighbourhood level. Over the next five years we will implement and support our Primary Care Networks development.

In the first stage of the plan, newly-forming Primary Care Networks will be provided with support to develop their **infrastructure, leadership and capacity.** Support will be given to maximise compliance with the Direct Enhanced Services network contract, interpret and adopt national guidance and to use nationally-issued protocols and tools. Where additional development needs are identified, the STP will work with local primary care leaders and stakeholders to stimulate debate and develop solutions for the benefit of all. This work will be complemented by the development of meaningful and proportionate monitoring requirements that comply with national reporting without placing an undue burden on local Primary Care Networks.

In the second element of the plan, the focus will be on **delivering the extended model of primary care and a standardised set of specifications for care,** which will include standard national processes, metrics and expected quantified benefits for patients. The specifications will be developed with General Practitioners Committee England as part of annual contract negotiations and agreed as part of confirming each year's funding. Five of the seven specifications will start by April 2020: structured medication reviews; enhanced health in care homes; anticipatory care (with community services); personalised care; and supporting early cancer diagnosis. The other two will start by 2021: cardiovascular disease case finding; and locally-agreed action to tackle inequalities. Across Birmingham and Solihull considerable good practice exists in the delivery of an extended model of primary care and embedding the seven specifications.

A number of our practices have been at the forefront of service improvement and innovation. Through our development plan we will showcase this learning and seek to extend the reach of excellent practice to have a system wide impact.

We recognise the distribution of health inequalities is not equal across our area with local people living in some areas being more likely to experience poor health than others. A key component of

our strategy for developing Primary Care Networks will be the use of public health data and other intelligence to ensure that services delivered at a local level are appropriate to the needs of the local community. This will mean the distribution of services across Birmingham and Solihull may not be equal, but it will be fair, equitable and relevant to local needs and population outcomes for improvement. Transforming the way that we plan and deliver services via the creation of an agreed set of local needs led priorities will allow us to work more closely with people, understand the way they live, and bring teams and services together for them to create more local and personalised packages of care and support.

The third component of the Primary Care Network development plan will focus on **integration.** A core aim of the Primary Care Network is to provide a footprint which other community and social care services can connect with. As part of our development of primary care, we will build effective local delivery partnerships which bring together community providers for the benefit of local people. The work of these partnerships will be underpinned by an effective model for multi-disciplinary working, developed with reference to good practice. Our strategy for developing neighbourhood working acknowledges that integrated health and care is just one element of a network of support which enables people to live happy, healthy and successful lives within their local community. More detail around the development of Primary Care Networks to support the integration of services is highlighted in the later sections of the plan around prevention, personalisation, long term conditions and ageing well and later life.

Enabling support to Primary Care Networks – Primary Care Networks and neighbourhood working are a critical part of our infrastructure and a key building block of an effective integrated care system. Over the coming period we will work to increasingly align support to Primary Care Networks. These include the Primary Care Estates Strategy, which will seek to review the estate and ensure we work towards developing the infrastructure that can support at scale working and integrated teams working innovatively through shared space. In addition, part of the digital plan will be to ensure we develop shared records of patients alongside initially the improvement of the digital infrastructure to support future innovation.

How does this deliver the STP aspirations?

Independence and resilience

- ✓ Supports our citizens to retain their maximum independence via health promotion and effective service delivery
- ✓ Embeds strong referral protocols for those at imminent risk of a health crisis to ensure that support is provided within a two-hour timescale
- ✓ Enables regular dialogue with secondary and urgent care teams to embed our successful reablement model which will enable a person to come out of hospital and return home within two days.

Equity, equality and inclusion

- ✓ Reduces variation through the development and delivery of clear integrated care pathways, a review of performance in each area, which will support us to tackle unnecessary variation

- ✓ Supports people to access multi-disciplinary care more locally, which will support the delivery of the right care, the right place, at the right time and improve inclusion and equity
- ✓ Treats people equally wherever they live; this will improve support to residents in care homes so that each care home is linked to a local Primary Care Network so that everyone benefits from good practice
- ✓ Whilst delivery of our community services model is at a neighbourhood level, planning and development will happen at a scale which maximise efficiency and enables health inequalities to be tackled through effective targeting.

Integration and simplification

- ✓ Increases the use of assistive technology and an enhanced digital infrastructure to support an increase in the range of access points and the types of support, which enables effective information exchange thereby promoting Digital First
- ✓ Ensuring that the needs of local patients are well understood through information sharing and multi-disciplinary working at a Primary Care Network level, thereby allowing risk factors to be identified and programmes of anticipatory care put in place
- ✓ Develops a clear understanding of the collective workforce required to deliver the new integrated community services model. Enables partners to highlight and resolve capacity and skills gaps through effective workforce planning.

Promoting prosperity

- ✓ Supports people to be able to work for longer, improving economic growth, prosperity and wellbeing.

Social value

- ✓ Reduces the environmental impact of travel, through the use of digital solutions.

Delivering our commitments in practice

Primary care workforce

When considering our primary care needs, it is essential we review how the current and future primary care workforce is placed to deliver new ways of caring for people. To manage the current workforce need, a proactive Primary Care Workforce Plan has been developed which addresses both the challenges and opportunities, building on our workforce strengths and addressing the weaknesses through a robust programme of support. Over the next five years we will implement this system Primary Care Workforce Plan.

Our workforce programme addresses four key interdependent priorities: recruitment, retention, role substitution and return to work, and we have active targeted programme projects to deliver successful outcomes in these areas:

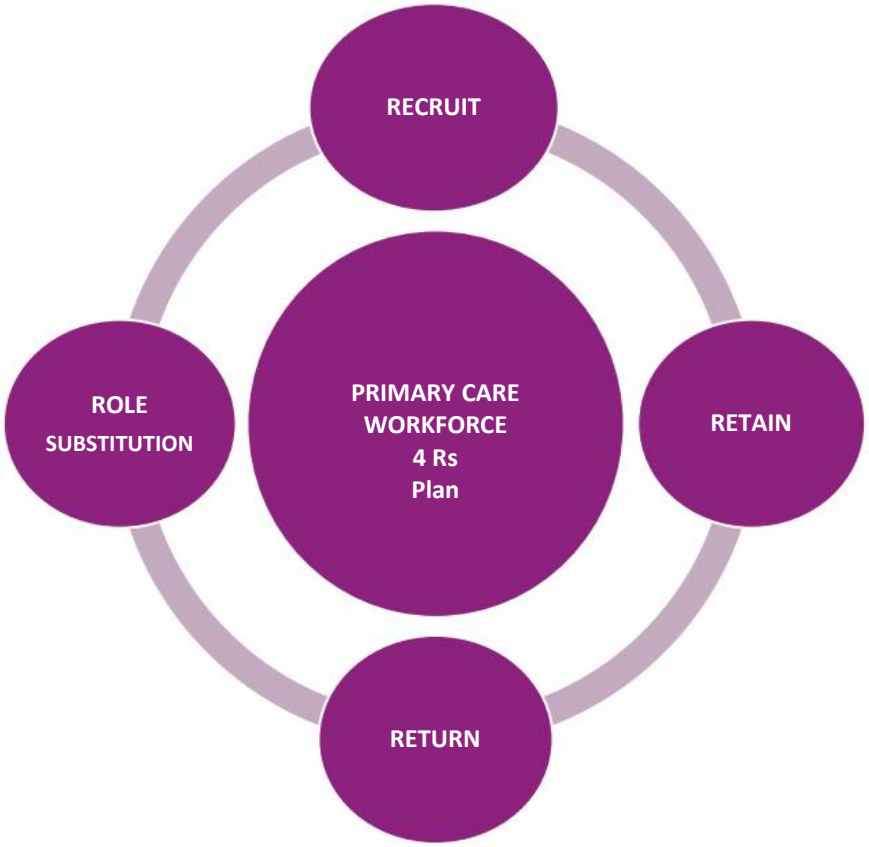

Figure 5: Primary Care workforce priorities

A snapshot summary of how we are responding positively to some of these challenges and actively mitigating the risks is described later. However, many more areas are covered in the formal workforce plan.

Workforce priority	Examples of STP work programme actions
Recruitment	• GP trainee recruitment with a focus on localities that are under-resourced – working with academic institutions locally to realise change • International GP recruitment programme with local hosting and mentoring of recruits already working well • Working with Health Education England and our local training hub to increase the number of learning placements across professional staff groups for both undergraduate and postgraduate medical and nursing students • Increasing the number and resilience of mentors, nurse facilitators and other educators • Upscaling and expanding the coverage of the West Midlands GP fundamentals course for practice nursing • Increasing the number of support workers by expanding the number of apprentices in primary care.
Retention	• The GP Peer Support Group is working with more than 60 practices currently to support resilience, improve workflow, support Care Quality

Workforce priority	Examples of STP work programme actions
	Commission inspections, work with individual clinicians and share best practice • Develop the role of clinical directors in Primary Care Networks • Focus continuing professional development investment to enhance clinical skills in pathways (e.g. dementia, end of life, mental health) • Introduce a dynamic programme of work supporting the GP "First 5s" to retain them at the beginning of their careers • Develop the primary and community multi-professional post registered workforce pathway in advanced clinical practice with a focus on nursing and clinical pharmacy • Upskill through apprenticeships – e.g. healthcare assistants working to become nursing associates.
Return	• Delivery of the GP Retention scheme and GP Retainer scheme and First 5 Network • Delivery of the ten-point action plan for general practice nursing • Support and promote preceptorship and Post-Certificate of Completion of Training Fellowships Schemes for nurses • Pilot and spread West Midlands Principles of Integrated Working supporting at scale multi-disciplinary working. • Supporting a return to salaried portfolio posts for retiring GPs.

Role Substitution	• Funding Through a new Additional Roles Reimbursement Scheme, Primary Care Networks will be guaranteed funding for an up to estimated 20,000+ additional staff by 2023/24 (our share equates to approx. 443 staff). These five reimbursable roles are clinical pharmacists, social prescribing link workers, physician associates, first contact physiotherapists and first contact community paramedics
	• Model role specifications will be published by March 2019 as a guide for networks. Networks will decide the job descriptions of their own staff, and in so doing they will want to bear in mind the new service requirements in the Network Contract Direct Enhanced Service. These staff are in addition to the additional nurses and GPs that will be funded through the real terms increases in the core GP contract
	• The scope of the scheme extends gradually. This reflects available supply and funding:
	  ○ In 2019 it starts with clinical pharmacists and social prescribing link workers only
	  ○ In 2020 physician associates and first contact physiotherapists are added

Workforce priority	Examples of STP work programme actions
	○ In 2021 it also includes first contact community paramedics. Only at this point do enough additional paramedics come out of training; and we want to avoid net transfer from the ambulance service • Increasing the number of link workers and care co-ordination roles to include the multi-disciplinary working liaison role • Targeting the expansion of clinical pharmacy roles across Primary Care Networks • Nursing associates – initiation of apprenticeships – applying the learning from the local training hub fast follower pilots • Working with academic institutions and local GP provider organisations to expand the number of physician associates in practices/Primary Care Networks • Programme for increasing the number of primary care based paramedics • Mental health therapists – ensuring appropriate links with the wider Integrated Care System – mental health personalisation programme • Assist with the development of the medical assistants role, building on national work aligned to new apprenticeship standards.

How will services be different in 2023/24?

By 2023/24 primary care services will be provided through integrated Primary Care Networks made up of multi-disciplinary teams of staff working alongside the GP.

They will be working together in the local community to ensure joined up care is provided seamlessly to the population they serve.

Focusing on prevention

Ensuring everyone has the opportunity for good health and wellbeing through a proactive approach to preventing illnesses and identifying symptoms early

There are strong relationships between the NHS and Public Health in Birmingham and Solihull and the STP has established a prevention board co-chaired by the two directors of public health. There are good relationships with the two health and wellbeing boards and the CCG is a substantive member of both boards. As a result of joint working, relationships continue to move from strength to strength.

Through the east Birmingham and north Solihull growth corridor we are working in partnership with the local councils and strategic partners to address, in the context of significant economic growth, how to protect and improve the health and wellbeing of citizens and patients and use the opportunity to transform the approach at pace in place.

Why do we want to change?

Demand for health and care services continues to grow. Our current way of providing healthcare focuses largely on the reactive curative treatment of those already in poor health, as opposed to focusing on the proactive prevention and early intervention of people getting ill in the first place. Moving to such a system therefore offers significant benefits. Not only will this improve population health and wellbeing, it will also reduce pressure on services to enable better support for those people who need it most.

In Birmingham and Solihull prevention is essential for tackling the difficulties currently faced. The main challenges are:

- Improving the number of years that people live in good physical and mental health (healthy life expectancy), **particularly in parts of our area where people experience a large number of years in poor health**
- Reducing premature mortality, including infant mortality and the number of preventable deaths from cardiovascular disease, respiratory disease and preventable cancers
- Child poverty and the impact on health outcomes.

The current situation is that there are demonstrable area-based differences in socio-economic and/or cultural group deprivation; disease incidence and prevalence with premature mortality; infant mortality; and age adjusted urgent/emergency care presentations.

There is local evidence concerning variations in the services provided as well as the uptake of evidence-based interventions to tobacco use, alcohol use and misuse, and weight management to patients and staff.

Priorities for change

We need a fundamental shift in the approach to prevention at scale to reduce the incidence of disease, premature mortality and the burden on health and care services for the future.

Our future way of providing services will see the STP playing its full role in preventing ill health as part of a wider system response to prevention, increasing healthy life expectancy and improving life expectancy of groups with particularly poor outcomes. This will particularly focus on modifiable risk factors, including smoking, obesity and alcohol.

We recognise the potential for action is there for all health and care professionals and in every health and care setting. By working in partnership in local communities and with citizens we can achieve sustainable, community-embedded opportunities for action for all ages and all communities to improve their own health and the health of their families.

We want to maximise the role of the NHS and other health and care providers in tackling the wider determinants of health including our role as major local employers (improving access to local jobs and skills), the impact on factors such as air quality and sustainability, and stimulating the local economy through its supply chains and local purchasing power. Our plans to maximise social impact described in more detail later in this plan but is a key part of our local prevention approach.

While the **NHS Long Term Plan** has a clear focus on stepping up the NHS's role around prevention, this needs to be done as a system across health, care and wider local government, connecting many of the primary prevention opportunities of local government's health and wellbeing responsibilities with secondary and tertiary prevention within the NHS. This also needs to harness the wider range of partners that can improve health and wellbeing including local businesses, the West Midlands Combined Authority, schools, colleges and the voluntary and community sector and to use the local leadership role of health and wellbeing boards.

The Birmingham and Solihull Prevention Board, co-chaired by the directors of Public Health from Birmingham City Council and Solihull Metropolitan Borough Council, has been established to provide system-wide leadership for prevention. This includes clinical leaders from primary care and secondary care, including clinical leads for our STP workstreams, locality leads for Birmingham and Solihull, CCG commissioners and Public Health England.

Our overall approach to prevention has been developed in collaboration with local health and wellbeing boards and aligns to Birmingham and Solihull's Health and Wellbeing Strategies and locality planning within both Birmingham and Solihull. Primary Care Networks have been engaged at local level and there has been specific engagement with other primary care contractors including community pharmacy on aspects of this plan.

Our local approach to providing prevention services

System leadership
Clear responsibility for delivering key elements in each organisation. Clinical champions to mainstream prevention across the NHS

Universal Primary Prevention

- Asset-based working to mobilise people to take control of their health and wellbeing in their own areas
- Building health into the built environment through planning, regeneration, skills, transport and active travel
- Action to improve air quality and sustainability
- Promoting parks, green and blue spaces for health and wellbeing
- Giving children the best start in life
- Promoting healthy ageing and reducing social isolation
- Focus on mental health and wellbeing
- Focus on employee health and wellbeing through the Thrive programme at scale.

Targeted Secondary Prevention

Advice	Digital
• Health and care professionals confident to give brief advice to help people to take steps to live healthy lives • Social prescribing support to help people into community activities.	• Digital platforms to promote community activities and assets • Endorsed apps and online tools • Digital campaigns in community and NHS settings.

Tertiary Prevention

Health checks	Smoking	Healthy Weight	Alcohol
• Early identification of risk-factors for stroke, diabetes, cardiovascular disease • Develop more targeted approach in line with national review.	• Smoke-free generation target • Smoking in pregnancy • Smoke free hospitals • Inpatient support • Community services • Tobacco control • E-Cig framework.	• Working upstream • Early years advice • National Child Measurement Programme • Food environment • Increase physical activity at all ages using 'some is good; more is better' approach • Scale up Diabetes Prevention Programme • Increase access to bariatric surgery	• Licensing • Easy access to community-based service • Hospital in-reach.

It's never too late: encouraging patients to make lifestyle changes at any point
Cardia rehab/exercise on prescription.

This is a long-term delivery plan which will need close collaboration across local councils, the NHS and more broadly to be delivered. It will need to be underpinned by:

- Evidence of what works, including what works locally. We will use national evidence into practice, including Public Health England's *What Good Looks Like* to assess the effectiveness of prevention systems locally and to address local gaps
- Local data to understand needs within and across different population groups and localities, underpinned by our developing approach to Population Heath Management, building on existing data capabilities (Joint Strategic Needs Assessments, health equity audit, evaluation and impact assessments) and ensuring that service providers collect and share data by local geographies and population characteristics
- Systems leadership for prevention through the Birmingham and Solihull Prevention Board and local health and wellbeing boards, **including strong clinical leadership to further embed prevention in core NHS services and organisations**
- Developing community capacity and capability through social prescribing, link workers and better networking of community assets and resource to support prevention, led by and working with local authorities and other key partners including the voluntary and community sector, community activists
- Work at regional level where activities – such as digital platforms or single service models – may be most effective.

How does this deliver the STP aspirations?

Independence and resilience

- ✓ Improves the number of years that people live in good physical and mental health
- ✓ Builds confidence and capability among health and care staff, with clear clinical leadership, to give practical self-care and prevention advice to patients and the public across the life course and in a culturally competent way that takes account of diversity and inclusion
- ✓ Develops our frontline health and care practitioners as change agents who can advocate for behaviour change confidently, supported by digital resources and promoting online and digital solutions locally.

Equity, equality and inclusion

- ✓ Reduces variation through the development and delivery of clear integrated approach to prevention. This will support us to tackle unnecessary variation but will target interventions to reflect the diversity of our local communities, recognising that needs may be very different in different parts of Birmingham and Solihull and in different communities of place, identity and interest
- ✓ Treats people equally wherever they live and whatever their identity, recognising that some communities and individuals required additional support and specific consideration to enable change
- ✓ Makes it easy for people to access more dedicated support where this is needed – smoking during pregnancy and in hospital, a more comprehensive approach to alcohol prevention and support to maintain a healthy weight.

Integration and simplification

- ✓ Develops place-based approaches to improving health and wellbeing and tackling inequalities
- ✓ Develops system-wide approaches to tackling smoking, physical activity, obesity and alcohol misuse whilst developing more robust primary and secondary interventions that span the NHS and existing local government services
- ✓ Provides advice and support – either face to face or through digital tools – which is mainstreamed across health, care and in local community settings.

Promoting prosperity

- ✓ Helps to provide the best start in life
- ✓ Allows people to be active for longer
- ✓ Supports people to be able to work for longer, improving economic growth, prosperity and wellbeing
- ✓ Assists people to stay in their homes for longer by increasing their independence, social interaction and reducing isolation.

Social value

- ✓ Recognises the important role of the NHS as an employer to enable prevention in the workplace, not just for those we directly employ but also through our commissioning and partnership relationships
- ✓ Creates healthier environments which enable people to lead healthier lives
- ✓ Spreads best practice in sustainable development, including improving air quality, plastics and carbon reduction.

Delivering our commitments in practice

Fully mobilising will require a major shift, embedding primary and secondary prevention across many areas of this plan, making prevention everyone's role (see, for example our approach to children's services, mental health etc.), changing our relationship with local communities and using the capacity of NHS organisations as local 'anchor organisations' to tackle wider factors that drive health and care outcomes including employment, skills and air quality.

Prevention is a theme that runs throughout the **NHS Long Term Plan** and our STP owing to the considerable opportunities it presents in tackling the underlying drivers of demand for the other services discussed. Prevention will therefore support specific proposals in our wider plan. For example, the specific focus on tackling modifiable risk factors aims to create a 'common preventative platform' which will tackle some of the underlying drivers of our major diseases, including cardiovascular disease, stroke and cancer. Smoking in pregnancy forms a key part of the maternity pathway, contributing towards wider plans to reduce infant mortality and reduce low birth weight. This is already part of the local Birmingham and Solihull United Maternity and Newborn Partnership programme. There are also specific planned care proposals to increase access to bariatric surgery that will be part of the overall obesity pathway.

We will take a balanced course between delivering the high priority areas for prevention, phasing in implementation based on our highest priority areas, readiness to change and resource availability.

Our approach will be to focus on high-impact, evidence-based areas where we know we can improve outcomes rapidly but which will require investment, changes in working practices, skills and service delivery as a system to achieve.

We will initially focus on one main priority, which is smoking. This will include developing plans for implementation of the national priorities around smoking in pregnancy and inpatient smoking support but we want to use this as an opportunity to learn how to successfully develop and implement system-wide approaches which can then be applied to other areas of our local prevention model. This will involve using peer review and audit to assess the impact of our current approach to tobacco control and smoking cessation locally. It will involve identifying how we can progressively redesign these services locally to build into inpatient services as part of a wider and cohesive system so we are ready to use national funding as cost effectively as possible once this resource is released (from 2020/21).

Our other major priority will be the implementation of a clinical champion-led model, spearheaded by our medical directors and directors of public health, to champion physical activity for everyone, using digital apps, simple messages and schemes such as parkrun on prescription to sell and promote active lives for all.

We aim to use a similar approach for the implementation of other **NHS Long Term Plan** priorities (obesity, immunisation and vaccination, and alcohol harm reduction) once there is clarity about the availability of national funding, recognising that both areas are already subject to significant redesign and redevelopment as part of 'business as usual'.

The implementation of these priority areas will be overseen by the Birmingham and Solihull Prevention Board. Activity and outcomes will be monitored using existing local performance mechanisms including health and wellbeing strategy indicators at local level.

We also want to do more to detect disease early through our screening programmes. This is a key component in improving outcomes for cancer (breast, bowel and cervical cancer screening) in particular. NHS England and NHS Improvement has the lead for delivery of these programmes through the national Section 7a agreement and we will support the development of plans to improve uptake of screening locally, reflecting the findings of the Professor Sir Mike Richards' independent review of national cancer screening programmes in England.

We also need to see improvements in immunisation and vaccination, and to develop a systems-wide response to improving uptake across all programmes, with a particular focus on reducing the decline in uptake of the second MMR vaccination, with the leadership of NHS England and NHS Improvement and with expert input from Public Health England.

Deliverables

- **Smoking:** Expansion of the smoking in pregnancy programme through Birmingham and Solihull United Maternity and Newborn Partnership so that at all women and their partners have access to specialist smoking advice in our maternity services. Development and

phased roll out of acute inpatient support across our hospital sites and full implementation of smoke-free sites.

- **Screening and immunisation:** Agree action plans for improvements in uptake of screening, immunisation and vaccination led by NHS England and NHS Improvement.
- **Obesity:** Continued uptake of the Diabetes Prevention Programme – covered in the diabetes chapter.
- **Enhanced weight management support:** To be provided for those with a Body Mass Index of 30+ with Type 2 diabetes or hypertension and enhanced Tier 3 services for people with more severe obesity and co morbidities (2020/21 & 2021/22).
- **Collaborate as 'anchor institutions'** in place: To play our part in improving the food environment and active travel landscape of place through our corporate behaviours as well as in our patient facing behaviours e.g. all NHS providers having active travel plans and healthy food procurement policies.
- **Alcohol:** Development and improvement of optimal alcohol care teams in hospitals with the highest rates of alcohol dependence related admissions (2020/21).
- **Air pollution:** To spread best practice in sustainable development, including improving air quality, plastics and carbon reduction. Both Birmingham and Solihull councils have ambitious plans to support climate change and are signed up through the West Midlands Combined Authority's climate change emergency declaration. We also have strong alliances with academic partners including WM Air, led by Birmingham University. This provides a strong backdrop for wider work to maximise the NHS's role in climate change, including active travel for staff, green fleets and greater use of digital to reduce on-site visits.
- **Antimicrobial resistance:** Implementation of the Government's national action plan 'Tackling Antimicrobial Resistance' to reduce overall antibiotic use, healthcare associated gram negative infections and drug resistant infections.

How will services be different in 2023/24?

- By 2023/24 services will integrate prevention into routine everyday interactions that enable citizens to protect their own health, maximise their outcomes and work with health and care professionals to achieve their potential and thrive. We will see a step change in the prevalence of smoking in pregnancy and closing the smoking inequality gap in the two places as a result of our transformation approach.
- By 2023/24 as a system the NHS will play its role as 'anchor institutions' in contributing to structural and system-wide approaches to create healthier environments for our staff and our patients so that we exemplify sustainable and healthy working environments and embody social value through our values. We would see this through a measurable reduction in our carbon footprint, all NHS providers accredited as living wage employers and all NHS providers achieving silver or gold levels of achievement in the West Midlands Thrive at Work scheme.

- By 2023/24 healthcare professionals will be confident and competent to make every contact count at every level and every pathway of the system to support prevention in a way that is culturally competent and reflects local need as well as individual need. We would see this reflected through a reduction in the inequalities for immunisation, screening and preventable mortality.

Developing person-centred services

Enabling and empowering people to have more control over their own health and wellbeing and more personalised care when they need it

Becoming a more person-centred health system will require radical changes, not just in *what* support we provide but crucially in *how* we provide it.

In Birmingham and Solihull, we are developing new approaches to providing support which better reflects people's lives and priorities, for example:

- **Online mental health services:** Some young people experiencing mental health issues have been able to receive their assessment through a secure online system that lets them, and their parents or carers, talk face-to-face with a therapist at a time that suits them. People who have used this system have told us they felt more relaxed talking to someone from the comfort of their own home than going to a traditional appointment.
- **End of life care:** John Taylor Hospice has been funded by the Better Care Fund to offer personal health budgets to people at the end of life. Staff have found that even small sums of money have made an unquantifiable difference in people's lives in terms of providing greater choice. Some have used funds to purchase help to keep the garden they tended for years looking beautiful, which has enabled them to feel relaxed and less worried. Others have bought equipment to use at home which has enabled them to spend more time with loved ones. People who have received a personal health budget have also spent less time in hospital and have been more likely to have died where they wanted to. The scheme has also helped families talk more openly about death and dying changing lives and providing comfort to families and friends as well as those at the end of their life.

Why do we want to change?

The two examples above have made a positive difference to people's lives in terms of choice and making key decisions about their care, based on what matters most to them.

In recent years the NHS has also introduced greater choice, whilst both health and social care have offered direct payments for people who require certain levels of care and support. We have begun to change the way that professionals communicate with people by working together to make decisions.

Despite this progress we are still a way off person-centred care being the norm. All too often services are provided at the convenience of organisations and not the people who use them. We know that people want greater control over their own health and wellbeing and the interventions available to them. We all want to use services when it is most convenient, allowing us to balance often challenging schedules and conflicting priorities.

Priorities for change

Being healthy and happy means different things to different people. Our age, gender, social background, life experience and beliefs all have a role to play in shaping the way we think about our minds and bodies. What may be important to us when we are young is likely to change by the time we enter our middle or older age. The way we support people to maintain good health and provide care and treatment when people need help should reflect this diversity of perspective.

Put simply, personalised care is about providing support in way we would expect to be treated in other parts of our lives. For example, being involved in decisions that affect us, planning with those closest to us, having choices, using services that are local to us, taking control of our own health and having control of resources.

For person-centred care to become the norm, we need to embed the elements and principles (see Figure 6) described in the universal model, which are:

1. Shared decision making
2. Personalised care and support planning
3. Enabling choice, including legal right to choice
4. Social prescribing and community-based support
5. Supported self-management
6. Personal health budgets and integrated personal budgets.

These principles will need to be rooted in every part of care from maternity and early years; right through to end of life; encompassing both mental and physical health; and recognising the role and voice of carers. Our work will need to recognise and build upon the vital contribution that communities, faith groups and the voluntary and community sector play in our health and wellbeing.

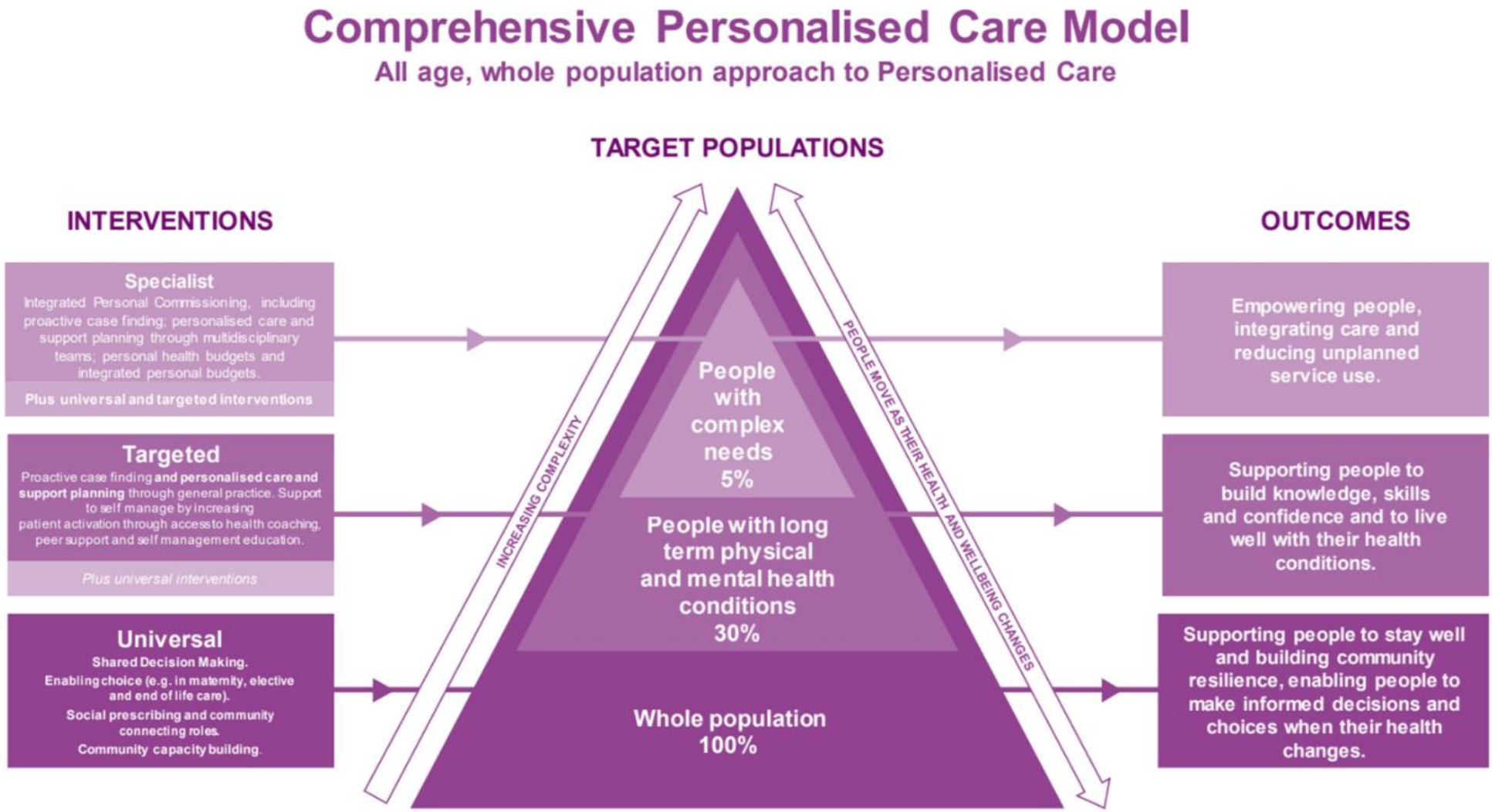

Figure 6: Comprehensive personalised care model

How will this deliver the STP aspirations?

There are huge benefits from a more person-centred system:

Independence and resilience

- ✓ Personalisation delivers improvements to patient outcomes and satisfaction when people are in control of their care and budget. In particular, it can help people with multiple physical and mental health conditions make decisions about managing their health, so they can live the life they want to live
- ✓ It promotes self-management and enables us to track the impact of this through patient activation measures. This is particularly useful for people with long term conditions or cancer as they are able to identify ways in which they can put themselves in the driving seat of their own health.

Equity, equality and inclusion

- ✓ Personalisation recognises that many people's needs arise from circumstances beyond the purely medical. Personalised care supports us connect to the care and support options available in our own communities.
- ✓ It promotes shared decision making and encourages true partnership between professionals and the people they serve
- ✓ It delivers better end of life care, based on people taking decisions about what matters most to them, supported through personal health budgets
- ✓ It drives consistency in costs for people using personal health budgets across continuing healthcare and learning disabilities including Section 117 by using common budget setting tools
- ✓ Online solutions like PHBChoices, make it easier for people to control their own care budget. It includes a payroll service to safely pay personal assistants and an online marketplace enabling people to choose the services that are right for them
- ✓ It puts people in control of telling their own story. We are trialling an online care and support plan for children in care reducing the number of times young people have to tell their story to new professionals involved in their care.
- ✓ Supporting people to access culturally competent services that support them to lives their own lives as they choose with the support their need.

Promoting prosperity

- ✓ When our care and support fits around our lives, rather than the other way around, we are better able to stay in employment, volunteer or attend school, college or university
- ✓ It delivers significant improvements in the use of resources contributing to local savings programmes. When people can direct their own care and resources, this can result in a reduction in NHS costs by helping health and care organisations be more efficient.

Social value

- ✓ It connects people to communities and creates opportunities for communities through health coaching, social prescribing activities
- ✓ It recognises the support and the wider determinants of people's health and wellbeing.

Delivering our commitments in practice

We will achieve a more person-centred system by effectively implementing all aspects of the universal model in ways that are meaningful to people, carers and our staff. We recognise this change will be challenging for both staff and people using services. We will work with our frontline teams to develop these approaches to give people more control over their own health and personalised care. This is central to the transformation of health and care for Birmingham and Solihull. The detailed breakdown of trajectories for each area for each year of this plan can be viewed in Appendix 3.

The section below sets out our ambitions in relation to the key areas of personalisation. We will influence change in the following ways:

Commissioning and contracting

- Reflecting personalised care in contracts/specifications and monitoring against this
- Working with providers to ensure people are supported to recognise and develop their own individual assets enabling them to better self-manage their health
- Working with partners to ensure that contracts and service specifications reflect the requirement to offer and expand personal health budgets for those who would benefit. We'll support this through robust financial systems.
- We will consider use of incentive schemes to increase the opportunity for personalised care.

Workforce development

- Increasing the number of people working in 'new roles' including personal health budget brokerage, health coaching, social prescribing and peer support
- Improving the training and supervision of new staff groups embedding them as valued members of the workforce
- Developing workforce training requirements to ensure all those who would benefit from a personalised care and support plan will be facilitated by a skilled workforce.

Partnership

- Working closely with our diverse voluntary and community sector to develop social prescribing options, linked to the wider community assets and resources across Birmingham and Solihull
- Working across health, social care, education and other public services to join together person-centred plans and budgets around an individual's and family's holistic needs.

Digital

- Developing local data systems and embed contract monitoring for measuring successful input of personalised care
- Testing and implementing digital solutions such as online marketplaces, citizen-held support plans and online assessment and treatment platforms.

Shared decision making

This ensures people are supported to:

- Understand the care, treatment and support options available and the risks, benefits and consequences of those options
- Make a decision about a preferred course of action on evidence-based, good quality information and their personal preferences. The process supports people to understand the diagnosis they have and the options they face (including doing nothing). Primary Care Networks will be a key delivery mechanism for this expansion.

Over the course of the Long Term Plan we will make shared decision making the norm across 30 of the highest-value clinical situations.

Working with our Right Care partners, we will identify the areas in which shared decision making has most impact. We will train staff in techniques like health coaching giving them new skills to work in a different way with people they support. Alongside this we will talk to patients and the public so people know what working in this way will mean for them.

Personal health budgets

A personal health budget is an amount of money to support the identified health and wellbeing needs of an individual, which is planned and agreed between the individual, or their representative, and the health and care team/local clinical commissioning group. It isn't new money, but a different way of spending health and care funding to meet the needs of an individual.

By March 2024 as many as 6,000 people will have a personal health budget for their care. We will have a robust infrastructure to ensure that funds are used for their intended purpose and online marketplace making it easy for people to choose the support they want. Personal health budgets will continue to be rolled out for wheelchair users, people with complex and ongoing care needs, learning disabilities and severe mental illness. We will continue to develop innovative approaches to using personal health budgets for people at the end of life and children in care.

Personalised care and support planning

Personalised care and support planning means people having proactive, person-centred conversations with professionals which focus on what matters to them, paying attention to their clinical needs as well as their wider health and social needs. Integrating health and care at the point of assessment and planning means the person will not have to repeatedly share their story time and time again. This will result in one assessment and planning experience, and a single integrated personalised care and support plan.

Personalised care and support planning is at the heart of personal health budgets or education, health and care plans for children and young people. The plan will be the start point for any personal or integrated budget.

More widely personalised care and support planning can be beneficial to anyone with ongoing care needs or long term conditions. A personalised care and support plan process should be considered for any cohort with a long term condition or which has complexity of care. It is

recommended that as any of these services are reviewed or redesigned, a personalised care and support plan process is embedded as standard.

Year-on-year the number of people with a personalised care and support plan will grow, with over 26,000 people having one by March 2023. We will achieve this by making the use of these plans standard practice for people with complex long term conditions and by training staff to confidently develop plans with individuals and their family and carers.

For example:

- Continuing our work with our maternity services so that by March 2021 all women have a personalised care plan
- Training staff within care homes across Birmingham and Solihull to undertake care and support planning
- Training staff within primary care to undertake care and support planning with patients with long term conditions, and then using the patient activation measure develop a baseline understanding of patient's ability to self-manage. Finally, to train practice nurses in health coaching to enable them to support people to achieve improved patient outcomes, and working with primary care leads to deliver this.

Enabling choice

The comprehensive model for personalised care will ensure patients will continue to have choice at point of referral and an option to change provider if waiting beyond specified waiting times (at present 18 weeks for routine appointments and two weeks for suspected cancer appointments). The money will follow the patient with their choice of provider to fund their care.

By 2024 choice will be available for all elective referrals via the electronic referrals system.

Social prescribing and community-based support

Social prescribing is a way of allowing GPs, nurses and other primary care professionals to refer people to a range of non-clinical services. This could include social, cultural, creative or other activities often available in the local community. The approach is driven by the recognition that people's health is determined primarily by a range of social, economic and environmental factors. Social prescribing seeks to address people's needs in a holistic way and aims to support individuals to take greater control of their own health.

Social prescribing works for a wide range of people, including people:

- With one or more long term condition
- Who need support with their mental health
- Who are lonely or isolated
- Who have complex social needs which affect their wellbeing.

Birmingham and Solihull contain areas of significant social need, including some of the country's most deprived wards. It is estimated that currently up to a quarter of all GP appointments relate to

non-medical problems and reflect the impact of the wider determinants of health such as unemployment, poverty, homelessness and domestic violence.

Additionally, many of the health problems experienced by our communities can be prevented or managed through the adoption of healthier lifestyles or through support from family, friends and the local community.

Birmingham and Solihull both have well-developed and vibrant voluntary and community sectors, however, the connections to health and care services are under-developed. Social prescribing represents a real opportunity for us to manage the demand for formal services and enable people to live independently, supported by communities of their choice.

Work is currently underway with both Birmingham City Council and Solihull Metropolitan Borough Council to develop a shared approach to tackling the wider determinants of health through social prescribing and asset-based community development in a way which is responsive to the needs of residents in Birmingham and Solihull respectively.

Over the next 12 months all Primary Care Networks will have employed a link worker able to support social prescribing in the local area. Mental health community development workers will work alongside to map and develop community assets – particular for smaller, sometimes excluded communities.

By 2024 we aim to be issuing over 24,000 social prescriptions a year. However, we recognise the impact is limited by the reality of austerity in the voluntary and community sector and the local authority infrastructures that are needed to support these social prescriptions delivering positive outcomes for patients.

Supported self-management

Supported self-management is the approach to supporting people to have choice and control over the way their care is planned and delivered, based on what matters to them and their individual strengths, needs and preferences. Supported self-management is underpinned by:

- **Health coaching:** Helping people gain the knowledge, skills, tools and confidence to become active participants in their care so that they can reach their self-identified health goals
- **Self-management education and learning:** Formal or informal learning, education or training for people with long-term conditions focused on helping them to develop the knowledge, skills and confidence they need to manage their own health and care effectively
- **Peer support:** A range of approaches through which people with similar long term conditions or health experiences support each other to better understand the conditions and aid recovery or self-management. Peer support may be formal or informal: it can be delivered by trained peer support staff and volunteers, or through more informal, ad hoc support among peers with lived experience.

Patient activation measures

Patient activation describes the knowledge, skills and confidence a person has in managing their own health and care. Evidence shows that when people are supported to become more actively involved in their health, they benefit from better outcomes, improved experiences of care and fewer unplanned trips to hospital. Patient activation is of particular importance to people living with long term conditions who rely, more than most, on NHS services.

We will support staff working with people with long term conditions, including primary care nurses, health coaches, link workers and others to use these tools.

By 2024 over 22,000 people will benefit from understanding not only changes in their health but also seeing the changing made in their behaviours and choices.

Co-production

This recognises and understands how people can contribute to care and support at all levels. It increases the scope for people to profoundly influence and shape the support they receive as an individual and as a community. It also enables strong working relationships built on direct, regular contact with senior managers and proximity to decision-making. To increase levels of co-production we will:

- **Train up to 500 people with lived experience to become system leaders by 2023/24**, that reflect the diversity of the local population, working with the NHS England and NHS Improvement Peer Leadership Academy to identify and support local peer leaders to attend
- Empower people with lived experience to access personalised care by providing good quality information
- Explore supporting people with a legal right to a personal health budget to have access to advocacy
- Develop links with the People for Public Services Forum and the Birmingham and Solihull Patient Participation Group Forum to ensure access to the views and expertise of service users
- Explore the creation of a strategic co-production group as part of the governance of personalised care; monitoring progress across workstreams and setting future priorities.

How will services be different in 2023/24?

By 2023/24:

- Services will provide more information to people and communities to help them stay healthy
- Professionals will be able to prescribe social activities and opportunities that contribute to people's health and wellbeing as part of their care and treatment
- Shared decision making will become the norm across many areas of care and support

- Care and support planning will be person-centred, reflecting a person's holistic needs not just their health condition
- Many more people will have control of the budget for their care through a personal health budget
- Service design and delivery will be informed by the experience of people who live with a range of health conditions.

Transforming services using digital innovation

Providing faster access to convenient care through a Digital First approach, which connects people and staff

Why do we want to change?

Navigating through the NHS is complex. We want to provide a single digital front door for patients no matter what care they need using the NHS login, providing advice and guidance through a symptom checker to navigate to the services patients need. This will provide the opportunity to direct patients to the relevant professional at the right time for the right reason, as well as providing care professionals with real time data. It will enable patients to have access to their record and support for self-care, with greater choice such as the ability to book appointments directly.

The rate of technological change over the last quarter of a century has been extraordinary and it will only accelerate. The world is changing profoundly and rapidly in the digital era. Few of us could have even imagined the internet 30 years ago or smartphones 15 years ago. But now many of us take them for granted and rely on them for much of our daily lives.

Digital technologies have already revolutionised the ways in which we learn, work, bank, shop and socialise. You can buy and sell a house online, with perhaps only one visit in person. You can obtain a university degree without ever touching a book or sitting in a lecture theatre. You can meet a future partner, having matched compatibility against hundreds of preferences. You can buy a product from almost anywhere in the world and have it delivered to your door within days. In the near future, you may no longer need to handle cash, drive a car or commute to work.

The demand is certainly out there; as is the opportunity as 7% of all Google searches are health-related. There is plenty of evidence that people want to access some aspects of health and care online. But still it is unusual for a person to be able to seek interactive advice or treatment from an NHS clinician without visiting them in person. This has to change if we are to meet citizen's needs, and if the NHS and social care are to stay relevant and pioneering in the digital era.

As an STP, we are continually striving to improve our digital maturity. We have already carried out a digital maturity assessment which provides a benchmark for where we currently are and what the "gap" is in terms of achieving greater maturity (digital capability). In 2018, NHS England and NHS Improvement Midlands region commissioned work undertaken by Arden & GEM Commissioning Support Unit to understand and discuss building a digital agenda. It looked at gaps for the three themes of leadership, strategy and architecture for the STP. The remaining challenge relates to architecture regarding resource for an economy-wide shared record suitable for integration with neighbouring economies and work to expand the existing integrated care records across the STP.

Across the STP there are differing levels of digital maturity. In 2018 readiness reports were prepared for each organisation within the STP for the continuity of care maturity model by Healthcare Information and Management Systems Society (HIMSS) Analytics. HIMSS Analytics

created the continuity of care maturity model to guide healthcare organisations implementing seamlessly co-ordinated patient care across a continuum of care sites and providers. All key stakeholders within the STP achieve Level 1 but the accomplishment towards Level 7 is extremely varied.

The digital ambitions detailed in this plan contribute to improving the digital maturity across the STP. The development of the Birmingham and Solihull STP Digital Enablement Group brings together leaders in the digital field whose role is to integrate digital solutions seamlessly with transformation of clinical and business practices. This includes significant capability in project and business planning and change management and delivery.

There are three Global Digital Exemplars across the STP including University Hospitals Birmingham NHS Foundation Trust, West Midlands Ambulance Service University NHS Foundation Trust and Birmingham and Solihull Mental Health NHS Foundation Trust and primary care within Birmingham and Solihull has been paperless since 2001. Digital success has been reported in numerous journals including several blueprints published by the Global Digital Exemplars and awards have been won, including:

- The Birmingham and Solihull Mental Health NHS Foundation Trust Electronic Health Record Viewer winning the Mental Health Innovation Award at the Meridian Celebration of Innovation Awards
- University Hospitals Birmingham NHS Foundation Trust won two categories at the eHealth Insider Awards for the Prescribing, Information and Communications Systems and for the Patient Portal myhealth@QEHB
- The West Midlands Regional Image Sharing Platform (RISP) developed by University Hospitals Birmingham NHS Foundation Trust won a West Midlands Academic Health Science Network Innovation Award
- Birmingham City Council won a Government Technology Award
- In addition, The Royal Orthopaedic Hospital NHS Foundation Trust and West Midlands Ambulance Service University NHS Foundation Trust have been nominated as finalists in the HSJ Awards 2019.

There is already a framework in place for a Local Health and Care Record. This includes Your Care Connected which allows access to GP records with a patient population of 1.8 million and a mental health information exchange (MERIT). There are also a range of apps providing patients with access to their data including primary care (Birmingham & Solihull Health APP), the MyHealth patient portal at University Hospitals Birmingham NHS Foundation Trust and the BadgerNet maternity record.

This arguably unique combination of clinical and digital leadership has a proven track record of delivering usable systems focused on standardising processes and improving process and outcomes of patient care. Working together as digital pioneers our expectation of the Birmingham and Solihull STP Digital Enablement Group is to improve the process of care and use of information to better inform decision making.

This chapter describes what will be the foundations for the digital tools, solutions, apps, technology, possibilities and workforce for the future that will support the **NHS Long Term Plan** ambitions. The current digital organisational programmes of work across the STP will be aligned and also align directly with the Long Term Plan ambitions.

Priorities for change

The Digital First programme aligns with existing workstreams embedded within partner organisations and is synergistic with the **NHS Long Term Plan**. The Digital First plan will allow health and care organisations, patients, carers and the wider economy to access the benefits afforded by a digitally-mature health ecosystem. The digital programmes underpinning the key priorities will be managed using a suitably tailored version of the PRINCE2 project methodology through an STP-wide digital group, and each of its priority workstreams can be represented by a perpetual lifecycle (see Figure 7).

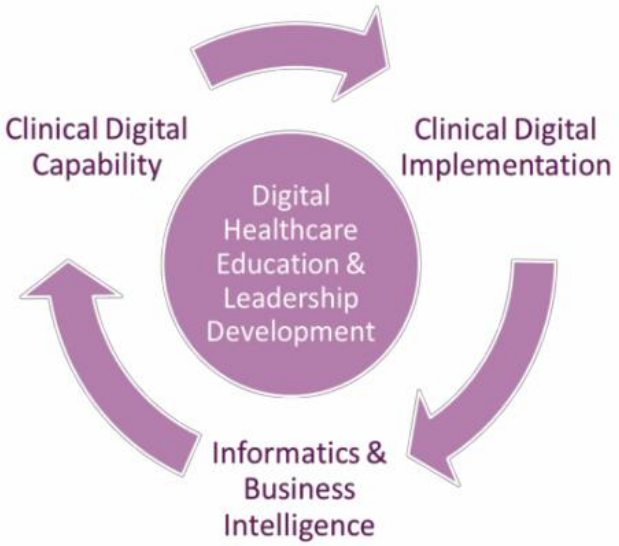

Figure 7: Digital priority workstreams

A Digital First future for health and care is the way we want to deliver services in future. It will benefit our citizens by improving access to health and care. It will also support our local economy to have equal access to evolving digital technologies and enable a digital workforce for the future, supporting the digital literacy of our population. It will be driven by clinical engagement and public participation and together it will simplify the way our citizens access health and care in future.

Our digital **aspirations** by 2024 are to provide a single digital 'front door'. This means **people will access advice and care very differently.** There is a dramatic and expanding mismatch between people's thirst for information and advice about their health and the professional supply of such advice. There are a million health related Google searches each day in the UK, while the average waiting time for a GP appointment is over two weeks. This will be achieved through:

- Digital First apps and online resources to enable positive decisions in knowing how to support yourself and also where to go. This will give individuals and communities access to face to face and digital education and self-management support tools. This will support Digital First self-care and advice.
- Digital First early help and prevention will use advanced artificial intelligence and a symptom checker to help us identify early changes in risk factors so preventative steps and early help can be provided. It will also support the use of patient activation measures or associated patient measures. 100% of patients who are able to do so will be able to access a Digital First primary care offer where this is applicable to their health and care journey.

This will provide improved and rapid GP and primary care access, targeted assessments at the right time and place, which will in turn address primary care workforce pressures. This will include access to online/telephone consultations in GP surgeries, hospitals and mental health and care.

- Digital First urgent care will give access to applications including an online symptom checker to navigate to the right health and care professional at the right time for the right reason including remote video consultations when needed
- Digital First diagnosis, care and treatment will connect you to the right support and access to the right professional. It will promote remote access in real time, with professional advice where appropriate.
- Digital First outpatient consultations will deliver a substantial proportion of outpatient appointments remotely (currently c.2 million appointments across University Hospitals Birmingham NHS Foundation Trust), linking seamlessly with our electronic patient record. This will reduce face to face outpatient appointments by 33% when rolled out
- Digital prescriptions so patients can request prescriptions electronically
- Enhanced online diagnostic interpretation through access to electronic decision trees that support health and care professionals to diagnose conditions and identify the most appropriate treatment for them
- Support integration of digital services and improvements to quality in services by providing enhanced healthcare in care homes, delivering shared care record platforms allowing organisations to share data for direct care for clinical need and to allow for analytics to focus where resources need to be directed to ensure patients are receiving the care where they need. Ensuring General Data Protection Rules (GDPR) are adhered to ensuring data is safe, secure and in line with national policy.

There will be fewer, more specialised healthcare buildings. There will always be an essential role for NHS hospitals to provide acute and specialised healthcare. However, much of what they currently do, in terms of outpatients, unscheduled ambulatory care and some diagnostics, does not need to be located in an acute hospital. That model is much more for the convenience of the 'producer' rather than the 'consumer'. In other words, it has been most convenient and economical for health and care professionals to be grouped together in large buildings and for patients to come to them.

- We are exploring placing diagnostics, such as phlebotomy, in convenient community settings, which in turn would enable more people to be monitored and seen virtually. It will reduce physical journeys having a positive impact on our environment and reduce travelling time to and from hospitals
- In addition, the development of an agile workforce will support more flexible working supporting professionals with families and work-life balance allowing more working from home supporting the need for less estate.

There will be an adaptable, technology savvy workforce for the future. Even in a digitally transformed system of the future, we should never underestimate the vital importance of having

enough professionally qualified workers. There are many aspects of health and personal care that will always remain profoundly human. However, we can predict that many more tasks in future will be automated, from routine tasks such as scheduling and booking appointments, to complex ones such as interpreting medical images, making diagnoses and performing some surgical procedures. Much as human pilots oversee autopilots on aeroplanes, clinicians will help to programme and oversee some of the clinical tasks performed by machines.

There will be a continued and increased globalisation of healthcare and potential for research and enterprise. If more and more services are provided online, they can be hosted anywhere and people will seek out the best and most accessible offerings. To stay relevant and at the forefront, the NHS must embrace and lead this change, which can be a terrific asset for the UK economy, a generator of intellectual property and highly skilled employment and can support the long term sustainability of our domestic health and care services.

There will be an understanding and mitigation of new risks. Alongside the exciting possibilities to use technology to fundamentally transform health and care, there will be new risks that we need to consider and mitigate. As we become more dependent on the digital economy, we need to guard a broader front against cyber-attacks and data theft. There are complex ethical debates ahead about the role of artificial intelligence in health and care. As we are able to know ever more about people's health status, there will be further debate about the balance between individual privacy and responsibility and the provision of public resources.

There are a range of benefits that this will bring to patients, citizens and our staff. It will:

- **Support people with faster access to care:** Fundamentally, citizens will be able to access much more effective self-care and education tools to support them to stay well and also manage conditions. This was a key priority identified from the Healthwatch report. People will also be able to access faster care through online consultations, reducing travel time. For those people needing to see a health and care practitioner in person, it will still facilitate that but will help health and care to prioritise those people who are most vulnerable and unwell.
- **Enable health and care professionals:** Transforming digital services will also make Birmingham and Solihull a more satisfying place to work for our staff. Providing staff with the technology, tools and systems they need, whilst allowing them to capture and view the information they need, will reduce the administrative burden and increase the amount of time they can spend with people. A crucial part of this will be supporting the workforce to develop the digital skills that they need. Digital transformation will also enable professionals to better identify and understand individual risk factors and enable a more personalised approach to reducing these. In addition, the development of an agile workforce can support a profession that can work 24/7 in an efficient and effective manner.
- **Enhance clinical care:** The use of technology will change the way that patients, carers and clinicians interact. The increased access to services through digital mediums that have already been discussed will enhance the experience of interactions and enable care to be designed and delivered to suit their needs. Technology will support the NHS to redesign clinical pathways and allow patients to be managed digitally through the use of digital clinics

and consultations, replacing traditional face-to-face follow-up appointments, where appropriate.

- **Improve population health:** Digital innovation is also critical for population health improvement. Population health management describes how we can use data insights to improve health and wellbeing of whole populations of people. We can use this approach to measure the impact and outcomes of our programmes and interventions within specific groups of people who have similar health requirements (e.g. frail elderly). This will help us to understand the outcomes of all of our improvements and work out how we can make the most impact to people.
- **Improve clinical efficiency and safety:** Clinical efficiency and safety can be enhanced with the use of digital technologies, such as artificial intelligence. These can be used for automating tasks and increasing quality, allowing staff to focus on more complex activities. This supports safer evidenced-based consistent care. The infrastructure developed will need to allow innovation to prosper. Cyber security will be essential in keeping systems, information and staff safe from cyber-attacks.

How does this deliver the STP aspirations?

Independence and resilience

- ✓ Provides high quality wellbeing support, care and treatment for preventable diseases and to halt disease progression
- ✓ Supports people with chronic conditions and complex care needs to be supported at home rather than hospital through digital safety nets, use of technology and point of care testing
- ✓ Develops our frontline health and care practitioners as change agents who can advocate for behaviour change confidently, supported by digital resources and promoting on-line and digital solutions locally.

Equity, equality and inclusion

- ✓ Provides a holistic and person-centred approach. Artificial intelligence and technology does not discriminate between diseases or physical and mental health or age in the same way services do
- ✓ People can receive the right care in the right place, through the use of virtual consultations, also reducing variation
- ✓ Supports professionals to manage people in the community for longer or in nursing homes
- ✓ Improves the health and wellbeing of our highly-skilled workforce by providing them with the time and capacity to treat those people that really need their skillsets. It also offers greater flexibility and opportunities in their roles and is more rewarding for them
- ✓ Makes it easier for people to access more dedicated support where this is needed.

Integration and simplification

- ✓ Provides simple access to information

- ✓ Integrates data and information so that patients can benefit from seamless care with professionals accessing the right information at the right time
- ✓ Provides advice and support, either face-to-face or through digital tools, which is mainstreamed across health, care and in local community settings.

Promoting prosperity

- ✓ Delivers economic benefits in the form of productivity and output gains with less time off work required when using of virtual consultations.

Social value

- ✓ Promotes healthier environments with reduced emissions as a result of the diminished need to travel, which enables people to lead healthier lives.

Delivering our commitments in practice

Each partner organisation's digital leads have come together through a Digital Enablement Group reporting to the Birmingham and Solihull STP Senior Responsible Officer for Digital. University Hospitals Birmingham NHS Foundation Trust's Chief Executive Officer is the designated Senior Responsible Officer for digital across the STP. The Digital Enablement Group reports to the STP Chief Executive Officers. This provides leadership for the Digital First programme ensuring that the work undertaken reflects agreed programme deliverables including ensuring sound IT financial management with aligned work programmes and performance managing the programme outputs to maximise efficiency.

The group consists of partners across primary care, secondary care, ambulance service, community services, social care and mental health and care. The group has developed a set of key strategic pillars of digital enablement for a Digital First health and care system to support digital transformation including the clinical priority areas of cancer, mental health, primary care, urgent and emergency care, elective care and maternity services.

The digital enablement pillars support the guiding principles of the **Future of healthcare: our vision for digital, data and technology in health and care** published in October 2018; which covers user need, privacy and security, interoperability and openness and inclusion.

The pillars demonstrate how we will meet the digital ambitions of the STP by providing an innovative STP approach which will encompass: an architecture framework; cyber risk; funding aspirations; aligned programmes of work; governance of the digital programme; and risk intelligence. The digital strategic pillars of the Birmingham and Solihull STP Digital Enablement Group are summarised below:

Pillar 1 – delivery of a shared care record to:

- Ensure that health and care organisations and professionals have access to comprehensive information about citizens to enable intelligent led planning across communities and geographies
- Ensure that professionals will have efficient access to comprehensive, contemporaneous records for the people in their care

- Enable citizens to access their health and care records to empower them to take ownership of their own health and wellbeing where possible and control who can access their information
- Enable the research community to develop innovative, evidence-based tools, products and services that improve outcomes and drive efficiencies.

Pillar 2 – delivery of a consistent information governance approach to shared information and information security. This will underpin the delivery of:

- Digital First approach
- The patient held record
- Predictive and preventative system powered data driven intelligence
- Virtual clinic oversight
- Cloud first approach
- Remote imaging and diagnostics
- Genomics and personalised medicine
- Information security standards
- The 5G network.

Pillar 3 – greater use and availability of digital consultations and clinical advice as well as more out of hospital lifestyle support will provide effective support for people with continuing and lifelong conditions. Digital consultations will use video technology and data to identify if a person needs an appointment using artificial intelligence. Aspirations are described throughout this plan.

Pillar 4 – delivering digital connectivity between services and improved architecture, a more efficient digital structure with business capabilities shared across organisations, lower change management costs, flexible workforce and improved productivity. To also deliver a more efficient IT operation with increased portability of applications, improved network management, improved ability to address critical enterprise wide issues like security and easier upgrades and exchanges of system components.

Pillar 5 – compliance with agreed cyber security standards with a leading expert workforce. We will work towards 100% compliance with mandated cyber security standards across all NHS organisations in the health and care system.

Pillar 6 – ensuring economies of scale for sustainable financial models for the pillars of digital enablement to support a better return on taxpayer investment and reduced risk for future investment, ensuring the maximum return on investment in IT infrastructure and aligning in-house produced or out-sourced IT solutions reducing the risk overall in new investments and their costs of ownership. There will be faster, simpler and cheaper procurement with buying decisions simpler because the information is readily available, agreed in a coherent programme. This will maximise economic capabilities. Opportunities provided by the new GP IT Futures model, to support the digital needs of our Primary Care Networks and support meeting the STP Digital First priorities and the Health Systems Support Framework will support economies of scale. The digital investment

profile across the STP ranges from 1-3%. The sustainability pillar will look at the system control total and the potential for economies of scale.

Pillar 7 – data driven transformation with analytics methods and solutions creating near-infinite possibilities for deriving value from data. Continuing to enable data-driven decision-making and articulating data to employees at all levels of the STP to ensure that both health and care organisations and citizens understand the importance of analysing data for measurable outcomes and better care goals. The group will create a culture of decision-making with advanced analytics at its foundation and a culture of predicting outcomes and results through predictive analytics becoming 'the norm'. The STP will work with West Midlands Combined Authority Office of Data Analytics, Health Data Research UK and the West Midlands Academic Health Science Network to maximize the value of data while maintaining high levels of data security, quality and agility.

What are the deliverables?

- Delivery of digital enablement planning is dependent on workforce, funding and prioritisation of digital requirements according to the STP and Government policy
- Appendix 4 outlines the specific deliverable 'must dos' for digital transformation leading to 2024. The focus of the roadmap is utilising The Open Group Architecture Framework (TOGAF) for enterprise architecture that provides an approach for designing, planning, implementing, and governing an enterprise information technology architecture to underpin the digital transformation (see Figure 8). This ensures both the vision and drivers and business capabilities through setting deliverables for each of the digital pillars, ensuring effective operations of the capability which drives the need for maturity, ensuring refinement and understanding of the technical need and ensuring maintenance and sustainability of business change.

Resources required to deliver

The strategic oversight of the programme will be provided by the STP Chief Executive Group, the Birmingham and Solihull STP Digital Enablement Group and associated priority groups will oversee the related work packages and prioritisation to ensure these address the priorities for citizen need and translational into digital application(s); coherence with other areas of digital health and care work to provide economies of scale; and build on existing strengths. Due consideration will be given to work with potential early return on investment and/or opportunities for innovation/commercialisation as projects are scoped. There is an ambition for a consolidated digital economic system across the STP.

Funds made available through NHS organisations will support high-quality digital developments and implementation of the technical asks described throughout the **NHS Long Term Plan** and in particular within milestones Appendix 4. Detailed project plans will be produced for all digital **NHS Long Term Plan** activities and quality assured. A transparent digital programme financial audit trail will be created and maintained through the Birmingham and Solihull STP Digital Enablement Group and progress against digital plans will provide the basis for key performance indicators against which the group will monitor progress.

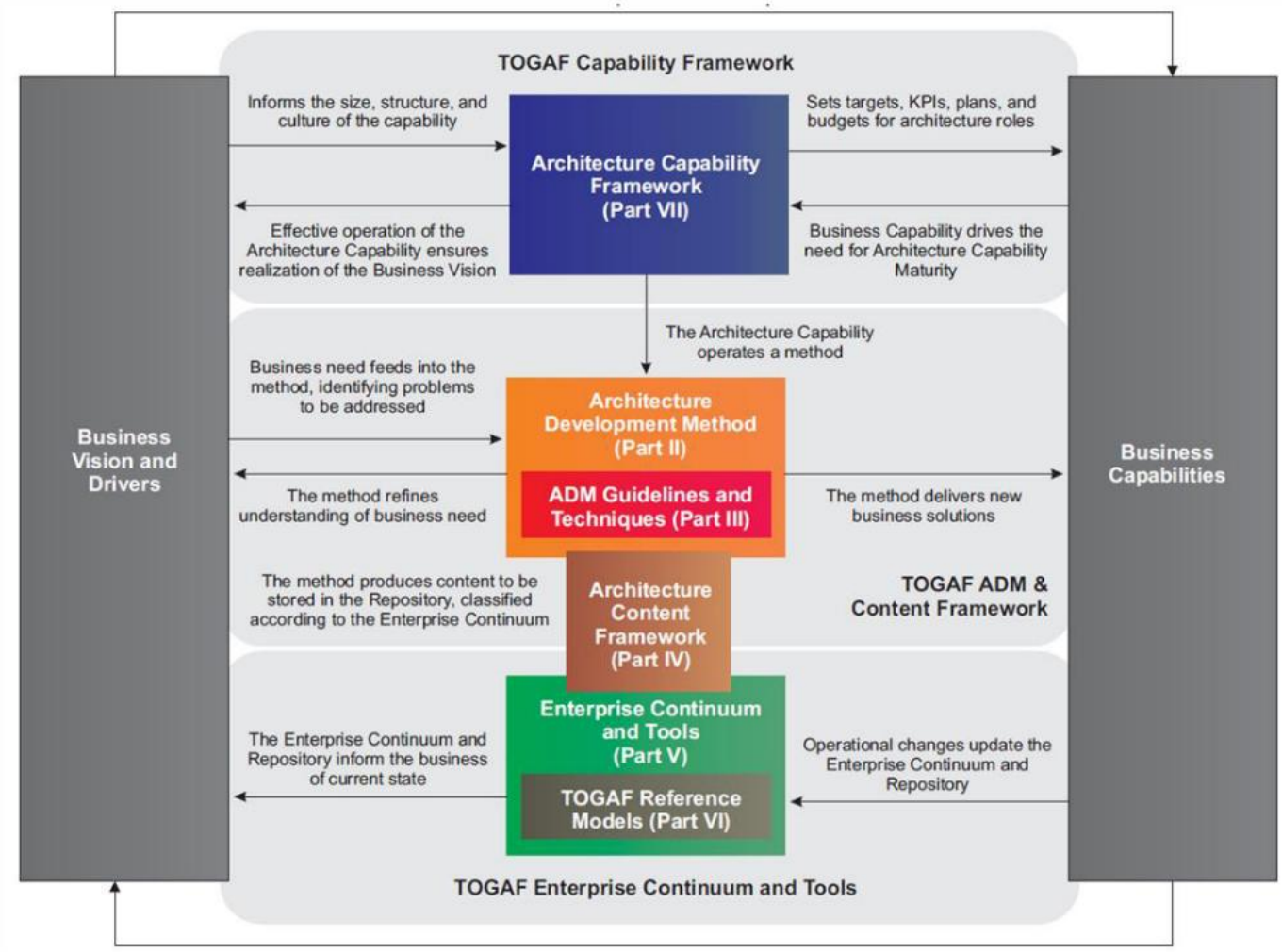

Figure 8: The Open Group Architecture Framework (TOGAF), TOGAF.org (21 October 2019)

Return on investment

We propose to assess return on investment across the following broad categories in addition to the value for money analysis already submitted as part of the NHS England and NHS Improvement Health System Led Investment programme:

- Organisational efficiency gains; measured for example by adjustment to workforce, cost avoidance associated with change to clinical pathways, reduction in clinical incidents, improvements in patient experience and satisfaction, prescribing cost reduction, improved patient outcomes (mortality, reductions in length of stay; shift of place of care from secondary to primary/home sectors)
- Increase in the digital maturity index of NHS partner organisations subject to an agreed level of increased maturity within each organisation (this may also be a dis-benefit of return on investment with further investment needed to enhance maturity)

- New job creation and development to support an agile workforce (this may also be an initial dis-benefit of return on investment with further investment needed to provide the tools for a truly agile workforce)
- New (inward) Investment in the wider economy through economies of scale fed back into the digital transformation programme
- Research grants supporting the work of the Birmingham and Solihull STP through digital transformation and population health analytics.

How will services be different in 2023/24?

There will be a single digital front door for patients no matter what care they need using the NHS login, providing advice and guidance through a symptom checker to navigate to services that patients need. This will provide the opportunity to direct patients to the relevant healthcare professional at the right time for the right reason as well as providing care professionals with real time data for their citizen journey and providing patients with access to their record, support for self-care and greater choice with the ability to book appointments directly.

There will be an expectation of the digital programme to establish and consolidate the STP as a centre of Digital First care excellence through the development of novel solutions in digital care highly-attuned to the NHS environment.

By 2023/2024 there will be increased digital maturity, organisational readiness for digital transformation, which will provide targeted education and training to create a health technology competent, multi-professional workforce that will continue to support and evolve the use of technology to deliver high value care. It will also involve established collaborations across the STP with aligned digital programmes of work and consolidated relationships with third parties to accelerate innovation, adoption and knowledge transfer. The specific digital deliverables are listed in the milestone section and described throughout this document. This plan will drive the digital transformation enabled by radically interoperable data and open, secure platforms.

Practical examples include:

- Alternative pathways for urgent, ambulatory care
- Rapid triage potentially bypassing A&E
- Projecting specialist health and social care into care homes
- Digital consultations for urgent, outpatient and primary care
- Digital tools for long term condition management such as e-learning packages and applications
- Embedded patient and healthcare professional experienced based co design and testing
- Greater ability to obtain live clinical information to support quicker decision making with patients accessing their data to support self-care.

Empowering our workforce

To be the employer of choice in Birmingham and Solihull, attracting the best staff locally and from around the world, by creating fulfilling careers and opportunities for people at every level

This is an exciting opportunity to maximise the diversity of Birmingham and Solihull to make our STP the employer of choice and ensure our services meet the needs of our population. Our health and care workforce are very much our population and therefore play a critical role in shaping and implementing our Building Healthy Lives strategy.

Whilst we have some workforce challenges, we have a very good insight into what these are. Our workforce supply and demand understanding has led to targeted work programmes in collaboration with primary, secondary, social care and our higher education providers. There is a well-integrated approach to working with schools and colleges to maximise our workforce pipeline, to attract the local population into meaningful careers across health and care. These areas of work will be built on as part of the system-wide solutions detailed below.

Context

This plan highlights the current context and details our key workforce challenges before proposing a revised strategic framework, aligning with the **Interim NHS People Plan *(2019)*** and the **NHS Long Term Plan**. As far as possible, the workforce requirements from other chapters have been considered; however, it is important to note that the workforce impact for the changes to clinical models and integrated services will continue to evolve over the next year. Work to understand the digital readiness of our staff to deliver with new systems and technology has begun and will continue to be developed.

The relevant Long Term Plan headline metrics and workforce planning data can be found in Appendix 5. The information provides baseline data from across the STP; however, the workforce plan does not yet include robust information from social care.

Why do we want to change?

Workforce shortages: Our workforce challenges are similar to the national picture. Birmingham and Solihull has challenges around the recruitment and retention of GPs and secondary care doctors (consultants and junior doctors), all branches of nursing (adult, children, mental health, learning disability and practice nurses), social workers and social care staff. More specifically Birmingham and Solihull has over 1,100 nurse vacancies and other key shortages exist in diagnostic and therapeutic radiography, operating department practitioners, sonography, health visitors, podiatrists and paediatric speech and language therapists, in addition to all health and care professionals delivering mental health services.

The current workforce shortages are further compounded by the EU Exit. In the event of a 'no deal' or further delays, we face a significant risk of losing staff who are EU nationals. This is a particular issue within the adult social care workforce, where EU nationals make up to 10% of nursing staff, 5% of care workers and 1% of social workers.

Therefore, we have continued to plan for the worst-case scenario where increased use of temporary staffing would be required to provide continuity of care where there are workforce shortages.

Ageing workforce: We have an ageing workforce with 17% of our NHS staff aged 55 or over and are therefore potentially retiring in the next five years. Many senior staff are impacted by the changes to pension and HMRC rules, resulting in more early retirements and reduced willingness to work additional hours. The position is similar in adult social care, which compounds the issues of capacity, recruitment and retention.

Changing expectations: We know we have significant challenges in addressing expectations and priorities of different generations within our current and future workforce with now five generations in the workplace. The generational demands will require health and care employers to develop new and innovative job roles and create greater flexibility and mobility across employment terms with more robust and available career development frameworks. We expect these generational differences to have an impact on retention particularly across nursing. We fully recognise the gap and have introduced the trainee nursing associate and will deliver these changes at the scale and pace required.

Meeting the needs of our diverse communities: We must capitalise on the opportunities afforded to us by being one of the UK's most diverse and young cities as our organisations still do not represent the populations they serve, particularly in our areas of high deprivation and hard to reach communities. The plan identifies how we are improving the experience and development for Black, Asian and minority ethnic staff groups across our system, along with the activity already in place.

Changing structures and organisations: With significant mergers and restructuring of clinical services and organisations continuing to take place, we cannot underestimate the impact of this on our current and future workforce. Leaders in our system are both focusing on developing and improving staff engagement and cultures, whilst making significant changes to our services. The effect of the changing structures makes system leadership a priority to ensure the collective impact on our workforce is understood and responded to with any system-wide risks managed.

Primary care: Primary Care Networks are central to developing locally-responsive services to address the needs of local populations, increasing the breadth of services offered locally with roles such as first contact practitioner and clinical pharmacists, as well as social prescribing. There are a number of areas identified where additional training is planned to upskill staff in primary care to deliver extended roles. We will work as a system to offer a systematic and robust approach based on national best practice standards utilising the Training Hub and education infrastructure. Detail on the headline workforce requirements for Primary Care Networks is included within the Primary care chapter.

Financial challenges: The financial challenges we face require us to be even more innovative in the development and deployment of our workforce. This will require robust information and productivity analysis and will need to be considered alongside the availability of shortage workforce groups and workforce transformation. Further detail on affordability of the plan and efficiencies can be found within the finance chapter and financial plans.

Digital readiness: Given our Digital First approach and the exciting opportunities this brings we must understand the digital readiness/competence of our staff so we can fully capitalise on this opportunity. The use of technology to streamline services, deliver virtual consultations and increase out of hospital care will require significant investment and staff development. We must also ensure apprenticeship and undergraduate curricula are amended to meet the digital requirements. We are reviewing the recommendations from **The Topol Review: Preparing the health and care workforce to deliver the digital future (2019)** and will take decisive action to ensure we have a digitally-ready workforce to deliver the STP ambition, adopting nationally available solutions and deliver a system-wide approach to implementation.

Priorities for change

Our health and care workforce are pivotal to our ability to deliver the STP strategy and are our greatest asset. Our plan identifies a number of challenges around both the creation and maintenance of a sustainable and dynamic workforce with the need to create both a healthy pipeline into careers in health and care but also a flexible and dynamic workforce able to deliver the care required both now and into the future. We have recognised that there are short and medium term challenges around:

- Current and predicted **shortages of staff**
- The **age demographic** of some of our most highly skilled and experienced workforce with many due to retire in the next five years
- The need to respond to **changing expectations** for standards of care, digital readiness and our ability to meet the needs of our diverse communities amongst others.

Whilst we have developed a range of robust solutions and strategies to overcome these challenges, we will be continually faced with the need to deliver these changes rapidly in order to deliver safe and high quality care. New programmes to recruit and attract staff will take time to have the level of impact required. Significant investment and the financial challenges we face reduces our flexibility to fund or pump-prime workforce initiatives whilst also meeting our financial targets. However, these are not just risks for our STP as many of these challenges will be faced across the country, creating an even greater need for us to be competitive in creating attractive jobs for people.

We are tackling the challenges of shortages in the nursing workforce and other professions by creating a system-wide workforce offer; making Birmingham and Solihull health and care the best place to work. Achievements include:

Comprehensive analysis has been undertaken for the Local Workforce Action Board on the non-medical workforce supply, evidencing the impact of the national educational reforms, with

recommendations for recruitment of the numbers of undergraduates needed per programme. Collective action has been agreed to improve both student recruitment and retention with detailed ongoing work for locally identified shortage groups.

Collaboration to implement best practice on key aspects of staff health and wellbeing, including occupational health services, physiotherapy/musculoskeletal, preventing and treating mental ill-health and a specific support programme for junior doctors; all of which should also help to reduce sickness absence.

The **Primary Care Training Hub** has worked across the system, e.g. on clinical pharmacy mentoring, to support the retention of existing and newly-qualified pharmacists and increasing primary care placements for undergraduate nurses

The Local Workforce Action Board Education Reform Group has delivered a joint **education partnership agreement between trusts and universities** which requires the sharing of key workforce/student data and has a focus on ensuring the quality of the student experience across both sectors. Work continues to maximise student placements and drive improvements in quality of teaching across the health and care system.

Birmingham and Solihull health and care branding, promotional materials and the 'Fedcat' online repository of interactive materials have been developed by the **Birmingham and Solihull Apprenticeship Federation** for use in recruitment projects, career pathway work and school engagement, enabling young people to experience the NHS and social care system and identify potential job opportunities. Our STP has the advantage of a dedicated learning hub working to maximise the employment opportunities for the local population and a vast breadth of services providing multiple opportunities to retain talent though improving the mobility of staff within the STP.

We have **delivered an increase in nurse entrants,** working with our educational institutions we have realised a 25% increase in nurse entrants on to programmes in September 2019 and we will continue to build on this to increase our future nursing workforce supply.

How does this deliver the STP aspirations?

Independence and resilience

- ✓ Builds knowledge, skills and capability among health and care staff, with clear clinical leadership
- ✓ Develops our frontline health and care practitioners as change agents who can advocate for behaviour change confidently
- ✓ Promotes the health and wellbeing of staff.

Equity, equality and inclusion

- ✓ Invests in recruitment and retention locally, from entry level posts supported by the Apprenticeship Levy, through to the highest skilled posts
- ✓ Treats people equally wherever they live and develops a workforce at all levels that represents the community it serves
- ✓ Targets efforts to areas that have greatest scope for economic regeneration.

Integration and simplification

- ✓ Supports place-based approaches to improving health and wellbeing and tackling inequalities
- ✓ Develops cross-organisational integrated teams and services
- ✓ Embraces technology, supporting patients and staff.

Promoting prosperity

- ✓ Develops a healthy and happy workplace, which is more productive
- ✓ Supports people to be able to work for longer, improving economic growth, prosperity and wellbeing
- ✓ Supports career progression maximising the opportunities provided by the apprenticeship levy
- ✓ Provides secure jobs for all skill levels in the local economy and with long term career prospects.

Social value

- ✓ Recognises the important role of the NHS and social care as employers to enable prevention in the workplace, not just for those we directly employ but also through our commissioning and partnership relationships
- ✓ Creates healthier environments which enable people to lead healthier lives.

Delivering our commitments in practice

We will implement a unified approach to workforce planning and development that promotes healthy living and working in our area.

The development of our **strategic workforce framework** will be critical to our success. This builds on the work of the current Local Workforce Action Board priorities and is designed to ensure we provide focus for our biggest risks. Our track record of partnership working is mixed, so ensuring we have clear commitment and a collaborative approach to the development and delivery of this framework will be essential.

With the development of the STP People Plan we will review the requirements and role of the Local Workforce Action Board and establish the **STP people function**. This centralised people function with responsibility for co-ordination and transition towards a shared service approach for key transactional services. The structure, governance framework, funding and focus for this function will be determined through the senior leadership teams of the organisations within the STP together with Health Education England and NHS England and NHS Improvement. To deliver our ambition we have identified four key programmes of work, all of which will address local and national priorities.

Figure 9: The People Programme Structure

As part of this development we will review the skills and capabilities to deliver this plan, in particular the skills linked to workforce analysis, workforce modelling and role redesign will need to be enhanced. Detail on each of the programmes of work is found in the sections below.

1. System workforce planning and redesign

This programme will work to deliver the STP ambition for system workforce planning as a health and social care economy.

Building on the existing work undertaken across the Local Workforce Action Board to understand workforce supply, we will expand on the system level planning and analysis of workforce numbers to inform the redesign and new role opportunities linked to the changes in clinical models and integrated services. A key element to this is how we manage the gap between need and affordability and the STP will be sighted on any gaps which will compromise ongoing service developments. Future developments in technology will feed into the planning process to ensure that workforce models adapt accordingly. The priority for the STP is in nursing and role redesign to fill the current gaps.

The workforce implications of the other chapters in this plan have been reviewed and the key priorities distilled, and we will continue to review the work as it evolves. Further detail on the workforce implications for STP clinical priorities is contained within each chapter. Work is already underway to understand in greater detail the workforce implications for the new models of care in cancer, learning disabilities and autism and children and young people.

We will build on the learning, methodology and approach taken from the experience of developing the multi-agency mental health workforce plan, which sets out a trajectory for growth in the mental health workforce and describes the local work required to achieve this growth, including: developing new roles; new ways of working; building the new ways of working; building the necessary skills to deliver care and support in the future; retaining experienced staff.

Within mental health services the approach taken identified specific workforce requirements identified including the need to deliver:

- An increase in mental health competent staff in acute and ambulance services
- Increased checking of physical health in mental health settings
- Additional training in primary care on severe mental illnesses
- Workforce modelling which is underway in perinatal and children and young people mental health services
- A better understanding of the impact of Black, Asian and minority ethnic population on workforce and service demand.

Within maternity services, the workforce challenges identified include the recruitment and training of sonographers and the development of sustainable middle grade rosters to meet demand. There will be additional training requirements to deliver clinical communication between practitioners using new digital platforms. Work is in place to expand midwifery and maternity support workforce numbers in order to offer continuity of care. There is also a planned growth in the theatre workforce across the board.

The STP digital strategy will inform new models of care delivery and the subsequent skills required. We will, as far as possible, move from role-based workforce planning to skill-based planning to ensure innovation is not compromised with traditional expectations around job titles.

There is a continuing challenge with staffing in urgent care and there is a need to redesign our approach to develop flexible roles and rotations across organisations in our urgent care system.

In addition to the nursing workforce shortages, a number of other workforce groups have identified recruitment challenges. These include medical workforce shortages in stroke and mental health services, sonographers in maternity and cardiovascular services have been identified and work is required to address these.

Working with each system priority lead we will utilise the methodology and toolkit developed for system-wide workforce planning to ensure the workforce implications are identified at an early stage in the redesign of pathways and services. This will enable a robust approach to system workforce planning across the STP.

2. Education, development and career progression

We have tremendous opportunities to improve access to health and care careers. The provision of meaningful training and development will be the foundation of our success. We are

one of the youngest and most diverse cities in the country and we will capitalise on this diversity to deliver high-quality care to our citizens. Changes to the way education and training is funded and structured impacts all our organisations and requires us to adapt the way we plan, recruit, develop and retain our workforce mindful of the economic challenges for individual staff. We have strong links to all of our universities; however, we know that the current pipeline of undergraduates will not close the vacancy gap for at least another 3-5 years. Therefore, we will address the challenges in three ways focusing on:

- Attracting more people into health and care careers
- Increasing our workforce supply through focusing on both recruitment and retention
- Developing new and extended roles.

Careers hub

The **Birmingham and Solihull Careers Hub** will be the main vehicle for health and care workforce careers. Supporting communities from under-represented groups will be a golden thread throughout this work. In particular, we have a very successful initiative to employ people with a learning disability and this will be rolled out across the STP. There are five main components that will be developed and will build on existing infrastructure:

- Social media platform
- Ambassador Network
- Work-related learning
- Work experience and apprenticeships
- Volunteering strategy.

Developing apprenticeships at all levels to offer attractive alternative entry points into clinical and non-clinical roles is critical to ensure we attract our future workforce from diverse backgrounds. The development of degree apprenticeships for nursing and allied health professionals is central to this. Details on the expansion of apprenticeships can be found in the STP Workforce Plan. To support primary care and the private independent and voluntary sector providers of health and care services, a collaborative approach has been formally agreed in the STP to maximise levy gifting for the benefit of primary care and social care organisations. We will build on the existing gifting arrangements in place which to date as allowed the growth of trainee nurse associates in primary care and increased paramedic trainees. A particular emphasis moving forward is supporting apprenticeships for children leaving the care system.

Increasing workforce supply

Through the Local Workforce Action Board, we have established robust mechanisms to understand the local supply and demand profile. Further analysis of workforce and student data to include primary and social care will be undertaken to review progress and inform future plans. This programme will focus on the broad range of activities which ensure we have a

sustainable and affordable supply of the workforce which is deployed in the most cost-effective way.

The priority areas for improving workforce supply are:

- **Nursing** – adoption and expansion of nursing associates and intensive recruitment and retention work, including work with schools, colleges, new graduate support and the introduction of a better framework for career progression. Programmes of work have already commenced to improve recruitment of nursing and allied health professional students and address the negative trends in demographic diversity by:
- Increasing the number of providers of nurse education, working with a range of educational institutions to maximise different entry points i.e. apprenticeships, graduate entrants and dual registration programmes to provide access into health and care careers
- Opening up additional placements in social care and primary care and delivery of a 25% increase in students across all fields of nursing across Birmingham and Solihull.
- **Mental health** – plans to adopt and embed new roles such as physician associates, nursing associates, advanced clinical practitioners and peer support workers are being developed and recruited to. An employer-led return to practice campaign is planned in partnership with a local university and options of a 'recruit to train' nursing apprenticeship is being explored. This would enable us to train nurses via an apprenticeship route and, as apprentices are paid a salary, it will also help with diversity and widening participation.
- **Primary care** – the implementation of Primary Care Networks has significant workforce implications and presents exciting new opportunities for placements, rotational roles, secondment opportunities and continued integration across our organisations. Within Birmingham and Solihull this sector has been proactive in the expansion of the use of physician associates, advanced clinical practitioners, clinical pharmacists and access to support around career progression and positive messaging around being a GP. Support will be required to ensure that all our services are safe and deliver high-quality provision. The STP and Local Workforce Action Board will continue to work across all health and care organisations to be clear about the workforce implications as Primary Care Networks mature. For emerging roles such as the community paramedic we will work collaboratively with West Midlands Ambulance Service University NHS Foundation Trust to understand the implications for the paramedic training pipeline and future workforce requirements.
- There is an increasing focus on the demand and supply of the radiology, therapeutic radiography, and wider diagnostic workforce in response to the increased requirement for earlier diagnosis and improved outcomes within the **West Midlands Cancer Alliance service vision**. There is already a predicted shortfall across all of these disciplines and work over the next year will focus on both improving recruitment to undergraduate programmes using social media to support better marketing of these roles, using the degree apprenticeship route where possible and improving retention both in training and within the existing workforce. The increased requirement for endoscopy has resulted in an increased development of the nurse endoscopist role and this will now be reviewed as part of this

ongoing work programme. Health Education England has developed an accelerated clinical endoscopist programme in response to the increasing demand for endoscopy services; as an STP we need to assess the opportunity this presents and ensure we continue to build training capacity to deliver the future workforce via a variety of routes to meet service demand

- The workforce shortages in pathology together with the increasing demand for pathology services are a challenge for the STP. The move to **digital pathology services** offers a solution to help address the significant pressure in this area allowing work to be shared, extension of subspecialist reporting and in some areas automated reporting. This will drive changes both in the number and skill mix of the laboratory professionals working in these laboratories. The STP will work with the West Midlands Cancer Alliance to identify the staff impacted and the training required for the planned introduction of digital pathology services to ensure a managed and successful transition to digital pathology.
- **Medical workforce** – the future supply of the medical workforce is forecast to grow based on increased medical undergraduate numbers. For the West Midlands there will be two new medical schools at Aston and Worcester universities. The STP is already working with Aston to support training and the provision of a high-quality training experience will assist in increasing the numbers of doctors recruited to the area and a projected reduction in the current vacancy rates across medical staff in the STP. 2020 will see a further focus to improve junior doctor working lives as in order to maximise this area of workforce supply significant work is needed to address the current junior doctor drift after the foundation training period with up to 70% of foundation doctors not progressing directly into run-through training.
- There are very specific challenges with current **education programmes** and work is underway to improve retention of students on programmes; for some programmes current attrition is running at 40-50%. Priority actions agreed are:
- Improve the experience for all nursing students in mental health/learning disability/frail elderly
- Apply best practice from the Health Education England RePAIR (Reducing Pre-registration Attrition and Improving Retention) programme
- Improve the quality of the student experience through system-wide IT access
- Lead discussions on the growth of student numbers to meet demand and monitor conversion rates across health and care.
- A comprehensive, systematic and targeted approach to delivering new and additional skills to enable the workforce transformation will be required, with a focus on prevention, digital literacy, genomics, research and new systems and processes to the way care is delivered. The cultural change required to deliver a fundamental shift to a focus on self-care and prevention with digital technologies and will change how care is delivered and will require clinical leadership at all levels. There will be an impact on curricula for future clinical staff,

and a diverse range of education programmes required for current staff to maximise the use and impact of the different digital solutions being developed.

New and extended roles

We are reshaping the NHS workforce to deliver 21st century care, by understanding, identifying, promoting, supporting and embedding new roles as part of a transformed workforce with a more varied and richer skill mix, to reflect new ways of working. New roles have been recruited to address key workforce shortages, and new apprenticeships have been put in place by the apprenticeship federation career pathway work, including opening up degree level apprenticeship routes for hard-to-recruit to professions.

Achievements include:

- Introduction of new roles and skill mix changes; with the use of physician associates and nursing associates, developing effective inter-disciplinary teams. The effective deployment of locality teams to support place-based models of care has involved cross-organisational integrated clinical teams operating across a range of areas of practice.
- To support delivery of the Home First service model, new roles to support our new model of care including generic rehabilitation or reablement roles across health and care are being scoped alongside an increase in advanced practitioner roles in community nursing and therapies. How care will be delivered will also be different with an emphasis on supporting staff to work at the interface between organisations in co-located multi-disciplinary teams. The development of generic and primary care specific best practice guides on new roles have been produced and widely disseminated and used at new roles events.
- The development of a collective understanding and targeted growth in placement capacity allowing new role development has achieved an increase in capacity in primary care, including clinical pharmacists
- As a second wave pilot site for nursing associates, the STP now has staff employed who are qualified and registered and successfully undertaking their role in trusts. The STP has seen significant growth in future trainee nurse associates from 140 starting training in 2018 to approximately 240 expected to commence in 2019. Continued plans are in place for expansion of training moving from two to three cohorts a year to realise the skill mix changes planned across the STP.
- The recruitment of a Physician Associate Ambassador within the STP will engage with mental health and primary care to develop an integrated physician associate internship across primary care, Forward Thinking Birmingham and Birmingham and Solihull Mental Health NHS Foundation Trust.
- There is exploration of the role of artificial intelligence in diagnostics in the future. At University Hospitals Birmingham NHS Foundation Trust this is being developed in ophthalmology and radiology and this has the potential to alleviate capacity constraints in future and lead to new ways of delivering care.

- We need to work collectively to recruit the workforce in certain services such as urgent care where there are shortages in middle grade doctors, out of hours staffing and emergency nurse practitioners. Given the breadth of services within urgent care there is opportunity to develop attractive roles when compared with other service areas and scope to consider developing roles which offer portfolio careers e.g. across primary care, urgent care and NHS 111.
- Investment will be required in supporting development of these new and different teams at all levels across the system to be competent and confident to deliver care. The STP workforce plan provides detail on the scale of ambition to use new and alternative roles to enhance the services provided to patients.

3. Workforce availability and productivity

This programme will encompass the systems and processes for effective recruitment and deployment to improve retention and productivity. We will explore the development of a centralised temporary staffing function to reduce bank and agency usage and gain competitive advantage. This will support the achievement of the agency cap targets for the STP. To facilitate this, we will develop electronic rostering systems that align to the NHS England and NHS Improvement levels of attainment.

The growth identified in the STP Workforce Plan takes account of cost improvement programmes and workforce efficiencies identified within the individual organisation financial plans. Workforce efficiencies will be sought through workforce innovation which should be influenced by changes to clinical pathways and integrated services (covered in other chapters), without both of these approaches the workforce growth would be considerably higher. The detailed STP Workforce Plan has been triangulated with strategic planning tool to ensure alignment of activity, finance and workforce planning assumptions.

Where possible, the Model Hospital and Get It Right First Time analysis will inform these changes, alongside Productive General Practice in Primary Care. Further detail on these areas can be found in the Finance chapter. To deliver the transformation required, we will develop powerful recruitment strategies that attract the very best staff to our organisations. We will develop a STP-approach to deliver a staff passport, bulk recruitment both national and international whilst at the same time offering great training and career development opportunities across Birmingham and Solihull which take into account the need to grow our diversity in particular at senior levels. The impact of EU Exit on the health and care workforce will need to be monitored, and the impact of the removal of reciprocal recognition' of professional qualifications across the European Economic Area. The use of digital technology will allow different ways of delivering services and, for the workforce, provides opportunities for remote and flexible working practices which can support retention strategies.

We will work to address the shortfall in future workforce supply by investing in our existing workforce and continuing to identify opportunities to improve retention, offering flexible employment opportunities and responding to feedback from staff. Our ambition is to increase the use of volunteers and align processes for attraction, recruitment and learning and work to

share volunteers across the organisations. See the chapter on social impact, which covers volunteering for further detail.

There is opportunity across the health and care providers to undertake a system wide approach to international recruitment. Preliminary discussions have taken place with a particular emphasis on reviewing the use of Health Education England Global Learners Programme to recruit qualified nurses from overseas.

4. Leadership, culture and experience

The STP Board will set the standards for how we will create the best environments for our staff to **succeed, be happy and feel safe** at work. Unless we create Birmingham and Solihull as the best place to live and work, we cannot deliver the world class services we aspire to.

From the NHS organisations represented in the STP, two have been rated as 'Requires improvement' in relation to the Care Quality Commission's rating for being **Well Led**. It is incumbent on us as leaders to ensure our whole system develops systems, processes and cultures that moves towards a consistent rating of 'Outstanding' or 'Good'. Improving our leadership culture will require commitment at every level and we will maximise the support and development opportunities for system wide leadership available from the NHS Leadership Academy.

Improving our leadership culture to include compassionate and inclusive leadership will require commitment at every level. We will explore the differing cultures and work to maximise the great things we do to create compassionate, inclusive and positive cultures. We must continue to build on our successes and listen to our staff building on the strong staff experience scores in all of our organisations. The challenge now is to ensure all leaders are focused on organisation and system success.

The shift from individual organisations to an Integrated Care System will require changes to ways of working and skills development. However, the attitudes and behaviours to the system commitment will be the critical success factor.

A bespoke system leadership programme is being delivered by the NHS Leadership Academy, with STP sponsorship. This is for an initial ten cohorts from across the STP portfolio boards. Teams from across NHS, primary care, adult social care and private, independent and voluntary sector organisations are working collaboratively to develop system leadership skills.

Within this programme we will co-ordinate **leadership development, talent planning, staff experience measurements and interventions**. The latter will focus particularly on the experience of those staff with a protected characteristic, in particular people who are Black, Asian or from a minority ethnicity community; Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Plus and those with a disability. We strongly feel that if we get it right for these groups then all staff will benefit. We will co-ordinate resources and structures to make best use of our expertise. The principles of **the Workforce Race Equality Standards** will be adopted for our primary and social care partners, although the data collection process is very different. There will be four STP wide priorities for making improvements both in representation and experience of our Black, Asian and minority ethnic workforce. These are:

- Set representation targets by band by year
- Close the gap in likelihood of Black, Asian and minority ethnic staff being involved in disciplinary action
- Close the gap in likelihood of Black, Asian and minority ethnic staff being appointed in our organisations
- Reduce the National Staff Survey score for Black, Asian and minority ethnic staff experiencing bullying or harassment
- Detail on how we plan to work with the Workforce Race Equality team to identify our ambition can be found in Appendix 5.

Our systematic approach to **organisational development** and specifically culture and staff experience is fairly immature. Whilst we have developed system-wide leadership development opportunities and individual organisations have robust development offers, we are only in the early stages of the development of an STP leadership talent map to provide a specific focus on Black, Asian and minority ethnic leaders. Workforce transformation at the scale we describe will require a robust approach and investment in change management and organisational development.

The impact of personalisation, Digital First and focus on delivery of community based multi-disciplinary teams will require our workforce to work differently. The cultural and behavioural changes required from these ambitions will require clear and robust organisational development to rapidly maximise the impact of the shift towards working in partnership with patients, the use of digital technologies, increasing use of personal health budgets and health coaching.

Our collaborative approach to **health and wellbeing** will be further embedded over the next few years. We have set the foundations for improved occupational health and staff support services and will be looking to capitalise on a shared approach to resilience training and self-care. The focus is to ensure our staff have the skills to care for themselves and each other, which will be a golden thread throughout.

The role of people managers across the STP will be significant. We will develop aligned policies to reduce sickness absence and improve staff retention, which will be grounded in the development of a ‘just culture’ and putting our staff at the centre of our policies. Our specific plans for retention will sit as part of this programme and we will ensure that the NHS England and NHS Improvement best practice recommendations are applied consistently in all organisations. A shared approach to our staff health and wellbeing offer will ensure that working in the NHS has a positive impact on wellbeing and staff are supported at those times when their health is poor. Further detail on the STP approach to health and wellbeing can be found in the Adulthood and work chapter

There is a commitment from all organisations to have a shared improvement target for certain workforce metrics, such as sickness absence, with a view to aligning a single target over the next few years.

Key milestones

Key milestones	2019/20	2020/21	2021/22	2022/23	2023/24
Review and Implement STP Workforce Governance Structure	X				
Systematic response to current nursing and AHP challenge including: 25% increase for nursing entrants, new providers, new entry points, apprenticeships, reducing attrition and attract staff to stay	X	X	X	X	X
Careers hub infrastructure in place to attract, recruit, retain and progress future and existing staff across health and social care	X	X	X		
Develop a system wide response to enhance BAME representation and evidence progress in improving workforce equality	X	X	X	X	X
Rationalise terms and conditions of employment across health and care providers	X	X			
Design and implement a staff passport: Health – year 1 Social care – year 2		X	X		
Develop a system-wide co-ordinated response to up skilling the existing workforce across: Prevention Digital Genomics		X	X	X	
Maximise the impact of new roles to address current workforce shortages and provide safe, high-quality skill mix changes	X	X	X	X	X
Develop a STP improvement trajectory for each of the workforce metrics	X	X	X	X	X

How will the workforce be different in 2023/24?

- By 2023/24 we will be the employer of choice in the region and have a sustainable supply of clinical; professional and support staff. We will be attracting and retaining the very best national and international expertise, whilst providing great opportunities to develop meaningful careers for our local population.
- All staff will feel included and we will have real diversity in leadership roles at every level across our system
- The workforce will be well-led and supported to take full advantage of new roles, embracing the opportunities provided by new ways of working; role development and digital technology
- All staff will feel that their health and wellbeing is important and they will be happy in their work.

Evolving from the STP into an Integrated Care System

We define our ambition in terms that we believe matter to our citizens, rather than in terms of institutional responsibilities. We want to do everything that is within our considerable, collective power to contribute to our people's health and happiness.

As described in the introduction, the Birmingham and Solihull STP agreed a draft strategy in May 2018 and we are well underway to become an Integrated Care System. In our recent self-assessment of Integrated Care System maturity, we assessed our readiness and have met the criteria for an Aspirant Integrated Care System. We are now working to achieve Shadow Maturity Integrated Care System status within 18 months to reach full status by April 2021. We have identified a strong common vision in the system, which we will now build on to scale our work and develop specific criteria to support us to operate at system and place.

Fundamentally we know there are a number of ways where we are able to work more closely together to address the big system issues and deliver benefits for people in Birmingham and Solihull.

What is an Integrated Care System?

An Integrated Care System is simply a way of working. It brings together all the health and care organisations within a large area and creates agreements, structures and ways of working necessary to deliver care in the best ways for everyone who lives in the system.

If we are to improve services and look after people's physical, social and mental health needs, we need to focus primarily on what matters to people where they live and work, rather than what may appear convenient for public institutions. Where possible, help and support should be close to home, supporting people to remain independent and in control, with hospitals and residential care for those who need them.

This might sound straightforward but it is not the way that public services have typically worked so it represents a fundamental change in how we operate as a health and care system.

Several Integrated Care Systems are now in operation across England, covering about a third of the population, at various stages of development. The **NHS Long Term Plan** outlines the whole of England will be covered by Integrated Care Systems by April 2021. This means that within a relatively short timeframe all health and care systems in England are working towards becoming and then developing as an Integrated Care System.

What are the potential benefits of moving to an Integrated Care System?

We are already developing as an Integrated Care System. In our recent self-assessment of Integrated Care System maturity for Birmingham and Solihull we assessed our readiness. We have met the criteria for an Aspirant Integrated Care System and are working to achieve Shadow Maturity status within 18 months to reach full status by April 2021. We have a strong common

vision in the system to build on to scale our work and develop specific criteria to support us to operate at system and place.

Fundamentally we know there are a number of ways we are able to work more closely together to address the big system issues and deliver benefits for people in Birmingham and Solihull. Moving to an Integrated Care System will enable us to:

- **Connect services together**. Most people do not understand or see benefit from the boundaries between our health and care organisations. People are navigating a complex system, which is confusing and inefficient.
- **Address complex challenges** through closer collaboration. Together we can implement new integrated care models to improve population health, ensure **improvements in quality**, **reduce inequalities** and enable future **financial sustainability**.
- **Understand the local population better** by continuing to work with other organisations involved in people's health and wellbeing such as local charities, community groups, patients and local residents in the planning and delivery of services
- **Work more collaboratively across different organisations to benefit patients.** Staff will be supported by improved technology, digitally-enabled support, care and treatment, which will be **easier to use and more efficient** than current manual processes**.** There will also be more local control and freedom to make decisions, plus extra **support to go further and faster in improving services**.
- **Remove bureaucracy** and **save time** by addressing duplication and misaligned processes.

Priorities for change

By developing an Integrated Care System, we will take collective responsibility for managing resources, delivering standards and improving the health and wellbeing of the wider population. It will build on our existing footprint of our STP.

Our Integrated Care System brings together three key groups: commissioning organisations, acute and specialist providers, and organisations delivering community, mental health and primary care services. Place and system-focused boards sit at the heart of these organisations.

We will also partner with local services (such as police and fire services) and voluntary and community organisations to identify and meet local priorities.

A number of further components will be developed to support this new way of working, including:

- **Integrated strategic commissioning**. This is the term used for **all the activities involved in assessing and forecasting needs.** It links investment to agreed desired outcomes, considers options and planning the range and quality of future services, which is jointly delivered by the CCG and local government. For our area this will be two places – one for Birmingham and one for Solihull.
- **Provider alliance(s)**. This is the term used for when more than one provider comes together to deliver services and functions. They can range from back office support (such as

human resources or finance for example) through to support and clinical/care services i.e. acute alliance, mental health alliance or community alliance.

- **Primary Care Networks**. These consist of groups of general practices working together with a range of local providers, including primary care, community services, social care and the voluntary and community sector. Primary Care Networks will provide proactive, co-ordinated care to populations of between 30,000-50,000. Collaboration needs to happen as broadly as possible and decisions and delivery will also happen at multiple partnerships levels:
- **System:** Partners work together to set strategy, outcomes, system-level financial arrangements and workforce planning. They will lead system improvement and transformations and agree overall levels of integration.
- **Place:** This will focus on health and wellbeing footprints within a system. Work involves planning localised heath and care services and the delivery of secondary and community care in partnership. It includes the delivery and partnership working with wider public sector partners such as police and fire service; marshalling and enhancing our community assets.
- **Localities:** For some areas we will cluster our Primary Care Networks/neighbourhood delivery and partnerships on a slightly larger footprint, particularly for our more specialised communities, social care and primary care services to serve populations from 50,000-250,000.
- **Neighbourhood:** This level is based around Primary Care Networks, groups of GP practices covering populations of 30,000 to 50,000 people. Multi-disciplinary teams will be central to Primary Care Networks, with clinicians and health and care professionals from a wide range of services working together to provide primary, social and community care.

As we mature to full Integrated Care System status we will continue to develop how to work together across a number of areas. We will assess our progress against the NHS England and NHS Improvement Maturity Matrix which identifies five key domains of core capability (Figure 10).

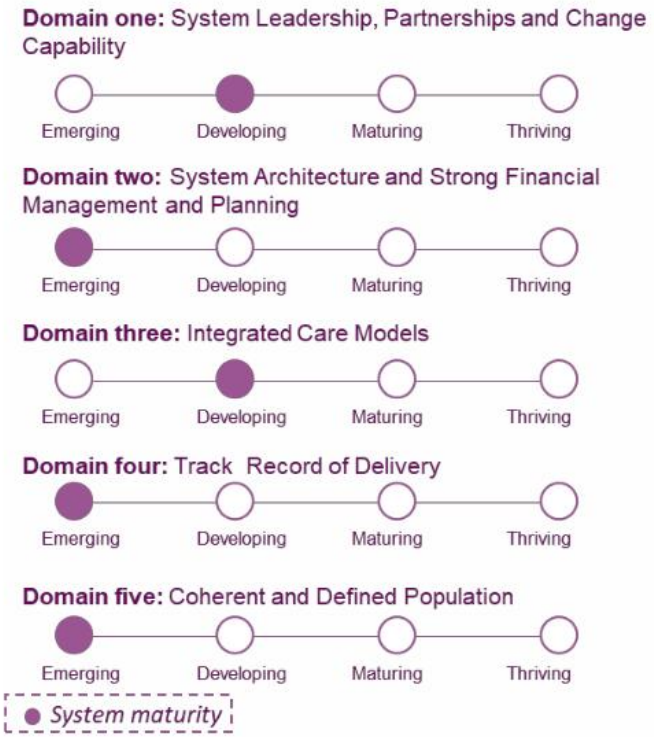

Figure 10 Overview of current self-assessment for Birmingham and Solihull ICS

In summer 2019, we undertook a maturity assessment of our readiness to attain Integrated Care System status. The diagram provides a high-level summary of how we performed. For the emerging areas, we do have examples in the developing domain but not across all areas.

As a result, in early summer 2019 the STP Board agreed to establish a core Integrated Care System development team to support the key themes to help us prepare for Integrated Care System status by April 2021. Our Chief Executive meeting forms our Integrated Care System development group.

In addition, NHS Birmingham and Solihull CCG, Birmingham City Council and Solihull Metropolitan Borough Council signed up to a population health management support programme commissioned by NHS England and NHS Improvement. Population health management describes how we can use data to improve health and wellbeing of whole populations of people. We can use this approach to measure the impact and outcomes of our programmes and interventions within specific groups of people who have similar health and wellbeing requirements (e.g. homeless, frail elderly).

How does this deliver the STP aspirations?

Independence and resilience

- ✓ Increases the focus in the system on preventing ill health and increasing self-care through targeted measures using a population health management approach to create capacity and capability
- ✓ Supports people with holistic support delivered by multi-disciplinary teams to best meet their individual needs and remain independent for longer.

Equity, equality and inclusion

- ✓ Delivers our core STP strategy of reducing inequality within Birmingham and Solihull
- ✓ Achieves greater coordination between health and care organisations will reduce inequality of access and service dependent on where people live within Birmingham and Solihull
- ✓ Includes system-wide use of digital tools and technology to support people's access to health and care and advice with the purpose of increasing access and inclusion
- ✓ Helps prioritise resources to people who most need or would most benefit from targeted interventions through a population health management approach that supports services with evidence-based data.

Integration and simplification

- ✓ Creates closer joint working to design an integrated way of providing services. This will help us to plan as a single system, removing duplication and inefficiencies.
- ✓ Enables health and care partners to undertake resource planning as a system to put effort in the system where it can make the biggest impact.

Promoting prosperity

- ✓ Enables health and care partners to go beyond managing illness or discrete problems, towards a whole view of health and wellness through greater integration across health and care services. By working with other organisations, including third sector organisations, we can begin to look at other factors affecting health and prosperity for example housing and employment.

Social value

- ✓ Achieve more influence locally, regionally and nationally through one voice as we work together as health and care organisations
- ✓ Supports our ambition to deliver collective social value by working together.

Delivering our commitments in practice

Developing as an Integrated Care System will require participation and work from participants from all our health and care organisations. This will have to occur in parallel to existing workloads and pressures, within a short timeframe.

Delivering priority areas

The STP Board and chief executives from across the system have approved four priority areas that capture the key areas of focus for delivery. At a high level these are:

Governance and decision-making

Agreeing the governance, processes and mechanisms to support system leadership to take appropriate decisions, delegate authority to individuals and hold each other to account as a system.

This will help us to progress Domain 1: System Leadership, Partnerships and Change Capability.

Future care model

Establishing the future care model and service development that will support us as a system to tackle inequality and deliver outcomes. This will be developed with providers and services and will work with them to deliver new ways of working in the future (e.g. digital front door, reducing estate footprint). This will include support to priority life-course priority programmes which will deliver practical system results, while developing and testing the emerging model.

This will help us to progress Domain 3: Integrated Care Models.

System change management and improvement

Agreeing a coherent approach for change management approach and improvement strategy to support system-wide transformation and interventions. This will include agreeing criteria for where a system approach (rather than organisation led) will be most effective.

This will help us to progress Domain 1: System Leadership, Partnerships and Change Capability.

Integrated strategic commissioning and delivery

Developing an innovative model of commissioning and delivery of joined-up care for the people of Birmingham and Solihull. Establishing what integrated strategic commissioning will look like for the system and supporting provider alliances. This will be supported by a shared system financial management approach. Care and support will be delivered at a neighbourhood, place and system levels guided by population need.

This will help us to progress Domain 2: System Architecture and Strong Financial Management and Planning.

To support us to become an Integrated Care System we have been nominated by the regional team in NHS England and NHS Improvement to participate on a national accelerator programme. This means the STP has started to receive intensive support from NHS England and NHS Improvement across each of the priority areas to accelerate progress over 15 weeks to January 2020. Support includes dedicated programme resource, access to expertise; knowledge, tools and resources, and access to networks, peer learning groups and forums. At the end of the support we will have a roadmap outlining the next steps in line with our development plan to target achievement of the Shadow Integrated Care System status by April 2020 to then become a full Integrated Care System by April 2021.

As the core development programme develops, we will continue to refine the detail of specific deliverables and products to be produced including governance arrangements and a financial framework.

The Core Development Programme Team will provide regular programme reporting demonstrating progress against the programme plan, workstream scope and deliverables. Chief executives and the STP Board will provide oversight and direction.

We have established representatives to guide the development of the four delivery functions appointing a delivery lead, a clinical representative, a non-executive director/chair representative and a local government representative. This is designed to ensure the programme supported by clinical leadership and alternative perspectives.

We will undertake a refreshed assessment of the maturity matrix at the beginning of 2020 to reassess our position and to identify progress and further priorities. The Integrated Care System core development team will work in close partnership with the NHS England and NHS Improvement regional team as part of this gateway review.

The programme will engage with a wide range of stakeholders through a range of mediums including workshops, working groups, surveys and interviews to develop and test the key components and deliverables of the programme. This engagement will initially primarily focus on representatives from participant organisations, but we acknowledge that broader engagement will be required, including:

- Patient and representative groups
- Third sector organisations
- Health and care adjacent services i.e. housing, employment, regeneration, education, leisure and transport.

In addition to engagement the programme will provide consistent communications throughout the system to give organisations, staff and wider population relevant updates on progress.

How will services be different in 2023/24?

By 2023/24 our system partnership will be formed as an Integrated Care System (by April 2021), which will result in joint planning, development and delivery of all health care for people in Birmingham and Solihull.

Across our workstreams we have defined what responsibilities will be in place.

System governance and decision making by April 2021

- System leaders promptly take decisions collectively on complex system issues, including prioritisation.
- System leaders can safely debate issues, challenge and hold each other to account.
- Full delegation to the Integrated Care System Board so they can take responsibility for appropriate system-level decision making.

Future integrated care model by April 2021

- We work more strategically and proactively guide services to deliver system-wide outcomes rather than spending time and energy on areas that do not support the central vision.
- Our integrated care model across health and social care improves outcomes for people, makes it easier for people to navigate our system and reduces inefficiencies.
- As a system we clearly understand where to direct resources to deliver key outcomes/reduce inequalities.

System change management and improvement by April 2021

- We know where it will be beneficial for us to come together as a system to address and make improvements on system issues.

- We know that interventions will be impactful and well managed, with appropriate governance and oversight.
- Birmingham and Solihull as a system collaborate to proactively prevent system performance issues, and rapidly respond to system performance/transformation issues.

Integrated strategic commissioning and delivery by April 2021

- Health and care for the people of Birmingham and Solihull is joined up and appropriately locally tailored. Care is delivered at the most appropriate level (primarily neighbourhood, but also place and system) for patient outcomes and system efficiency.
- We are delivering improved outcomes for local people.
- We have integrated elements of our CCG and local government commissioning for our two places of Birmingham and Solihull i.e. special educational needs and disabilities and the Better Care Fund.
- We are commissioning for outcomes and enabling our integrated care model through provider alliances to deliver those outcomes.

Delivering best financial value

Delivering the best value possible for public resources to make high-quality health and care sustainable now and for future generations

Birmingham and Solihull STP is committed to delivering best value health and social care to our citizens. In doing so it aims to invest more in downstream care, especially in general practice and mental health; to intervene earlier to keep people well; to support them with their conditions; to prevent people escalating to crisis and to ensure that when this happens pathways of care are clear and appropriate; and to ensure that people are discharged from care appropriately and as quickly as possible.

As described earlier, we are also committed to using the emergent digital technologies to revolutionise the way care is delivered, ensuring there is a digital first offer for the people of Birmingham and Solihull. In delivering this we hope to reduce pressure on frontline services whilst still enabling equity of access to those unable, unwilling or for whom it is inappropriate to access healthcare in this way.

Why do we want to change?

The STP faces significant financial challenges. The collective financial challenge across the five years relating to this plan (2019-2024) is £621m for the system to achieve breakeven. At this time £155m remains to be addressed to deliver a breakeven plan for the system for the five-year period, with a further £52m, net of additional Financial Recovery Fund, required to deliver the total expected by regulators for the five-year period.

NHS funding to STP areas is based upon a funding formula. This formula attempts to calculate the amount of funding an area ‘should’ receive compared to historic levels, with an aspiration to move all areas, whether over or under that target, towards their ‘fair share’ funding.

Currently Birmingham and Solihull is below target compared with fair share allocation and is ranked 35th out of the 42 STPs for 2020/21 in terms of its distance from fair share. This represents a circa £40m shortfall per annum compared to target, a total of £200m across the five years, based on notified allocations. Unlike some neighbouring areas, we are not anticipating any improvement to this position over the life of the plan.

We have significant levels of specialised services activity, commissioned by NHS England and NHS Improvement and we remain in discussion to understand the additional financial risk this creates. The current plan assumes baseline NHS England and NHS Improvement investment made in 2019/20, is reflected in the 2020/21 contract. In part this situation is confused as NHS England and NHS Improvement commissioned services are not included in STP financial targets. This means a reduction in funding recognised by NHS England and NHS Improvement could be detrimental to the position of local providers and the area with no matching benefit reflected within the Birmingham and Solihull STP.

In developing our plans, we have worked closely with local authority partners and it should be noted the financial plan currently only refers to the NHS-funded proportion of the STP despite the financial challenge faced by both partner local authorities.

Our approach to planning

In line with national guidance the system has used national assumptions on inflation and tariff and, through our strategic and operational finance groups, the STP health partners have agreed local growth assumptions which are based on historical growth, adjusted to reflect future expectations. The expenditure required to support this level of growth has been built into provider plans at 100%. We have commenced work to determine the capacity required by the system and the impact on waiting lists of our agreed growth assumptions. This will continue beyond the **NHS Long Term Plan** planning period. We are working to incorporate expectations of specialised services growth where possible.

Partner organisations have identified any cost pressures arising from historical non-recurrent solutions delivering prior-year control totals and the need to rely on non-recurrent solutions to reach 2019/20 targets is reflected in the size of system deficit in 2020/21.

As per NHS guidance, we have assumed the income that providers have been in receipt of from the Provider Sustainability Fund and Financial Recovery Fund, will cease from 2020/21 onwards.

In line with all STPs, we have been allocated fair share funding for a range of priorities within the **NHS Long Term Plan**. Our initial allocation for cancer has been adjusted to reflect the funding of initiatives to be delivered on a regional footprint, with this funding managed through the West Midlands Cancer Alliance. Finance colleagues have worked with operational leads across the STP to support the development of appropriate allocations of fair share funding across partner organisations, as well as organisations outside of our system. The West Midlands Cancer Alliance has provided updated figures to the values first provided to the system for cancer. Some of the cancer funding will be held by the West Midlands Cancer Alliance to fund the core team and for schemes more appropriately managed on a regional footprint, including rapid diagnostic centres and other regional initiatives. The system allocation, along with current partner shares which are indicative beyond 2020/21, are as follows:

Long Term Plan fair share funding					
By workstream	**19/20 Forecast £000s**	**20/21 Plan £000s**	**21/22 Plan £000s**	**22/23 Plan £000s**	**23/24 Plan £000s**
Mental health					
Children and young people	1,749	92	1,758	2,716	4,474
Adult and older adult Crisis Resolution Home Treatment Teams and crisis alternatives		1,798	817	1,095	1,427
Serious mental illness		0	3,155	7,695	9,539
Primary and community services					
Primary care	10,099	10,394	10,844	11,070	10,948
Ageing well	0	686	1,603	4,681	7,889
Cancer*	2,189	1,488	1,162	1,115	1,116
Other	907	961	2,158	3,143	9,486
Total Birmingham and Solihull allocation	14,944	15,418	21,497	31,516	44,879

*Original cancer allocation was indicative and now amended

Long Term Plan fair share funding					
By organisation	**19/20 Forecast £000s**	**20/21 Plan £000s**	**21/22 Plan £000s**	**22/23 Plan £000s**	**23/24 Plan £000s**
Birmingham and Solihull System					
Birmingham Women and Children NHS Foundation Trust	884	756	2,850	4,234	6,874
Birmingham and Solihull Mental Health NHS Foundation Trust	1,260	1,557	3,693	7,980	10,932
Birmingham Community Healthcare NHS Foundation Trust	0	514	1,201	3,868	8,103
The Royal Orthopaedic NHS Foundation Trust	0	0	0	0	0
University Hospitals Birmingham NHS Foundation Trust	730	913	1,734	3,123	5,747
Sub-total Birmingham and Solihull providers	2,874	3,740	9,478	19,205	31,656
Birmingham and Solihull primary care	10,732	10,819	11,200	11,412	12,132
Total Birmingham and Solihull system	13,606	14,559	20,678	30,617	43,788
Outside of system	38	54	191	296	487
West Midlands Cancer Alliance	1,300	805	629	603	604
Total	14,944	15,418	21,497	31,516	44,879

Our finance and activity plan has been reviewed through weekly meetings of our Operational Finance Group and has been signed off through our Strategic Finance Group, following delegated authority by the STP Board.

Meeting the tests

1. Achieving financial balance

Overview

The Birmingham and Solihull system has previously been able to meet its financial control totals through a variety of non-recurrent means, which has included non-recurrent NHS funding for sustainability.

For 2019/20 our provider organisations are supported by £34m of Provider Sustainability Funding (PSF) and a further £7m of Financial Recovery Funding (FRF), in addition to £10m of Marginal Rate Emergency Tariff (MRET) funding.

Non-recurrent allocations	PSF £m	FRF £m	MRET £m	Total £m
Birmingham Women and Children NHS Foundation Trust	5.479	0	0	5.479
Birmingham and Solihull Mental Health NHS Foundation Trust	1.962	0	0	1.962
Birmingham Community Healthcare NHS Foundation Trust	2.354	0	0	2.354
The Royal Orthopaedic Hospital NHS Foundation Trust	0.286	5.026	0	5.312
University Hospitals Birmingham NHS Foundation Trust	23.670	2.255	10.230	36.155
Total provider	**33.751**	**7.281**	**10.230**	**51.262**
NHS Birmingham and Solihull CCG	N/A	N/A	N/A	N/A
System total	**33.751**	**7.281**	**10.230**	**51.262**

In line with guidance, our total five-year plan assumes the cessation of the Provider Sustainability Funding and Financial Recovery Funding totalling £41m from 2020/21 onwards and the continuation of the £10m Marginal Rate Emergency Tariff funding for University Hospitals Birmingham NHS Foundation Trust.

Our financial plan delivers a system deficit position of £65.5m in 2020/21, falling to a deficit of £18m by 2023/24. This is broken down as follows:

Organisation	Surplus / (Deficit) Financial Plan*					
	2019/20 Plan £m	2019/20 Forecast £m	2020/21 Plan £m	2021/22 Plan £m	2022/23 Plan £m	2023/24 Plan £m
NHS Birmingham and Solihull CCG	4.600	4.600	-24.049	-23.540	-12.191	-4.259
Birmingham Women and Children NHS Foundation Trust	2.333	2.333	0.515	0.510	0.530	0.557
Birmingham and Solihull Mental Health NHS Foundation Trust	-0.913	-3.869	-4.929	-	-	-
Birmingham Community Healthcare NHS Foundation Trust	1.875	1.962	1.000	1.000	1.000	1.000
The Royal Orthopaedic Hospital NHS Foundation Trust	-5.312	-5.312	-6.306	-5.453	-4.901	-3.166
University Hospitals Birmingham NHS Foundation Trust	-36.155	-36.155	-41.924	-35.260	-28.821	-22.353
System total excluding PSF/FRF/MRET	**-33.572**	**-36.440**	**-75.692**	**-62.743**	**-44.382**	**-28.221**
Marginal Rate Emergency Tariff Funding	10.230	10.230	10.230	10.230	10.230	10.230
Provider Sustainability Funding	33.751	33.653	-	-	-	-
Financial Recovery Funding	7.281	7.281	-	-	-	-
System total including PSF/FRF	**17.690**	**14.724**	**-65.462**	**-52.513**	**-34.152**	**-17.991**
*Positive numbers = Surplus, Negative numbers = Deficit						

Within this plan the system delivers on the requirements for the Mental Health Investment Standard and for primary care investment.

There are, however, risks within the above position, associated with efficiency schemes. NHS Birmingham and Solihull CCG currently has unidentified efficiency schemes, of £10.6m, £17.5m and £23.3m in the three years 2021/22 to 2023/24, whilst provider organisations are still in the process of fully developing their efficiency programmes, particularly for the later years of the planning period.

Our providers have significant contracts with NHS England and NHS Improvement for services which are commissioned for specialised services. Providers are forecasting an outturn position of

£989m for 2019/20. Discussions are ongoing between our system providers and NHS England and NHS Improvement specialised commissioners around the levels of income that our providers will receive for the planning period, including the efficiency asks within them and the assumptions around the recurrent nature of some items. There is a risk within this financial plan of £22m in 2020/21, rising to £113m in 2023/24, particularly for University Hospitals Birmingham NHS Foundation Trust and Birmingham Women and Children NHS Foundation Trust.

In addition, there remains a risk in relation to the provider income and CCG commissioner expenditure assumptions relating to the delivery of system-wide efficiency assumptions. This equates to £13m in 2020/21, rising to £30m by 2023/24. Discussions are ongoing between the CCG and trusts to resolve these gaps.

The use of digital solutions is key to the delivery of our financial plan and the Digital First workstream underpins much of our strategy. We will be seeking external funding from the "targeted Long Term Plan funds" detailed in the **NHS Long Term Plan** to support the implementation of Digital First. The costs and anticipated income to support this have not currently been incorporated in our plan. The full savings to be derived from this workstream are to be further developed.

The system cash position gives cause for concern. The loss of Provider Sustainability Funding and Financial Recovery Funding, in addition to the high levels of outstanding loan repayments due, particularly relating to the legacy Heart of England NHS Foundation Trust loans, along with the Private Finance Initiative repayments not picked up in the Long Term Plan return, give rise to significant reductions in cash balances, with potential provider cash shortfalls of £19m and £46m by the end of 2022/23 and 2023/24 respectively.

Cash memorandum – STP	2019/20	2020/21	2021/22	2022/23	2023/24
Forecast cash position					
Cash balance at 1 April		**162,383**	**64,605**	**15,468**	**-19,400**
Previous year's Provider Sustainability Fund		5,479			
In year income and expenditure		-41,413	-28,973	-21,961	-13,732
+ Depreciation		62,618	64,967	67,891	69,670
-Capital Programme (CDEL)		-98,665	-157,335	-92,092	-97,766
+/- known Working Capital Movements		0	0	0	0
+ Loans received		33,800	100,000	38,450	42,431
- Loans repaid		-59,597	-27,795	-27,157	-27,085
Cash balance at 31 March	**162,383**	**64,605**	**15,468**	**-19,400**	**-45,882**

2. Delivering cash-releasing efficiency programmes of >1.1% (plus 0.5% for deficit organisations)

Overview of efficiency percentages

National requirements are for delivery of a minimum of 1.1% efficiency for all organisations plus a minimum additional 0.5% for any organisations with a deficit. Our system has efficiency plans, totalling between £81m and £137m across the five-year period, which are shown in the table below.

Organisation	Efficiencies									
	2019/20 Forecast		2020/21 Plan		2021/22 Plan		2022/23 Plan		2023/24 Plan	
	£m	%*	£m	%*	£m	%*	£m	%*	£m	%*
NHS Birmingham and Solihull CCG	64.4	3.3	34.1	1.7	32.9	1.6	34.3	1.6	35.6	1.6
Birmingham Women and Children NHS Foundation Trust	12.8	3.1	11.0	2.5	4.9	1.1	5.1	1.1	5.3	1.1
Birmingham and Solihull Mental Health NHS Foundation Trust	10.7	4.0	10.9	4.0	7.1	2.6	5.6	2.0	4.8	1.7
Birmingham Community Healthcare NHS Foundation Trust	5.4	1.9	8.0	2.7	8.8	2.8	8.3	2.6	8.2	2.4
The Royal Orthopaedic Hospital NHS Foundation Trust	1.6	1.6	1.6	1.6	1.7	1.6	1.7	1.6	1.7	1.6
University Hospitals Birmingham NHS Foundation Trust	42.0	2.8	24.6	1.6	25.5	1.6	26.6	1.6	27.8	1.6
System total efficiencies	**136.8**		**90.2**		**80.8**		**81.4**		**83.4**	

* Providers: % of expenditure before efficiencies; CCG: % of recurrent allocation

The high-level calculation of the percentage efficiency in the table above understates the levels to be achieved by the provider organisations. For all organisations within the STP there are significant sources of income within “other income” for which efficiencies are not levied, as they are not expected to be made against the expenditure generating the income. Once these are taken into account the net efficiencies planned to be delivered by providers within the STP are in excess of 1.1% for those trusts in financial balance and 1.6% for those trusts in deficit.

System efficiency programmes

Birmingham and Solihull STP has a number of system-wide efficiency programmes, including:

- **Early intervention:** The commencement of major transformational programme of work, by partners within Birmingham (Birmingham City Council, Birmingham Community Healthcare NHS Foundation Trust, NHS Birmingham and Solihull CCG, Birmingham and Solihull Mental Health NHS Foundation Trust, and University Hospitals Birmingham NHS Foundation Trust), in partnership with Newton Europe, for 60 weeks from September 2018. The aim of this transformational scheme is to avoid older people having to be admitted into hospital, to reduce their length of stay and to get older people back home from hospital as soon as clinically appropriate, with the right care and support services in the community to ensure they can become as healthy and independent as possible. Further, this supported work undertaken with RightCare partners that identified general frailty, rather than condition-specific management, as the cause of much of the variation in non-elective admissions in Birmingham; and further developed work already undertaken in Solihull around frailty pathways. We are currently prototyping this model, which will deliver savings across both health and social care. For the health sector of the system, cash-releasing savings are expected to be £4-9million. Further efficiencies around length of stay will release capacity to deliver elective work and relieve pressure on occupancy rates.
- **Diabetes and respiratory:** The CCG identified as a significant outlier in these specialties via its RightCare work. Following collaboration between primary care, community and secondary care physicians, a whole system redesign for both diabetes and respiratory has been developed to implement a robust care pathway that will support patients from prevention, through to diagnosis, planned, urgent and end of life care. This will be delivered through a phased roll out over the remaining four years of the plan, with savings of up to £10m per annum when fully rolled out.
- **Digital First/New model of urgent care:** Led via the A&E Delivery Board, the system is redesigning routes of access into A&E through a radical shift to the use of a Digital First approach to care. This also includes working with West Midlands Ambulance Service University NHS Foundation Trust to redesign and reinvigorate the Clinical Advisory Service within NHS 111/999 and the provision for rapid access to community, urgent treatment centre and primary care services, as appropriate, to result in a higher proportion of patients being able to access the right care, in the right place, at the right time. It is anticipated that savings arising from the Clinical Assessment Service initiative could deliver up to £1m per year. The model for rollout of outpatient transformation is being developed within the STP. With a phased introduction, it is anticipated that this could deliver savings of up to £7m per year once fully implemented. We will be seeking additional funding from the **NHS Long Term Plan** targeted funding to support the costs of implementation of our digital agenda.
- **Mental health:** Birmingham and Solihull are refreshing work to identify both the service model and recurrent capacity required for mental health services. This will include ensuring patients are far less likely to be placed out of area, building on work undertaken earlier with Birmingham and Solihull Mental Health NHS Foundation Trust and Forward Thinking Birmingham at Birmingham Women and Children NHS Foundation Trust, on changes required to models of care to impact this and wider issues and the opening of additional bed capacity. The work is likely to require significant capital investment to support an expansion

of beds and this has been prioritised in the STP estates plan. NHS Birmingham and Solihull CCG currently incurs £4m of expenditure on acute out-of-area placements for adult mental healthcare and has been working with Birmingham and Solihull Mental Health NHS Foundation Trust to reinvest in local capacity focussed in primary care, community and home treatments, to support the reduction in this spend. Further work is being scoped to reduce the out of area costs for the 18 to 25-year population.

- **Improved utilisation of estate and reduction of void space**: There is a need to reduce the significant expenditure on void space across the system. The void reduction programme involves NHS Birmingham and Solihull CCG working with providers and building operators to improve utilisation of the buildings and support the move of services into the community. Current projects include the relocation of the chest clinic, sexual assault referral centres and Birmingham Heartlands ophthalmology services and the expansion of Queen Elizabeth ophthalmology services, along with the relocation of a GP practice, into currently void facilities, as well as the use of these facilities by Forward Thinking Birmingham.
- **Special educational needs and disabilities:** In response to the Care Quality Commission inspection of special educational needs and disabilities services within Birmingham, a multi-agency group has led the work to recover and improve on the position. Organisations across health, social care and education are working in partnership to better leverage the c£140m committed on various packages of care, whilst also ensuring the efficacy of the current process. This is also linked to both services provided by Forward Thinking Birmingham and Birmingham Community Healthcare NHS Foundation Trust, where work is ongoing to revise and expand neuro-developmental pathways and to resolve wider issues around paediatric services generally.

Other organisational themes

Other multi-organisation efficiency themes include:

- **Workforce redesign and transformation including reduced agency usage:** For example, development of shared e-rostering, a Birmingham bank, a ‘passport to work’ between organisations and a more transformational human resource function concentrating on improved workforce planning.
- **Procurement:** Largely driven through procurement Birmingham (see below)
- **Back office:** Investigation as to whether further collaboration can drive down back office input costs, as opposed to the transformational benefits outlined elsewhere
- **Digital transformation:** As the enabler for change. Delivery of outpatient services, of access to care, of pathway adherence, of reducing workloads on frontline staff and of ensuring best use of most appropriately skilled staff
- **Productivity, reduction of waste and efficient use of resources:** Both in terms of above but also in terms of allocative efficiency, discontinuing of services that are not performing; cessation of purchasing treatments and drugs that are of limited value or that do not add value

- **Provider alliance:** Within the system we are looking to formally establish a joint venture across the STP acute providers and others as a vehicle to deliver benefits e.g. through Procurement Birmingham.

Delivery of national improving productivity requirements

Birmingham and Solihull STP's approach to these is as follows:

- **Improving clinical productivity and releasing more time for patient care**

  Plans have been developed to realign gynaecology and trauma and orthopaedics services across Birmingham and Solihull. This will optimise bed and theatre capacity across three hospital sites, improve clinical productivity and patient wait times, reduce cancellations and ensure the best possible patient experience is delivered.

  To further improve clinical productivity and release more time for patient care, University Hospitals Birmingham NHS Foundation Trust, commissioners and general practice are collaborating with Babylon as part of Digital First Healthcare. This collaboration will focus on using Babylon's health technologies to first find effective ways to reduce A&E attendances; ensuring care is received in the right setting and reducing footfall across hospital sites where possible. This will be followed by a planned roll out of the same technology to general practice, with the aim of redirecting from and reducing demand on general practice and getting patients to the right place first time.

  Proposals are being developed to explore how the benefits of the collaboration can be leveraged across the STP, once it has been successfully implemented at University Hospitals Birmingham NHS Foundation Trust. The STP is reviewing the potential of aligning IT/digital capacity across the Birmingham Hospitals Alliance and wider system to ensure a greater wider economies of scale benefit.

  The STP digital enablement group has identified key priorities to support digital transformation across Birmingham and Solihull which will improve clinical productivity and release more time for patient care:

  - Completing the roll out of Your Care Connected, to ensure more organisations have access to the GP record in secondary care
  - Implementing a single patient record across the health and social care system
  - Aligning the strategy and vision, to ensure that we are joining efforts to make best use of national/local funding streams
  - Moving to a single platform for video consultations to ensure interoperability
  - Aligning the infrastructure/architecture to bring consistency to Birmingham and Solihull e.g. taking a consistent approach to digitising the community workforce.

  University Hospitals Birmingham NHS Foundation Trust, the largest acute provider, is currently in the process of rationalising and integrating its clinical systems following the acquisition of Heart of England NHS Foundation Trust. This includes the implementation of the Oceano PAS, PICS (electronic rules based prescribing) and Clinical Portal (Electronic

Patient Record) across the Heartlands, Good Hope and Solihull sites to ensure there are standardised systems and ways of working along with consistent booking and scheduling. It will also support the development of clinical and performance management dashboards to help the identification of unwarranted variation and give staff access to timely clinical information to support the optimal decision-making and reduce errors. PICS (electronic rules based prescribing) is also being implemented at The Royal Orthopaedic Hospital NHS Foundation Trust and Birmingham Women and Children NHS Foundation Trust.

All organisations have e-rostering for nurses fully embedded to effectively deploy staff. The STP is scoping the implementation of a single medic e-rostering and e-planning system which will provide economies of scale and ensure the right staff are in the right place at the right time, increase productivity and provide the ability to plan resources effectively. To accelerate this development a bid for capital funding will be submitted to NHS England and NHS Improvement.

- **Maximising the buying power of the NHS**

  The Birmingham Hospitals Alliance Shared Procurement Service collaboration between University Hospitals Birmingham NHS Foundation Trust, Birmingham Women and Children NHS Foundation Trust and The Royal Orthopaedic Hospital NHS Foundation Trust was launched on 1 July 2019. The newly-formed service will enable the delivery of operational efficiencies from standardisation and rationalisation of products and increased purchasing power. The shared service function is using the Purchasing Price Index and Benchmarking tool to support this work.

  The collaboration will also improve performance and responsiveness of the procurement function through a unified approach including the full implementation of Global Healthcare Exchange (GHX) to enable standard electronic ordering and invoicing. Plans are being developed to procure pharmaceuticals through the collaboration which will increase purchasing power in this area. Moving to a common supply chain and logistics model will provide further price opportunities through bulk purchasing and reduce transactional costs in relation to deliveries. Further efficiency benefits will be achieved through the newly-combined function being better able to recruit and retain skilled procurement professionals, as a consequence of the career development opportunities, and increasing staff satisfaction through a shared vision and purpose.

  Birmingham Community Healthcare NHS Foundation Trust and Birmingham and Solihull Mental Health NHS Foundation Trust use the procurement Purchasing Price Index and Benchmarking tool to help support divisional analysis of efficiency opportunities.

- **Pathology and diagnostic imaging networks**

  Over 90% of the actions to achieve the consolidation recommended by the Carter productivity review have been implemented. The Birmingham and Solihull Pathology Network has already delivered significant savings and there are fully-developed plans which will deliver further efficiencies over the next three years. Network partners are committed to ensuring further savings from the integration are identified and delivered. Following on from

the merger of the two largest acute trusts within Birmingham and Solihull STP, a common radiology strategy has been developed which now allows better engagement with the national imaging operating model. The implementation of the imaging strategy will deliver benefits including standardised working and a planned programme of capital investment.

- **Delivering better value on medicines spend**

  Within the acute pharmacy setting, a model has been developed which uses the wholly-owned subsidiary to deliver core dispensary aspects. This model releases clinical pharmacists from dispensary commitments so they can focus on more patient-facing roles. This has seen an expansion in the number of pharmacists who are supporting out-patient clinics in highly complex disease areas. It has also supported the seven-day clinical service in the Acute Medical Units and has resulted 82.9% of pharmacist time being spent on clinical duties. This will be expanded further through a robust training programme which has been developed to enhance the clinical skills of pharmacists with 91.6% of eligible pharmacists now trained as non-medical prescribers, and an aim to train a further 25 over the next nine months. All trusts are actively involved with the Medicines Value Programme and are committed to utilising the best value medications.

  The CCG will continue to invest in and support the CCG Medicines Management and Optimisation team. This will deliver the productivity benefits described by the national Medicines Value Programme and locally identified benefits opportunities as appropriate, using the Universal Patient Offer Local Improvement Scheme as a commissioning vehicle for transacting with practices. As productivity benefits are realised, Medicines Management and Optimisation staff will increasingly focus on patient medication reviews as the primary lever for improving clinical outcomes, minimising harms from medications and increasing the cost-effectiveness of prescribing. It is envisaged the current 25% of the workforce occupying roles that mainly deliver medication review will rise to around 75% over the five years of the plan.

- **Reduction of administration costs**

  A significant degree of administration savings has already been realised through the consolidation of corporate and support services following the two acute trust mergers (University Hospital Birmingham NHS Foundation Trust/Heart of England NHS Foundation Trust and Birmingham Children's Hospital NHS Foundation Trust/Birmingham Women's Hospital NHS Foundation Trust). Further benefits will be realised through the harmonisation of clinical and business IT systems including the implementation of a single finance ledger at University Hospitals Birmingham NHS Foundation Trust, which will result in significant savings in transactional finance, and the rollout of common IT systems as described above which will result in reductions in the headcount in medical records and the booking centre.

  Within this plan we have already successfully merged the three CCGs within the system, ensuring delivery of 20% administrative efficiency savings ahead of the ask within the **NHS Long Term Plan** and releasing an additional funding to be invested in patient care.

Following the successful launch of the procurement collaborative, the Birmingham Hospitals Alliance will explore further opportunities to deliver administrative savings through shared services which could potentially include transactional finance, transactional human resources and recruitment, occupational health, IT and estates. In those instances, where there are clear synergies, this model may extend to the wider STP footprint. Shared services will not just replicate existing delivery models and processes but will be underpinned by a commitment to principles of radical redesign and streamlining to improve quality and reduce cost and a much greater use of IT including the adoption of artificial intelligence and robotic process automation technologies where this delivers benefits.

Birmingham Community Healthcare NHS Foundation Trust has, in recent years, seen corporate functions deliver savings at least proportional to clinical divisions. The NHS back office benchmarking tool has been used to inform discussions about potential savings areas.

Birmingham and Solihull Mental Health NHS Foundation Trust has undertaken a number of IT initiatives which have delivered back office savings over the last few years. These include:

- The use of artificial intelligence in providing predictive analytics, for acute and urgent care, highlighting patients who should be seen before they go into crisis
- Decision support software on wards to highlight patients with deteriorating conditions prior to going into crisis and alerting staff to make an intervention
- The implementation of the MERIT shared care record across mental health services, resulting in a corresponding record of mental health activity regardless of which provider accessed MERIT
- The introduction of a robot within pharmacy
- The use of digital technology for therapeutic and physical observations, reducing the need for paper.

Birmingham and Solihull Mental Health NHS Foundation Trust continues to use the opportunities afforded as a mental health Global Digital Exemplar to explore new technology to deliver improved patient care, alongside plans within MERIT and the STP.

- **Making better use of capital investment and existing assets to drive transformation**

  A comprehensive system-wide estates strategy is being developed to transform patient pathways and enable appropriate clinical realignment. The estates configuration will be underpinned by the STP clinical strategy as well as aligning to the STP digital strategy and the outpatient transformation plans. The development of the Ambulatory Care and Diagnostic Centre and the Birmingham Women's and Children's hospital redevelopment are key STP priorities. Ambulatory Care and Diagnostic Centre will provide the ability to deliver efficient pathways, treat patients in an ambulatory setting and enable the redesign of a more effective workforce model. This will be supported by recently announced capital funding.

There is a need to reduce the significant expenditure on void space across the system. The void reduction programme involves the CCG working with providers and building operators to improve utilisation of the buildings and support the move of services into the community. Current projects include the relocation of the chest clinic, sexual assault referral centres and Birmingham Heartlands ophthalmology services and the expansion of Queen Elizabeth ophthalmology services, along with the relocation of a GP practice, into currently void facilities, as well as the use of these facilities by Forward Thinking Birmingham.

- **Evidence Based Interventions Programme**

  NHS England launched Phase 1 of the new national treatment policies programme from April 2019 which addressed 17 procedures (four category 1 procedures – not routinely commissioned and 13 category 2 procedures – restricted criteria) with proposed national criteria, based on the clinical evidence reviews that had been undertaken.

  NHS Birmingham and Solihull CCG and NHS Sandwell and West Birmingham CCG are part of the demonstrator community. We have shared our knowledge and experience of policy making, the barriers we continue to face with implementing policy and the importance of communication and engagement with clinicians and patients. NHS Birmingham and Solihull CCG has provided feedback to the demonstrator community through a series of workshops, sharing of documentation and also presenting at webinars nationally. NHS England (in partnership with NHS Improvement, NICE and the Royal College of Physicians) will be engaging on a Phase 2 list of the Evidence Based Interventions Programme during autumn 2019. 75% of Phase 2 treatment policies and pathway protocols are not part of the current Birmingham and Solihull treatment policy suite. Further development of the national programme is expected to 2023/24.

- **National Patient Safety Strategy Programme**

  The **NHS National Patient Safety Strategy** was published on 2 July 2019 setting out high-level ambitions for improving patient safety in the NHS. The strategy requires organisations to develop organisational patient safety specialists to be in place by mid-2020. NHS Birmingham and Solihull CCG Patient Safety Team is one of two local CCGs currently participating in the NHS England and NHS Improvement group established to develop these roles.

  When the Patient Safety Incident Response Framework is published in autumn 2019, the NHS Birmingham and Solihull CCG Patient Safety Team will review and develop an implementation plan detailing the steps required within the CCG and local system to adopt this new approach. The CCG has a continued commitment to improve quality through learning from incidents and through the identification of key strategies with all our providers across acute, community and primary care. This will be adopted locally and aimed at improving the way we investigate and learn from the findings. Local implementation plans will be informed by publication of guidance on to how organisations and systems can introduce the new framework most effectively.

In preparation for the introduction of the Patient Safety Incident Response Framework from autumn 2020 and to ensure the principles and requirements of the new framework have been addressed, local providers will be required to submit their investigation strategies with appropriate timeframes to the CCG Clinical Quality Review Meetings during spring/summer of 2020. These will be taken through CCG governance processes including serious incident review panels, Learning from Deaths Group, Quality & Safety Committee and Governing Body. They will also be reported to the NHS England and NHS Improvement Regional Quality Surveillance Group. Engagement with providers will continue to support complete roll out by summer 2021.

3. Supporting reductions in growth of demand for care

If historic growth levels were to continue, we have identified a need for an additional 500 beds over the course of the five-year plan. The system is working on a number of initiatives, designed to support managing activity in a more effective way, to relieve pressure on our overstretched partner organisations. This includes the following:

- **Early intervention programme:** System partners are working collaboratively across health and social care to reduce admissions, shorten length of stay and support citizens to be discharged from hospital as soon as it is clinically safe to do so, with the right care and support services in the community to ensure that they can become as healthy and as independent as possible.
- **Ongoing personalised support:** Ongoing support to help older people remain in their own homes and communities.
- **Multi-disciplinary teams for long term conditions (diabetes and respiratory):** A whole system redesign for both diabetes and respiratory has been developed to implement a robust care pathway that will support patients from prevention, through to diagnosis, planned, urgent and end of life care.
- **Care homes:** Support to improve quality and reduce unnecessary admission and A&E attendances.
- **Transformation of outpatients follow up model:** Using digital technology to reduce the number of patients seen face to face by 30%, as well as ensuring patients see the most appropriate healthcare professional.
- **Rolling out first primary care mental health pilot:** Evidence from pilot sites of 30% reduction in referrals to secondary care mental health services. The plan is to roll out this model across the CCG over the next two years.
- **Social prescribing (see personalisation):** This will provide a range of alternatives to referral for clinical mental health services where needs are assessed and being primarily social/situational.
- **Mental Health Support Teams in schools:** A preventative approach which builds capacity in schools to promote positive mental health and identify and intervene early when issues

emerge. This is intended to reduce the number of children and young people who ultimately need to access psychiatry.

- **Increased capacity in Home Treatment Teams:** An additional Home Treatment Team will provide improved capacity to reduce admissions into psychiatric inpatient beds. We currently spend approximately £4.6m per year on inpatient beds above the commissioned bedded capacity.
- **Crisis Houses and Crisis Cafes:** Providing alternatives to people experiencing mental health crisis. These are intended to divert people from A&E where they do not require medical treatment and again reduce inpatient admissions.
- **Pathways for people with a diagnosis of personality disorder:** We know that people with this diagnosis are often hospitalised due to the level of risk that they present to themselves. These new approaches work with people to manage their needs differently with a view to reducing their utilisation of inpatient beds.
- **Expansion of Solihull Improving Access to Psychological Therapies (IAPT) programme:** Including specialist services for people with long term conditions. IAPT for long term conditions is intended to reduce unplanned acute admissions and A&E attendance. We also know that A&E attendance reduces amongst people who have received IAPT irrespective of whether they have a comorbid health condition.
- **Transformation of rehabilitation pathway:** Reduce the use of, often costly, out-of-area high-dependency placements and supported living settings with a view to promoting greater independence and personalised control of care budgets.
- **Reducing children and young people's avoidable activity** at A&Es and outpatients: Through delivery of the Big 6 reasons for A&E activity and Top 20 reasons for outpatient activity programme rolled out in primary care. Educating and providing to GPs with assessment tools, guidelines, training and the opportunity to speak with a secondary care paediatrician as part of a demand management approach and clinical decision-making. We have also talked with children's social care colleagues about implementing a similar methodology and principles to demand management linked to the top reasons for children and young people entering statutory care services.
- **Special educational needs and disabilities in Birmingham:** We have produced a Joint Strategic Needs Assessment to assist with population predictions and management which will underpin commissioning and delivery.
- **Single electronic record across the Local Maternity System:** In maternity we have a single electronic record across the Local Maternity System which also provides the means to deliver information, advice and guidance to women who may early support/help, including preventative messages.

4. Reducing variation across the health system

Clinical variation nationally and locally is being addressed in a number of complementary ways:

- National – Get It Right First Time
- National/local – RightCare
- Local treatment policies
- National Evidence Based Intervention (EBI) treatment policies

Get It Right First Time

Our providers have actively engaged with the Get It Right First Time programme.

University Hospitals Birmingham NHS Foundation Trust has participated in a number of Get It Right First Time reviews of specialties, with individual specialty action plans in place or in development in response. Common themes are fed into service improvement work (cancer, scheduled care, emergency care). Key actions planned:

- **Orthopaedics**: Review and realignment of orthopaedic surgery across four hospital sites.
- **Day case rates at Heartlands**: Pathways channelled through the proposed Ambulatory Care and Diagnostic Centre.
- **Day case rates at Heartlands**: Pathways channelled through the proposed Ambulatory Care and Diagnostic Centre.
- **Day case rates across the trust**: Pre-operative length of stay review within Scheduled Care Improvement Group chaired by the deputy chief operating officer.
- **Apparent under-coding of comorbidities when triangulated with socio-economic and other demographic information**: Strategic coding review led by the Chief Finance Officer to better facilitate planning and possible interventions.
- **Standardisation of pathways and procedures:** Task and finish groups within orthopaedics, gynaecology, urology and ear, nose and throat to ensure consistency. The gynaecology work resulted in the recruitment of consultants with laparoscopic experience and the urology and ear, nose and throat reviews supported the current roll out of robotic surgery in the specialties.

Where national reviews have core indicators published within Model Hospital dashboards, this information is being used as part of the process.

The Royal Orthopaedic Hospital NHS Foundation Trust has participated in a number of Get It Right First Time visits/reviews of its sub-specialties within orthopaedics, with individual sub-specialty action plans developed in response. Key sub-specialty actions planned include:

- **Spinal services:**
  - Improved spinal audit and outcomes work to support BASS spinal best practice works
  - Improving length of stay for elective anterior cervical discectomy and fusion activity
  - A review of emergency readmissions within 30 days for all patients following a posterior lumbar fusion procedure (Level 1 or 2).

- **Orthopaedics (not spinal):**
    - Improving length of stay for total hip replacement/total knee replacement, (primary and revision). The trust will liaise with Wrightington, Wigan and Leigh NHS Foundation Trust to identify and implement the day case total hip replacement/total knee replacement model (currently the trust's average length of stay is approximately four days for these procedures)
    - Joint care project established at the trust is focused on reducing length of stay and improving outcomes for hips and knees patients. This will run in conjunction with the implementation of day case total hip replacement/total knee replacement
    - Active work on increasing the usage of cemented or hybrid hip replacements for patients aged 70+ where clinically appropriate
    - A review is being undertaken on emergency readmissions following elective hip replacements.

Common/significant improvement themes are fed into service improvement work, which is then reviewed at the Royal Orthopaedic Model Hospital Club, which meets regularly to review all opportunities outlined within the Model Hospital system, including Get It Right First Time indicators. To date the group have identified a number of key indicators where the trust outlies against its peer group. These indicators are being validated to assess the opportunity and to scope out the best way to realise the efficiencies/productivity gain. The group reports opportunities identified into several forums including; Cost Improvement Board, Clinical Audit and Effectiveness Committee and Perfecting Pathways Board. It is working with its Get It Right First Time lead to scope how she can support the model hospital club work as it matures.

The trust has also done further work as follows:

- The Trust Coding & Data Quality Group has reviewed under-coding of co-morbidities. This has been supported by clinicians and the benefits are apparent with a significant improvement (over the last 18 months) in co-morbidities captured
- Standardisation of pathways and procedures led by the Perfecting Pathways Group
- Increased links with Heartlands, Good Hope and Solihull hospitals to provide assistance in the development of their own hip and knee replacement pathway, providing an advisory role to improve pathway standardisation across the system.

Birmingham Women and Children NHS Foundation Trust has participated in a number of Get IT Right First Time reviews of specialties, with individual specialty action plans in place or in development in response. Common themes are being identified and incorporated into the work of the Clinical Outcomes Group. Actions linked to individual reviews include:

- Consultant utilisation – review of the efficiency and management of multi-disciplinary teams
- Explore more extended practice across non-medical staff groups
- Review efficiency of booking and appointments to ensure capacity is maximised

- New to follow-up outpatient ratios
- Potential under-coding of comorbidities when assessed against other socio-economic and demographic factors
- Potential to increase number of laparoscopic procedures
- Opportunities to access best practice tariffs
- Opportunities arising out of litigation data pack
- Opportunities linked to a discharge lounge
- Look at number of patients that are seen by a urology nurse compared to consultants. Consider nurse-surgery workforce reviews.
- Monitor and review out of area neonatal transfers
- Scope to look into day case rates and list planning.

RightCare

In 2019/20 a number of delivery plans are being put into place to target variation based on the latest published NHS Birmingham and Solihull CCG/STP Right Care 'Where to look' opportunity packs, released March 2019 based on 2017/18 activity and spend. Existing delivery plans with updated logic models, outputs and outcomes and finance and activity tables were completed by June 2019. Gross RightCare opportunities were £49m, which reduced to £27.9m following local analytical validation.

For 2019/20 the focus programme areas, with locally validated opportunity are:

Programme area	£	Opportunity
Endocrine (diabetes)	£0.6m	Range of pathways cross cutting with diabetes transformation sub-chapter and some prescribing variation
Gastro/abdominal pain – subset of neurology	£0.6m	Cross-cutting themes with ageing well/falls/falls prevention
Ageing well	£3.6m	Cross-cutting themes with respiratory, neuro-pain (see above) and genito-urinary medicine (non-elective urinary tract infections)
Genito-urinary (urinary tract infections)	£0.2m	
Vision	£1.2m	Transforming eye health/sight loss pathways and patient/carer support and navigation services – more detail in shorter planned care waits
Respiratory	£0.4m	Variation addressed in respiratory transformation sub-chapter

Programme area	£	Opportunity
Musculoskeletal (MSK)	£3.4m	Being addressed by orthopaedic clinical treatment policies e.g. sub-acromial shoulder pain, steroidal injections and arthroscopy – acute or degenerative. Also phased roll out of MSK first contact practitioner services – more detail in shorter planned care waits
Trauma and injury (falls – Birmingham and Solihull)	£0.3m	Falls management/prevention
Advice & Guidance	£0.9m	Development of new eRS Referral Assessment Services; new pathway and FAQ guidance in liver medicine, endocrinology and gynaecology; new Paediatric Dermatology A&G service; dietetic-led irritable bowel syndrome A&G; other capacity supporting specialty guidance – more detail in shorter planned care waits
Medicines management	£17.3m	Overall reductions in prescribing spend not specifically Right Care programme delivery related to cross-cutting themes in medicines optimisation

For 2020/21-2023/24, Birmingham and Solihull will continue to review opportunities for pathway re-design from RightCare data packs and pathway guides (**https://www.england.nhs.uk/rightcare/workstreams/**).

In addition, CCG business intelligence is developing a new analysis tool based around e-referral and SUS data sets which will allow Birmingham and Solihull STP to review variation in pathways by clinic (condition) type, provider, point of delivery and tariff cost to identify outlier provider/hospital sites.

Local treatment policies

NHS Birmingham and Solihull CCG, NHS Sandwell and West Birmingham CCG and our local authority public health commissioners work collaboratively to develop new clinical treatment policies and evidence update existing treatment policies, aiming to:

- Ensure policies incorporate the most up-to-date published clinical evidence so that we prioritise funded treatments that are proven to have clinical benefit for patients
- Stop variation in access to NHS-funded services across Birmingham, Solihull and Sandwell (sometimes called the ‘postcode lottery’ in the media) and allow fair and equitable treatment for all local patients
- Ensure access to NHS-funded treatment is equal and fair, whilst considering the needs of the overall population and evidence of clinical and cost effectiveness.

Further details of our joint work can be seen at: https://www.birminghamandsolihullccg.nhs.uk/your-health/treatment-policies.

We have engaged on 12 new treatment policies for a winter 2019-20 launch. Policy development work for 2020-2024 is likely to focus on:

- Treatments affected by a raising of the Clinical Prioritisation Advisory Group commissioning threshold
- Existing policies where new evidence warrants policy review.

National Evidence Based Intervention treatment policies

As detailed in the earlier section, on Evidence Based Interventions programme.

Key risks to delivery

There are a range of risks relating to our financial position, outlined below:

- **Delivering a break-even financial position:** Our system has been able to deliver on its financial plans to date, largely through the use of non-recurrent solutions, including the use of Provider Sustainability Funding and Financial Recovery Funding. Much of our historical flexibility has now been exhausted and the changes to the financial regime associated with the withdrawal of Provider Sustainability Funding and Financial Recovery Funding and the uncertainty over future changes to tariff including specialist top-ups, coupled with our systems distance from target and combined with the on-going scale of challenge for social care demand and associated funding levels, for our local authority partners, gives our system significant financial pressure, both in delivery of our control total and in our working capital.

  The scale of challenge of delivering a break-even position within the provider sector, including the rectification of children's services issues in Birmingham, over a short time frame is immense and there continues to be a risk to our system, which has high levels of services commissioned by NHS England specialised commissioners, whilst this commissioner remains outside of the control total for our system.

- **Capacity to deliver waiting times:** Our capacity to deliver elective waiting time targets is a risk, in the context of non-elective pressures, some of which we hope will be mitigated by implementation of the work coming out of the early intervention programme and other initiatives to manage demand.
- **Workforce challenges:** We also face workforce challenges around the availability of staff, with the right skills and the management of sickness. The financial challenges we face reduces our flexibility to fund or pump-prime workforce initiatives, whilst also meeting our financial targets.
- **Access to funding:** Access to both capital funding, and additional targeted revenue funding, to enable us to deliver on our transformational schemes, particularly connected to our digital agenda, is key.

- **EU Exit:** The position regarding EU Exit is also a risk, as it will be for all STPs.
- **Assumptions for system efficiencies:** We have also factored in a range of assumptions for system efficiencies. In practice, we may be faced with financial risks from this if the efficiencies are not realised in practice. Best estimates and forecasts have been undertaken at this point but will be subject to change as transformation programmes get underway.
- **Financial projections:** Finally, our financial projections are aligned to the proposed activity and performance trajectories outlined in other areas of the plan. This assumes a predicted level of growth and demand in a range of services, which may be impacted as a result of delays of particular transformation activities coming on stream, changes in policy direction should these arise and funding constraints from partner organisations, which result in changes in demand for care, potentially in higher cost settings to deliver safe service.

Mitigations

- Regular review of all financial forecasts for each programme as they develop to support early identification of risks and issues, which compromise the financial position for the STP
- Appraisal of risks at each programme board governance forum, with escalation to the STP chief finance officers, as appropriate, so early action can be taken
- Monitor impacts of programmes as they deliver against forecasted financial activity, to support continual refinement of efficiency savings and identify mitigations elsewhere in the system.

Systems approach to financial management

Currently the Birmingham and Solihull system regularly shares financial information and performance between all parties, with these being reviewed by the operational finance group, chief executive officers and the STP Board. The system also continues to share and understand the system risk created by divergent assumptions between providers, and providers and (CCG) commissioners, with specialised services the main omission. This assists in organisations managing the risk individually and in attempting to conclude mutually affordable solutions to disputes. It has also meant historically we have not entered financial years with any material difference between provider and commissioner assumptions.

In addition, the system is managing some of its larger workstreams collectively, for example the older peoples work is resourced and supported from across the health and social care sector with joint agreement to related investments, savings and risks, whilst the work relating to Birmingham children's services, and effective utilisation of funding already committed has taken place between local authority and health commissioners. Within mental health services, commissioners and providers are jointly designing future capacity requirements and investment around urgent care, and the CCG has worked with GP providers in considering what the most effective use of additional general practice funding could be for our population.

It is recognised we need to go further and the STP is working with NHS England and NHS Improvement as part of the Integrated Care System accelerator programme to consider future

approaches to shared risk and, especially important for this health economy, how specialised services forms part of this conversation going forwards. In addition, the local NHS Midlands team are working on how we can influence wider primary care investment they commission in our city and borough.

Recently chief executive officers agreed to transparency of financial positions, costs and investments in our organisations and this will be carried into the discussions above to ensure there is a consistent view of investment (and outcomes) and efficiencies across Birmingham and Solihull.

Further discussion will occur as part of our Integrated Care System development about how we share risk and how we deliver provider savings at an organisation level; commissioner savings in those areas it has more ‘direct’ control, such as prescribing and continuing healthcare spend; with additional contributory savings from those initiatives that require cross organisation working. Early intervention is an initial example of this that contribute to the wider system gap (recognising some of the expression of this comes through CCG spend).

A move away from individual statutory accountability is a must for this to happen effectively. This will prevent the return of old behaviours where organisations feel left with little choice but to enter into a transactional and time-consuming approach to tariff-based payments and discussions. This old approach focuses on ‘winners’ and ‘losers’ rather than best use of the public pound. Albeit in times of very low growth funding over recent years this remains extremely challenging.

The detailed financial projections for 2019-2024 are available in Appendix 6.

Using our buildings to deliver change

Creating positive environments to improve the experience of care and create great places to work

Why do we want to change?

From the inception of the NHS, the estate has provided the physical backbone for the delivery of clinical services and has grown and adapted to meet the health and care needs of an ever-changing population. However, due to historical underinvestment in the estate and infrastructure across Birmingham and Solihull and indeed nationally, there is now significant strain on the estate to meet the needs of an ageing and increasing population with a high prevalence of long term health conditions.

At present, the estate will be unable to meet the needs of the population of the future and fundamental improvements are required to ensure the estate is able to support clinical services in the coming years. We are working on moving away from the reliance on 'bricks and mortar' solutions to make clinical services more accessible and maximise the opportunity of digitally-enabled access to services and care. This is to ensure patients are treated in the right location, at the right time and at the right level and maximise the value and efficiency of our public estate. As a system we are also working closely to improve utilisation of space, reduce the age of our buildings and diminish any unwarranted variation in our estate. In this context, our goal is to first, adhere to, and then exceed the ambitious targets outlined by Lord Carter and Sir Robert Naylor.

Underpinning the STP estate strategy and estate developments across Birmingham and Solihull are the principles of provision of care closer to home and away from an acute setting in a safe, appropriate, high quality and modern environment, putting the patient at the heart of all key decision making.

There are hundreds of separate health and care sites across Birmingham and Solihull, ranging from large hospitals to localised clinics and care homes. Our NHS sites alone cover nearly 725,000m2 of land. These sites have been built, acquired or leased over many decades and sometimes in a rather patchwork manner. 56% of our NHS buildings are at least 25-years-old and several are over 50-years-old. Many are ill-suited to the requirements of modern care and are in need of substantial maintenance.

The way we plan, manage and use our public estates will be pivotal to our transformation from working as separate institutions to working as a single place in the best interests of our citizens and patients. The spread of our buildings gives us huge reach across our geography and into our many communities. We need to use these public assets efficiently and in the collective interest. We will be much more innovative in how we use our estates, as well as other assets such as technology and our workforce, to make co-location of services the norm. This will stop citizens and patients having to trek from A to B when they could have multiple needs met in a 'one stop shop'

and accessing care at a place and time convenient to them through the opportunity that virtual/digital access to care and services will bring.

Condition of the estate

The current estate requires significant investment and current backlog maintenance for the region was estimated last financial year at £893m. Iconic healthcare estate, which has not only stood for centuries, but also has considerable civic importance will require innovative solutions to not only to continue to maintain, but also improve condition, and at the same time support the expansion of services to an increasing number of patients with increasingly complex health conditions. Historically, the NHS has relied on 'bricks and mortar' solutions to manage capacity and condition problems but this is no longer feasible. As such we will develop cohesive estates and asset integration across public sector organisations in Birmingham and Solihull to provide cost-effective, collaborative estate solutions, that work across clinical pathways and models of care.

Rationalising public sector estate

There is a considerable work to be done to reduce the unoccupied and non-clinical floor space in health and care facilities across the region, to not only meet NHS national requirements, but to exceed them. For an STP as significant as Birmingham and Solihull, this is the minimum expectation.

At present, void space across the system sits at an unacceptable level. Solving this problem will sit at the very heart of the STP estate strategy decision making in the coming years and an underpinning design principle for our future model of care.

Similarly, there remains significant scope to co-locate back office and administrative processes across the area and we are also working closely across the digital agenda to maximise opportunities presented by the implementation of digital technologies.

Fiscal sustainability

With five of the most nationally significant NHS foundation trusts, a network of 164 primary care facilities and the biggest local authority in Europe all serving the second largest population in the UK, prioritisation and coordination of limited HM Treasury capital funding has, and will continue to be, essential for the development of the Birmingham and Solihull healthcare economy. Coupled with the scale of economic development opportunities across Birmingham and Solihull related to the metro expansion, HS2, increasing student population, new home developments and relocation of a number of large employers in the region, there is both an economic opportunity but also the impact of increased transient population flow through Birmingham and Solihull. Ensuring we have the public estate to support our populations' needs is therefore fundamental.

In addition, work is ongoing to quantify the full impact of the workforce, estates and digital investments required to deliver new models of care. This will also include any potential funding required to offset the costs where they cannot be contained within existing published allocations to 2023/24. Continuous work with both internal and external system stakeholders will be required to not only prioritise schemes which are of the upmost importance, but also to support those already underway. As of 7 November 2019 we have produced a capital

pipeline and prioritisation matrix with buy-in from all constituent NHS organisations in Birmingham and Solihull, which will go some way to implementing the schemes and priorities outlined in this document. This will constitute a significant and collaborative undertaking but will be absolutely essential to ensure that fiscal sustainability is achieved and that the health, wellbeing and prosperity of the population enhanced.

Digital

The issues facing Birmingham and Solihull outlined earlier are not new to the NHS, albeit they are extenuated because of the large and complex population. However, the implementation of digital technologies offers a never before seen opportunity to address them. Digitally-based solutions offer the opportunity to reduce the reliance on historical 'bricks and mortar' developments, and whilst implementing technology constitutes a massive challenge, it also provides the most innovative and sustainable solution that has ever been available, and will therefore, have to be at the heart of decision-making in the coming years.

Priorities for change

Over the next five years, the estates function in Birmingham and Solihull will make significant provisions to improve the support to its local population in line with the priorities of this plan. To achieve this, we acknowledge that change is required to improve the way we work as a system across the STP estate. This is a significant task given the size and scale of the NHS organisations across Birmingham and Solihull but will be essential if the value of the estate is to be realised both clinically and financially.

In view of this, a new STP system-wide estates governance process has been implemented, with senior representation across all NHS and key external public sector organisations through the new Strategic Estates Board. There are sub-group workstreams covering disposals and void management, efficiencies and backlog maintenance and capital pipeline and prioritisation. This new, dynamic governance structure has already begun to systematically and collaboratively address the issues across the estate to support the future needs of the population. This new way of working is central to the development of an integrated and financially-sustainable estate across Birmingham and Solihull, ensuring the best value and operational configuration.

Our model of care capital priorities

An important caveat to note regarding capital priorities for the Birmingham and Solihull STP below, is that planning, implementation and capital allocation will all be subject to the ongoing prioritisation process. The capital pipeline and prioritisation over the next five years has now been finalised and capital schemes that ranked highest on the matrix were able to fundamentally demonstrate how their respective developments will benefit the wider healthcare system in Birmingham and Solihull. This prioritisation matrix will be a standing item on the agenda for the capital pipeline and prioritisation workstream and will be reviewed quarterly by the Strategic Estates Board to ensure that estates capital application and planning strategy continues to reflect the Birmingham and Solihull healthcare context.

Provision of early years and maternity community hubs

Providing the estate to support families through pregnancy and until their child starts school will be an essential tenet to the Birmingham and Solihull estate planning over the coming years. Central to this will be moving care into the community and closer to home. Work has already begun on increasing the use of public sector estate to connect with local communities through the development of Early Years Hub, which will integrate health visiting services, children's centres and other support services in a safe, modern and high-quality estate environment. Likewise, the development of a new Women's and Children's healthcare care facilities in Birmingham to replace facilities with extremely high levels of backlog maintenance, the capital for which has been prioritised by the STP, will dramatically improve maternity and early years' services across the region and will integrate acute and community provision of care. The STP estates function will continue to work closely with system partners to provide a safe and appropriate environment for families, mothers and children.

Development of hyper acute and acute stroke units

Studies have shown the provision of hyper acute and acute stroke units have resulted in shorter lengths of stay and reduced mortality. NHS organisations and external partners are working together to ensure the estate can support the provision of these services over the coming years within acute sector settings.

Provision of direct access diagnostic hubs for respiratory care

The provision of early intervention services will be at the centre of estate decision making in the next five years. The development of direct access diagnostic hubs across the region will support this by delivering evidence-based spirometry and exhaled nitric oxide testing to better diagnose, and therefore treat asthma or chronic obstructive pulmonary disease.

Provision of care for older people

NHS and social care across Birmingham and Solihull have set ambitious priorities to enable and support older people to stay healthy, active and independent for as long as possible. However, when people do need support it should be accessed as close to their home with support networks as much as is possible. It is recognised there will be a set of estates consequences as a result of the "home first" service model. These include:

- A new intermediate care service model delivered through five care centres in Birmingham. We have identified the likely sites for these centres but they will require refurbishment.
- Our local neighbourhood teams across Birmingham and Solihull will require integrated bases and we will be working on the option for their locations within our existing estate
- There is an on-going piece of work to review the intermediate care bed capacity in Birmingham as the new service model is rolled out. This will potentially identify the decommissioning of beds and rationalisation of sites.

Finally, with a refreshed strategy for end of life care within Birmingham and Solihull there will be a need to work with hospices on developing the future estate.

Reducing reliance on A&E

The reliance on A&E departments as the first point of contact for patients is putting an incredible strain on the infrastructure, workforce and delivery of NHS services. Furthermore, evidence fundamentally points to the fact that patients get better, more quickly and crucially remain healthier when treated closer to home. Yet despite this, A&E has continued to see an increasing volume of patients who are both self-presenting or coming in through the ambulance service.

Working across the system, our plans are to relieve pressures on A&E by reducing demand on hospital emergency care and providing urgent and emergency care outside of the hospital. To achieve this, we are committed to delivering Digital First urgent care, integrating and expanding pre-hospital urgent care by embedding a multi-disciplinary Birmingham and Solihull Clinical Assessment Service and fully implementing urgent treatment centres, expanding a comprehensive model of same day emergency care, reforming hospital emergency care to reduce stays in hospital and encourage same-day discharge. Likewise, we will be remodelling the estate to increase extended access and capacity to deliver same day emergency care and offering access to short-stay psychiatric decisions units.

An estates system-wide approach and our digital first philosophy will be vital in supporting the reduction in demand on hospital emergency services, effectively meeting patients' needs and diverting them to the most appropriate setting to the fundamental benefit of their health and wellbeing

Cancer

The STP has made commitments to provide for rapid diagnostic centres and endoscopy suites to increase early diagnosis and therefore potentially the prevention of cancer at the earliest stage possible. At present we are looking at virtual solutions delivered through the introduction of pathways rather than 'bricks and mortar; solutions and a pilot is being planned in east Birmingham with an evaluation supported by the University of Birmingham. Dependant on the findings of this pilot, wider rollout plans will be developed, and this will be a collaborative process across the NHS organisations in the region.

Mental health

Providing a safe, compliant and fit-for-purpose environment for those with mental health illnesses is imperative for the delivery of better care quality, improved patient experience and the opportunity to improve on their mental health wellbeing. This will support the reduction of out of area placements by ensuring we have the capacity and infrastructure in place to enable access to care and treatment locally.

Birmingham and Solihull Mental Health NHS Foundation Trust has been working to a clear board-approved estates strategy, responding to clinical strategies and commissioning requirements.

The STP is currently working on three substantive mental health developments. A new Reaside Secure Mental Health Facility will require capital funding of circa £48m and will provide 107 beds. Highcroft Acute and Urgent Care Inpatient Facility will require funding of circa £45m to provide 95

beds and Hillis Lodge Low Secure Unit at circa £10m providing a compliant low secure and rehab mental health inpatient facility.

All three developments are on Birmingham and Solihull Mental Health NHS Foundation Trust's owned sites. They are supported by commissioning strategies, address significant backlog maintenance issues and meet patient compliance and quality standards. All projects have been discussed with the local planning department and received positive support. There is full buy-in and involvement from inpatient service user groups, patient carer governors and clinical teams.

The current accommodation does not fully comply with latest Department of Health guidance or enable patient safety and quality facilities to be addressed or build capacity to bring patients back into the area. As a result, we need to see facilities dramatically improved to meet the needs of the population and the new facilities will improve inpatient facilities for those suffering from long term mental health conditions.

In addition, Birmingham and Solihull Mental Health NHS Foundation Trust is looking across its whole estate portfolio to improve older people's mental health experience including dementia and frailty reviews, rehabilitation provisions and community care support. A further project example includes the reconfiguration provision for mental health within its urgent care provision at the Oleaster Centre. This will offer a more appropriate and flexible environment for people than traditional A&E settings and the STP estates function will work across the healthcare system to provide alternatives to A&E for people experiencing a crisis in their mental health.

Primary care estate

A Birmingham and Solihull-wide Primary Care Estate Strategy will also be completed by the end of December 2019. The work has developed a modelling and prioritisation tool which has identified a gap of circa 25,500m^2 to meet equity of access to appointments, but this will increase over the next ten years as a result of population growth and housing developments. The work has also identified that at present 35% of the buildings are not functionally suitable.

The estate also needs to adapt to meet the Primary Care Network contract service model and the provision of integrated hubs to enable closer working with community, social services and acute out of hospital diagnostics.

The strategy will identify the priorities and establish a programme of work to address the lack of capacity and unsuitable accommodation over the next five years. A range of solutions will be identified such as use of digital technology, longer opening hours, sharing accommodation and the use of void space prior to building capacity will be considered as a means of ensuring the needs of primary care facilities are at the forefront of estate planning.

As part of the capital prioritisation process undertaken in 2019, £10.73m has been allocated to address the first priority GP sites identified as having insufficient capacity to provide the number of consulting rooms to support the list size and are also in accommodation that is functionally unsuitable. These schemes are intended to support greater resilience in primary care to access appointments. It may be that these schemes will be funded through Estate Technology and Transformation Fund (ETTF) monies.

A further £19.3m is sought to support work that is needed to undertake facet surveys, feasibility studies, STP-wide engagement, healthcare planning, design and business case writing to enable the development of projects to deliver integrated hubs plus the next priority GP/Primary Care Network schemes to increase capacity to meet the Primary Care Network contract service model.

Of paramount importance in primary care developments over the next five years will be increasing diagnostic capabilities and reducing wait times for access to community-based care.

Diagnostics and outpatients

The STP has set ambitious targets to improve diagnostic capabilities and outpatient facilities across Birmingham and Solihull. A particularly notable priority in achieving this is the development at Heartlands hospital, where capital has already been provisionally allocated for the Ambulatory and Care and Diagnostics (ACAD) scheme, which will see circa £100m in capital invested into the system.

Work at The Royal Orthopaedic Hospital to provide for a new outpatients and diagnostic hub, and the provision of new general anaesthetic dental theatres in the community will further support these targets.

How does this deliver the STP aspirations?

Independence and resilience

- ✓ Delivers a healthcare estate that is resilient and responsive to future population needs and demands
- ✓ Delivers care closer to home in a setting that will allow you to get well quickly and stay well in the long-term.

Equity, equality and inclusion

- ✓ Targets tailored support for those most at need in society
- ✓ Reduces the reliance on support to access care when you need it most
- ✓ Challenges inequity in access and outcome.

Integration and simplification

- ✓ Creates an integrated healthcare economy with collaborative solutions developed with a system view.

Promoting prosperity

- ✓ Supports individuals to stay healthy.

Social value

- ✓ Reduces reliance on ‘bricks and mortar’ development through digital and collocated healthcare solutions.

Delivering our commitments in practice

With a vast estate across Birmingham and Solihull serving a population of over 1.3 million, in what is the one of the most complex healthcare systems in the country, developing an integrated and collaborative approach across the healthcare economy will be absolutely pivotal to the realisation of the Birmingham and Solihull estate as one of its most substantial and valued assets.

As our model of care continues to develop and estates needs are identified, we will apply the principles and approach to ensure we use void space as far as possible, use the opportunities of co-location and integration with wider public sector estate and the opportunities of digital to connect our communities, our care and our workforce as far as possible. Where that is possible, this will inform our system capital prioritisation.

System planning, prioritisation and joined up working through our new governance structure is already bringing together the directors of estate from each of the five NHS foundation trusts and the clinical commissioning group across Birmingham and Solihull, who are empowered to set the strategic direction of the STP through the Strategic Estates Board. Three workstream groups have been implemented that will begin to address the most prominent estate issues across the STP and will integrate both internal healthcare providers and senior members of Community Health Partnerships, NHS Property Services, One Public Estate and Local and Combined Authority to ensure that the strategic direction of the estate across Birmingham and Solihull is set with a system-wide view to achieve maximum value for patients and the public.

Disposals and void management

The disposals and void management workstream will seek to provide additional capital through the disposal and reconfiguration of healthcare services. Where possible, developments will integrate Community Health Partnerships and NHS Property Services to ensure that all developments take account of the large void space across the region and where possible, begin to fill this. This integrated approach to managing the estate will unlock huge potential for growth across Birmingham and Solihull and will be essential to fulfil the mandate of this Long Term Plan.

Efficiencies and backlog maintenance

This workstream group brings together each of the NHS organisations to collaborate and achieve the target of not only meeting, but exceeding Lord Carter's guidance on reduction of unoccupied and non-clinical space. A key facet of this workstream has been to begin to establish the full quantum of the backlog maintenance issue across Birmingham and Solihull, and to systematically reduce this figure through collaboration, the integration of digital and the sharing/co-location of back-office functions. Strategic Health Asset Planning and Evaluation metrics on condition of the estate in Birmingham and Solihull are currently being finalised which will go a long way to progressing this target.

Reducing the reliance on 'bricks and mortar' development will be another key element to this revised governance structure, and short, medium and long-term facilities and maintenance management strategies are being developed as we speak to ensure that the condition of the iconic Birmingham and Solihull healthcare remains safe, compliant and fit to meet the needs of the population.

Capital pipeline and prioritisation

As part of the ongoing work to prioritise and support capital schemes across Birmingham and Solihull, a capital prioritisation matrix has been developed and approved by the directors of estate from each NHS foundation trust and senior representation from the CCG and primary care. This matrix quantifies the priority of any capital application across the system based on clinical, STP and Long Term Plan priorities and STP estate priorities. It includes enabling disposals, reducing backlog maintenance and improving estate efficiencies, and where there is requirement to expand clinical services, property companies NHS Property Services and Community Health Partnerships will be fully integrated to reduce unnecessary void space and the reliance on 'bricks and mortar' development. This workstream will continue to ensure that capital developments are pursued, reviewed and prioritised that best serve the populations needs and in line with national and local guidance.

How will services be different in 2023/24?

By 2023/24:

- The estate will have enabled the provision of a safe, modern and fit-for-purpose health and care environment for citizens of Birmingham and Solihull
- The STP will have maximised disposals where feasible to support wider clinical and estates developments across the system
- The public will have improved access to community care infrastructure, in a location that is both convenient and to the benefit of their long-term health
- The Digital First agenda will have reduced reliance on bricks and mortar and streamlined access to care
- Non-clinical and unoccupied space across the Birmingham and Solihull estate will have been minimised
- Collaborative decision-making across the NHS organisations in the region will be the norm and estates decisions will be made with a system view.

Research and innovation to drive future outcome improvements

Advancing health and care and better outcomes by increasing participation in research, accelerating innovation

Birmingham and Solihull has a very vibrant and successful background in research and innovation, with a long-established history of collaborative working between academia, clinicians, industry and patients.

Our unique concentration of prestigious institutions makes Birmingham in particular one of the few global cities equipped to deliver multi-disciplinary leading edge research. Collectively we have one of Europe's largest clinical trial portfolios, providing many more opportunities for patients and staff to participate in research. It is one of the best places to invest, study and work in the life sciences research and innovation in the UK.

We already have a strong background in research, being one of the leading centres outside London and we have a track record of testing and proving new innovations, including the development of the Institute for Translational Medicine and the Medical Devices Testing and Evaluation Centre. A particular strength of the region is healthcare data, on account of the only Health Data Research UK site with an NHS provider being a core partner based in Birmingham.

Why do we want to change?

Research and innovation are critically important to drive future health and care advances and quality improvements and address many of the challenges in the **NHS Long Term Plan**. They are essential in enabling prevention, developing more effective treatments and delivering better outcomes for citizens and for the population as a whole. They are also critical in creating a learning environment to understand what works and why so we can spread innovation across our area.

However, there is scope to increase the participation in research and evaluation across the system to improve learning and the spread of innovation and best practice as part of our ambition to build a national and international reputation as a learning economy.

Priorities for change

Over the next five years, we will be increasing the participation in research and boosting the development and uptake of innovation by working with our citizens, staff, academic partners and innovators, utilising their valuable experience and expertise. Key to this will be empowering staff to develop ideas and new ways of working and then implement change to deliver results.

There will be a particular focus on innovation in relation to genomics, which is an emerging medical discipline that involves using gene-related information about an individual as part of their clinical care. The rollout of genomic testing has the potential to radically change the diagnosis and

treatment of certain groups of patients including children who are likely to have a rare genetic disorder, children with cancer, and adults suffering from certain rare conditions or specific cancers.

The West Midlands Genomics Medicine Centre is hosted within the STP and is a partnership of 16 NHS acute trusts across the West Midlands. It is hosted by University Hospitals Birmingham NHS Foundation Trust and includes all acute and specialist trusts across Birmingham and Solihull. During the 100,000 Genomes Project, the centre consented and transferred to the UK bio-repository more cancer samples than any other centre in the country. A number of legacy systems from the project will continue to exist as the NHS's plans for a genomic medicine service evolve. Within the STP there is potential to contribute significantly to the national ambition of sequencing 500,000 genomes by 2023/24.

By increasing the use of genomic medicine, we can ensure that patients receive targeted therapies that are individual and allow the best outcomes to be achieved in the management of their disease or their pre-disposition to disease. By harnessing these technologies, we can offer truly personalised medicine; including reducing the risk of an individual developing an illness we can promote good health, ensure that they receive absolutely the right care and thereby improve outcomes.

How does this deliver the STP aspirations?

Independence and resilience

- ✓ Enables the prevention of ill health, early diagnosis and more effective treatments, improving the number of years that people live in good physical and mental health
- ✓ Develops and empowers an innovation-ready workforce.

Equity, equality and inclusion

- ✓ Offers transformational and targeted treatment for conditions
- ✓ Provides consistent and equitable access
- ✓ Benefits society and people needing health and care as the benefits are not limited to only those patients who participate in research
- ✓ Ensures local adoption and spread of innovation.

Integration and simplification

- ✓ Brings together key partners across sectors spreading innovation to meet local needs, connecting and maximising the use of facilities, data and resources
- ✓ Makes it easier to undertake and participate in research with standardised methods and processes.

Promoting prosperity

- ✓ Benefits the local economy, increasing the value of the industry with jobs and services, attracting the best talent to the area.

Social value

- ✓ Benefits are felt by society as a whole e.g. disease prevention/treatment, community investment decision-making.

Delivering our commitments in practice

We will:

- Deliver a year-on-year increase in the number of people registering to participate in health research across Birmingham and Solihull
- Redefine the life sciences cluster model by putting the patient/citizen at the heart of the innovation ecosystem
- Generate solutions in partnership with local universities and the private sector to innovate thereby:
    - Improving efficiency
    - Meeting the expectations and requirements of patients
    - Attracting and retaining the best staff.
- Develop an internationally-leading med-tech cluster centred around Birmingham and, in partnership with the West Midlands Academic Health Science Network seek to spread and accelerate the adoption of innovation more widely
- Develop an innovation-ready workforce, providing them with the skills they need to be champions and developers of innovation and transformation and consumers of research. This will allow them to better tackle clinically and operationally-led challenges.
- Through the Academic Health Science Network we will align research opportunities to RightCare and ‘Get it Right First Time’ to ensure the adoption of innovation and service improvement are aligned
- Continue to connect the outstanding isolated assets (facilities/data/resources) to overcome the challenges of our currently fragmented ecosystem
- Scope the benefits that would be achieved by consolidating the back-office functions to support research and innovation across Birmingham and Solihull allowing unified and simplified processes across the STP
- Develop mechanisms for continuous improvement and evaluation of innovation activities, as well as the other transformative actions are covered in other chapters of this plan
- Use the delivery of the shared record to enable the research community to develop innovative, evidence-based tools, products and services that improve outcomes and drive efficiencies.

In relation to genomics:

- By 2019/20 we will complete the roll-out of Genomic Rare Disease Advisory Boards, with representation from across the STP hospitals, to undertake clinical interpretation of whole genome results, return the results to patients and families and alter treatment plans or enter patients into clinical trials
- In partnership with pathology and radiology networks we will build on the existing systems developed for the 100,000 Genomes Project to adopt innovative approaches to data sharing architecture which will further support the sharing of data required for clinical treatment
- We will continue to work with NHS England and NHS Improvement to shape the national specification for genomic medicine services and respond appropriately when this is finalised in line with the timescales set to ensure that all eligible patients receive appropriate genomic testing
- By 2020/21, we will reconfigure our clinical pathways for whole genome sequence readiness so that people can receive access to appropriate genomic testing consistent with the national directory
- By 2020/21 we will implement the national genomic test directory with whole genome sequencing for childhood cancer and mandatory panel tests, utilising the established genomic pathways to ensure patients receive the personalised care identified for them
- From 2021/22 we will implement a programme to upskill the nursing workforce to increase their understanding of genomics and allow them to support patients receiving genomic testing and personalised medicine.

How will services be different in 2023/24?

By 2023/24

- We will continue to access patients and staff opportunities to participate in leading edge research trials
- We will have increased the participation in research and translation in to practice by empowering staff to develop new ideas and ways of working.

Creating social impact

Tackling health inequalities and maximising our collective impact on communities to promote the highest standards of environmental and social prosperity

Our STP strategy places real emphasis on the importance of creating social impact, ranging from improving air quality through to driving social value.

We have a dynamic opportunity to realise social value on a much larger scale by working together as organisations. When we use our scale and act collectively, we have the potential to deliver social and economic benefits that are far broader than health and care alone. We have the chance to build on our role as a 'system anchor' and better use our resources in ways that meet the needs of our population, contributing to the future prosperity of our diverse communities and improving health and wellbeing. This can be achieved through influencing how we affect and interact with our environment, creating new jobs and learning opportunities and ensuring our models of care target health inequalities. Taking into account the wider social-economic consequences of our actions and embracing them in our decision making has the potential to derive greater overall social benefit from the investment of each public sector pound.

Why do we want to change?

We have acknowledged in this plan that we have huge health inequalities. It is clear there is not enough support for some of the most vulnerable in our society, such as the rough sleepers and homeless and victims of domestic and sexual abuse. Health and care organisations have an important role in tackling this.

We recognise that some of our pathways of care are fragmented, such as for those in the justice system, in particular those requiring immediate support post release.

We also have a significant environmental challenge. Air pollution is the largest environmental health risk to citizens in Birmingham and Solihull and one of the major causes of premature mortality on its own. Children, pregnant women, older people and those with chronic health conditions are among the most vulnerable.[1] Poor air quality also has the potential to exacerbate health inequalities across the region. Both Solihull and Birmingham councils have plans in place to reduce carbon emissions and improve air quality and are signed up to the West Midlands Combined Authority climate change emergency. This provides an important backdrop for the actions set out in this plan.

[1] RCP. Every breath we take: the lifelong impact of air pollution. February 2016

Priorities for change

Building healthier communities

The STP strategy prioritises social value as one of our key aspirations. We have developed a social value policy, which supports local authorities and health and care organisations to use the procurement of services to leverage social good. This will help us ensure we use our collective buying power to, for example, tackle some of the social determinants of poor health and increase employment opportunities. We are not using this as a one size fits all approach, as not all the relationships we have with suppliers will be appropriate for this purpose but wherever possible, we will adopt this approach.

Given our role in the wider community, we also see ourselves as 'anchor' institutions in terms of the wider benefits we can deliver from being an employer, purchaser, asset holder and partner. For example, University Hospitals Birmingham NHS Foundation Trust has worked with local partners such as The Prince's Trust to establish a learning hub, which offers pre-employment advice, training, guidance and direct links to jobs in the NHS to unemployed local people and those furthest from the labour market.[2]

We are also developing a number of inclusive growth corridors across Birmingham and Solihull, taking a more holistic approach to the redevelopment of some parts of the city, working also to tackle the deprivation and inequalities within some communities. A particular focus to date has been on the east Birmingham to north Solihull growth corridor. Led by the Solihull Inclusive Growth Board and the East Birmingham Board, this is developing new ways to make sure that citizens living in the most deprived parts of our area benefit from growth, economic development and regeneration planned for the area. Working with the West Midlands Combined Authority, this recognises that long-term improvements in health will only happen by improving people's life chances, routes into employment and the quality of the built environment. The NHS as an 'anchor organisation' and major regional employers has a key role to play in this as well as by making sure there is good access to local services, including primary care, in these areas.

Health and the environment

We have made improving air quality one of our key priorities as a system.

We have modelled the impact of the health outcomes travel tool across the STP with the aim of understanding our environmental impact as a system on air pollution. From this work, we have identified the following evidence-based priorities for the system:

- Reducing emissions from business travel, in line with NICE standards. STP providers are already moving to low emission and electric vehicles where practical to do so
- Producing staff travel plans to support more staff walking and cycling in to work

2 https://www.health.org.uk/sites/default/files/upload/publications/2019/I02_Building%20healthier%20communities_WEB.pdf

- Supporting and upskilling professionals to have conversations about air quality for people suffering from heart or respiratory disease
- Championing the development of green travel districts to improve air quality, transport safety and physical exercise
- Recognising we have a significant impact on the environment through our food system and will work across the system to review how we can use our procurement and leadership space to improve this.

A number of our organisations are also participating in Birmingham City Council's "Route to Zero" taskforce, aimed at putting together an action plan to support the council's recent climate emergency declaration.

Through our respective sustainability strategies or sustainable development management plans (SDMP) for NHS organisations, we have also identified a number of key changes to clinical pathways which support environmental sustainability:

- Removing physical journeys by using digital technologies, such as virtual consultations for primary care and outpatient appointments
- Green anaesthetic programmes, awareness raising for health and care staff to understand how they can move to low carbon alternatives
- New housing developments across Birmingham and Solihull, which have the potential to support our staff, patients and communities live in healthier, greener and more active communities.

Supporting those who need extra support

To support those who need extra support we will:

- Work across all partners, including the West Midlands Combined Authority, community and mental health services to identify current gaps in prison release pathways, focussing on services for post release
- Work with NHS England to support the roll-out of Community Service Treatment Requirement
- Prioritise awareness raising and guidance for domestic abuse, including sexual violence. We will roll out a programme of work around domestic abuse across the STP which will cover:
    - Training and awareness raising for staff across STP organisations and identification of domestic abuse champions
    - Signposting for victims (within our workforce and across the population) ensuring that health and care staff have confidence to ask the right questions
    - Providing neutral safe spaces for victims of domestic abuse to seek assistance from specialists

- Bidding for national funding to support local domestic violence services and implementing the Domestic Abuse Bill once this is in place.

- Tackle homelessness and be part of a multi-agency solution. We will continue to work through the West Midlands Combined Authority's homelessness task force to ensure that the needs of health, wellbeing and housing needs of at-risk groups are identified
- Review current pathways between sexual assault referral centre services and referrals into mental health and other specialist support services, to ensure seamless care for victims
- Continue to be a centre of excellence for physical health care for veterans and the armed forces, hosting the Royal Centre Defence Medicine at the Queen Elizabeth Hospital. Birmingham and Solihull Mental Health NHS Foundation Trust is also a member of the Veteran's Mental Health Network, is a signatory of the Armed Force Covenant and provides Mental Health Complex Treatment service for veterans experiencing physiological trauma, as well as help with substance misuse and physical health care. University Hospitals Birmingham NHS Foundation Trust is also a signatory of the covenant and is accredited by NHS Improvement as a Veteran Aware hospital. We will continue building on these initiatives, together with NHS England, to ensure alignment between national commissioning and locally-provided services for the benefit of the veteran population in Birmingham and Solihull.

Volunteering

We know how important volunteering is to our organisations and an overwhelming majority of frontline staff (70%) agree that volunteering in hospitals adds value for patients and staff and the majority of frontline staff enjoy working with volunteers[3].

Volunteering contributes to the wider social impact of health and care services and it can also have a significant impact at an individual level by enhancing wellbeing, reducing social isolation, promoting mental and physical health and also developing skills and employability.

In Birmingham and Solihull, we need to attract more people to volunteering and create flexible opportunities that fit with people's lifestyles, interests and skills. We also aim to improve the diversity of those volunteering with us to reflect our communities and ensure everyone has access to volunteering opportunities.

Currently there is limited integration of volunteering across organisations. However, we need to recognise that volunteers have preferences about where they volunteer and the type of roles they are interested in.

Over the next five years, we aim to double the number of volunteers across our partnership and raise awareness of the benefits and opportunities this can bring to an individual and their community. To achieve this, we will:

- Look to create a joined-up approach to volunteering across the STP, aligning marketing and advertising campaigns to improve our area's volunteering brand, including the development

[3] **https://www.kingsfund.org.uk/publications/role-volunteers-nhs-views-front-line**

of a volunteering prospectus. We will build on some of the collaborative efforts we have in place at the moment, such as 'Expert by Experience Connectors' which is a joint project across a number of providers, which connects expert patients with trainee nurse associates to work within them throughout their training, helping them to improve on a personalised approach. We will draw on the expertise of our delivery partner Helpforce to ensure that we are drawing on best practice across the NHS.

- Align our processes for recruiting, inducting and training volunteers to ensure cross-organisation sharing of volunteers where practical. Where a volunteer is registered and recruited in one site, they should be able to apply for opportunities at another site in a seamless way, giving them access to new and diverse experiences.
- Ensure equity of volunteering access and opportunity to all communities across Birmingham and Solihull, with a particular focus on recruitment from deprived communities
- Expand innovative volunteering programmes across the STP. Each of our organisations have exemplar programmes that could be expanded across a wider footprint, providing engaging volunteering opportunities. For example, some of our organisations support #iwill, a national initiative that promotes social action, including fundraising campaigning and volunteering among young people aged 10-20. Birmingham Women and Children NHS Foundation Trust is a regional beacon site for the programme. We are keen to continue looking for new opportunities to involve young people in volunteering programmes, with appropriate due diligence and safeguarding procedures put in place.
- Continue to use young people for service feedback and input e.g. in patient-led assessments of the care environment, University Hospitals Birmingham NHS Foundation Trust's young people's forums and Birmingham Women's and Children's Hospital NHS Foundation Trust's young person's advisory group.

How does this deliver the STP aspirations?

Independence and resilience

- ✓ Enhances health and wellbeing, increasing the physical and emotion resilience of individuals, communities and society as a whole
- ✓ Develops and empowers the workforce, including volunteers
- ✓ Uses complementary approaches to individual, community and public service efforts.

Equity, equality and inclusion

- ✓ Provides opportunity of access to volunteering across Birmingham and Solihull
- ✓ Benefits all citizens and society more widely by creating opportunities for all and by creating a caring society
- ✓ Improves diversity and a cohesive society by involving and creating positive impacts for all our communities.

Integration and simplification

- ✓ Brings together key partners across sectors, tackling issues with multi-agency solutions
- ✓ Aligns processes and initiatives across the system
- ✓ Creates a clear offer for volunteers in terms of the opportunities, benefits and work-related skills that can be developed to support future prosperity.

Promoting prosperity

- ✓ Increases economic potential at an individual, regional and national level
- ✓ Promotes productivity, employment and economic output
- ✓ Enhances skills, income and opportunities.

Social value

- ✓ Makes better use of public spending and creates added value to all our services
- ✓ Improves decision making, taking into account socio-economic consequences
- ✓ Promotes environmental and social sustainability.

Delivering our commitments in practice

From 2019/20 we will roll out our domestic violence training support and ensure all health and care professionals are trained by 2021/22.

From 2019/20 each organisation will develop an implementation plan for the roll out of the social value policy and by 2021/22 we will secure a procurement partner to implement this and measure impact.

From 2019/20 we will monitor and measure using the health outcomes travel tool air quality monitoring and upgrade our vehicle fleet on an ongoing basis and will take into consideration the digital transformation in relation to outpatients over the course of this plan. This will also include developing travel plans in 2020/21 to support improvements in air quality.

By the end of 20219/20 we will review existing prison release pathways and also review volunteering policies to address gaps.

How will services be different in 2023/24?

By 2023/24 we will put in place initiatives to tackle health inequalities, with a particular focus on social value, the environment and volunteering.

Taking a life course approach

We have identified a number of high-priority areas for action. These are by no means the only things we will be doing across health and care in the months and years ahead as we will continue to pursue numerous other goals and initiatives within our own organisations and services to meet national and local priorities as part of business as usual.

However, the areas listed in this strategy are those things where there is the greatest gap between how things are now and where we aspire to be in terms of people's outcomes and our services. They are also the things where we believe we can deliver the greatest benefit by working together in partnership as a health and care system, rather than those things that should happen within a single organisation.

We have focused on this by looking at how people use services throughout the different stages of their life. We are committed to transforming services to enable people to be **born well, grow well, live well, age well and die well.**

Maternity, childhood and adolescence

A healthy start in life

Birmingham and Solihull is home to one of the youngest urban populations in Europe. There are 330,000 children and young people here, which is nearly 20% of the total population. One in ten mothers suffer mental health problems in the first years after giving birth, one third of children are deemed to be living in poverty and one in ten have a mental health problem.

The impact of a difficult start in life can be very harmful to children's chances in life. In Birmingham, on average, children's overall health and wellbeing, development at the end of reception, levels of obesity and rates of emergency hospitalisation, are all worse than the national average.

By contrast, the average in Solihull is better than the national picture for childhood health and wellbeing, poverty and obesity. However, that average masks stark inequalities within Solihull. There are some unacceptably poor health outcomes, particularly in the north of the borough, and the rate of children in care is higher than the national average.

We want all of our children to have the best start in life, from birth through to adolescence. To deliver this priority, we will:

- Implement a single Local Maternity System for Birmingham and Solihull that will increase choice, enhance maternity care and support, and improve the experience for mothers. This will help to reduce neonatal mortality rates and adverse childhood experiences and will give babies the best start in life.
- Roll out community perinatal mental health support for mothers through multi-disciplinary teams.

- Integrate health visiting services, children's centres and other support services; creating local Early Years Hubs where families can access the help they need from pregnancy until their child starts school.
- Develop an integrated, strategic commissioning plan for children and young people's services across Birmingham and Solihull, involving schools, public health, NHS services and social care. Priorities for action will be delivered through place-based plans and will include special educational needs and disability services.
- Pilot a transformed model of healthcare for children through community-based, multi-disciplinary teams (virtual and physical) across primary and social care. These will have a clear focus on the prevention of key risk factors and will provide support for self-management from an early age, including diet, exercise, mental wellbeing, oral health and school readiness.
- Promote opportunities in our schools, youth centres, workplaces, and other services for which we are responsible, for increasing daily exercise, such as 2,000 step routes and the 'run a mile' schools programme, and post and pre-natal exercise programmes. In this we will harness the unique opportunity of Birmingham hosting the 2022 Commonwealth Games to build a legacy of physical activity and sporting participation, especially for our children and young people.
- Increase access to children's and young people's mental health services by 35%, in-line with the national ambition; and reduce the number who have to go out of the area to be admitted to hospital for psychiatric care, saving in the region of £2.7m per year and providing a better experience for our young patients and their parents or carers.
- Address variation in access and clinical provision across our urgent and emergency care pathways for children by implementing a single integrated clinical advice and guidance service and rolling out a standardised pathway of care for the most common conditions.

Maternity services

Delivering a consistent world class, safe service that empowers and cares for women and families so they can make informed choices and give their babies the best possible start in life

The Birmingham and Solihull Local Maternity System was part of the NHS England early adopter and has:

- Delivered a number of continuity of carer pilots across the full pregnancy and birth pathway to improve outcomes for women and babies. Study days to support local midwives understand their role and delivery options have been delivered.
- Developed scanning services in the community. A midwifery-led community outreach growth scanning clinic has been successfully piloted for high-risk women who require frequent growth scans because their baby is small for gestational age.
- Rolled out the BadgerNet clinical system enabling women to access their own records online or via a smartphone application. Local Maternity System organisations have signed up to a data sharing agreement enabling woman to have a single maternity record.
- Piloted a single point of access online portal that allows women to register their pregnancy and book for a community midwife appointment directly without visiting their GP
- Developed a dashboard to monitor key performance data across all Local Maternity System services such as smoking at booking and delivery, breastfeeding rates and mental health.

Why do we want to change?

Local needs

The Local Maternity System serves a population of 1.3 million people, with an above average proportion of young people (46% are under 30). Around 22% of the population were born outside of the UK, and English is not the first language for 17% of women of childbearing age[4].

Birmingham is ranked 6th in the Indices of Deprivation for England, and whilst this is not mirrored in Solihull, there are pockets of significant deprivation, highlighting the prosperity gap across Birmingham and Solihull, and as the consequent inequalities in breast feeding rates, health and wellbeing, and other markers of inequity amplified by deprivation.

In 2016/17 there were 18,640 births in the Local Maternity System, with nine out of ten taking place in an obstetric-led setting, placing significant pressure on hospital services. Although 3.8% of women were offered a choice of giving birth at home, only 2% actually went on to do so[5].

[4] BUMP (2017) Local Maternity System plan
[5] ibid

Prior to the start of the early adopter pilot, Birmingham and Solihull had the highest stillbirth rate in the West Midlands (six per 1,000 births); one in 25 babies born at term were a low birth weight, and there were higher than average pre-term labour rates. At booking, 23% of women were obese, and one in ten women went on to develop diabetes in pregnancy. Infant mortality was significantly higher than the England average, at seven deaths per 1,000 births.

Local challenges

- Reduction of perinatal mortality and preterm birth in line with the national ambition will continue to be a significant challenge given the local demographic and starting point
- Workforce challenges including training and recruitment of midwives and ultra-sonographers, sustainable middle grade rotas in obstetrics and paediatrics and a shortage of skilled health visitors will continue to impact on key deliverables e.g. continuity of care and the Saving Babies Lives Care Bundle
- There is an increasing demand for services and a lack of prevention at the required scale
- There are gaps in commissioning across some pathways, with variation in service delivery and offers across Birmingham and Solihull, for instance investment in infant feeding support
- There is a lack of provision of timely and effective infant feeding support in both acute and community settings, especially in Birmingham
- The lack of integrated care is compounded by data sharing issues across health and care organisations
- Financial constraints and system-wide deficits in the context of demand and complexity of need. Health visitors are now managing significant numbers of premature babies with increased complexity across the city.
- There is a challenge in meeting the complex needs of families who have only recently moved to this country or area.

Priorities for change

The future model (Figure 11) was set out within the national '*Better Births'* programme. The **NHS Long Term Plan** requirements enhance and build upon this foundation. Locally we continue to implement one standard maternity approach across the Local Maternity System. Variation in practice will be removed and efforts directed towards tackling inequalities by focusing on vulnerable groups and those who experience the poorest health outcomes. For example, increasing breastfeeding rates is one of the simplest ways of reducing health inequalities and benefits both women and babies.

Transformation and service change priorities are set out in the deliverables section of this report. There are aspects of this that will contribute towards prevention e.g. the Saving Babies Lives Care Bundle.

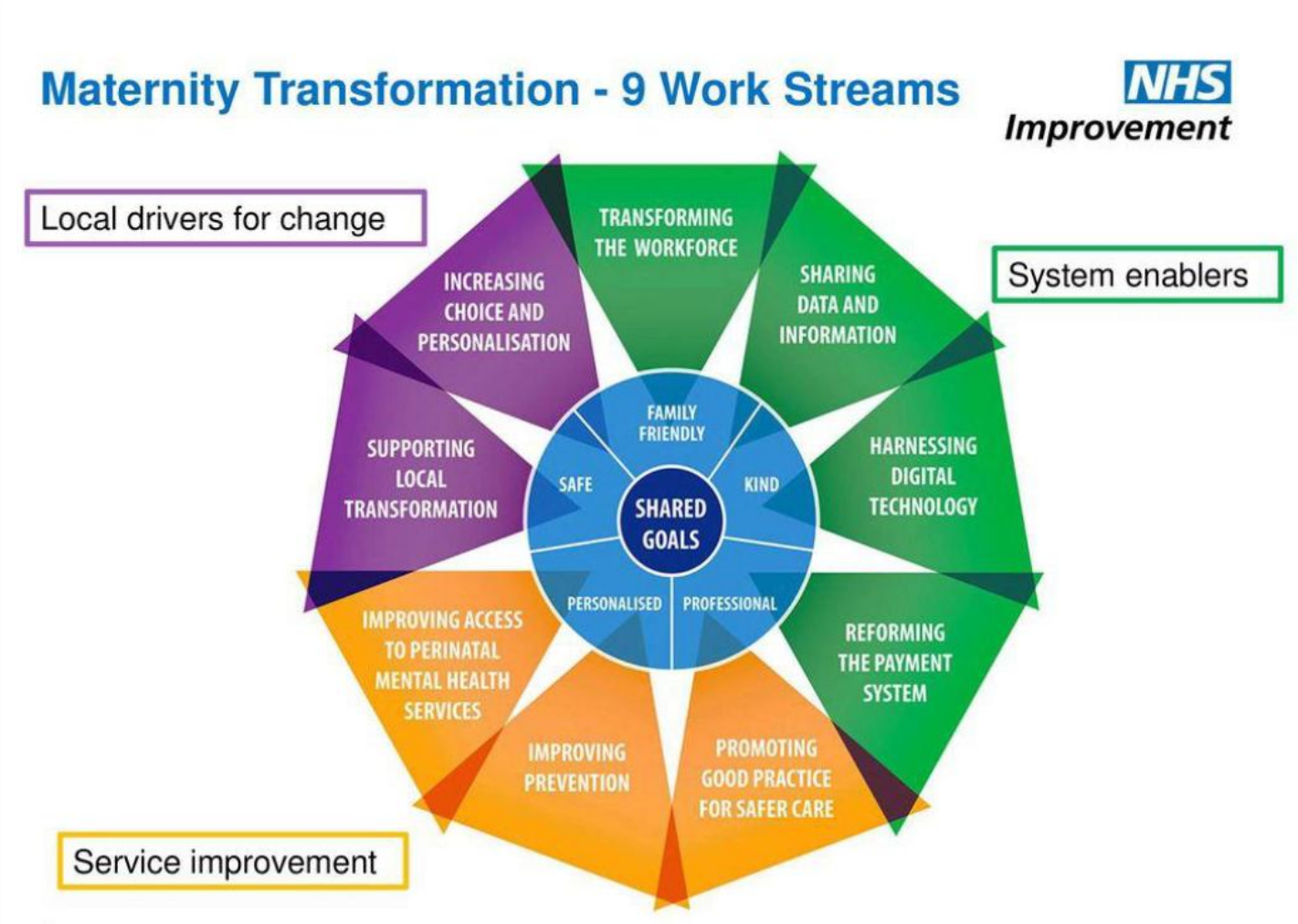

Figure 11: Better Birth Model

The Local Maternity System and the STP Maternity, Childhood and Adolescence Portfolio Board offer the governance and means to develop both the provider and commissioner landscape e.g. provider collaboration, arrangements to streamline commissioning. Several STP enablers including workforce, digital and estates are pertinent to this chapter.

The relevant Long Term Plan headline metrics are linked to:

- Prevention, inequalities, care quality, access and outcomes as well as NHS staff and investment being used to maximum effect
- Specifically, there is an agreed trajectory for 50% reduction in stillbirth, neonatal and maternal deaths and brain injury by 2025.

How does this deliver the STP aspirations?

Independence and resilience

✓ Early detection and intervention, early help, self-care and prevention.

Equity, equality and inclusion

✓ Reduces variation through the development and delivery of clear integrated approach

- ✓ Targets the most venerable mothers and children.

Integration and simplification

- ✓ Makes best use of technology and personal health budgets, rather than having to navigate complex services
- ✓ Integrates services and shares information across the system.

Promoting prosperity

- ✓ Helps to provide the best start in life, benefiting development and educational opportunities.

Social value

- ✓ Makes better use of public spending and creates added value to all our services.

Delivering our commitments in practice

There are a number of areas of focus that will support the delivery of the approach going forward.

Personalised care centred on the woman, her baby and her family based around their needs and their decisions where they have genuine choice informed by unbiased information

Digital maternity records

Digital care is referred to earlier in this plan. By 2023/24, the **NHS Long Term Plan** commits that all women will be able to access their maternity notes and information through smartphones or other devices.

During 2018/19 the BadgerNet clinical system was rolled out at Birmingham Women and Children NHS Foundation Trust and re-launched at University Hospitals Birmingham NHS Foundation Trust. The Local Maternity System worked with CleverMed, the software supplier, to develop the functionality of BadgerNet, allowing women to access their own records, and are building in health information and health promotion material.

Organisations across the Local Maternity System signed up to a data sharing agreement that has enabled us to ensure a woman will have a single maternity record across the Local Maternity System. The single record links with fetal medicine and the neonatal BadgerNet system and is being tested for GPs and health visitors. Other Local Maternity Systems across the West Midlands Maternity Alliance are considering joining this agreement with the aim to have a single maternity record across the region.

The Local Maternity System is currently piloting a single point of access online portal that allows women to register their pregnancy and book for a community midwife appointment without visiting their GP first. So far, over 100 women have used the system which they access from the secure web link they are given when they contact the surgery for an appointment with their GP. Women are able to do this in their own time and do not need to see their GP for a referral. There are

currently 11 GP surgeries across Birmingham involved in the pilot but the plan is to roll out the system to all GP surgeries in 2020. The approach was developed from feedback from local women and GPs who felt that having to access maternity services via a GP referral in most cases did not add value to the care journey.

The Local Maternity System will continue to focus on enhancing the existing BadgerNet system, providing access to the single electronic maternity record to primary and community care providers, roll out of the single point of access and further development of the online portal (digital maternity information tool).

They will also continue to work with other digital initiatives across the STP to ensure that maternity digital information is linked to other health platforms that are being developed. This will include continued work with the West Midlands Maternity Alliance to expand the number of provider trusts who have signed up to a single electronic maternity record across the West Midlands.

Personalisation

The Local Maternity System will continue to undertake work to enhance personalised care and support planning and increase the number of maternity personalised care plans offered to women. This will be delivered by continued implementation of the Local Maternity System digital maternity record, digital information tools, development and implementation of digital self-care referral for women through single point of access. Continued BadgerNet implementation across the Local Maternity System to support continuity of carer and personal care plans.

Continuity of carer, to ensure safe care based on a relationship of mutual trust and respect in line with the woman's decisions

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Continuity of carer, where women see the same midwife for all elements of their care, provides continuity, builds rapport, improves the woman's experience and improves outcomes.

By March 2021, it is expected that most women will receive continuity of the person caring for them during pregnancy, during birth and postnatally and we will aspire to meet the national target. This will be targeted towards women from Black, Asian and minority ethnic groups and those living in deprived areas, for whom midwifery-led continuity of carer is linked to significant improvements in clinical outcomes.

During 2018/19 the Local Maternity System ran a number of continuity of carer pilots in antenatal and postnatal care and across the full pregnancy and birth pathway. The Local Maternity System commissioned a number of study days from the Royal College of Midwives to support local midwives to understand the options and how this can be done in a way that does not impact on work-life balance.

The Local Maternity System has developed scanning services in the community at children's centres and GP practices. A midwifery-led community outreach growth scanning clinic was successfully piloted for high risk women who require frequent growth scans because their baby is small for gestational age. A single Local Maternity System wide scanning training list was agreed to enable midwives to gain the competency they need to become midwife sonographers.

The Local Maternity System continues to lead a programme of work to ensure that a range of continuity of carer pathways are developed that will support delivery of the 2020 target that by March 2020, 20% of women are booked on to a continuity of carer pathway in year one and we aspire to meet national targets and deliver better outcomes for women as the plan is delivered. Two continuity of carer midwives have been appointed to lead this work collaboratively across the Local Maternity System.

As a Local Maternity System it will be challenging to meet the national continuity of carer target by March 2020. This remains a national challenge across maternity services owing in the main to workforce challenges e.g. inadequate workforce currently in place, increase in early retirements and leavers, reluctance of some midwives to work in continuity models. Locally we are attempting to mitigate this through the recruitment of two continuity of carer midwifes and staff engagement as part of a solution-focused approach. Ongoing commissioner and provider discussions will be required with regards to financial viability/impact.

Safer care, with professionals working together across boundaries to ensure rapid referral, and access to the right care in the right place; leadership for a safety culture within and across organisations; and investigation, honesty and learning when things go wrong

Savings Babies Lives Care Bundle

The implementation of the Savings Babies Lives Care Bundle is pivotal in driving the reduction in perinatal mortality rates. This is delivered through the reduction of smoking in pregnancy, risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction, raising awareness of reduced fetal movement, effective fetal monitoring during labour and reducing pre-term birth.

We monitor the implementation of the above five elements of the Savings Babies Lives Care Bundle on a monthly basis through the Clinical Workstream Committee. This is chaired by the Local Maternity System medical director and a gap analysis is reviewed against these elements to ensure appropriate actions are in place.

The Local Maternity System has produced a dashboard which is reported at every programme board and Clinical Workstream Committee to monitor performance and includes specific metrics related to Savings Babies Lives Care Bundle such as smoking at booking and smoking at delivery, small for gestational age detection rate, perinatal mortality rates, neonatal deaths, still births and maternal mortality and morbidity. Additional elements relating to the second version of the Savings Babies Lives Care Bundle are planned for inclusion from November 2019.

To support full implementation of the second version of the Savings Babies Lives Care Bundle across the Local Maternity System by March 2020, the Local Maternity System has allocated funding for midwifery resources for prevention and surveillance of pregnancies at risk of fetal growth restriction and fetal heart rate and reduced fetal movement monitoring.

The harms of smoking during pregnancy are well-established and understood. In 2018/19 it was estimated that between 10-14% of women booked through the Birmingham and Solihull Local Maternity System, smoked at booking. Linked to the aim to reduce both perinatal mortality and infant mortality by 20% by 2020, there is a national aim to bring smoking at time of delivery rates down to 6%.

The Local Maternity System has reviewed the smoking cessation service provision both within maternity care and through local authority commissioned services. There was found to be disparity between the antenatal smoking offer between Birmingham Women and Children NHS Foundation Trust and University Hospitals Birmingham NHS Foundation Trust and between the local authority offers for pregnant women who smoke. In addition, it was highlighted that practice was not in line with NICE guidance or the Saving Babies Lives Care Bundle.

In 2018/19 a Smoking in Pregnancy Strategy was approved by the programme board and a single Local Maternity System smoking in pregnancy guideline has now been introduced.

Funding has been allocated to provide very brief advice smoking cessation training for community midwives and stop smoking practitioner training for a number of staff to provide smoking cessation services alongside midwifery clinics in the community and act as smoking cessation champions.

Approval has been obtained to roll out smoke free environments at maternity sites across the Local Maternity System and funding allocated to this.

A maternity support worker smoking cessation provider model is being piloted in Lordswood and Erdington. Following the pilot, a full evaluation of the model's effectiveness, together with additional funding to provide dedicated smoking cessation support worker support, will inform the expanded scope of this work.

An automated referral service for using BadgerNet to send referrals to a Solihull specialist antenatal smoking cessation service has been piloted and is now to be rolled out across the Local Maternity System.

Reducing perinatal mortality (in line with the national ambition to halve the rate of stillbirths, neonatal deaths, intrapartum brain injuries and maternal deaths by 2025 from a 2020 baseline) with a 20% reduction by 2020 will be an ongoing challenge given the local demographic and baseline. It will be a further challenge to reduce the rate of pre-term births by 25% from a 2015 baseline by 2025.

A Local Maternity System-wide perinatal mortality review process is in place. Birmingham Women's and Children NHS Foundation Trust and University Hospitals Birmingham NHS Foundation Trust have agreed to implement joint peer-to-peer perinatal mortality reviews commencing in the early part of 2020. This will support external input into cases where care issues were thought to be present and quality assurance of local perinatal mortality reviews and the continued use of the perinatal mortality review tool which is embedded in practice at both trusts. A Local Maternity System perinatal mortality event is planned for summer 2020.

Better postnatal and perinatal mental health care to address the historic underfunding and provision in these two vital areas, which can have a significant impact on the life chances and wellbeing of the woman, baby and family

Work has started to scope the provision of postnatal care and a multi-disciplinary working group has been established to deliver this piece of work. The focus is on ensuring an integrated pathway from maternity to community care which will involve working in partnership with Birmingham Forward Steps, a pioneering health and wellbeing initiative for all Birmingham children aged 0-5 and their families.

The new service has been designed to bring together the current health visiting service and children's centres so that families can access the help they need from pregnancy until their child starts school.

Postnatal physiotherapy

The Local Maternity System will ensure that access to postnatal physiotherapy to support women who need it to recover from birth will be improved to ensure that women have access to multi-disciplinary pelvic health clinics and pathways.

The scope of postnatal care referred to above will include postnatal physiotherapy. Roll out of postnatal physiotherapy and multi-disciplinary pelvic health clinics have been identified as a priority for 2020/2021, with targeted funding available until 2020/2023.

Type 1 diabetic checks

Across Birmingham and Solihull as a Local Maternity System we are aware that at booking, 23% of women were obese, and one in ten women went on to develop diabetes in pregnancy.

In line with the plans, the Local Maternity System will ensure that pregnant women with Type 1 diabetes are offered continuous glucose monitoring from April 2020, where clinically-appropriate. Funding arrangements will be confirmed later in 2019/20.

Perinatal mental health

For details about local mental health service provision, data and outcomes, please refer to the mental health chapter.

In 2018/19, having secured wave 1 and 2 funding, the Local Maternity System now provides specialist support for women with moderate to severe perinatal mental health needs across the Local Maternity System and a single clinical pathway has been developed and agreed. The new service provides a multi-disciplinary approach to supporting women with severe mental health concerns, alongside obstetric and midwifery colleagues.

The priorities for the perinatal mental health workstream of the Local Maternity System programme are to:

- Ensure that there are clear clinical pathways that cover all levels of need, with clear referral routes, escalation and discharge criteria
- Confirm and implement the training and education programme for maternity, primary care and health visiting staff
- Extend the existing provision of community-based specialist care for women with moderate to severe perinatal mental health difficulties and a personality disorder diagnosis from preconception to 24 months after birth
- Expand access to evidence-based psychological therapies within specialist perinatal mental health services so that they also include parent-infant, couple, co-parenting and family interventions.

To support delivery of these priorities, a dedicated perinatal mental health project manager has been appointed and funding allocated to provide dedicated consultant, senior nursing and psychology.

Infant feeding programmes

Infant feeding is a vital element of ensuring that babies get the best possible start in life. The Local Maternity System has worked to understand the current infant feeding provision across Birmingham and Solihull in maternity and early years' services, and will work to improve breastfeeding rates by ensuring that skilled, effective, timely breastfeeding support is available to all mothers across the Local Maternity System, both in groups and in the home. Funding has been allocated to providing more dedicated infant feeding support across the Local Maternity System.

UNICEF Baby Friendly Initiative accreditation reflects multi-professional working, breaking down barriers between midwives, obstetricians and other professionals to deliver safe and personalised care for women and their babies. Currently maternity services at Birmingham Women and Children NHS Foundation Trust are fully accredited, Good Hope Hospital is subject to further assessment, neonatal services at Birmingham Women's Hospital are subject to further assessment, and the neonatal surgical unit at Birmingham Children's Hospital has registered its intent.

Working across boundaries to provide and commission maternity services to support personalisation, safety and choice, with access to specialist care whenever needed

Maternity and neonatal care in communities

The Local Maternity System will work with acute providers, the CCG and the community trust in Birmingham to develop a 'place-based' model for community care and an integrated pathway from maternity to health visiting services. As part of this, opportunities to increase co-location of service provision in community venues will be explored.

See also **continuity of carer** section.

Neonatal critical care

To support babies getting the best possible start in life it is vitally important that they are able to access the level of care that they need. The Local Maternity System will develop a system to ensure that all babies born at less than 27 weeks' gestation from across the Local Maternity System and surrounding areas access care in Local Maternity System level 3 neonatal units.

Neonatal mortality (death of a baby in the first 28 days of life):

Statement
Pleliminary 2019 (Jan-Jul) data from BWH/UHB shows that there has been an increase in NNDs from the 2017 MBRRACE recently published rates, therefore 2019/20 has been set against this latest known position. A -5% reduction of the 2016 rate has been applied from 2020/21 onwards.

There has been an increase in neonatal deaths (2017/18 national maternity data) locally which makes the national target harder to achieve. In part, this may be driven by our local demographics, socio-economic factors and the complexity in clinical need of some women, for example, immigrants arriving from other countries or some of our very vulnerable women.

Maternal medicine networks

As stated previously, the Local Maternity System dashboard monitors maternal morbidity and mortality across the Local Maternity System on a monthly basis. This information is shared and discussed with Birmingham Women and Children NHS Foundation Trust and University Hospitals Birmingham NHS Foundation Trust at the Clinical Workstream Committee.

The clinical workstream also reviews the local responses to the recommendations from MBRRACE reports, providing support where required.

In August 2019 the Local Maternity System submitted a proposal, via the Maternity Clinical Network, expressing an interest in becoming a maternal medicine centre, staffed by an appropriate experienced multi-disciplinary team. The Local Maternity System has proposed that Birmingham has well-established and comprehensive specialist physician expertise supporting pregnancies complicated by pre-existing complex medical conditions and is well-placed to be designated a Maternal Medicine Centre.

The footprint of a Birmingham Women's and Children's Hospital NHS Foundation Trust and University Hospitals Birmingham NHS Foundation Trust maternal medicine centre is for some services regional (including renal, complex connective tissue, cardiac) and for some supra-regional (liver, maternal metabolic diseases).

The existing pathways for pregnancy complicated by complex and rare medical disorders together with the medical expertise based at both hospital trusts lends itself to a regional leadership role and hub and spoke model. A national procurement exercise is anticipated in 2020.

A payment system that fairly compensates providers for delivering high-quality care to all women, whilst supporting commissioners to commission for personalisation, safety and choice

Progress to date has been limited in this area but will be an area of focus going forward.

Personalised care budgets

During 2018/19, two Maternity Voices Partnership meetings and three focus groups were held to consider the benefits of personalised maternity care budgets. The findings of this work concluded that women did not feel that holding a personalised budget met their need to feel 'looked after'.

New financial models

Neonatal contracts have been agreed with NHS England and continuity of carer modelling costs completed across the Local Maternity System.

Work still needs to be done to agree financial models across the region and develop outcome-based model for commissioning maternity and neonatal services.

Further detail in relation to these deliverables can be found in Appendix 7.

How will services be different in 2023/24?

By 2023/24 all women will be able to access safe and high-quality services in a place and time which is convenient for them. There will be seamless pathways of continuous, personalised care that women understand and move through during and after pregnancy. Information, advice and guidance will be available via digital means to support on topics such as breastfeeding or low mood. There will be a greater focus on delivering better outcomes for all women and their babies. Some provision will be enhanced further for example, pelvic health after having a baby, diabetes testing and services for babies born prematurely and/or are very poorly.

Children and young people

Providing all children with the best start in life so they are happy, healthy, safe and reach their full potential as young adults

As an STP, we are committed to ensuring all children have the best start in life and have identified this as one of our key strategic priorities. Furthermore, we want all children and young people to achieve good outcomes at every stage of their life. This means being happy, healthy and safe from harm as well as being well-educated, developing skills for life and having influence.

So far, maternity, children and young people is a priority within both STP and local strategies and plans e.g. those developed by health and wellbeing boards. Partners are united in their vision to improve outcomes for all children and young people. This has led to a number of focused workstreams and collaborative working arrangements. For example, a focus on joining up organisations which are responsible for commissioning and providing services for children and young people with special educational needs and disabilities. Young people have been engaged with and asked for their views on what matters and is important to them. This has shaped our local STP priorities.

Despite these achievements, there is still some way to go to fully achieve our vision. As described earlier, we have one of the youngest populations in Europe, with over 490,000 young people under the age of 25 and with 284,000 children and young people under 15. This is expected to grow by 27,000 in 2027. Of the babies born today, 57% of newborns are from Black, Asian and minority ethnic groups in Birmingham representing our diverse communities, compared to 23% in Solihull.

This presents exciting opportunities in terms of creating vibrant communities. It also presents challenges in how we support children and young people to thrive given the high levels of deprivation in our area, as well as providing services that meet demand, are responsive and locally-based. This is key to addressing inequity and health inequalities for our communities.

Why do we want to change?

Across health, education and care, we have a number of challenges and key health inequalities:

- **Infant mortality is high** in Birmingham and equates to 7.8 deaths per 1,000 births. This is significantly worse than the national rate (3.9) and close to the worst rate in the country (8.1). Although, there is a better position in Solihull (5.2 deaths per 1,000 births), this is still above the national average.
- Over **34,000 young people receive special education needs support** at school which equates to an average of 13% across the whole area. (29,109 children and young people in Birmingham and 5,368 in Solihull).
- Over **10,000 children and young people aged 0-25 have an education, health and care plan.** 1,461 children and young people aged 0-25 in Solihull have an education, health and care plan compared to 9,437 in Birmingham.

- **67.7% of children in Birmingham and 72.7% in Solihull achieved a good level of development at the end of Reception.** The average rate in England as a whole is 71.5, which means in Birmingham we are below average. The lowest rate in the country was 63.9%.
- **28% of children under 16 in Birmingham live in low income families**, which is higher than the national and regional average. This compares to 16% of children living in lower income families in Solihull. The national average is 17% and regional average is 20%.
- Children in care equate to 67 of every 10,000 children in Birmingham, compared to 88 for every child 10,000 in Solihull. This is higher than the England average (64 children in care for every 10,000 children).
- **Emergency hospital admissions for long term conditions is high for under 19s who have asthma** in Birmingham. In Birmingham this is 319 emergency admissions for asthma for every 100,000 children under 19, compared to 148 emergency admissions for every 100,000 children in Solihull. The national average is 186 emergency admissions for every 100,000 children.
- 13% of 15-year-olds in Birmingham and Solihull said they have a long term illness, disability or medical condition. The national comparison was 14.1%.
- A detailed breakdown covering national and regional averages is available in Appendix 8.
- A number of challenges are evident locally:
- **There are high levels of demand for some specialist services across health and care**. This has resulted in long waiting times to access some services. One of the contributory factors is a limited local, tiered response with prevention and early help embedded.
- **Some families face complexities and challenge when navigating health and care systems** especially families where a child has complex and/or special educational needs or disabilities. Experiences of long waits to access services, multiple assessments, families telling their story a number of times, variation in funding or specialist support is commonplace.
- **A number of CQC/Ofsted poor or inadequate ratings**, which has led to scaled-up improvement agendas in some areas.
- Health and care organisations face **financial challenges**, which reflect our earlier statements in relation to creating efficiency to maximise taxpayers' money.
- There are **workforce challenges**, as referenced in earlier chapters, for example, the reduction in health visitors and attracting NHS and social care professionals to work with children and young people.
- **Fragmented and differing service provision** due to historic commissioning arrangements. Furthermore, there are underdeveloped integrated commissioning arrangements.

- **Lack of an overarching health, education and social care model** for all children and young people to enable system wide integration.

This aligns with the **voices of our children and young people** in response to the **NHS Long Term Plan**, who said we need to:

- Explain how health and care will improve communication with patients
- Address the individual and community skills gap for self-care, building resilience and community capacity
- Eliminate the gaps in meeting the Accessible Information Standard that exists locally
- Reflect on the availability of services to support individuals, with improvements made to referral pathways, waiting lists/times and the distribution of services
- Implement actions; where waiting times are unavoidable to support self-care
- Detail how community assets will be supported and enhanced, identifying and addressing any known gaps
- Address how the local STP will work across all partners to reduce the stigma of mental health, disability and other conditions, support individuals and build self-efficacy for self-care.

As services develop further engagement is planned as part of ongoing developments and local priority plans to ensure the system fully reflects local voices.

Priorities for change

Our commitment is to transform and better connect services to improve outcomes and meet needs for children, young people and their parents/carers. Support will be delivered more locally so families experience joined up and co-ordinated care if they need it.

As stated in other chapters, this means re-organising services based around people and not organisations. Where children have complex or multi-faceted needs, including social need or special educational needs and disabilities care should be coordinated and accessible across health, education and care. This collaborative approach will address the fragmentation that some families currently experience.

Local collaboration in the STP, strategically and operationally, has enabled us to jointly understand the needs of children and young people aiding joint planning, prioritising and shared decisions. The voices of children and young people will continue to be at the heart of local developments.

In addition, a number of priority programmes have been identified:

- **Transforming primary care**

  This programme will focus specifically on reducing avoidable A&E activity and the top reasons for outpatient referrals. There will be a focus on family and professional education as part of this work. **Digital** and **virtual solutions** will be adopted to enable easy access to advice, guidance and early help. More integrated care pathways for long term conditions

such as **asthma, diabetes, epilepsy and complex needs** will be created**.** Physical health services will integrate with the **new model of 0-25 mental health care** supporting the **expansion of services**. Services will be embedded in Primary Care Networks and links will be secured with children's clinical networks as they emerge to improve quality of care for children with long term conditions.

- **Transforming community care**

  This programme will work to review, transform and redesign quality care for children and young people to ensure all services are outcome- focused, equitable and accessible. A community commissioning framework will be developed to set out the current arrangements, a future vision and implementation plan for the future. There will be a greater focus on improving **end of life care** and outcomes for children and young people including those with **cancer**. Other areas of focus are transition from child to adult services and enabling a personalisation agenda to care.

- **Transforming secondary care**

  This programme will unify policies, procedures, transfer protocols and paediatric specific guidance across Birmingham Women and Children NHS Foundation Trust and University Hospitals Birmingham NHS Foundation Trust. The priorities delivered will focus on **reducing pressure on emergency hospital services** by working across the urgent care system. This will ensure full delivery of the paediatric critical care and surgery review.

- **Transforming interagency working for priority improvement areas**

  This programme involves collaborative working and transforming relationships between both health and care organisations and other partners such as schools. Establishing a new way of working with families is essential in order to promote self-care and build capacity and resilience in communities. A number of priorities will be driven under this workstream including:

- Improvement agendas for special educational needs and disabilities
- Reducing the number of children and young people in the social care system
- Keeping children and young people healthy and happy by effectively delivering the national **Healthy Child Programme** and **Start Well** initiative
- The latter encompasses treatment and **management of childhood obesity, oral health promotion** and improving uptake in **screening and immunisation** programmes for example. A scaled-up focus will be given to the **first 1,001 critical days** of a child's life by embedding robust evidence-based programmes for **prevention** and **early help**. Work will be scaled up to reduce the higher than average infant mortality rates in Birmingham e.g. ensuring vulnerable women access maternity care in a timely fashion, reducing smoking in pregnancy and safe sleep advice.
- **Transforming delivery, through local integrated care models and teams in neighbourhoods or localities through co-production, integrated pathways, joint education and training, and co-location.**

This programme will design, test and embed an **integrated model(s) and way of working across health and care**. This will recognise the local variation evident across Birmingham and Solihull various strands or programmes need to be aligned and/or encompassed for example, Primary Care Networks, school configurations and locality special educational needs and disabilities work.

How does this deliver the STP aspirations?

Independence and resilience

- ✓ Access to timely information, advice and guidance for your family when needed, supporting self-care and building resilience
- ✓ Digital solutions offering information and support to children and young people
- ✓ Children and young people friendly health services that are accessible, high-quality and improve outcomes
- ✓ A clearer understanding of health and care provision and where both can be accessed, seamless pathways and better patient experiences and outcomes
- ✓ More personalised care offering families choice and the opportunity to access personal health budgets.

Equity, equality and inclusion

- ✓ Consistency across Birmingham and Solihull to remove gaps and inequities in services
- ✓ Joined up heath and care models and provision accessible to all children and young people who need it
- ✓ Services that are inclusive and celebrate equality and diversity.

Integration and simplification

- ✓ Integrated health and care services with simplified pathways and systems
- ✓ An integrated model(s) of care delivering at local level in Birmingham and Solihull.

Promoting prosperity

- ✓ All children and young people achieving good outcomes throughout their life and into adulthood
- ✓ Happy and healthy children are more likely to do better at school and continue with lifelong learning
- ✓ Helps parents and carers in their vital role in supporting young people.

Social value

- ✓ Building community capacity so families become more resilient and able to self-care
- ✓ Listening to the powerful voices of our children and young people and building this into transformation.

Delivering our commitments in practice

We will work in conjunction with other areas identified in this plan that impact upon children to ensure connectivity, for example in our workforce, digital, estates, mental health, learning disabilities/autism, diabetes, respiratory, cancer, prevention, urgent and planned care plans.

The table sets out some specific deliverables which will continue to evolve as national metrics for children are clearly defined. This will influence investment planning decisions in future years. Cross-referencing of metrics will also be undertaken where relevant with other chapters. See Appendix 8 for more detail.

How will services be different in 2023/24?

By 2023/24

- Children, young people and their families will have the means to access information, advice and guidance through digital platforms in order to support self-help and resilience
- When support is required and challenges arise, effective prevention and early help will be available swiftly in order to stem some of the demand from specialist services
- Services for children and young people who need to access them, should be equitable, safe, streamlined and deliver good outcomes. Demand and capacity should be matched especially for children with complex health and care needs to prevent long waiting times.
- A clearer understanding of health and care provision and where both can be accessed, seamless pathways and better patient experiences and outcomes
- More personalised care offering families choice and the opportunity to access personal health budgets
- Integrated model(s) of care delivered locally in Birmingham and Solihull.

Adulthood and work

Promoting health and wellbeing and managing chronic disease

We know that modern lifestyles are contributing to an increase in chronic and non-communicable diseases, such as Type 2 diabetes, cardiovascular disease, respiratory, cancer and dementia.

We also know that if we lead healthier lifestyles that improve our health and wellbeing, a number of these conditions can be prevented or mitigated giving us heathier lives for longer. This is a key theme in this plan, as described in the focusing on prevention section. It can also support our prosperity, both social and financial, in being able to work, be independent and enjoy life.

Many of the risk factors are similar or linked for these diseases, including social isolation, smoking, excess alcohol consumption, high calorie diets and low exercise leading to being overweight or obese. These unhealthy behaviours are quite often established early in life. There are also close correlations between these risk factors and socio-economic status, with the least advantaged being at most risk for physical and mental health issues. For example, people with a severe mental illness have a life expectancy 20 years below the average. We want to ensure that everyone has a fair chance to enjoy good health and wellbeing. To achieve this, we will take a proactive approach to identifying and preventing illness and to supporting people to manage their chronic conditions. In particular, we will:

- Focus on prevention, as described earlier in the plan to encourage healthy lifestyles through each life course and in our all age services
- Put GP social prescribing at the heart of our support for citizens to access health and wellbeing initiatives, such as exercise, diet and opportunities to reduce isolation, and ensure our staff have the skills to support behavioural change
- Use the skills of GPs and their teams to support people in a holistic way, developing a consistent offer from general practice for enhanced services for patients across multiple chronic diseases
- Work with our partners, including the West Midlands Academic Healthy Science Network, to analyse large datasets (with appropriate and statutory safeguards for how identifiable data is used) to identify those people at greatest risk of major diseases, including Type 2 diabetes, cardiovascular disease and cancer. We will then target screening programmes accordingly.
- Offer targeted services, such as health checks and other preventative services, to promote wellbeing and early identification of symptoms for high risk groups, such as people with diabetes, mental illness or learning disabilities
- Implement the 2015 NICE cancer referral guidelines and redesign access and referral pathways, increasing the use of digital access points, to reduce unnecessary steps or delays in receiving support

- Set a ‘zero suicide’ ambition, supported by evidence-based, preventative actions and high-quality crisis support. This will reduce stigma around mental health and improve access through early intervention services. More information on mental health services is in the all age services section.

In the following sections, we outline specific interventions to improve services for people with a range of long term conditions. We explain the extent of the issue for our population and our plans to address these.

Cardiovascular disease

Providing early detection, monitoring and treatment of people at risk of and living with cardiovascular disease to support them to live longer, healthier and more independent lives

Why do we want to change?

Despite patient outcomes for cardiovascular disease improving substantially over the past ten years, cardiovascular disease continues to remain the second most common cause of death, accounting for just over a quarter of all deaths registered in England and Wales. We know that in Birmingham we still have unacceptably high levels of preventable cardiovascular disease mortality for the under-75s, with mortality rates reaching 67.7 per 100,000 when compared to a national average of 49.2 per 100,000. Solihull has a slightly lower preventable mortality rate compared to the national average, but there are still substantial opportunities for earlier detection and treatment.

Over the last six years, cardiovascular disease inpatient admissions in Birmingham have slowly increased and predominately these admissions have been unplanned.

Currently within Birmingham and Solihull there is a gap between patients already on primary care atrial fibrillation registers compared to expected prevalence figures. Nationally, the estimated prevalence for atrial fibrillation is 2.4 per 100,000. At a local level, the estimated prevalence range of observed-to-expected atrial fibrillation prevalence across general practice in our area is 0.13 to 1.04 per 100,000. Of those treated, large proportions are under-treated and therefore remain at increased risk. Optimal management of those with high blood pressure and heart failure will reduce the numbers of those developing permanent atrial fibrillation. This suggests there is still work to do in finding these missing patients and optimising their care at a local level.

Nationally we know that five million people in the UK have undiagnosed high blood pressure and 40% of those that are diagnosed remain poorly-controlled. Yet, there is strong evidence to link the lowering of blood pressure to a reduction in the incidence of heart attack or stroke. Locally, across our area, 20.7% of patients diagnosed with high blood pressure are not within therapeutic reference ranges of 150/90.

Right Care data (2019) suggests that 74.1% of patients across our area with a new diagnosis of high blood pressure who have been given a cardiovascular disease risk of 20% or higher are being treated with statins. Conversely, this means that 25.9% of people with the same risk factor are not being currently treated with statins to reduce their cholesterol levels, which in turn will help to reduce their risk of heart attack or stroke.

Heart failure admissions for Birmingham and Solihull are higher than the national average, representing 210.3 admissions per 100,000 patients compared to the national average of 161.7 admissions.

Nationally, the uptake of cardiac rehabilitation is limited. There is also recognised variation in how services are delivered across organisational boundaries, with services not being tailored towards

patient need or options offered for digital access. The availability of cardiac rehabilitation programmes for patients diagnosed with heart failure is also variable. This results in high drop-out rates for cardiac rehabilitation between pre and post-cardiac rehabilitation assessment. The National Audit of Cardiac Rehabilitation Quality and Outcomes Report (2018) also identified that only 40% of people from areas of high deprivation start cardiac rehabilitation, compared to 54% from areas of low deprivation. This is reflected in our area. The evidence tells us that attending a cardiac rehabilitation programme will reduce mortality rates and risk of readmission, as well as importantly improve clinical outcomes and the quality of life for people with chronic heart failure.

Priorities for change

By 2023, all Birmingham and Solihull patients will have access to a fully co-ordinated and integrated service for the detection and management of cardiovascular disease. We have an opportunity through the development of Primary Care Networks to provide a comprehensive set of services that promote a holistic approach to clinical review, where cardiovascular disease is seen as a family of diseases and not one specific condition in isolation. This will help to ensure that care is co-ordinated across organisational boundaries and links seamlessly with pathways for co-morbidities, such as diabetes.

Managing care systematically will help to ensure that patients are risk assessed for other high-risk cardiovascular disease conditions so they receive timely access to diagnosis and treatment for co-morbidities associated with their condition. In the longer term, taking a quality driven holistic approach to patient care will have a cumulative impact in reducing the number of stroke and heart attacks across our population.

Co-ordinating services in this way will also help to support a continuing reduction in cardiovascular disease mortality rates and enable local communities to lead longer, happier and healthier lives.

Improving prevention: The identification and management of cardiovascular disease

We will put prevention at the heart of our approach to managing cardiovascular disease by improving the detection and management of atrial fibrillation, high blood pressure and high cholesterol within primary care.

We will upskill clinicians in primary care, and patients in the community, with the knowledge, skills and technology to manage cardiovascular disease in more proactive ways. As part of our commitment towards cardiovascular disease prevention, we will continue to support practices to systematically provide NHS Health Checks for everyone between the ages of 40 and 74 years of age who have not yet been diagnosed with a cardiovascular condition. This will help to identify patients who have a high risk of cardiovascular disease so that advice and support can be offered to help them make positive behavioural and lifestyle changes for prevention e.g. access to alcohol and weight management advice and smoking cessation services.

We already have some of the building blocks in place for cardiovascular disease prevention and will continue to develop this further. Through the scope of the Universal Enhanced Service Patient Offer, practices are supported to offer improved patient access to primary care-based blood pressure monitoring services, including home monitoring for all at risk groups.

As Primary Care Networks start to mature, there are a number of exciting new opportunities for us to innovatively work at scale to systematically target local high-risk populations to diagnose and identify patients where treatment could be improved. This will include drawing upon new workforce models within Primary Care Networks, including clinical pharmacists to help take a proactive targeted approach to managing population health.

Our intention is to work towards the implementation of the cardiovascular disease prevent audit to support networks to identify their local cardiovascular disease patient population who are of highest risk, but not optimally treated. This tool will be embedded in GP systems and aims to identify people with one or more of the six high-risk conditions undiagnosed or sub-optimally managed, putting them at increased risk of cardiovascular disease. This will all be underpinned by the implementation of the cardiovascular prevention and diagnosis service specifications for Primary Care Networks from 2021/22, in line with recommendations from the Test Bed Programme. We can then start to explore ways in which we can use our current Local Enhanced Service Universal Patient Offer to systematically identify and treat high cholesterol levels, develop lower and continually more challenging targets for blood pressure and revised measures for heart failure and heart valve disease.

Familial hypercholesterolemia is a common life-threatening genetic condition that causes high cholesterol. Left untreated, it leads to early heart attacks and heart disease. We know that familial hypercholesterolemia is inherited and passed down through families. When one individual is diagnosed, it is important that all family members are screened for familial hypercholesterolemia. Genetic screening for this condition is already in place across our area. However, we are committed to reviewing access to this service to make sure that the screening programme continues to remain accessible to everyone who needs it.

It is important that patients are actively involved in decisions about their care and wellbeing. We will strive towards listening to what matters most to the patient in the care planning discussion. This will help to make sure that plans are personalised, co-ordinated and adaptable to each individual's health condition, situation and support needs.

We will explore the use of new technologies, including the use of digital apps and online resources to support patients to make positive decisions about their care and management of their conditions e.g. heart age tool.

Working in partnership with the West Midlands Atrial Fibrillation Strategic Network, we are rolling out a programme of education, training and awareness in primary care through a series of practical workshops. These sessions are focused upon the upskilling of primary care clinicians to improve their understanding and management of atrial fibrillation from detection through to initial management and ongoing follow-up and monitoring.

Birmingham and Solihull patients already have access to access to the BNP (B-type natriuretic peptide) blood test and echocardiography to improve the early detection and optimum management of heart failure and heart valve disease. We will build on this further and explore opportunities for supporting greater access to echocardiography in primary care, which will improve the investigation of those with breathlessness and the early detection of heart failure and valve disease.

However, workforce capacity will be a key constraint for us in expanding our capacity, which is reflected in the earlier workforce chapter. For example, sonographers are currently in short supply and number of training places limited. The current vacancy rate according to the Society and College of Radiographers is 12.6%, higher than the vacancy rate for the wider diagnostic radiography workforce (9%).[6] This means we need to balance the need to improve detection and monitoring, such as increasing access to echocardiography, with these capacity constraints. Over the long term, new technologies and self-monitoring might go some way to closing some of the gap in capacity.

Currently, only 3% of patients who suffer cardiac arrests that happen outside of hospital are treated with public access defibrillators. Nationally, it is recognised that one of the biggest barriers to use is the location of the devices is often unknown, yet tens of thousands of defibrillators are placed prominently in workplaces, train stations, leisure centres and public places across the country. Working in partnership with the West Midlands Ambulance Service University NHS Foundation Trust and the British Heart Foundation, we will support the mapping of this equipment across our area so local ambulance teams are aware of the location of all public access defibrillators and can direct members of the public to their nearest life-saving device in the event of a cardiac arrest.

Improving access and uptake to cardiac rehabilitation

We will work collaboratively to review the existing model for cardiac rehabilitation and align existing services to make sure that programmes are co-ordinated. This will help us to deliver a single consistent offer for cardiac rehabilitation, regardless of where people live. In addition to the service we already have in place for cardiac rehabilitation following coronary disease, we will explore expanding the service to include heart failure patients.

To tackle poor uptake of cardiac rehabilitation services we will explore the development of a menu-based approach offering different modes of delivery aligned to patients' needs and preferences. The patient assessment process will be a priority of our delivery plan because we know this has the greatest impact upon whether a patient will engage in the programme. This work will be closely interlinked between primary, community and secondary care providers to maximise opportunities for patient referral and re-engagement in the cardiac rehabilitation programme at all stages in the rehabilitation pathway.

We will work with voluntary and community organisations to ensure that following the completion of the more formal programme of rehabilitation, patients are also offered opportunities to continue with exercise in the longer term. This will be through signposting services offered by social enterprise and community groups, such as green gyms and walking groups.

The services we deliver will work towards developing certified status for the delivery of cardiac rehabilitation. We will work with the National Audit of Cardiac Rehabilitation to acquire these certified competencies for delivery against national clinical standards.

[6] **https://www.sor.org/sites/default/files/document-versions/2019.7.5_final_scor_ultrasound_workforce_uk_survey_2019_report_v3.pdf**

Initial engagement has already been undertaken with local GP practices and West Midlands Atrial Fibrillation Strategic Network, who are supportive of approaches to new innovative ways of working. Local stakeholders will now be engaged with more extensively to help inform final plans.

How does this deliver the STP aspirations?

Independence and resilience

- ✓ Improves the number of years that people live in good physical and mental health
- ✓ Builds confidence and capability among health and care staff, with clear clinical leadership, to give practical advice to patients and the public
- ✓ Improves access to patient education services, with an emphasis on person-centred care, improved knowledge and self-management
- ✓ Supports patients to make positive decisions about their cardiovascular disease care and flexible access to cardiac rehabilitation programmes through the use of technologies, digital apps and online resources
- ✓ Gives people more control over their own health and more personalised care.

Equity, equality and inclusion

- ✓ Delivers of a single consistent offer for cardiac rehabilitation for local people, regardless of where they live.

Integration and simplification

- ✓ Delivers of a single integrated approach for the identification and management of cardiovascular disease across Birmingham and Solihull. This will help to improve diagnosed rates against expected prevalence and make sure that care is optimised and patients are managed in the correct setting.

Promoting prosperity

- ✓ Allows people to be active for longer
- ✓ Supports people to be able to work for longer, improving economic growth, prosperity and wellbeing.

Social value

- ✓ Enables care to be co-ordinated across organisational boundaries, which includes the voluntary and community sector.

How will services be different in 2023/24?

By 2023/24

- We will be able to identify many more patients at risk of cardiovascular disease and proactively support them better manage their condition

- Patients will have access to a menu of community and digital online cardiac rehabilitation programmes, which can be specifically tailored to fit the individual needs of each patient
- Primary care teams will have a systematic process in place to identify patients at risk of cardiovascular disease so that they can put care plans in place to help reduce modifiable risk factors through medication and lifestyle change
- The management of cardiovascular disease will be co-ordinated holistically across organisational boundaries so that services link seamlessly with pathways for other co-morbidities, such as diabetes.

Stroke

To provide stroke patients with the specialist care and rehabilitation through creating an Integrated Stroke Network, so that every person receives the right care in the most appropriate setting

We already deliver high standards of hyper acute and acute stroke care and deliver some exemplary rehabilitation services across Birmingham and Solihull. However, we know more is now needed to reduce variation in services and outcomes for patients. Good progress has already been made on bringing regional partners together to develop a strategic framework for advancing stroke services in the West Midlands.

Why do we want to change?

The **NHS Long Term Plan** states that "Stroke, a preventable disease, is the fourth single leading cause of death in the UK and the single largest cause of complex disability". Demand is expected to rise with the incidence of stroke increasing by 3% in Birmingham and Solihull between 2017 and 2023. Across England as a whole, the number of people having a stroke is expected to rise by 50% by 2035. In the West Midlands, a regional stroke strategy has been developed by NHS England and NHS Improvement and is awaiting final approval. There is variation in mortality even within our STP area, with the rate in Birmingham for under-75s having a stroke being 50% higher than Solihull.

Currently there are two hyper-acute stroke units, four acute stroke units and one rehabilitation stroke unit within Birmingham and Solihull. Studies have shown significant benefit from increasing the scale of hyper-acute stroke units in terms of reducing length of stay (seen in Greater Manchester, London and the North-East) and, in London, mortality.

A trial mechanical thrombectomy service was established at the Queen Elizabeth Hospital Birmingham in 2011 on a carefully selected case-by-case basis with extremely promising results. A number of other centres in the UK and across the world did likewise and, as of early 2015, four separate trials were published which showed that clot extraction and mechanical thrombectomy were effective. The service was therefore expanded to cover the whole of the West Midlands 9am-5pm from spring 2019, with a further extension to midnight from September 2019. However, due to vacant consultant posts it is not currently possible to staff this service 24/7.

Due to historical commissioner and provider boundaries there is currently variation in the service offered to the population across Birmingham and Solihull for early supported discharge and rehabilitation. Some rehabilitation is being provided in non-specialised settings (with in-reach from the Early Supported Discharge Team).

Priorities for change

Birmingham and Solihull STP will be part of an Integrated Stroke Delivery Network covering a larger area, also including Coventry and Warwickshire, Hereford and Worcestershire and the Black

Country. A network of this size will give the scale required to unlock the pathway. Within the wider Integrated Stroke Delivery Network there will be a local working group with membership from University Hospitals Birmingham NHS Foundation Trust, Birmingham Community Healthcare NHS Foundation Trust, West Midlands Ambulance Service University NHS Foundation Trust, adult social care and the voluntary sector to support the local system to deliver the **NHS Long Term Plan** ambitions of:

- 90% of stroke patients receiving care on a specialist stroke unit
- Allowing all patients who could benefit from thrombolysis (about 20%) to receive it
- A regional stroke strategy
- Meeting the NHS seven-day standards for stroke care and the National Clinical Guidelines for Stroke.

We will offer mechanical thrombectomy 24/7 so that by 2022 we will deliver a ten-fold increase in the proportion of patients who receive a thrombectomy after a stroke, in line with the regional stroke strategy ambition. NHS England and NHS Improvement has signalled its intention to commission this.

We will seek to engage with national programmes around accreditation of thrombectomy practitioners as they develop. Specialist inpatient rehabilitation services across the Integrated Stroke Delivery Network will be aligned and we will implement and further develop, in partnership with existing providers and the voluntary sector, higher-intensity care models for stroke rehabilitation whilst ensuring capacity matches demand. We will give all patients who have had a stroke equal access to an aligned early supported discharge service. We will explore whether outcomes would be improved by reconfiguring the provision of hyper-acute stroke care. As the hyper-acute provider University Hospitals Birmingham NHS Foundation Trust already receives referrals from other providers electronically using the NORSE system, we will explore whether this can be refined using artificial intelligence to review imaging.

The implementation of this plan will reduce variation in the care and treatment offered to stroke patients across Birmingham and Solihull, in line with the **NHS Long Term Plan** headline metric, which is to reduce variation in performance across the health system.

How does this deliver the STP aspirations?

Independence and resilience

- ✓ Improves the number of years that people live in good physical and mental health
- ✓ Supports health promotion and independence.

Equity, equality and inclusion

- ✓ Offers equity of access across the whole of Birmingham and Solihull.

Integration and simplification

- ✓ Reduces variation in care and treatment across the system.

Promoting prosperity

- ✓ Allows people to be active for longer
- ✓ Supports people to be able to work for longer, improving economic growth, prosperity and wellbeing.

Social value

- ✓ Enables care to be co-ordinated across organisational boundaries, which includes the voluntary and community sector.

Delivering our commitments in practice

We will need to ensure links to other services such as cardiovascular disease. Prevention of hypertension and atrial fibrillation is key to reducing the incidence of stroke. Where 100 people with atrial fibrillation are identified and receive anticoagulation medication, an average of four strokes are averted. Focusing on prevention will also be a significant enabler to improving patient outcomes, with links to smoking and air pollution.

How will services be different in 2023/24?

By 2023/24 we will:

- Create an integrated stroke network so that all patients who experience a stroke have access to high-quality care 24/7 and high-quality life after stroke rehabilitation
- Reduce variation in provision and care, so that patients suffering a stroke have equity of access across Birmingham and Solihull.

Diabetes care

Improving diabetes care by delivering an integrated community-based approach focused on prevention, health promotion, early diagnosis, risk reduction and self-management

We have been at the leading edge of trialling new models of care for diabetes, treating more patients out of hospital and in community and primary care settings. Our aspiration now is to build on this and ensure patients with diabetes have the tools and flexibility to better manage their own conditions.

Why do we want to change?

Diabetes can have a profound impact on quality of life. People living with the condition are at increased risk of cardiovascular disease and other complications including heart disease, stroke, blindness, amputation, renal disease and depression. Diabetes is a major challenge for the NHS, causing premature mortality with at least 22,000 avoidable deaths each year. Birmingham and Solihull has a higher than national average prevalence of diabetes (9-13%), more than double the national average in some of our more disadvantaged communities. From the point of diagnosis, individuals with diabetes receive care from a wide spectrum of health and care, with service commissioning and delivery fragmented. This results in variation, duplication, service gaps, inefficiencies and poorer health outcomes. NHS RightCare analysis demonstrated that Birmingham and Solihull is an outlier in relation to diabetes prescribing costs when compared to similar populations.

Within our area there is now a system-wide ambition to drive change and improvement in diabetes care with the STP identifying improvement in diabetes care as a high priority focused on:

- Tackling inequality, reducing variation and improving outcomes
- Improving early diagnosis and individualised care planning and treatment
- Increasing access to diabetes structured education.

Priorities for change

By 2023, there will be a fully-integrated and system-wide approach to delivering diabetes care across Birmingham and Solihull, with a focus upon prevention, health promotion, early diagnosis, risk reduction and self-management.

Our organisations have already been working in collaborative partnership to realise this ambition, developing an integrated model of diabetes care streamlining services across primary, community, secondary, tertiary and third sector services to ensure that diabetes care is co-ordinated around the needs of patients and their families. Implementation of this new model of care will be based on:

- Managing patients in the most appropriate settings, avoiding referral and admission to hospital wherever possible, through establishing community-based multi-disciplinary teams

- Improving access to monitoring equipment so that patients can better manage their own conditions, such as flash glucose monitoring for patients with Type 1 diabetes and continuous glucose monitoring for pregnant women
- Establishing community-based multi-disciplinary teams working together to support increasing levels of self-management, reducing the presence of complication of diabetes and reducing the number of patients in secondary care (planned and unplanned)
- Creating a knowledgeable and upskilled primary care workforce enabling more people to achieve the recommended diabetes treatment targets; reduce variation and minimise the risk of complications associated with diabetes
- Improving access to patient education services, with an emphasis on person-centred care, improved knowledge and self-management, supporting a reduction in the risk of complications associated with poorly managed diabetes.

Our service delivery model will:

- Increase referral into and uptake of the NHS Diabetes Prevention Programme. We will use the NHS Health Check to increase the identification of patients at risk of diabetes, and work with Primary Care Networks to improve awareness and engagement of the NHS Diabetes Prevention Programme
- Increase the number of individuals achieving the three NICE-recommended treatment targets (HbA1c, blood pressure, cholesterol) and eight care processes by:
- Providing new tools to more individuals living with diabetes to support patient engagement in self-care; for example, by increasing the offer and uptake of diabetes education programmes for those newly-diagnosed with the condition
- Providing access to digital self-management support tools, including increasing access to HeLP Diabetes online self-management tool.
- Implementing a standardised multi-disciplinary team model delivered at scale across Birmingham and Solihull. This builds on the success we have already had in developing community diabetes models, where patients can be managed in primary care settings through ‘virtual’ multi-disciplinary teams, reducing diabetes-related referrals and admissions, and supporting patients in more proactive ways.
- Ensure that individuals requiring secondary care support have access to multi-disciplinary foot care teams and diabetes inpatient specialist nursing teams to improve recovery, reduce lengths of stay and readmission rates
- Ensure eligible patients with Type 1 diabetes are offered flash glucose monitors, including all pregnant women with Type 1 diabetes, to help improve neonatal outcomes
- Invest in training and education to upskill primary care teams so that they can support more people to achieve the recommended diabetes treatment targets, reduce variation and minimise the risk of complications associated with diabetes

- Standardisation of specialist diabetic nursing roles across services to work towards the provision of seven-day inpatient and outpatient clinical cover across the Birmingham and Solihull footprint. This will to help reduce the length of hospital stays and readmission rates.
- A Diabetes Transformation Programme Partnership Delivery Group has been established with the purpose of driving forward transformation change and improvement in diabetes services. The group membership includes representatives from service providers as well as patient representatives, clinicians, commissioners and representatives from Diabetes UK.

How does this deliver the STP aspirations?

Independence and resilience

- ✓ Improves the number of years that people live in good physical and mental health
- ✓ Expands the provision of structured education and digital self-management support tools supporting independence
- ✓ Supports individuals at risk of diabetes to share responsibility for managing their health
- ✓ Builds confidence and capability among health and care staff, with clear clinical leadership, to give practical advice to patients and the public
- ✓ Improves access to patient education services, with an emphasis on person-centred care, improved knowledge and self-management
- ✓ Gives people more control over their own health and more personalised care.

Equity, equality and inclusion

- ✓ Offers flexible services at local, place-based locations, whilst providing opportunities to utilise different tools for people to improve their health.

Integration and simplification

- ✓ Reduces variation in diabetes management, treatment and care processes through a standardised multi-disciplinary team model delivered at scale across Birmingham and Solihull.

Promoting prosperity

- ✓ Allows people to be active for longer
- ✓ Supports people to be able to work for longer, improving economic growth, prosperity and wellbeing.

Social value

- ✓ Promotes environmental sustainability through the use of digital solutions.

Delivering our commitments in practice

Key deliverables	2019/20	2020/21	2021/22	2022/23	2023/24
Continued referral into National Diabetes Prevention Programme	6,900	8,233	8,233		
Continue multi-disciplinary team pilots (covering 58% of Birmingham and Solihull working to standardised specification	Apr-Sept				
Phased roll out of multi-disciplinary teams to cover remainder of Birmingham and Solihull	Oct 2019	Sept 2020			
Standardised model of patient education commissioning and provision		New Service procured			

High-quality diabetes care includes an emphasis on disease prevention and health promotion with training and education for both patients and staff to support individuals to make the right decisions to manage their own health.

This approach is supported by the NHS Diabetes Prevention Programme, the NHS personalised care model and social prescribing. Diabetes services will be supported by expansion of access to digital self-management support tools, including expanding access to the HeLP Diabetes online self-management tool for those with Type 2.

Key to successful delivery of consistently high-quality diabetes care and outcomes in Birmingham and Solihull will be a skilled and knowledgeable workforce to deliver the multi-disciplinary team approach and to support the move towards working within an Integrated Care System.

How will services be different in 2023/24?

By 2023/24:

- There will be a fully-integrated and system-wide approach to delivering diabetes care across Birmingham and Solihull, with a focus upon prevention, health promotion, early diagnosis, risk reduction and self-management
- Diabetes patients across Birmingham and Solihull will have access to multi-disciplinary teams of specialist professionals, helping them better manage their conditions in proactive ways.

Respiratory care

Improving care for people with respiratory conditions so they can live well supported by high-quality, integrated care across GP, community and hospital services

We have already put the key pillars in place to support a more integrated model of care for respiratory patients, creating a local respiratory clinical network and trailing a number of new pilots to support patients better in the community and in primary care.

Why do we want to change?

Currently, there is no standardised approach for the delivery of respiratory care across Birmingham and Solihull. In the main, service providers work independently, which creates variation in the type and range of respiratory services being offered across the local health community. Working in this way can lead to interventions becoming uncoordinated across providers. This in turn restricts the ability for patients to move seamlessly across organisational boundaries for each stage of their care.

NHS RightCare data has provided a clear evidence base to review existing service provision across Birmingham and Solihull and for providers to work collaboratively towards greater multi-professional working. Delivering services in this way will help to tackle health inequalities and improve the prevention rates and health outcomes for patients living with a respiratory condition.

Priorities for change

- Improve primary care identification and signposting of patients to respiratory diagnostic services through the requirements of Universal Enhanced Service Patient Offer Local Improvement Scheme. This will help us deliver services through Primary Care Networks to support the diagnosis of respiratory conditions at scale.
- Tackle the health inequalities gap in respiratory disease, for example by using NHS RightCare programme data to identify variations in care and supporting clean air initiatives across Birmingham. Some of these initiatives will be focused on some of the most deprived populations, where there are persistent health inequalities e.g. the inclusive growth corridor in east Birmingham is taking a holistic approach to redevelopment, including taking into consideration environmental factors which has a knock-on impact on respiratory conditions.
- Continue to roll out services closer to home with multi-disciplinary team community or virtual clinics for patient GP/specialist review, bringing care closer to a patient's home. We will build on evidence, evaluation and lessons from existing and current pilots to design the most effective models to ensure patients are reviewed promptly and seen in the right setting and can move seamlessly between services according to clinical need.

- Develop Direct Access Diagnostic Hubs across Birmingham and Solihull Primary Care Networks to deliver evidence-based spirometry and exhaled nitric oxide (FeNO) testing to confirm diagnosis of chronic obstructive pulmonary disease or asthma to support early treatment interventions
- Reduce variation in spirometry testing through offering increased access to the Direct Diagnostic Hubs and the Association for Respiratory Technology and Physiology training programmes to help support local accreditation
- Improve care of chronic obstructive pulmonary disease patients by:
- Adopting a standardised chronic obstructive pulmonary disease discharge bundle across Birmingham and Solihull and giving the maximum number of patients access to the high-impact actions to ensure the best clinical outcome for patients admitted with an acute exacerbation of chronic obstructive pulmonary disease
- Using the British Thoracic Society five Impact Actions 7 to ensure the best clinical outcomes for patients admitted with an acute exacerbation of chronic obstructive pulmonary disease. This includes, offering medication reviews and inhaler technique assessment, self-management plans and emergency medication packs, referral to smoking cessation services, assessment for pulmonary rehabilitation and follow up call within 72 hours of hospital discharge.
- Following the best practice pathway for the management of community acquired pneumonia by working to ensure that patients are managed and discharged to their usual place of residence on the same day as attendance/admission
- Review existing community respiratory teams to ensure equitable access for patients. The community respiratory team service will optimise treatment for patients not requiring hospital-based interventions and also provide a step-down service from secondary care.
- Development of an equitable home oxygen service to support patients who require this treatment to improve their longer-term health management
- Delivery of an evidence-based pulmonary rehabilitation service to support patient health education in line with national guidance. The service will be delivered across multiple locations in Birmingham and Solihull to make service access equitable to all.
- Building on existing education and training offers, development of a rolling programme of clinical education for respiratory care to keep clinicians apprised of changes to evidence-based guidelines for patient review and ongoing management. This will be a mandatory requirement for primary care clinicians to attend through the scope of the primary care local improvement scheme.

All service proposals have been discussed and agreed through the local Respiratory Clinical Network. The membership of this group includes representation from primary, community and secondary, care, patient representation groups, NHS RightCare, NHS England and NHS

[7] **https://www.brit-thoracic.org.uk/media/70102/bts-asthma-care-bundle-april-2016-v3.pdf**

Improvement and local authority partners. Discussions have included reaching consensus upon the criteria for service access, final service model, clinical pathways, workforce requirement and service specification.

How does this deliver the STP aspirations?

Independence and resilience

- ✓ Improves the number of years that people live in good physical and mental health
- ✓ Supports health promotion and independence
- ✓ Delivers primary care-based patient self-management plans, including information upon key actions following an exacerbation of their condition.

Equity, equality and inclusion

- ✓ Offers equity of access across the whole of Birmingham and Solihull.

Integration and simplification

- ✓ Reduces variation in care and treatment across the system
- ✓ Delivers of a single integrated respiratory pathway across Birmingham and Solihull, which supports a harmonised approach to the management of patients with a respiratory condition across Birmingham and Solihull and improved working across primary, community and secondary care teams.

Promoting prosperity

- ✓ Allows people to be active for longer
- ✓ Supports people to be able to work for longer, improving economic growth, prosperity and wellbeing.

Social value

- ✓ See promoting prosperity.

Delivering our commitments in practice

Key deliverables	2019/20	2020/21	2021/22	2022/23	2023/24
Phase 1	Test multi-disciplinary team model across two Primary Care Networks Standardise home oxygen service.	Review outcomes from network multi-disciplinary team pilots and roll our community respiratory team and	Fully implemented service		

Key deliverables	2019/20	2020/21	2021/22	2022/23	2023/24
	Standardise pulmonary rehabilitation service and review outcomes from West Midlands Quality Review Service – pulmonary rehabilitation review to inform final service specification for roll out in 2020/21 Pilot diagnostic hub	multi-disciplinary team service model across all networks. Roll out diagnostic hubs Roll out pulmonary rehabilitation service Work towards transition of 8-8 service and where appropriate, seven days a week service			

Data capture in 2019/20 will provide a baseline for data requirements in 2020/21. Data will be provided on a monthly and quarterly basis in accordance with the required KPIs and activity assumptions via the contractual reporting arrangements.

How will services be different in 2023/24?

By 2023/24:

- All patients across Birmingham and Solihull will be able to access an integrated respiratory service, bringing together GP/specialist review in more appropriate settings
- Care will be coordinated across organisational boundaries to make sure that patients are reviewed promptly and can move seamlessly between services according to clinical need
- Patients will have timely access to evidence-based pulmonary rehabilitation programme close to their home
- We will start tackling the health inequalities gap in respiratory disease through public health, planning and environmental campaigns.

Staff health and wellbeing

As the health and social care organisations of Birmingham and Solihull, we are major regional employers, with over 45,000 staff between us. There is certainly room for improvement in terms of our staff health and wellbeing. The most common reasons for sickness absence are stress, musculoskeletal conditions and cold and flu (the latter predominantly in the winter). We lose an average of 6.6 days each year in sickness absence per member of staff, 40% of which is related to mental health. The health and wellbeing of our staff is extremely important for its own sake, and to support those for whom they care for. Most of our staff have families and dependents, so our ability through them to influence lives for the better extends to many thousands more people. A healthy and happy workforce is also more productive. We want to play our part in Birmingham and Solihull being an attractive place to work and live. To deliver this priority, we will:

- Work together to scale-up an overall staff health and wellbeing offer to support each other's staff as if they were our own, making full use of the resources we have available, such as clinical services, gyms, leisure facilities, online resources and support forums. This will apply to all staff directly employed in the NHS, general practice and council-run social care
- Extend progressively the scope of staff clinics by pooling the specialist expertise across our organisations and encourage staff to have check-ups
- Identify innovative practices for promoting staff health and wellbeing within our organisations and spread them more widely across our partnership
- Adopt a common engagement standard to promote best practice in how we engage with staff and respond to their wishes and feedback
- Make mental health first aid widely available within workforce training and ensure our managers have the skills to support staff with mental health problems
- Ensure that canteens and food available to staff encourage healthy choices and cut down on high fat, sugar and salt content, and that we make available a range of structured exercise options for staff
- Aim for best practice levels of uptake of the seasonal flu vaccine for all staff and undertake local research into the most effective methods of encouraging uptake
- Support our staff to volunteer and mentor within approved schemes that have social value in our local community.

Promoting skills and prosperity

Nationally and locally there is a significant shortfall in the number of health and care professionals required to meet the demand for our services, as described earlier in the plan. This can impact on the wellbeing of existing staff, the quality of care we are able to provide and can raise costs when we have to hire locums or from agencies rather than directly employed staff.

Our organisations provide secure jobs for all skill levels in the formal economy and with long term career prospects. The majority of our staff live in Birmingham or Solihull, as well as working here, and they contribute positively to the local economy.

We will invest in recruitment and retention locally, from entry level posts supported by the Apprenticeship Levy, through to the highest-skilled posts, so that we, as major local employers, can support a virtuous cycle of employment and economic growth. We will target this effort to areas that have greatest scope for economic regeneration, such as east Birmingham and north Solihull. To deliver on this priority, we will:

- Develop a staff training passport so that staff who undertake core induction and training can have that experience recognised and not repeated when they move between our organisations
- Take a collaborative approach to recruitment and appointments: using our collective scale and reputation to attract the best candidates to Birmingham and Solihull, for instance through careers fairs; making more joint appointments to promote system working; and deploying staff more flexibly across our organisations, for example to address critical shortages or skills gaps
- Maximise the possibilities for new professional roles, such as nursing associates, to meet the service needs of the future
- Improve significantly the retention rates of GPs each year by developing a workforce plan for general practice, including training hubs and opportunities for flexible working
- Support our staff to gain experience in different parts of the sector through work shadowing and placements, including in primary care centres
- Develop a joint staff bank and agency protocol, building on work that is already taking place
- Develop and enact an STP social value policy, building on the good work of Birmingham City Council; increase social value weightings in our contracts for procurement, in line with best practice, and include common indicators on apprenticeships and recruitment from vulnerable groups
- Provide mentoring, coaching and work experience, and offer apprenticeships and entry level employment opportunities, to people with mental health conditions, young people in the care system and other vulnerable people within our communities, so that they are supported to find work. This will build on initiatives such as University Hospitals Birmingham NHS Foundation Trust's Learning Hub and Birmingham and Solihull Mental Health NHS Foundation Trust's Integrated Placement Support for new routes to employment. The

learning hub, for example, provides a range of employability-based programmes for potential applicants, giving them in-depth knowledge and understanding of careers within the NHS. Some of the programmes are delivered directly with the aim of upskilling candidates before application to NHS entry roles, including apprenticeships. Through the learning hub, we co-ordinate and deliver programmes under the Youth Promise Plus (YPP), a project which aims to support 16,000 Birmingham and Solihull young people who are not engaged in employment, education or training, including unemployed and economically inactive.

- Commission a workforce economic analysis of traditionally lower paid roles (e.g. care workers) to assess the potential of systematic pay progression to deliver offsetting savings through better retention and development of people and skills, reduced agency spending and improved quality of care.

Breaking the cycle of deprivation

Whilst there is quite widespread economic and social disadvantage in Birmingham and areas of Solihull, there are a relatively small number of people who are stuck in a cycle of chronic and severe disadvantage. Often the cycle starts before birth because their parents were in the same cycle, and they may have had one or more of the recognised adverse childhood experiences. They may have dysfunctional families, poor educational outcomes, low employment prospects, and suffer poverty, unhappiness and poor mental and physical health as a result. Some may have been traumatised through exploitation or people trafficking.

There are about 2,500 people with at least three markers of extreme disadvantage, including homelessness, severe mental illness, substance misuse, or having been offenders. Approximately 750 looked-after children leave care every year, 60% of whom have emotional and mental health problems. Nine out of ten people in prison have a mental health or drug problem. About 1,500 supported adults with a learning disability live in unsettled accommodation and their life expectancy is lower than the average by 19.2 years for men and 14.9 years for women.

We will take a targeted approach to support people in severe disadvantage to break out of the pernicious cycle and will:

- Commit our full support as partners to delivering the aims of the Changing Futures and Fulfilling Lives initiative for people with the most entrenched and severe problems, which is led by the voluntary and third sector in Birmingham
- Work in partnership with the voluntary and community sector in Solihull on a joint investment strategy to make the best use of our resources and target them to specific challenges in Solihull
- Support local social enterprises that share our aim of helping people build skills, independence and resilience, and finding work, to break out of the cycle of disadvantage
- Expand our efforts to help people in severe need get back on their feet through our hospital-based food and clothing banks

- Roll out the Red Thread programme across our hospital A&E departments to help prevent gang-related and other serious youth violence and to support young victims of violent crime
- Commit to the delivery of the Transforming Care Programme by 2020 to support people with learning disabilities as close to home as possible, in the least restrictive environment
- Increase significantly the proportion of people with learning disabilities who receive their annual health check from the current low level of 28%
- Implement the West Midlands Combined Authority Mental Health Commission concordat and deliver the Thrive West Midlands action plan across our organisations to improve mental health and wellbeing
- Support the MERIT programme to reduce the number of people who are placed out of their area for acute psychiatric care, and to improve their recovery and outcomes.

Ageing and later life

Ageing well and improving health and care services for older people, creating a better experience at the end of life

Better health and care and living standards mean more people are living longer. The number living beyond 85 will double over the next generation, and there will be a three-fold increase in those reaching 100. Longer lives are a major success overall but they present challenges too.

The latest estimates also show there are more than 146,000 people in Birmingham aged 65 years and older, making up 13% of the total population of the city. Conversely, Solihull has an older population, on average, with 21% aged over 65. Whereas Birmingham is currently below the national average, the most recent population projections suggest a 15% increase in Birmingham's population aged 65 and over by 2027. The biggest percentage increase is expected in the 90 years and over age range.

Many people reach older age in relatively good health. However, with an ageing population there will be more people living with dementia, musculoskeletal problems and frailty.

Our ambition is to enable and support older people to stay healthy, active, independent and with meaningful engagement for as long as possible. When people do need assistance and support, they should be able to access it easily and promptly, from skilled and caring teams and professionals, and receive help as close to their own home and support networks as possible right through to the end of their lives.

Across Birmingham and Solihull, we have developed a range of services for older people, which are working well. These include:

- The Older People's Assessment Service in Solihull and south Birmingham, which is improving outcomes such as preventing unnecessary admissions. The Solihull service provides a timely, multi-disciplinary, patient-centred, comprehensive assessment to those who have an urgent care need. This has led to approximately five patients a day receiving support without the need for a hospital admission.
- Community-based support teams to care homes in Solihull, working in partnership with nursing and residential homes to educate and meet the health needs of residents
- Neighbourhood networks across Birmingham. They involve a lead facilitator who has a budget and responsibilities within the constituency based network to support older people to find/develop and fund local activities and groups specifically for their needs.
- Personal health budgets for end of life care, which has been piloted in east Birmingham and has now been extended across Birmingham
- Support to frontline teams to improve complex discharge processes through integrated working to improve timely discharges

- Roll out of a strength based, person-centred social work framework, which reduces the bureaucracy and allows social workers to have more time to have real conversations with people, focusing on their strengths and maximising their independence
- Development of an integrated carers' strategy, supporting carers and their health and wellbeing
- A Dementia Navigator Service and Dementia cafes/activity groups, which are in place across Birmingham and Solihull. The person living with dementia and their family/carer is allocated a dedicated dementia advisor following diagnosis. The Dementia Navigator Service also provides early intervention/preventative support through a single point of access for information and advice about dementia, information about what support is available pre and post-diagnosis, and how to access this support will be available from the Alzheimer's Society's Dementia Connect.

Why do we want to change?

Whilst we have made great progress, there is still work to do to meet the needs of older people and their carers. We want to make Birmingham and Solihull a great place to age well, which means looking further into meeting the challenges we face.

In the autumn of 2017, the STP commissioned 'Phyllis', a production by the Women in Theatre Group, which focussed on the experiences of Phyllis and her family when she was admitted to hospital. It was based on the experiences of staff, patients and carers receiving care and support in Birmingham and Solihull and has been seen by hundreds of people across our area. It graphically highlighted the impact of poorly aligned services on older people's experiences of health and care and their outcomes.

The theatre production also echoed the findings of a 2018 Care Quality Commission Birmingham system-wide report, which found that health and care organisations needed to develop and drive forward a shared strategic vision for the future and work more closely together to realise improvements on the front line to meet the needs of our diverse population.

In Solihull in June 2019, a Delayed Transfer of Care Peer Challenge was held. This was an external review of the progress Solihull was making to improve the delays in getting patients out of hospital to a suitable home in a timely manner. It was clear the reviewing peer team were hugely-impressed by the committed and positive staff who consistently demonstrated their enthusiasm for their work and the wellbeing of those in their care across the whole partnership. The peer team thought that what was being progressed as a system in Solihull was good, with the potential to move from 'good to great'.

These challenges are:

Service area	Current provision
Community teams	• Multi-disciplinary working not consistently in place

Service area	Current provision
	• Fragmented services provided by individual partners to enable rapid discharge, supporting people in their homes or prevent admission to acute • Multiple hand offs for some individuals, no co-ordinated approach • Multiple assessments and plans with delays • Inconsistent/ poor outcomes • Workforce and skill mix shortages.
Non-acute intermediate care beds	• Significantly more beds than best performing equivalent systems • Multiple commissioning arrangements and providers including specialist beds with inconsistent access across city • Variable access criteria including acuity accepted • Multiple medical management arrangements • Inconsistent/poor outcomes • Workforce and skill mix shortages.
Hospital pre-admission assessment and intervention	• Different 'front-door' services in place at acute hospitals • Limited multi-disciplinary working • Lack of support to carers and families around dementia after diagnosis • Not effectively linked to community teams • Different operating models and facilities • Inconsistent//poor outcomes • Increased unplanned admissions from dementia patients • 56% die in hospital when most would prefer to be at home • Increased unplanned admissions to hospital in the last months of life • Workforce and skill mix shortages • Increase public understanding and allow staff to better manage expectations about people's care at a time when individuals and families are unsure about the options available to them.
Hospital discharge planning	• Different hub services in place at acute hospitals • Limited multi-disciplinary working

Service area	Current provision
	• Not effectively linked to community teams • Different operating models and facilities • Inconsistent/poor outcomes • Workforce and skill mix shortages • Include independent sector social care providers as equal partners in this work, and further build on early work with the Primary Care Networks to fully involve primary care.

Priorities for action

To address these challenges and deliver on our ambition to enable and support older people to stay healthy, active, independent and with meaningful engagement for as long as possible we will:

- **Develop and implement an Ageing Well strategy**. This will support people to manage their own health, wellbeing and social participation. It will signpost community opportunities and activities to citizens and carers, and to GPs as social prescribers. It will establish the concept of supportive communities, involving businesses, educational institutions and the voluntary and community sector. It will support people to remain healthy, engaged in society and reduce loneliness and isolation. It will take a life course perspective to educate children about how living well in earlier life can help with good ageing, and to support inter-generational opportunities.
- **Promote dementia awareness** so that our community becomes more dementia friendly
- **Co-ordinate health and care into a locality neighbourhood framework**, aligning mental health, and primary, secondary and community care with the local authorities, independent social care providers and third sector. This will ensure there is co-ordinated ongoing support.
- **Establish multi-disciplinary teams** to remove barriers in the care system that cause delays when people need care urgently. When a person is unwell, they will receive a comprehensive assessment by an expert team of professionals to make an accurate diagnosis, and a plan will be made for treatment and care, including their physical, mental and social needs. This will be accessible at the front door of hospitals seven days a week to avoid unnecessary hospitalisation and promote the ‘home first’ ethos, building on developments such as SupportUHome.
- **Establish intermediate care centres** for older people in Birmingham to bridge the gap between hospital and home. These community-based centres will provide enablement beds, therapies, mental health support.

- **Provide increased support to care homes** over a phased period to incorporate the need for care staff to deliver an enabling approach, supporting people to maximise their abilities and remain as mobile as possible
- **Take a joint approach to commissioning** and supporting high-quality residential and nursing home provision and associated services, so that people in residential care have the same access to multi-disciplinary teams as those who remain in their own homes
- **Test and take up current and emerging assistive technologies**, especially in settings where they have the most potential to enhance care, such as care homes and extra care housing
- **Establish a carers' commitment** and recognise the vital role that 135,000 unpaid carers play across Birmingham and Solihull, to help them access the support that they need to age well in later life.

Ageing well and later life is already a priority workstream in our STP. Our approach is for parity of esteem where older people with mental health/complex needs are given equal priority and their needs are integral across the whole programme.

Our principles for delivering our priorities are based on:

- **Home first,** supporting older people to live at home as well as possible for as long as possible
- **Provide care that makes sense to people**, including their carers and families, so that people get the support they need, when they need it
- **Provide joined up support across organisations** so that older people do not experience duplication of services or delays in accessing support or fall between the gaps
- **Provide services in the right place**, being open to new ways of doing things and making the most of the strengths of all partner organisations from the public, private, voluntary and community sectors
- **Ensure there is no wrong door throughout the system**, avoiding people struggling and often failing to get the support, care and advice they need
- **Measure the performance of transformational initiatives** to evaluate and justify success. Establishing a baseline of how our services are operating and reviewing this regularly is an integral part of our change process.

This aligns with the priorities of the National Ageing Well Programme and means we need to:

- Create a change in approach to health and care
- Prevent poor outcomes through active ageing
- Deliver improvements to quality in existing acute and community services
- Transform 'out-of-hospital care' and fully-integrated community-based care based on four overarching elements:

- Delivering improved crisis response within two hours, and reablement care within two days
- Working together with GP practices as part of Primary Care Network delivery
- Providing ‘anticipatory care’ jointly with primary care
- Supporting primary care to develop enhanced health in care homes
- Helping tackle workforce challenges in community services.

As a result, we are focusing on three overlapping components – prevention, early intervention and ongoing personalised support (see Figure 12). It is underpinned by the ethos of a ‘home first’ approach. This includes better choices for people as they reach the end of their lives, through death, dying and loss, supported by greater access to personal health budgets to help wellbeing and independence.

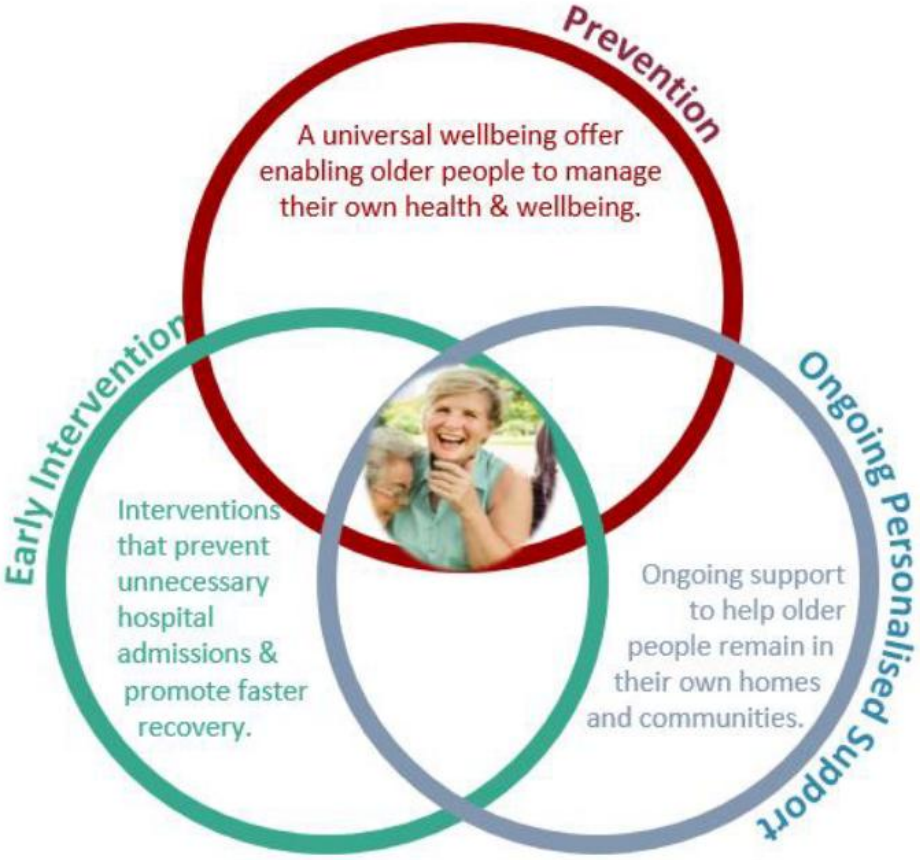

Figure 12: Prevention, early intervention and ongoing personalised support model

Delivering ‘home first’

In practice, this is based on the following key components (Figure 13):

- Supporting people to live well in communities
- Embedding neighbourhood multi-disciplinary teams
- Changing how we deliver intermediate care

- Provide support to care home residents
- Delivery of improved integrated end of life care.

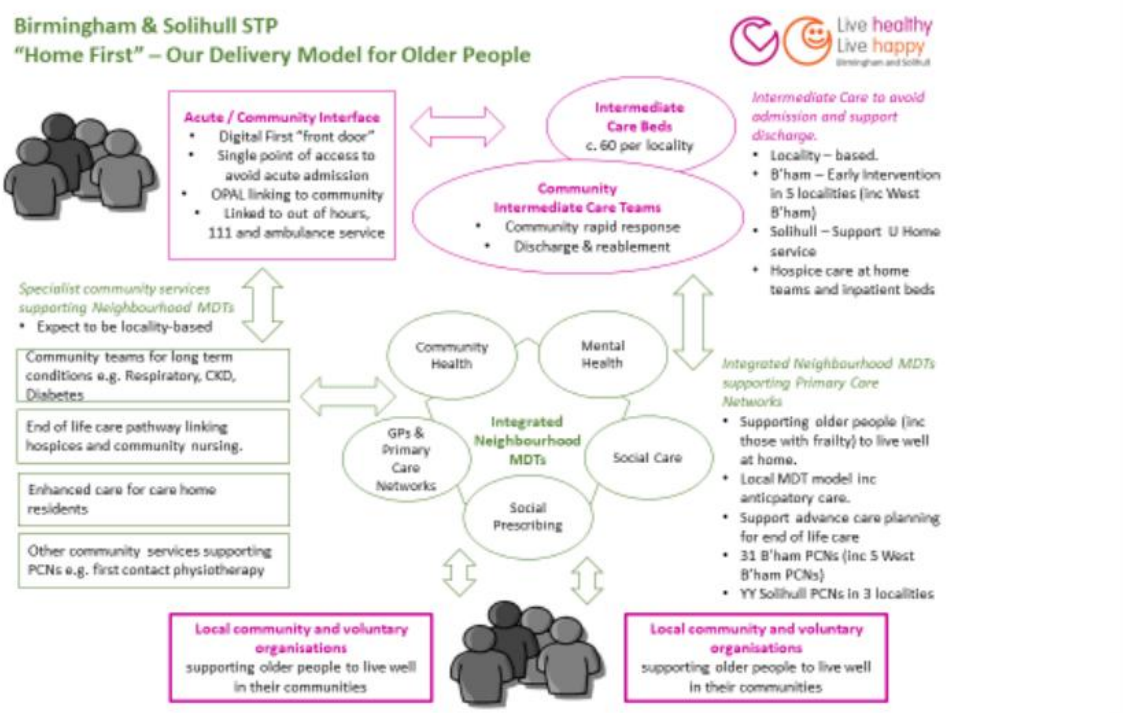

Figure 13: Home First delivery model

This means:

Supporting people to live well in communities

The Neighbourhood Network Scheme was commissioned by Birmingham City Council in 2018, to develop, implement, lead and co-ordinate Neighbourhood Network Schemes to meet the needs of the older people. This was to enable them to access local support across the city's constituencies and neighbourhoods. Broadly they are responsible at a constituency and neighbourhood level for the following:

- Identifying, engaging with and supporting the development of community assets which are local voluntary schemes, support groups as well physical buildings for the community
- Connecting and developing relationships between local stakeholders, particularly communities and social care, as well as through a local Neighbourhood Network Scheme Steering Group
- Local commissioning and grant funding of activities which can support the accessibility and development of the community offer for older people
- Developing ideas and practices between Neighbourhood Network Schemes.

In Solihull, community wellbeing and safety is increasingly co-ordinated via effective multi-agency partnership groups covering three geographical areas (locally called 'localities'). Utilising these

arrangements, including housing, council and police partners, agreed locality plans have been put in place. Through these and the wider work of the newly-developed Prevention, Localities and Communities programme, the ongoing drive is creating the conditions for communities to thrive and the work is promoting a community asset-based approach across all agencies, together with the community. It will take an all age view, building on the work already underway such as the introduction of locality working, social prescribing and wider community developments, and bringing them together into a single cohesive approach.

The programme has been described more as a movement and aims to change the relationship between the citizen and statutory organisations, promoting true community development and resilience which in turn will improve health and wellbeing, with significantly strengthened ability to co-develop with local communities. The programme also includes the development of a platform to share information on community support available in the area. The programme will draw on similar work elsewhere in the country which promotes independence and strength-based approaches. The programme is being launched in October 2019 with a multi-agency group of officers who are being supported through the STP systems leadership training.

Neighbourhood multi-disciplinary teams

From a diagnostic review undertaken in Birmingham in 2019:

- 36% of citizens were not receiving the right ongoing care for their needs in the community
- 23% of citizens had the wrong mix of services to meet their needs, and
- 55% of these non-ideal outcomes were driven by not having the right professional input.

As a result, our focus will be on developing neighbourhood teams of professionals who will work together to shape improved ways of integrated working around primary care networks. Primarily the work will involve practice/Primary Care Network teams, professionals working within the council, community health provider organisations and the voluntary and community sector. The teams will develop in response to local need building on work begun by the STP prior to the formation of Primary Care Networks. These virtual teams will provide the interface between primary and community care, link into wider community assets promoting people to stay well, independent and feel more in control of their health.

Work will begin in a number of pilot sites in 2020/21 and then supported to evolve across the whole area by 2021/22. The work will involve formation of improved relationships between professionals as well as provider co-production of more formal systems and processes to support care, including bring the right information together in one place. All changes will be designed around a series of shared principles including reduction in dependency on statutory services, taking a wider holistic view of health, the consideration of people's personal goals, designed with older people to promote independence.

We will also be focusing on the implementation of anticipatory care for complex patients at risk of unwarranted health outcomes. We will target support towards older people with moderate frailty as well as people of all ages living with multiple comorbidities. Anticipatory care will be delivered jointly by primary and community services and we will ensure integrated teams are in place along

with social care and the voluntary sector. The programme will be delivered through primary care networks and multi-disciplinary teams and will use the electronic frailty index and clinical judgement. This will identify older people living with frailty and their carers who are at risk of adverse health outcomes and provide them with tailored and personalised care. Through the implementation of anticipatory care, patients will be supported to stay well and at home for as long as possible.

A new way of delivering intermediate care

Increasing the capacity and responsiveness of community health crisis response services to deliver the services within two hours of referral in line with NICE guidelines where clinically judged to be appropriate, and delivering reablement care within two days of referral to those patients who are judged to be in need.

We know some older people will need treatment and support on occasion for a short period of time. Our aim is to prevent unnecessary hospital admission, support appropriate discharge from hospital and maximise people's ability to lead independent lives outside of health and care services. In providing a proactive response we will try to prevent premature admission for people into long term residential care, minimise delays and not take decisions about long term care in a hospital setting. This includes enabling people will remain in their homes whenever possible. In most cases, older people are more comfortable in their own homes and recover and regain their independence more quickly if good quality therapeutic support can be provided. This is supported by a single co-ordinated plan tailored to their needs and desired outcomes. They will know who to talk to for help during this time and who will be supporting them if they need ongoing support. They will be assessed by an appropriate clinician prior to any hospital admission and not have to wait for the next stage of their enablement to be put into place.

Delivering this commitment in Birmingham is via early intervention, which is currently prototyping the service and delivering a positive impact. For example, the Early Intervention Community Team in Edgbaston has looked after 120 people and 75% of its discharges do not need an ongoing social care package, which is also supported by 100% satisfaction in friends and family responses.

For Solihull the commitments are delivered by SupportUHome, where there have been improvements in reduction in length of stay and increased occupancy and throughput in intermediate care beds.

Support to care home residents

In December 2017, based on national learning from the enhanced health to care home vanguards, and from successful local service such as Walsall, an Enhanced Support to Care Homes Service was commissioned in Solihull to provide support to 30 care homes (nursing and residential). The aim was to improve quality and reduce unnecessary admissions and A&E attendances by 10%. The Solihull service had a good impact in delivering these targets, costs of admissions to hospital and A&E attendances in 2018/19 have reduced by 4%, compared to increasing costs of over 20% during the previous two years. It is acknowledged there are still further improvements, for example testing the Digital First approach with video consultations and understanding the impact of these.

Learning from these areas, we are building on the Solihull model as our starting point to deliver a consistent service offer across Birmingham and Solihull. This will ensure we have parity of esteem for care home residents, with a consistent service offer across our entire area. Critical to delivery is a partnership approach to work with people to create improvements rather than a 'do to' approach. Operational testing of enhanced support with two Birmingham care homes is in progress. Alongside this is hospice supported facilitation and education of care home staff across 30 care homes.

Improved end of life care

Palliative and end of life care is a priority as it affects everyone in the community. The impact of grief on mental and physical health affects the whole health and care system. Palliative care is also changing given more people are living longer with multiple conditions who may require support and intervention across years as well as the last months, weeks and days of life.

Evidence demonstrates that over 78% of individuals achieve their preferred place of care and death when providers and specialist hospice and palliative care teams work together in a co-ordinated way. In addition, sampling and monitoring of patient feedback shows that individuals also experience improved symptom management as well as improved carer and family resilience. However, there is also evidence that many people continue to die at home without adequate support especially where there is fear of prejudice or lack of understanding including people who are homeless, people from ethnic minorities and people who identify themselves as Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Plus.

Our five end of life programme priorities supporting an integrated model of care include:

- **Increased education** to support identification of individuals with palliative care needs and those approaching death. This also includes building the capacity of more providers and citizens in the delivery of palliative and end of life care by mapping and delivering core education requirements to offset demand on specialist services.
- **Advance care planning and quality improvement auditing** to ensure that everyone identified with palliative care needs and approaching death has had a conversation about their wishes and that this is recorded and reviewed.
- **Joined up palliative and end of life care** to provide better choices at end of life. This will be achieved by scaling up the use of personal health budgets for end of life patients from our current level of 30 to at least 100 or more in the first 18 months. Better palliative care co-ordination will include improved by:
    - Communication and responsiveness across GPs, district nurses, community teams, hospital and hospices
    - Improved handover between hospital and primary care
    - A system of urgent response and a 24-hour one-number support line for hospice and end of life care backed up with specialist palliative care staff able to enhance current out-of-hours services. This will ensure people not only achieve their preferred place of care but also a good death.

- **Embedding a compassionate communities approach** to draw upon existing community organised end of life care and build further capacity for support and resilience at community and neighbourhood level. Worldwide studies demonstrate this approach reduces demand on professional services and improves equality for marginalised groups. This is as a result of building upon community knowledge and enhancing community capability including workplaces and schools for improved bereavement support; reducing social isolation through community effort; and breaking down barriers to accessing specialist palliative and end of life care and ensuring people are better supported during death, dying, bereavement and loss.
- **Birmingham and Solihull to be recognised as a centre of excellence for end of life care.** This builds upon existing initiatives and plans in place to create an integrated system of health and care of which the quality and delivery of end of life and palliative care is a priority at all levels of community, citizenship, clinical practice, education and research.

Dementia

Dementia is a syndrome, usually of a chronic or progressive nature, where there is a progressive decline in cognitive function beyond what might be expected from normal ageing. It affects memory, thinking, orientation, comprehension, calculation, learning capacity, language, and judgement and the skills need to carry out daily activities.

Dementia is one of the major causes of disability and dependency among older people worldwide. It is overwhelming not only for the people who have it, but also for their carers and families. Costs for care are generally high and the majority of costs fall on informal carers. The costs relating to dementia in the UK are expected to be £55bn by 2040.

For Birmingham and Solihull, there are around 13,000 people aged 65 plus with dementia. Of these 8,785 have a diagnosis. The local diagnosis rate for NHS Birmingham and Solihull CCG is currently 67.5%.

The aim of the Birmingham and Solihull dementia strategies is to ensure that significant improvements are made to dementia services across four key areas, namely:

- Enabling people to have access to a timely diagnosis and then ongoing support with information and services at the earliest opportunity
- Preventing crises and supporting people with dementia within communities
- Improving the quality of care for people with dementia and ensuring services are person-centred, integrated across health and care and fit for purpose
- Improving advance care planning and end of life care.

A steering group has been established to support the development of a refreshed strategy, which includes representation from STP partner organisations as well as the police, fire service, public health and voluntary and community organisations. Stakeholder engagement events were also held during the summer of 2019 to inform the strategy going forward. The refreshed strategy will be published in April 2020 and will reflect the progress to date and future planning requirements.

When strategic priorities are implemented at a local level, these should result in significant improvements in the quality of services provided to people living with dementia and their families/carers across the STP. These will include:

- **Early diagnosis**: Whilst the STP already achieves the national target for diagnosing dementia early (two thirds of those people over 65 in Birmingham and Solihull who we think might have dementia are diagnosed). Our aim is to better this target to achieve 77% by 2022/23.
- **Memory assessment service**: We want to ensure access to the memory assessment service where the diagnosis is confirmed is timely. Currently people are waiting up to 26 weeks for a diagnosis and we aim to reduce the waiting times to a maximum of 18 weeks by September 2020.
- **Early help and support**: We want to ensure all GPs identify patients with dementia on their local registers to ensure they have the offer of support and guidance. This work commenced in September 2019 and we expect improvements year-on-year to reach our target in 2022/23.
- **Primary Care Networks**: We want to improve support to patients and their carers/families with a named dementia advisor supporting each Primary Care Network by November 2019
- **Assistive technologies**: Developing and expanding the way we use equipment and technology offers opportunities to address these challenges. Our key aim is to ensure that we can enable our citizens to remain independent in their own homes for as long as possible, supporting themselves and their carers. This could be enabled with the use of equipment and technology in that it should not be seen as an added extra. A diagnostic exercise is planned for May 2020 to be subsequently supported by a business case to support this investment.
- **Integrated dementia care – reducing hospital admissions and length of stay for people with dementia through STPs.** As an STP, we are one of three national pilot sites to work on reducing avoidable hospital admissions; the other two sites are West Yorkshire and Harrogate STP and North Central London STP. The STP successfully bid for an advance care planning project manager with a particular focus on dementia and four additional qualified staff for Birmingham and Solihull Mental Health NHS Foundation Trust to expand its enablement work to reduce hospital admissions, length of stay and upskill care home staff on the management of people with dementia. NHS England funding supports the programme of work during 2019/20.

To deliver the comprehensive service offer we acknowledge a number of key enablers that will be required to support the transformational programme of work.

Workforce

Ensuring that we have a workforce that is the right size and shape to deliver our new home first service model for Birmingham and Solihull will be key to the success of our plans. In approaching this part of our work we have identified three important themes:

- **Supply**: In the next stage of our programme, we will work together across health and care to assess our future workforce requirement in more detail. Our expectation is that we need to expand the capacity of our community-based teams to deliver the model of care that we have set out. Understanding the impact of the planned expansion in the primary care workforce will also be important to this part of our work. We will work with the wider STP workforce programme to seek to recruit and retain sufficient staff to deliver this.
- **Skills**: We are likely to want to develop new roles to support our new model of care including generic rehabilitation or reablement roles across health and care and advanced practitioner roles in community nursing and therapies
- **Support**: Our plans for more community-focussed, multi-disciplinary working will need us to support our workforce with the skills needed for the new model of care. This will include supporting staff to work at the interface between organisations and in multi-disciplinary teams as well as equipping staff with the skills to work in a Digital First health and care system.

Estates

We recognise that there will be a set of estates consequences as a result of the home first service model. For example:

- The new intermediate care service model in Birmingham envisages delivery through five care centres, one in each of five localities. We have identified the likely sites for these centres but there will be refurbishment work required to ensure they are fit for their new purpose
- We will be working on the options for the location of our neighbourhood teams in a way that supports the integrated model of care that we are aiming for.

The detail of these plans will be developed further as part of the next stages of the work of our programme.

Digital

The ageing well programme is committed and to will work within the STP's wider Digital First approach to the delivery of care. The detail of this will be developed in the next stages of our work but at this stage we have identified a small set of key areas in which Digital First will need to be built into our service model from the start:

- **Support to care homes:** We will work with care home providers to build remote access to specialist opinion into our work with care home residents, ensuring real-time access to specialist opinions and advice needed to prevent emergency acute admissions
- **Neighbourhood teams:** We will work to ensure that multi-disciplinary neighbourhood teams are able to access the full care record for their patients and have appropriate tools to identify and flag patients at risk of admission and in need of improved care planning and co-ordination

- **Intermediate care:** We will ensure that our intermediate care teams and especially the new interface service has access to the fully integrated care record
- **Mobile working:** We will build on work already underway within our community providers to ensure our teams are equipped to access care records and work remotely as they support people at home.

The care homes work has already been identified as a Digital First priority for the STP and we will develop more detailed plans for these priorities as the next stage of our work**.**

How does this deliver the STP aspirations?

Independence and resilience

- ✓ Improves the number of years that people live in good physical and mental health with independence
- ✓ Creates choices and shared decision making in care plans, resulting in more person-centred services
- ✓ Co-ordinates care in a way that makes sense to people.

Equity, equality and inclusion

- ✓ Reduces variation through the development and delivery of a clear integrated approach
- ✓ Supports people in the place they call home, wherever that is
- ✓ Provides support closer to home
- ✓ Makes it easier for people to access more dedicated support where this is needed
- ✓ Delivers a wider support service, based on what matters most to people
- ✓ Includes the experiences of older people and their carers in developing the way services are delivered, through an active approach to understand what works in different communities.

Integration and simplification

- ✓ Develops place-based approaches to improving health and wellbeing as well as living up to and at the end of life
- ✓ Connects services together, making access easier for people
- ✓ Creates a single care plan which reduces the need for people to tell their story multiple times.

Promoting Prosperity

- ✓ Helps people to thrive in their communities, living well for longer
- ✓ Prevents avoidable admissions to hospitals
- ✓ Assists people to stay in their homes for longer.

Social value

- ✓ Brings together communities to provide support, recognising the value of the wider community
- ✓ Recognises the value older people can play in communities
- ✓ Creates opportunities to share learning on what works.

Delivering our commitments in practice

The following is a summary of our delivery approach, which will help to deliver the best possible sustainable service models for the future, whilst recognising there is more than one way of improving services. The benefit of combining learning from our different developments delivers a synergistic effect what otherwise wouldn't be possible. This approach also allows the essential tailoring of service delivery to local place and communities where it makes sense to do so. The high levels of diversity and therefore the need for a tailored, inclusive approach are a particularly important consideration for the population served within this STP. This approach therefore recognises and embraces the individual needs for both Birmingham and Solihull in relation to the phasing for each delivery element.

Birmingham and Solihull priorities	**Phased delivery**			
	2020/21	**2021/22**	**2022/23**	**2023/24**
1. Supporting people to live well in communities	Birmingham neighbourhood networks in place. Integrated carers service in place. In Solihull, finalise deliverables of newly-established Prevention, Localities and Communities workstream, including: 1) Increased social prescribing 2) Social connectedness project 3) Work with voluntary sector on 'common purpose'	Evaluate the impact of the Birmingham neighbourhood network. On-going development of Prevention, Localities and Communities workstream – with regular review and monitoring. 100 more people accessing personal health budgets at the end of life through hospice personal health budgets pilot.	Review integrated carers strategy and impact. Evaluate and refine as appropriate. Share and combine learning across the STP Evaluate impact of end of life care personal health budgets and refine appropriately. Decide approach to comprehensive roll out.	Community assets approach embedded within communities. Embed compassionate communities.

Birmingham and Solihull priorities	Phased delivery			
	2020/21	2021/22	2022/23	2023/24
	objectives for ageing well 4) Active travel 5) Establish and evaluate the community space pilot 6) Fully aligning Primary Care Network development with localities developments 7) Launch and further develop the MySolihull online community resources platform Assistive technology prototyping Social prescribing Identification of existing community-organised resources and assets to support end of life.	Citizens supporting people to live well at end of life in their communities.		
2. Neighbourhood multi-disciplinary teams	Align teams to Primary Care Networks Test multi-disciplinary teams in practice (six sites). System-wide organisational	Roll out coverage of multi-disciplinary teams across Birmingham and Solihull to deliver anticipatory care. Roll out mobile technology and	Consider options for personalisation to meet anticipatory care needs. Review impact of multi-disciplinary team working and	Integrated working across neighbourhood multi-disciplinary teams fully embedded. New staff groups recruited for Primary Care Network working.

Birmingham and Solihull priorities	Phased delivery			
	2020/21	2021/22	2022/23	2023/24
	development programme. IT and data sharing to support neighbourhood working. Integrating new staff into employed through the Primary Care Network direct enhanced service specifications.	Digital First technologies.	refine delivery model. Develop neighbour multi-disciplinary outcomes and shared approach to monitoring.	
3. A new model for intermediate care	Complete roll out of Early Intervention Community Teams (EICT) in Birmingham. Consider Organisational development to ensure sustainability. Establish system wider dashboard for monitoring. Develop home first pathway in Solihull. Review existing workforce capacity Achieve two-hour rapid response. Agree bed model and interface. Pilot Clinical Assessment Service including	Full EICT coverage in Birmingham Bed model roll out. Agree system-wide approach to monitoring impact of intermediate care. Evaluate and refine Clinical Assessment Service acting as the single point of access. Consider digital innovations to improve integrated working. Implement workforce strategy and	Evaluate outcomes from EICT working and make any improvements. New bed model fully operational. Embed all target monitoring across the system to achieve reablement within two days of referral. Clinical Assessment Service fully operational as the only single point of access. Adopt agreed system-wide approach for digital capability in the community.	Full delivery of intermediate care service

Birmingham and Solihull priorities	Phased delivery			
	2020/21	2021/22	2022/23	2023/24
	single point of access Single workforce strategy for intermediate care.	monitoring impact.		
4. Support to care home residents	Full coverage of NHS email in care homes. In Solihull expand enhanced support to care homes (EHCH) team as per the Primary Care Network Direct Enhanced Service contract. Commission EHCH service to achieve full elements of clinical care. Test digital first approach and video consultation in Solihull and evaluate impact. Evaluation of red bag scheme in Solihull.	EHCH business case developed to achieve fully operational service. Widen digital approach as part of the Clinical Advice Service. Understand market developments and how best to meet the needs of an expanding care home market.	Full clinical support offer in place for care homes. Evaluate approach and test outcomes. Agreed approach to digital working with care homes as partners. Clinical Assessment Service working to benefit care home residents and meet their needs appropriately. Develop a joint approach to workforce recruitment and retention with care homes.	Further developments to care homes offer as per evaluation and new digital offers.
5. Improved end of life care	Agreement to tools to identify people with palliative care needs and those approaching death. Consistent advance care planning.	Consistent application of tools to identify people at end of life and documentation of advance care conversations and plans.	Hospices part of testing Digital First approach with video consultation. Expansion of hospice pilot for personal health budgets.	Communities actively supporting care at end of life. Birmingham and Solihull recognised as a centre of excellence for research, clinical

Birmingham and Solihull priorities	Phased delivery			
	2020/21	2021/22	2022/23	2023/24
	Development of an end of life care education programme for public and professionals.	End of life care education programme in place for building capacity in providers and public. Hospices part of digital health and care early adopter pilots.	Palliative and end of life care work programme integrated across STP workstreams. Community-based advance care planning conversations.	practice, education and community led palliative and end of life care.
6. Dementia	Full implementation of dementia navigation services and cafes. 18-week wait for memory assessment service achieved, Diagnostic for assisted technologies completed.	Review and roll out of national dementia pilot findings. Case for change for assisted technologies completed	Delivery of 77% diagnosis rate achieved	All registers for dementia patients up to date and used by general practice for ongoing support and care.

How will services be different in 2023/24?

By 2023/24:

- We will have a comprehensive integrated support for people to age well, offering proactive personalised support and helping stay well, better manage their own conditions and live independently at home for longer. This includes guaranteed NHS support for people living in care homes. If needed, there will be timely urgent community response and recovery support, via a single clinical advice service which includes end of life care support.
- We will listen to and adapt to meet the needs of the local communities we serve including addressing inequalities in both access to services and in health care outcomes.

All age services

Improving urgent care access and experience

A Digital First urgent care that is a simple, single system, which inspires trust and confidence, to access appropriate high-quality urgent and emergency care and support at the right time and in the right place

In Birmingham and Solihull our initial work plan has been to stabilise and improve services which directly affect the quality of care, safety and the patient's experience when accessing urgent and emergency care. In doing so we have focused on:

- **Pre-hospital care**
  - Designated Solihull urgent treatment centre
  - Launched Ask A&E in October 2019
  - West Midlands integration of the 999 and 111 services into a single service which will lead to further developments in integration with local services for the benefit of patients
  - Expand "Hear and Treat" and "See and Treat" ambulance services, with the provision of telephone advice and treatment of people in their homes saving unnecessary trips to hospital.
- **0-72 hours**
  - Delivered older people's assessment liaison service at Solihull and Queen Elizabeth hospitals
  - Same day emergency care – extended physical capacity across hospital sites.
- **Post 72 hours/out of hospital**
  - Complex discharge hub – prototyped an integrated model at Queen Elizabeth Hospital, which has improved flow and timely discharges
  - Sometimes patients spend days in hospital which do not directly contribute towards their discharge, we have ensured daily Red2Green meetings are in place across medicine and older people division. Red2Green approach is a visual management system to assist in the identification of wasted time in a patient's journey.

This has built a foundation to deliver improvements and transformation which will contribute to a better urgent and emergency care system.

Why do we want to change?

Like many places in the country, we face the challenge of fragmented urgent and emergency care services, with multiple points of entry, duplication of services, and high levels of demand. This is compounded by staff vacancies, as seen across the country, with particular recruitment issues within GP practices and A&E departments as they are not seen as an attractive place to work. In addition, many staff vacancies are filled, albeit on a temporary basis, which can bear a huge drain on overstretched finances. By reducing the fragmentation and duplication we can empower staff to deliver continuous improvement across the integrated urgent and emergency care system whilst making the best use of their skills and capacity.

Waiting times in urgent and emergency care are often used as a barometer for overall performance of the NHS and social care system. It is acknowledged that the Clinical Standards Access Review proposes a set of new measures for A&E departments, which are currently being tested. The aim is to review the way care is delivered since the introduction of the four-hour standard for treatment. Recommendations are due in spring 2020. However, in terms of current performance our main hospital providing emergency care has been substantially below the four-hour standard, linked to pressures of demand and staffing.

Together, as a health and care partnership, our A&E Delivery Board has focused on improving performance and gaining a system-wide understanding of the issues. In summary this analysis has established:

- Performance fluctuates due to flow/time of attendance between 4-10pm
- There has been an increase in walk-in attendances
- Demand drives a higher admission rate to hospital, which affects the use of hospital beds in other areas
- We have challenges in terms of vacancies and rates of sickness amongst our staff
- Patient audits have been undertaken to understand the reasons why people are walking into emergency departments. These indicated:
    - Patients are often not contacting 111 before attending A&E or walk-in centre. Equally, if they do contact 111, they are frequently advised to attend A&E.
    - Patients are not frequently attempting to contact their GP before attending A&E
    - People are attending A&E or walk-in centres if they are closer to them.
- We are seeing an increasing number of ambulances from other areas attending our A&Es, which include people from Bromsgrove, Sandwell, North Warwickshire and Tamworth.

Priorities for change

The **NHS Long Term Plan** challenges the NHS to reduce pressure on emergency hospital services by expanding and reforming urgent and emergency care services to:

- **Embed a single multi-disciplinary Clinical Assessment Service** within integrated NHS 111, ambulance dispatch and GP out-of-hours services from 2019/20 to support people to identify the most appropriate route for care
- **Fully establish urgent treatment centres by autumn 2020** so that all areas have a consistent offer for out-of-hospital urgent care, with the option of appointments booked through a call to NHS 111
- **Implement the recommendations from Lord Carter's report on operational productivity and performance** in ambulance trusts, ensuring that ambulance services offer the most clinically and operationally-effective response
- **Implement a comprehensive model of same day emergency care, providing services at least 12 hours a day, seven days a week by the end of 2019/20**
- **Provide an acute frailty service for at least 70 hours a week**, working towards achieving clinical frailty assessment within 30 minutes of arrival
- **Embed the Emergency Care Data Set into urgent treatment centres and same day emergency care services from 2020** to help us better understand the needs of patients accessing A&E
- **Further reduce delays transfers of care**, in partnership with local authorities.

Clinical leadership and engagement are critical to set the urgent and emergency care vision and enable delivery. In Birmingham and Solihull, the A&E Delivery Board has brought partners from across health and care together to plan service delivery. This has had a particular focus on the delivery and sustainability of the four-hour target; with a clear methodology for addressing the longer term delivery of urgent and emergency care transformation.

A system-wide recovery plan has been approved and all delivery groups report to the A&E Delivery Board. This has involved clinical workshops to create commitment to translate our vision into reality by:

An integrated urgent and emergency care system delivering Digital First urgent care

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This will be delivered by:

- **Promoting a 24/7 simple, single-entry point for patients and professionals that has an overarching digital symptom checker,** such as Ask A&E and artificial intelligence solutions as the first way to access all urgent care services or support in the patient's own home
- **Maximising the number of patients who can be treated without being admitted** overnight via same day emergency care, resulting in a better patient experience and reducing the pressure on inpatient beds

- **Improving patient flow and appropriate reduction in length of stay**
- **Ensuring timely safe discharge and reduce delays** working in partnership with local authorities.

In turn, this will:

- **Promote self-care and build care around the patient** not the existing services. This includes a communication and engagement campaign with the public to share the vision for an integrated urgent and emergency care system and how they can access the right service, at the right time, first time. This will be repeated with consistent messages as changing patient and public behaviour and perceptions alongside understanding how to access urgent and emergency care is critical for success. This includes targeting different population groups i.e. student population with key tailored messages.
- **Simplify access** and help people with urgent care needs to get the right advice in the right place, first time
- **Support people in more local in-hours services and through urgent primary care settings**, which will balance demand across our area
- **Deliver early intervention and prevention to avoid hospital-focused urgent care.** This includes multi-disciplinary teams working together to deliver agreed care plans, expected dates of discharge (our aim is to do this within 14 hours of admission), reduce length of stay, ensure effective daily review and implementation of the SAFER patient flow bundle:

S	**Senior review**	All patients will have a senior review before midday by a clinician able to make management and discharge decisions
A	**All patients**	Will have an expected discharge date and clinical criteria for discharge. This is set assuming ideal recovery and assuming no unnecessary waiting.
F	**Flow**	Flow of patients will commence at the earliest opportunity from assessment units to inpatient wards. Wards that routinely receive patients from assessment units will ensure the first patient arrives on the ward by 10am
E	**Early discharge**	33% of patients will be discharged from base inpatient wards before midday
R	**Review**	A systematic multi-disciplinary team review of patients with extended lengths of stay, focusing on a clear home first mind-set. This will be relevant for patients who have a length of stay greater than seven days).

- **Social care and community services are a critical partner** and the improvements will ensure the responsiveness of community health crisis response services to deliver the services within two hours of referral in line with NICE guidelines, where clinically judged to be appropriate. This will be alongside reablement care within two days of referral for those patients who are assessed as needing it.
- **Ensure the urgent and emergency care system works seamlessly together** across all providers of care. This includes highlighting alternative ways to access care and re-directing care appropriately and safely for example, through booked appointments in general practice.
- **Embrace emerging Digital First and artificial intelligence technologies,** which will enable patients to be navigated to the right care more quickly. This also includes the development of alternative access to care so they can be treated by skilled paramedics at home or in a more appropriate setting outside hospital. Where digital access is not an option for patients, they will be supported to use the same symptom checker when they access the integrated urgent and emergency care system.
- **Attract and retain a new and existing and new workforce** whilst being financially sustainable
- **Implement the recommendations of the clinical review of NHS access standards** expected in spring 2020.

Summary of key priority areas for transformation in Birmingham and Solihull

Pre-hospital urgent care

- **Clinical Advice Service**: This will be staffed by local GPs, senior nurses, including mental health, receiving calls from NHS111 and supporting professionals to enable the right solution for our population and the ability to mobilise alternative pathways. This will include single point of access for both professionals and patients.
- **Digital First:** This will be a system-wide approach, referenced in our digital chapter
- **Urgent treatment centres**: This is the designation and upgrading of all urgent treatment centres, which will include embedding the Emergency Care Data Set. This will standardise the current confusing range of options and simplify the system, so patients know where to go and have clarity of which services are on offer where. The benefits to patients and the STP is to redirect as appropriate patients from services such as NHS111/Clinical Assessment Service/A&E to urgent treatment centres.
- **Out-of-hours:** This will include a review of out-of-hours contracts and realign them to integrate better into our system-wide approach. Integrating the out-of-hours service provision and extended access as part of our Clinical Assessment Service will form a key element of our integrated urgent and emergency care.

- **Enhanced health in care homes:** This will include support to care homes who, as early adopters, which will include testing video consultation/digital innovations to prevent unnecessary hospital attendance and support people to be cared for in the place they call home.

0-72-hour care

- **Estate development at acute sites:** This will provide increased space for same day emergency care. This includes expanding the space for frailty assessment units.
- **Same day emergency care:** This includes optimising the delivery of same day emergency care ensuring effective capacity and pathways in place to deliver a 12-hour/7-day-a-week service by September 2019 and by March 2020 for surgical same day emergency care. This will be reflected in the Emergency Care Data Set.
- **Older people assessment service**: This will provide early intervention and a frailty assessment unit with comprehensive assessment for at least 70 hours per week across all sites, which at the front door of our hospital sites. Solihull's Older People's Assessment Service is the most established service delivering improved outcomes through preventing unnecessary hospital admission and also reducing length of stay. This is through a comprehensive assessment and care plan which is put in place for people who are admitted. It also includes the standardisation and expansion of multi-disciplinary team working to deliver a quick response, with the delivery of traditionally acute clinical interventions for older people provided safely at home. This forms part of the improved crisis response.

Post 72 hours and out of hospital care

- **Birmingham early intervention and Solihull SupportUHome** aim to provide an integrated approach to intermediate care services that is person and carer-centred and encompasses physical, mental health and care needs. This includes improving urgent community health crisis response services to deliver the services within two hours of referral, and reablement care within two days of referral. It also delivers an integrated approach to intermediate care, both beds and home first approaches. Any learning from the Birmingham early intervention prototypes will be shared and adopted as appropriate in Solihull.
- **Birmingham early intervention** is based on a system diagnostic that found some people were admitted to hospital with social care needs who could have been managed better at home and patient stays in hospital were longer than needed. This is a system-wide transformation programme which has been prototyped to deliver integrated therapy-led intermediate care at home, as the preferred option, or bedded if required. The prototypes have demonstrated a reduction in length of stay and ongoing packages of care alongside improved service user experience. This will be rolled out across the city in 2019/20.
- **Complex discharge hub** is based at each hospital site which is a multi-disciplinary team responsible for the appropriate and timely discharge of people with complex care needs.

This ensures we make the best decision for each individual, prioritising active recovery at home.

It has been agreed that for early intervention we will be developing an integrated commissioning approach within the Birmingham Better Care Fund, which will provide the single funding stream, integrated governance and processes for monitoring the service. By 2020/21 we want to be strategically commissioning the early intervention model, which includes the roadmap towards a single funding stream and integrated delivery arrangements. The overall aim is commission through a single provider model such as an alliance or prime provider model. Through integration and prevention, we will reduce the demand for care.

Discussions are in progress regarding the approach to integrated commissioning in Solihull.

This will deliver a number of benefits:

- Approximately 5,000 more, older people receive a more ideal service than hospital admission per year (such as care in the community)
- The 5,500 older people discharged per year in Birmingham with complex needs will receive a measurably more independent package of ongoing care
- By improving discharge pathways and focusing on reducing delays, these complex patients will stay in hospital, on average for four less days
- By delivering more independence for people and reducing delays in transfer of care, we will create an estimated 25% reduction in the need for non-hospital bed based care in Birmingham
- The length of stay for our mental health patients will be reduced by approximately 10%
- We will create a city-wide, joint health and social community service capable of seeing 6,000 people per year and supporting them towards independence
- We develop this joint health and care service such that it has measurably improved outcomes relative to existing services
- We will deliver significant financial savings, supporting the financial sustainability of our area. Birmingham City Council, partner NHS organisations and Newton supported by STP finance colleagues have calculated a forecast that by making the above improvements, we will achieve an estimated £27-37m per year in savings as a result of improved and more independent outcomes for thousands of older people across Birmingham every year. The same approach will be adopted to demonstrate impact of our transformation programmes for Digital First and 111/Clinical Assessment Services, which could result in even greater savings.

How does this deliver the STP aspirations?

Independence and resilience

- ✓ Delivers health promotion and independence through a Digital First option providing self-care advice

- ✓ Gives people the right information to prevent wasted journeys in accessing care.

Equity, equality and inclusion

- ✓ Promotes right care, right place through the Clinical Assessment Service and digital options
- ✓ Reduces variation through system-wide initiatives with the same metrics – i.e. early intervention/SupportUHome
- ✓ Delivers the national service specification in place for all urgent treatment centres.

Integration and simplification

- ✓ Reduces fragmentation and consolidates urgent and emergency care in our areas
- ✓ Integrates other areas of single digital access together in the form of Clinical Assessment Service, which will make it easier to identify gaps in future
- ✓ Creates standardised practice across all hospital sites.

Promoting prosperity

- ✓ Creates more financially sustainable services and balances demand
- ✓ Makes our urgent and emergency services more attractive places to work and learn through embracing new technologies and standardising practice and efficiencies from service consolidation
- ✓ Delivers economies of scale and efficiency.

Social value

- ✓ Creates opportunities to share learning on what works.

Delivering our commitments in practice

Building on what we have already achieved and by taking into account the needs of our population, **we aim to achieve Digital First urgent care by 2024**.

There are a number of defining activities which are required to produce the deliverable and expected benefits given this work has clear links with our digital programmes, primary care, community care, mental health and also workforce developments.

Some of these are more complex and challenging than others, such as culture change, changing the way the population understand and appropriately access urgent and emergency, recruiting and retaining critical staff, investment in digital wide solutions and infrastructure.

The A&E Delivery Board will receive assurance of the urgent and emergency care portfolio of programmes, which will include project scope, time, cost, quality objectives and benefits realisation as well as risk.

Key deliverables	2019/20	2020/21	2021/22	2022/23	2023/24
Digital First urgent care	Ask A&E (online symptom checker). Develop a single digital front door starting with urgent care. Review the recommendations of the clinical standards access review and agree process to embed.	Develop digital platform across urgent treatment centres/ Clinical Assessment Service. Test with service users. Implement clinical standards access recommendations.	Build concept and development of Digital First and artificial intelligence. Review impact of clinical standards access.	Further expand digital first approach	Review impact of Digital First as business as usual.
New Birmingham and Solihull Clinical Assessment Service	Out-of-hours GP response. Develop and define Clinical Assessment Service and phasing. Advantage of a Clinical Assessment Service is access to medical records. Review alternative pathways to ensure capacity and capability available.	Interface of single point of access with Clinical Assessment Service. Early intervention offer included. Understand alternative pathways – ambulance dispatch and access to out of hospital care. Ensure effective/up-to-date directory of services.	Develop an integrated network of community/ hospital-based care. Digital/artificial intelligence solutions in wide use.	Clinical Assessment Service embedded within integrated Urgent care as the first port of call.	Business as usual.
Early Intervention /SupportUHome	Prototype and roll out of providing response, reablement care and	Track progress in delivering the national	Consolidation of early intervention into single sites across	Review progress and outcome delivery.	Business as usual.

Key deliverables	2019/20	2020/21	2021/22	2022/23	2023/24
	community multi-disciplinary teams. Delivery reducing in delayed transfers of care and reduction in length of stay.	two-hour and two-day standards. System-wide dashboard. Develop integrated commissioning approaches. Test digital solutions.	Birmingham integrated commissioning from a provider alliance. Continue to develop out of hospital pathways. Digital solutions.	Consider and scope further improvements.	
Urgent treatment centres	Designation of all urgent treatment centres which will ensure a consistent offer, operating to the same national service specification. Undertake engagement process.	Develop digital solutions. Consider site locations in light of system-wide estate developments. Monitor ECDS to understand the end-to-end pathway.	Evolve approach to simple diagnostics to reflect digital/ artificial intelligence solutions.	Review and potential consolidation of sites delivering urgent treatment centres.	Business as usual.
Estate/workforce	Determine demand for assessment units. Deliver 30% of A&E activity via same day emergency care.	Focussed recruitment campaigns – providing flexible roles and rotations across sector.	Embed new workforce roles i.e. physician assistant. Review impact of workforce approaches. Continuous patient engagement to test and understand impact of channel changes.	Impact of digital/ artificial intelligence developments on estate/ workforce.	Impact of digital/artificial intelligence developments on estate/ workforce.

How will services be different in 2023/24?

By 2023/24 every patient will access a single digital front door to services, which enables them to receive urgent and emergency access and support at the right time and in the right place:

- Birmingham and Solihull Clinical Advice Service will be the single point of access for patients, carers and health professionals for integrated urgent care and discharge from hospital care
- Appropriately resourced urgent care will manage the majority urgent care away from A&E via face-to-face, video consultation or alternative digital solutions
- The most appropriate patients will be taken to A&E by utilising intelligent conveyances and alternative pathways
- Seven-day services will be in operation to remove weekend delays and improve flow
- More people discharged to their usual place of residence
- Improved workforce satisfaction demonstrated through recruitment and retention and new roles.

Mental health

With an increasing public awareness of the importance of good mental health we have made good progress in modernising the way we support people to do this. We have put people at the centre of designing services, particularly our services for children and young people and took the bold step of establishing one of the country's first mental health pathways for people aged 0-25 in Birmingham in 2016. In Solihull, young people have told us how much they like new online ways of accessing support and we are now developing better support for young people in schools.

Some of our GPs have been working closely with mental health professionals and the voluntary sector to offer a different sort of support which helps direct people to the right service to meet their needs. People with a diagnosis of personality disorder have often found themselves excluded by services and new ways of working with people with this diagnosis are reducing the number of people being hospitalised and improving their experience of support.

We have begun to make progress in reducing the number of people being admitted to inpatient beds outside our area. Since January 2019 we have seen a reduction of 40% in the number of people in long-stay high-dependency units in other parts of the country and innovative partnerships between the NHS and voluntary sector in providing both rehabilitation and psychiatric liaison services.

Why do we want to change?

With one in six people experiencing a common mental health condition in the past week, there is no doubt that poor mental health can and does affect people of all ages and backgrounds. Mental health issues account for half of all ill health of people under the age of 65. Despite this, funding of mental health services is only 11% of the total spending of the NHS.

In recent years there has been an increase in the number of people who experience a diagnosable mental health condition. The success of high-profile campaigns and the bravery of growing numbers of people talking openly about their mental health difficulties have encouraged more people to seek support.

Recognising when we are struggling, talking to others and asking for help are vital steps in a person's recovery. As more people come forward, we will need to respond differently than we have done in the past and in ways that reflect the support that people want.

Many people have very good experiences of getting support, but where experiences aren't so good feedback in what people want is consistent:

- I want to be able to access services when I need them most
- I want to have my family and friends involved in my support when that's right for me
- I want to be able to manage my mental health myself wherever possible
- I want more people to be aware of mental health issues in schools, colleges and the workplace
- I want access to the talking therapy that best suits me

- I want to be supported by people I can relate to, including those with direct personal experience of mental health issues
- I want to be involved in my own care and in helping design the support of the future.

Whilst we have supported more people to access help, we have limited information about the difference this has made to them. We know that some people have spent many years in receipt of care and treatment, sometimes in hospital or rehabilitation units. As we seek to make best use of the resources, we need to ensure that people achieve the best possible level of recovery, enabling them to live the life they want.

Sadly, we know factors including age, gender, sexuality, ethnicity and economic circumstance affect people's likelihood of experiencing mental illness, how they access help, the experience they have of support and the outcomes of treatment. It is true also that people with severe mental health conditions die on average 15-20 years earlier than their peers[8]. These disparities can no-longer be tolerated as acceptable or inevitable if we are to make a real impact on health inequalities.

Whilst real progress has been made in recent years the following is evidence of the scale of the challenge:

- Referrals for people aged 0-25 have risen significantly between 2015/16 and 2018/19
- High proportions of Employment Support Allowance claims are for mental health conditions and only 6% of people on the Serious Mental Illness register are currently employed
- There is an increased use of out-of-area inpatient beds, alongside an increase of admissions into Tier 4 for children and young people
- Waiting times for assessments for neurodevelopmental conditions such as autism and ADHD are in excess of 12 months
- There is evidence of potentially preventable deaths by suicide and other serious incidents involving people known to mental health services
- Caseloads in community mental health teams, early intervention in psychosis teams. Eating disorder team and crisis resolution home treatment teams are all above best practice levels
- There are challenges in recruiting and retaining staff across all key professions.

Priorities for change

Our all-age approach is underpinned by a set of strategic aims which support the broader focus on economic growth, a clean, green environment and thriving education and cultural sectors described in the STP strategy. Tackling the challenge of mental ill health requires us to work as a system to **prevent** poor mental health and maintain people's wellbeing; **protect** those who we

[8] **https://www.gov.uk/government/publications/severe-mental-illness-smi-physical-health-inequalities/severe-mental-illness-and-physical-health-inequalities-briefing**

know are most vulnerable; provide safe and effective treatment to **manage** people's conditions when help is needed and share a will to support meaningful **recovery**[9].

A significant proportion of the money we spend on mental health funds hospital beds and specialist care. Our future model (see Figure 14) is based on the need to move resource within the system to respond earlier to need and promote timely recovery and independence. Over the course of our plan we will strive to achieve **parity of esteem**, increasing spending on mental health year-on-year and at a faster rate than for any other part of the health economy. We will also seek to bring resources back into Birmingham and Solihull where this is currently funding expensive care for people placed miles outside our area.

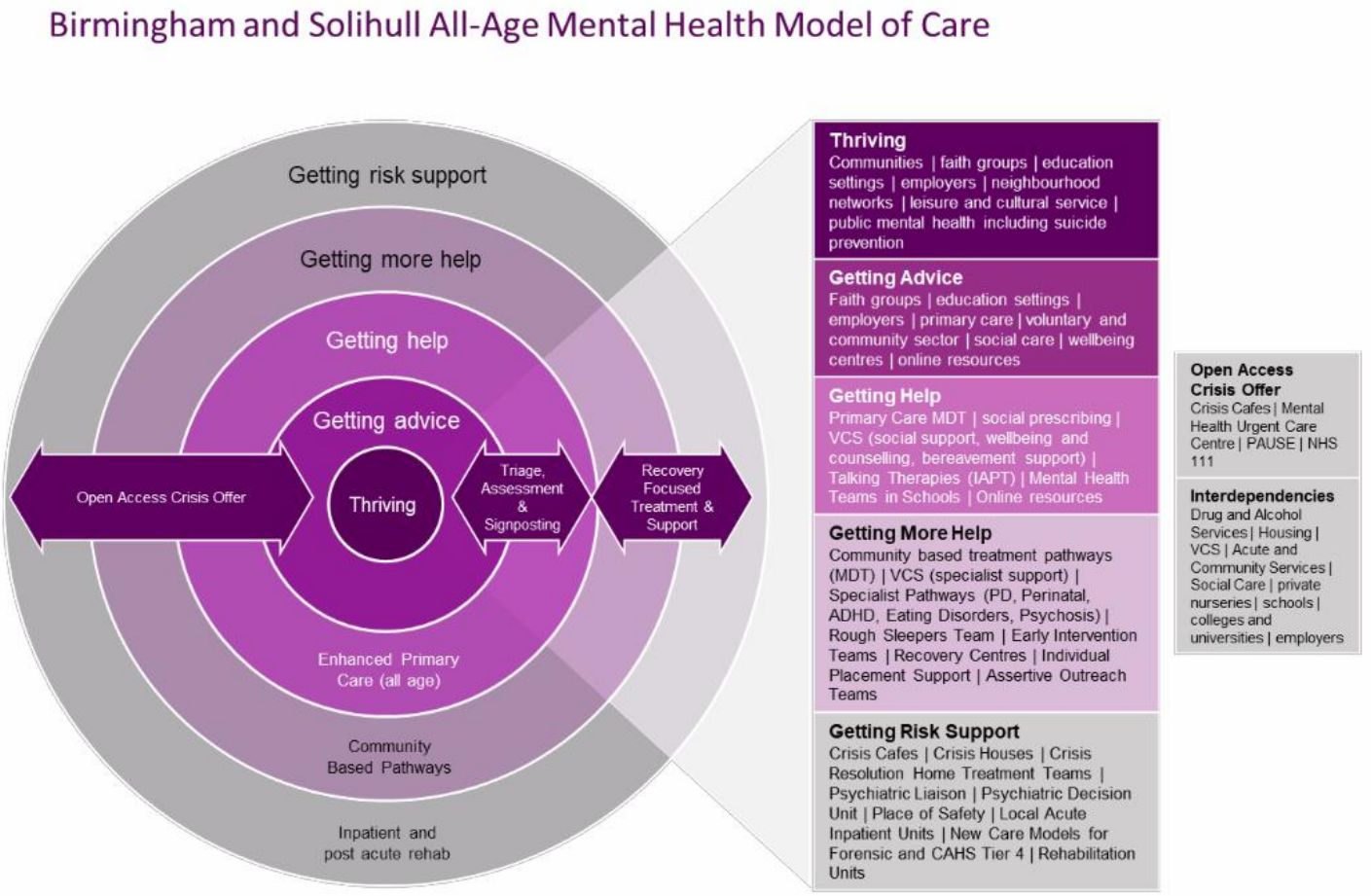

Figure 14: Birmingham and Solihull Mental Health Model of Care

The model above describes an all-age system of support, care and treatment. The system seeks to prevent poor mental health and provides support for people which actively promotes their recovery. It aims to increase independence, self-agency and hope, enabling people to live the life they want to live. The model is informed by **i-Thrive Framework**[10] (see Appendix 9)

Our work builds on an existing consensus about the change that is required achieving long standing local aims, such as transforming provision for people with **neurodevelopmental** needs and those needing mental health **rehabilitation** whilst delivering on the ambitions of the **NHS**

[9] **https://www.bsmhft.nhs.uk/about-us/news/news-archives-2015/an-agreed-purpose-for-improved-mental-health-in-birmingham**
[10] **https://www.annafreud.org/media/9254/thrive-framework-for-system-change-2019.pdf**

Long Term Plan. The highlighted boxes show how delivery of the **NHS Long Term Plan** is integrated with our own local vision. Our detailed commitments are included in Appendix 9.

The provider collaboratives will be responsible for the development and implementation of new care models for forensic services, children and adolescence mental health services tier 4 and eating disorders. Collaboratives will develop new patient pathways, create greater community provision, provide better outcomes and treat patients closer to home. The funding, commissioning, quality improvement and performance oversight of these specialist services will be transferred to the provider collaboratives from NHS England and NHS Improvement.

Meeting growing demand is a particular challenge in the context of pressures of **workforce and estates**. Our plans include steps to increase the use of **digital solutions** that offer greater flexibility and choice to both people receiving a service and to staff whilst reducing the pressure on rooms.

Thriving and getting advice

Helping people to maintain positive mental health must be our first aim. We will continue to invest in our environment, cultural and leisure services and take steps to help our communities to flourish. Through measures that allow all our citizens to benefit from economic growth and by supporting schools, colleges and employers to develop healthy working environments we will build a climate in which creates a climate in which good mental health can thrive.

Through the **Time to Change Hub** we will build a network of champions confident in talking about their own experience of mental health with family, friends, colleagues and members of the public. **community development workers** and **neighbourhood network facilitators** will work alongside others in health and care to build on the assets our communities already possess.

Our model of care for children and young people will extend into **schools and colleges** providing support to professionals enabling them to better identify issues early, offer support and signpost to other resources. We will continue to work in partnership with **universities** to build their capacity to help students manage their mental health while ensuring treatment is available when it's needed.

Link workers in Primary Care Networks will help people find opportunities through social prescribing that support their health and wellbeing, tackle social isolation and build their own resources of resilience.

A robust universal offer in schools and communities will form the bedrock of our 0-25 model of mental health care for children and young people. The model will see 12,138 children under-18 receiving NHS-funded treatment annually by 2024.

Getting help through enhanced primary care

The inclusion of mental health staff, including those from the voluntary and community sector, in **primary care multi-disciplinary teams** will mean that people whose needs are not urgent can be assessed in primary care and directed to appropriate support **talking therapies, counselling and social interventions**. Those who require a more specialist treatment pathway will be referred as such. Where appropriate, people will be able to choose to have an assessment or therapy via **an**

online platform, making access more convenient and helping staff who want to work less traditional hours.

Over the past 12 months a number of initiatives have explored new approaches to supporting people with mental health needs in primary care. Early adopter sites in Modality, Omina, Our Health Care, Midlands Medical Partnership and practices in Solihull have operated **primary care liaison** models. Whilst local arrangements vary, the principle of locating mental health workers in practices has been proven to reduce 'did not attend' rates, reduce referrals to secondary care, increase step-down from secondary care, increase knowledge, skills and competency in GPs and provide reassurance to GPs managing patients with ongoing mental ill health. The approach goes further than previous models, offering support around social determinants of poor mental health, via voluntary sector organisations, rather than being limited to clinical input.

We want to see this approach extended with a view to a shift of both resource and activity from secondary to primary care developing a mental health multi-disciplinary team approach. This will be **an all-age approach** with professionals supporting the mental health needs of children and young people, adults of working age and older adults, including those with dementia. This will mean a realignment and reconfiguration of the current service provision provided through secondary care services (community mental health teams) and Improving Access to Psychological Therapies (IAPT) for example.

Alongside this **shared care arrangements**, set out within the universal offer to patients, will facilitate general practice working collaboratively with specialists in the management of patients with complex but stable needs. Importantly, individuals will have a **single care and support plan** shared between agencies through **better connected IT systems** and coproduced with the person and those closest to them. The plan will enable care to continue seamlessly where needs change and their care is transferred between professionals. The approach will improve the ability of professionals to **treat mental and physical health holistically** helping us to reduce the mortality gap for people with severe mental health conditions over time. To encourage meaningful action public health-funded smoking cessation support will carry an additional incentive payment for the provider where the recipient has a mental health condition. We will also explore the use of **patient activation measures** to ensure that checks lead to change.

In addition to existing IAPT provision, which may be reorganised to better align with the emerging Primary Care Networks, enhanced primary care will also include new **integrated IAPT** workers who will participate in the care and support of people with long term conditions and medically-unexplained symptoms.

We will increase the number of people accessing evidence-based psychological therapies year-on-year to 44,961 annually by 2024.

IAPT therapists specialising in working with people with long term conditions will be in all Primary Care Networks by 2022.

By the end of 2019/20 the majority of people on GP Serious Mental Illness registers will be receiving a comprehensive set of physical health checks in primary care.

Getting more help and risk support through community-based and crisis pathways

When a person's needs are sufficiently acute or complex, or where they present a high level of risk, they may require more specialist support and clinical oversight. Increasingly community mental health teams have become 'catch-all' services for the majority of people under specialist care. The breadth of their scope and size of caseload has been inhibiting for professionals and has led to clinical variation. In children and young people's mental health services, young people have sat on waiting lists for specialist care rather than being directed to NHS-funded support from voluntary sector providers that could meet their needs.

Within the new model people requiring more specialist support will be initiated on pathways designed to meet their needs through a range of evidence-based interventions. Commissioners recognise that current providers operate very different community-based models of care and as such are not specifying these pathways in detail. Our plans align with the recently published The Community Mental Health Framework for Adults and Older Adults[11]. However, we anticipate that pathways will fall into the two broad categories of **mood and personality** and **psychosis**. These pathways will be supported by a **range of resources** that form part of the **person-centred recovery plan** owned by the individual and contributed to by all those involved in a person's care. Bespoke pathways for **perinatal mental health, eating disorders, people with a diagnosis of personality disorder, neurodevelopmental needs** and **psychosis** will allow staff to deliver more personalised and condition appropriate care.

In recent years Birmingham has seen an unacceptable rise in the number of people **sleeping rough on our streets**. Poor mental and physical health can be both cause and effect of homelessness and rough sleeping. Targeted funding is enabling us to increase mental health support for people living on the streets. Alongside this, partners are renewing a commitment to work together to better support people with multiple complex needs who are often some of the most vulnerable in our society.

We will increase the number of women receiving specialist community-based perinatal mental health support from 753 in 2019 to 1,669 in 2024. We will also provide better support for women's partners.

By 2024, 8304 adults will be receiving specialist mental health support through our new model of enhanced primary care and pathway-based secondary care for mental health.

More people will access assessment, diagnosis and support for neurodevelopmental needs such as autism and ADHD. Starting with a focus on 5-16-year-olds in 2019/20; with further investment in 2020/21 for adults.

By 2020, our early intervention in psychosis services will have aligned employment workers and will be making great progress towards achieving quality standards. By 2024 all early intervention in psychosis teams will be operating at level 3 of the early intervention in psychosis standards.

An enhanced mental health service for people sleeping rough will be in place by April 2020.

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[11] https://www.england.nhs.uk/publication/the-community-mental-health-framework-for-adults-and-older-adults/

Working our partners in the voluntary and community sector we will establish a network of Crisis Cafés. These will be open access facilities that provide an alternative to A&E for people experiencing a crisis in their mental health. They will be available in the evenings and at weekends when we know people are less able to find appropriate support.

For people who need a little time and space to begin their recovery we will open **Crisis Houses** and offer overnight accommodation where people do not need to be admitted to an inpatient unit.

These alternatives will form part of the crisis offer which will be available 24/7 for people of all ages. Additional investment in **psychiatric liaison** will ensure that all our A&E sites offer a **'Core 24'** compliant service. Support for people by phone will be available through our work with NHS 111 whilst **Birmingham Mind** is working to develop a **helpline** to support its Crisis Café offer.

A **new digital platform to improve access to Section 12 medics** will be introduced. Designed by an approved mental health professional, the system has been shown to reduce the time taken to secure an S12 medic making the Mental Health Act assessment process timelier and more streamlined, reducing cost to both the NHS and social care.

The tragic consequences of mental health crisis can be significant self-harm, suicide or in rare cases serious injury to others or homicide. We know that by working together across a range of areas we can reduce the number of people who take their own lives each year. **Multi-agency suicide reduction plans** in Birmingham and Solihull provide a collective focus on the steps we can all take to make a difference. Actions range from reducing access to means to working with communities and individuals where the risk may be higher.

Both Birmingham and Solihull have Suicide Prevention Action Plans which describe the vision and intent around suicide reduction and prevention. The ambition of working towards zero suicides is an aim shared across all partners and stakeholders. We will seek to achieve this through preventative action and improvements in the quality and safety of care pathways for people experiencing mental ill health. Both Birmingham and Solihull plans share aims that deliver against national priorities while reflecting the needs of local people.

Although rates of suicide in Birmingham and Solihull are better or the same respectively as similar areas, we know there is more we can do. In recent years, coroners in Birmingham have drawn attention to a number of deaths which they felt could have been prevented. This provides further impetus for us to redouble our efforts in this area.

Across our system we have identified the groups of people at greatest risk of suicide. This includes care leavers, people who are homeless or isolated, people from particular cultural or ethnic groups, people who may identify as Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Plus, working age men and people with drug and alcohol-related problems. We are exploring the best ways of reducing risk amongst these groups and tailoring services to best meet their needs. Helping people, families, employers, schools and colleges and communities to talk more openly about suicide and suicidal thoughts is an important part of our work. Birmingham is currently hosting a Time to Change Hub which trains champions with lived-experience of mental health issues to have conversations with those around them about mental health.

Providers of mental health services continue to develop and review their approaches to preventing suicides amongst people known to services. This work has included further training for staff,

changes to inpatient environments and observation policies, using personalised safety plans and improving working relationships across health and care. At the heart of our wider mental health strategy is the commitment to getting resources where they are best placed to prevent and intervene early when people need help, support or treatment.

When lives are lost to suicide the impact on families, friends and communities is inevitably huge. We will improve access to **bereavement support** to offer some assistance in these circumstances.

Birmingham Suicide Prevention Strategy (2019-2024) and Solihull Suicide Prevention Strategy (2017-2021) can be found at Appendices 10 and 11.

A network of four Crisis Café's will be in place by 2021 serving our communities.

Our first Crisis House will be operational early in 2020.

Recruitment to our fully-funded Core 24 psychiatric liaison services in all A&E sites began in October 2019.

Multi-agency suicide reduction plans and increased bereavement support.

Getting risk support through acute inpatient beds

Ending the practice of admitting people into **inpatient units outside our area** is our top priority as a mental health system as this increases the risk on when the person is discharged and results in longer stays.

Our model assumes that people are supported in **the least restrictive environment**. Inpatient beds should be used only in those circumstances where there is no clinically appropriate alternative and where such a setting is necessary for the provision of assessment and/or treatment. Broadly speaking we would not usually expect inpatient care to form part of the treatment of people on the mood and personality pathway. This can only be achieved through increasing the availability of alternatives to admission and by supporting clinicians to take an enablement approach to the management of risk.

When an admission is necessary the stay will be as short as possible. Increased numbers of occupational therapists and other professionals on wards will help deliver a **more therapeutic environment.**

Our aim is to have reduced out of area admissions to zero by March 2021.

Where an admission is necessary, we will reduce length of stay by an average of four days per person.

Getting more help and risk support through recovery and reablement

Discharge from an acute setting should be a **catalyst for recovery and independence**. Person-centred planning should become the norm enabling people to shape the support they need to live the life they want. **Personal health budgets** offer a mechanism to hand more control to individuals and their families. Our aim is that everyone eligible for after-care under Section 117 should be enabled to have a personal health budget. **Digital platforms** to both identify an indicative budget and to then safely and securely enable people to manage direct payments are being implemented.

As post-acute support is increasingly provided in response to people's expressed preferences and goals a **market will be shaped** to meet these demands. Commissioners will work proactively in the space between the individual, statutory services and the market to facilitate the growth of provision that transforms the opportunities for recovery for people following hospitalisation. We want to expand the successes of approaches delivered by provision like Rookery Gardens, empowering service users to move through recovery and rehabilitation pathways to independence.

Health and local authority commissioners, Birmingham and Solihull Mental Health NHS Foundation Trust and Forward Thinking Birmingham have committed to the principles of a rehabilitation, recovery and reablement system which will be characterised by:

- Support and treatment **close to home**
- **Personalised** support planning
- The goal of each person having their **own front door** with the right support
- The opportunity for education, training or employment
- Support to be an active and engaged citizen.

Our intention is to start by focusing on the needs of people in **out of area rehabilitation** settings with the aim of supporting them to achieve greater levels of independence in the local community.

We anticipate the establishment of **community recovery teams** working with people with severe mental illness both pre and post admission. An approach of this type is being developed in **Solihull**. Teams will work closely with agencies providing care and support around a single recovery plan that pulls together housing, employment and social activity alongside care and treatment.

We will continue to work with people who use services to shape our **recovery centre** and college offers. Closely linked to this is our full-fidelity **individual placement support** service which now covers the whole STP area and includes targeted support for people on the **early intervention in psychosis** pathway.

By 2024 over 1,000 people annually will access individual placement support service services, with around 200 of those achieving sustained employment.

All people eligible for Section 117 will have a co-produced person-centred care and support plan and a personal health budget.

Workforce strategy

Nationally, mental health systems are challenged by under-supply of medics, nurses, allied health professionals (occupational therapists, speech and language therapists etc.) and psychological therapists. Our local system is no exception to this and is grappling with both recruitment and retention of staff.

We also know that achieving the sort of transformation described here will require some fundamental shifts in culture and practice around recovery, coproduction, personalisation, inclusion and multi-disciplinary team working. Moreover, there will be a need to provide education for staff

across the wider workforce, including those in primary care and education settings, not least to ensure that a common language and understanding of the mental health system is shared.

Responding to **Stepping Forward to 20/21: The Mental Health Workforce Plan for England**, STP partners submitted a Workforce Delivery Plan which set out how the mental health workforce would grow by around 500 working time equivalent staff by 2021. While the plan's primary focus was on numeric growth, there is a strong consensus that a Workforce Strategy which addresses culture and practice as well as issues of supply and the introduction of new roles and new ways of working is needed. The development of a strategy will be led by the Mental Health Workforce Delivery Group. This will be delivered by spring 2020.

How will we know we've made a difference?

We have shared a commitment to achieve the outcomes set out below. These are only achievable through the coordinated actions of all partners working alongside individuals and communities.

- Reduction of out of area placements to zero by 2021
- Increased equity of access and outcomes by ethnic group
- Improved levels of self-reported recovery
- Less deaths from suicide or undetermined intent
- Reduced gap in mortality between people with severe mental illness and the general population
- More people with mental illness in employment
- More people with mental illness in stable housing

How does this deliver the STP aspirations?

Independence and resilience

- ✓ Targets prevention and early intervention
- ✓ Supports citizens to be active and engaged
- ✓ Offers access to good quality information resources that support self-care
- ✓ Provides education to staff across the wider workforce to benefit their work and themselves.

Equity, equality and inclusion

- ✓ Targets tailored support for those most at need in society
- ✓ Reduces the barriers of stigma
- ✓ Easy to access support in a place convenient to the individual
- ✓ Challenges inequity in access and outcome.

Integration and simplification

- ✓ Shares resources across organisations

- ✓ Utilises shared information systems.

Promoting prosperity

- ✓ Supports individuals into education and employment.

Social value

- ✓ Promotes environmental and social sustainability.

Delivering our commitments in practice can be found in Appendix 9.

How will services be different in 2023/24?

By 2023/24:

- There will be less stigma attached to seeking help for a mental health issue, meaning more people asking for help
- When people do step forward they will access support that better matches their needs. This may not always be clinical support and could be help to make important changes in their life.
- Children and young people aged up to 25 will receive input specifically design to meet their needs, with more support in schools, colleges and universities
- More talking therapies will be available for people across the spectrum of needs and ages. Services won't always be provided face-to-face and 9-5.
- There will be greater use of technology to enable people to get support at a time and in a place that is convenient to them
- Admissions to psychiatric inpatient units will only happen when clinically necessary, people experiencing a crisis will have options open to them that can provide the help they need like Crisis Cafés.
- Finally, services will be more accessible to some of the most vulnerable in our communities such as those sleeping rough, people with neurodevelopmental differences, Black, Asian and ethnic minority communities and people who identify as Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Plus.

Learning disability and autism

Enabling people with learning disability and autism to have happy and healthy lives supported through high-quality community-based support

We have made a number of improvements to services for people with learning disability and autism as a result of the Transforming Care Programme.

Within Birmingham there has been substantial investment into the adult and children and young people community intensive support teams. The adult service now runs on a 24/7 basis, which is in line with the national specification, and the children and young people service offers extended hours. The increased hours within the teams have led to a decrease in out-of-hours' admissions.

We have also safely discharged a number of clients from inpatient care into the community. During the last 18 months alone, there have been 30 children and young people and 57 adult discharges into community-based settings, which is a marked increase when compared to previous years. There have also been zero adult readmissions to hospital within the last 18 months. Alongside this, we have seen a reduction for average length of stay and have less people in inpatient units.

As a result of partnership working, we now have an agreed system-wide commitment in place to develop a neurodevelopmental pathway. This will include a robust pathway for assessment, diagnosis and support for people with neurodevelopmental needs including autism and attention deficit hyperactivity disorder.

As a partnership, we have also been successful and secured additional financial support for three social workers, who are working specifically with clients to support them to live well in their communities.

A significant development has been as a result of increased investment into the community provision within Birmingham and Solihull, which has seen a number of existing large providers develop new community services within the area. We are also setting up a workstream focused on attracting visionary and skilled individuals who have an interest in developing person-centred bespoke community provision in Birmingham and Solihull. The bespoke community provision will be a small business which cares for no more than four people per year.

Finally, we have developed a clear commitment within Birmingham and Solihull to progress the local Learning Disability Mortality Review Programme. Through promotion of the programme there are currently reviewers from 11 different organisations which continues to grow. 75% of adult reviews have been completed, with a number of reviews currently in progress. A local steering group and a multi-agency review panel has been established and our first conference looking at these issues was also held in Birmingham in October.

Why do we want to change?

The Transforming Care Partnership recognises there is a need to move away from historic ways of providing support to people with learning disabilities and autism spectrum disorder (referred to as autism) to reduce the reliance on inpatient provision to the absolute minimum. Whilst our partnership has provided a system-wide focus on reducing the demand for hospital care, the use of

inpatient provision still remains high. Fundamentally, this outdated way of supporting people prevents them from living meaningful lives in the community.

Levels of morbidity and mortality rates or people with a learning disability and for autistic people are unacceptable, on average a person with a learning disability will die 27 years earlier than a person with no learning disability (NHS Digital 2017).

Priorities for change

The Transforming Care Partnership has membership from all of our key partners who have a role in delivering the transformation programme. The programme has a governance structure in place which supports the co-production of services and plans creating organisational ownership across the partnership. Over the programme, we have increased our engagement with clients, families and carers to promote the principles of co-production and ensure services meet local needs and transform care.

This approach has enabled our partnership to test and accelerate the development of community-based services and support. This has enabled us to reduce the over reliance on hospital-based provision; to enable our clients to live safe and meaningful lives within their community.

Our strategy will continue to have a clear focus on earlier intervention, reducing the reliance on hospital-based and inpatient care, and will be underpinned by the continued transformation of community services to build capacity and greater resilience. This is based on the nine principles outlined within the **Building the right support framework**, which focuses on the development of enhanced community capacity to support people within the community and creating a shift away from inpatient provision.

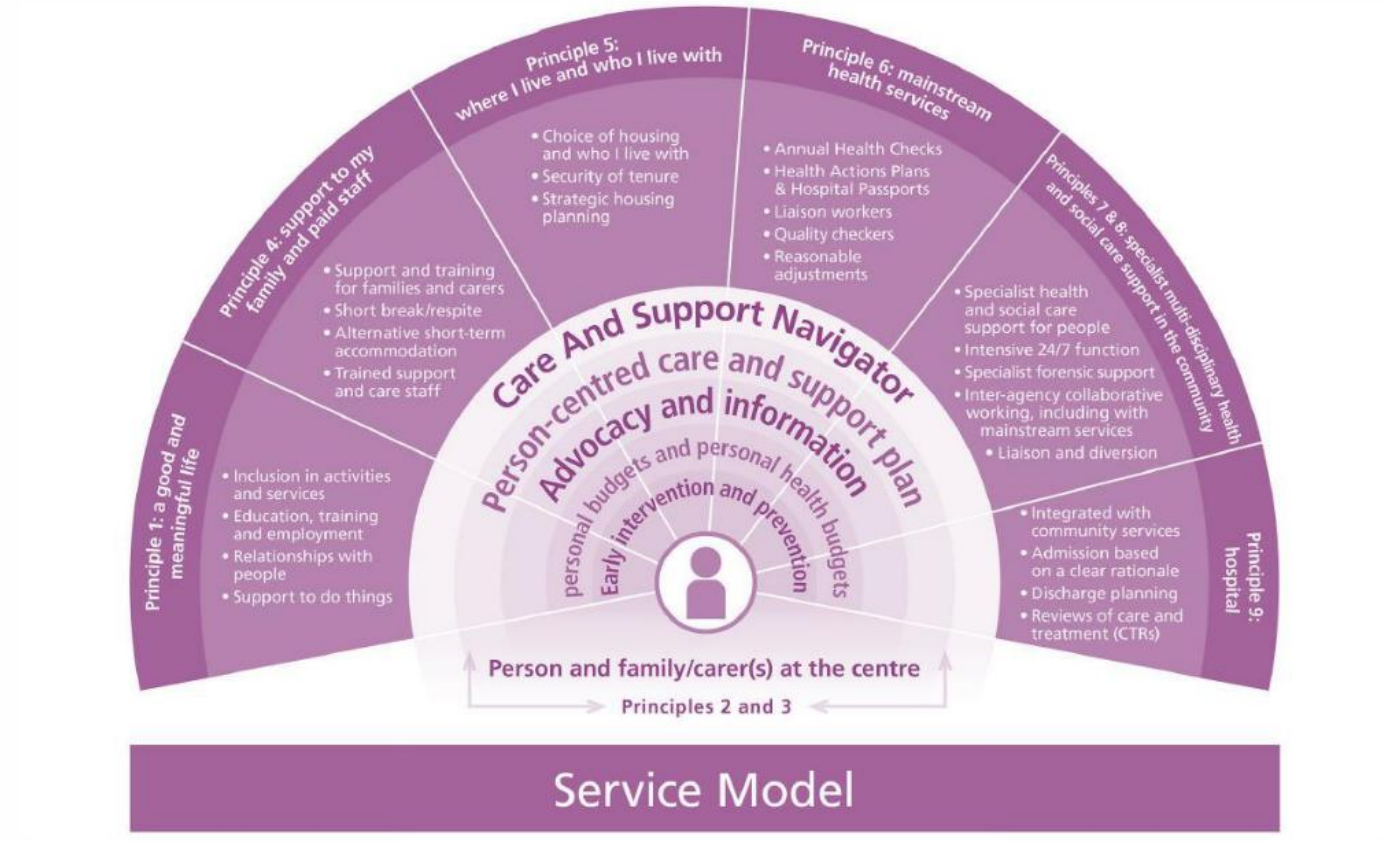

Figure 15: Service Model

This will achieve the ambitions set out in the **NHS Long Term Plan** and ultimately improve outcomes, ensuring all people with learning disabilities or autism have access to treatment, care and support.

The STP will continue to build on the strong foundations of the Transforming Care Programme to deliver this model over and beyond the next five years for the wider learning disability and autistic population in Birmingham and Solihull.

We will build on these strong foundations and create a unified future vision across our area, based on a set of universal principles:

- Where admission is required, we will continue to focus on reduced average length of stay
- As a partnership, we will increase the provision of high-quality community-based care and support in Solihull and Birmingham to meet the needs of our clients to enable them to live meaningful lives within the community
- The demand on services for clients with autism is increasing and services will need to be able to respond in a timely way to ensure the needs of clients are met, recognising this has an impact on the wider system including social care, housing and third sector organisations
- Our partnership will continue to develop alternative models where people can be supported in crisis to prevent hospital admission and the need for residential care e.g. respite, community enhanced outreach services and crises café models
- To ensure our population with a learning disability and/or autism have access to care, treatment and support within the community, which will be embedded to enable them to live meaningful and healthier lives
- We will develop a clear workforce plan to ensure there is a sufficient and appropriately trained workforce in place to support the sustainable transformation of services.

We also recognise the need for the local delivery to be provided using a place-based approach, echoed throughout other chapters, to reflect our unique local challenges. Our key STP priority areas are to:

- **Reduce the reliance on inpatient hospital care**: We will work with partners to and invest in intensive crisis support and community forensic services to support the people to leave inpatient settings and live in the community
- **Ensure our services meet the needs of people with a learning disability and/or autism**: We will continue to work with providers to increase the accessibility of services for our clients. Working with service users and families to ensure services are responsive and reflective of the local needs. This will support the use of ‘digital flags’ within patient records.
- **Increase the uptake of annual health checks**: Our Universal Offer for patients through general practice includes the commitment to deliver increased numbers of annual health checks for our clients. We continue to deliver training and education for practices, including health facilitation from our community provider and educational resources developed with services users and families.

- **Ensure our services are based on the needs of our clients and not organisations**: We will ensure that our STP plans for mental health, special education needs and disability, children and young people's services, health and justice are fully integrated and support one another. We will build on the recommendations of the Transforming Care Partnership's children and young people's benchmarking exercises, and work closely with our local children's commissioners to ensure services are focused on young people.
- **Address the causes of morbidity and reduce preventable deaths**: We will address this through a clear focus on reducing some of the key determinants, including stopping over medicating patients (STOMP/STAMP) and delivering the Learning Disability Mortality Review Programme
- **Promote knowledge and expertise across the STP**: Working with our providers we will develop their awareness, expertise and inform their service delivery models to ensure they meet the needs of people with learning disabilities and autism, ensuring reasonable adjustments are made and to work towards the implementation of the national learning disability improvement standards
- **Reduce waiting times for diagnosis and increase access to specialist support**: We plan increase the community support offer pre and post-diagnosis. We will also ensure all children and young people with a learning disability and/or autism with the most complex needs will have a designated key worker by 2023/24.
- **Ensure effective use of our resources**: We will continue to strengthen the use of care (education) and treatment reviews to reduce and avoid admissions into hospital, reduce the length of inpatient stays, improve the quality of care people receive in hospital, as well as improving the planning of current and future care.

How does this deliver the STP aspirations?

Independence and resilience

- ✓ Creates better outcomes for people with learning disabilities and autism to live well and independently in their community, through the use of personal health budgets, the reduction in over-medication and in preventing avoidable deaths
- ✓ Focuses on health promotion and wellbeing
- ✓ Builds confidence and capability among health and care staff through effective training.

Equity, equality and inclusion

- ✓ Creates opportunities for people with learning and disabilities to be part of their community, breaking down institutional ways of providing care
- ✓ Creates opportunities for people with learning disabilities and autism to volunteer or be employed.

Integration and simplification

- ✓ Supports place-based approaches to improving health and wellbeing
- ✓ Services are designed based on people working together to meet local needs involving people with learning disabilities and autism, their carers and our workforce

- ✓ Develops cross-organisational integrated teams and services, supporting people with learning disabilities and autism.

Promoting prosperity

- ✓ Supports people with learning disabilities and autism to engage in paid work, improving economic growth, prosperity and wellbeing
- ✓ Creates opportunities for our population in terms of new jobs to address staff shortages.

Social value

- ✓ Recognises the value everyone can make in our society
- ✓ Through volunteering and place-based approaches, it builds stronger communities.

Delivering our commitments in practice

- **Cross-cutting approach to programme delivery:** We will work across a range of programme areas to ensure our priorities are delivered. This includes mental health (including the neurodevelopmental pathway), children and young people services, special educational needs and disabilities improvement programmes, public health and health and wellbeing promotion. We will also work with colleagues in relation to workforce development to support staff training and also to identify employment opportunities to increase paid and voluntary work opportunities for people with learning disabilities. This aligns with our priorities in relation to workforce development and also volunteering to maximise opportunities across the STP.
- **Funding:** NHS Birmingham and Solihull CCG has previously successfully bid for funding from NHS England in 2017/18, 2018/19 and 2019/20 to support the delivery of the Transforming Care Programme. This has enabled additional community capacity to be commissioned on a recurrent basis, including intensive crisis support and community forensic support. Going forward the NHS Long Term Plan implementation guidance outlines that funding will be made available to support the delivery of the plan by 2023/24, and the CCG intends to apply via these funding route once they become available.
- **Additional activity:** We have **c**ommissioned additional activity within existing contractual arrangements to support the resettlement of clients from inpatient provision into the community. Capacity is reviewed on an ongoing basis to ensure sufficient capacity is in place. We will use our existing mechanisms to track performance allowing our partnership to proactively respond to any barriers to delivery.
- **Reviewing diagnostic provision:** There is a rising demand for autism services both to diagnose and to provide post diagnostic support. The partnership will continue to identify gaps in provision and develop services to meet the increasing demand in co-production with service users, families and carers.
- **Address workforce shortages aligned to the STP workforce priorities:** Nationally there is a recognised shortage of learning disability practitioners. The CCG has worked with NHS England and Health Education England throughout the lifetime of the Transforming Care Programme to understand and address these challenges locally. This work will continue

though linkages to existing workforce committees across the STP including the Provider Alliance which has a dedicated workforce work-stream.

We have outlined a specific programme of targets to be met, which is in Appendix 12.

How will services be different in 2023/24?

By 2023/24 people will be able to:

- Be supported with learning disabilities and autism by a larger range of services in the community, which will include small businesses as well as larger providers of care
- Spend less time in hospital linked to their learning disability or autism as a result of reductions in inpatient hospital care, supported by providers in a community setting
- Access a robust neurodevelopmental pathway, which will support assessment, diagnosis and support for people with neurodevelopmental needs including autism and attention deficit hyperactivity disorder
- Access services in a more integrated way, from partnership working, to enable them to live well in their communities.

Cancer

To provide world class services for people with cancer so people have the best quality of life possible through faster diagnosis, treatment and care

During 2019/20 Birmingham and Solihull has successfully brought partners together involved in cancer services via the Birmingham and Solihull Cancer Programme Board. This includes all partner organisations in the STP as well as the West Midlands Cancer Alliance. The board has responsibility for providing leadership, oversight, and scrutiny over all aspects of cancer delivery including performance and transformation across the system. This group is supported by project specific workstream groups such as screening and early diagnosis, primary care cancer education and development, and performance delivery.

The governance continues to evolve as priorities and challenges crystallise. Work is already underway in delivering a number of priorities set out in the **NHS Long Term Plan**. This includes being accepted as a pilot site for the Rapid Diagnostic Centre, the implementation of Genomic Tumour Advisory Boards, as well as making progress towards implementation of faecal immunochemical testing for symptomatic patients. We will also be holding a cancer vision and strategy event in January 2020, which is generating significant interest and enthusiasm. This will act as a vehicle to setting and delivering our ambition as set out at the start of this plan.

Why do we want to change?

Within Birmingham and Solihull, we face a number of challenges that need to be addressed. As a summary, there is variation in screening uptake, particularly amongst Black, Asian and minority ethnic communities as well as variation in the time taken for diagnosis, treatment and outcomes. As a system we are committed to focusing on prevention to support our health and wellbeing, address the health inequalities for our population and address workforce challenges. To do this, we recognise we need support from our partners across health, the local authority, and the voluntary and community sector to address our challenges. The below is an analysis of our challenges in more detail.

Health inequalities and outcomes

Nationally, it is reported that:

- 1,000 people per day are diagnosed with cancer in the UK
- One in two people will be diagnosed with one or more cancer in their lifetime
- The numbers of cancer diagnosed in the UK will increase by 20.7% from 352,000 (2013) cases to 422,789 by 2030 (Cancer Research UK 2016)
- England's five-year survival rates lag behind those of comparable countries with the exception of breast cancer (Health Foundation 2018)
- There is also a strong relationship between cancer stage at diagnosis and deprivation.
- This corresponds with our challenges. In 2018, Public Health England reported that Birmingham is one of the 20% most deprived districts/unitary authorities in England and

cancer survival in deprived areas is poorer than more affluent areas as cancer present at a later stage (3 and 4). The stark difference in comparing Birmingham to Solihull is shown in the proportion of cancers diagnosed in early stages (1 & 2) where Birmingham is 41% and in Solihull this rises to 49% (highest in the West Midlands). Across our entire area over 45% of patients are presenting with late stage cancers (stage 3 and 4)/emergency presentation. This has a detrimental impact on survival.

Birmingham and Solihull's all-cancer one-year net survival rate was 71% (Public Health England 2016) and age-standardised mortality rates for all cancers were significantly higher in Birmingham (316 per 100,000) than the England average. There are issues of variability in outcomes and health inequalities across our geography that need to be addressed.

Inequalities (including deprivation) has an adverse impact on timely access to cancer screening, diagnosis and care. This has an impact on quality of life, outcomes and survival. Those, who live in the most deprived area are also more likely to present with later stage cancers.

Smoking is by far the biggest preventable cause of cancer and accounts for more than one in four UK cancer deaths. Alcohol and obesity are also well-known risk factors for cancer. This is particularly relevant given the high levels of smoking in our area, which is described in our focusing on prevention chapter.

National screening programmes

We have low uptake rates for all three national cancer screening programmes (i.e. breast, bowel and cervical), particularly in deprived areas and amongst the Black, Asian, and minority ethnic community. There is a pressing need to ensure screening uptake rates are improved to ensure patients have early access to services to either rule out cancer or ensure they are able to access the appropriate services for diagnosis and treatment.

Diagnosis and treatment pathways

We have seen increasing demand and complexity against a backdrop of physical capacity and workforce constraints, as described in the empowering our workforce chapter. This has had an impact on the ability to consistently meet the national cancer waiting times standards. It has also placed additional pressure on diagnostic capacity in particular in areas such as radiology, pathology and endoscopy.

Patient choice issues may also affect timely delivery of diagnostics/treatments (e.g. delay for time to think about possible choices, also patient choice of hospital site particularly within the four hospital sites of Queen Elizabeth, Heartlands, Good Hope and Solihull hospitals).

Further improvements in pathways are required to ensure efficient use of resources and avoid delays for patients. This includes ensuring appropriate investigations are completed in primary care before referral and within the secondary care provider where tertiary referrals are made.

There are also opportunities for improved and easy access to information on symptoms of suspected cancer in primary care (e.g. GatewayC).

Workforce

As seen in other areas, workforce challenges described earlier in the plan affect cancer services. In reality, this is often results in trusts competing to appoint from same pool of people.

This is because there are shortfalls in certain roles, which is an ongoing challenge (for example histopathologists, radiologists, radiographers, oncologists (medical and clinical), endoscopists, palliative care consultants, surgeons and allied health professionals). 38% of cancer clinical nurse specialists across the region are approaching retirement age in the next three years with little or no succession planning in place.

Historic ways of working in primary, secondary and tertiary care operational silos are not the best use of our collective workforce. The move towards more integrated working is key as there is increased requirement to move patients out of hospital based care. However, whilst this is desired, this is against the backdrop of a lack of appropriately trained people in primary care and community services.

Innovations (i.e. genomics, artificial intelligence, information technology, and immunotherapy) will change the way current service models are delivered so the workforce will need to include new roles to provide new modalities.

Priorities for change

Prevention and screening

We are committed to working with partners around screening, prevention, and early diagnosis including reducing emergency cancer presentations.

To improve services, we will focus on addressing the low screening uptake rates bowel, breast, and cervical screening. We have already established a Cancer Screening and Early Diagnosis Group to support this work and working across our area will mean we focus on ensuring screening services are accessible to all, including targeting communities where uptake is lowest. To this, we need to work beyond a purely medical model and recognise the vital role that the local authority and voluntary and community sector has in supporting this objective. This will include focusing on screening and immunisations at the Screening and Immunisations Partnership Forum, which aims to improve uptake and address health inequalities. We will also work with Primary Care Networks to drive screening uptake and access opportunities through roles such as Cancer Champions.

The national cancer screening independent Review report is expected to be published soon. We will work with system partners including Public Health England, West Midlands Cancer Alliance and Primary Care Networks to assess the findings and develop implementation plans.

The Faecal Immunochemical Test (FIT) is now in place as part of the bowel screening programme. Building upon this we will implement FIT testing for symptomatic patients starting with a pilot and evaluation to understand the impact and to ensure the operational sustainability of existing services is not adversely affected.

Earlier and faster diagnosis

To enable people to access timely diagnosis and treatment and ensure cancer is detected early there are a number of priorities that need to be delivered. Key enablers include commencing the work on establishing a one stop Rapid Diagnostic Centre to work towards the ambition of early diagnosis (for a specific cohort of patients with non-specific symptoms).

The new faster diagnosis standard will also be implemented supported by mandatory data collection. Pathways for lung, prostate, and colorectal have been identified to show demonstrable

improvement against the 28-day standard. This will be supplemented by the implementation of timed pathways for oesophagogastric, breast, gynaecology, and head and neck cancers.

We also need to ensure we work with our Primary Care Networks to enable early diagnosis through improvement access to information on symptoms and standardisation of referral criteria.

An important driver for earlier and faster diagnosis is the implementation of the national cancer waiting times standards and the best practice pathways.

Diagnostics and treatment

To maximise on the opportunities for improving diagnostics and treatment for our patients, we will work with specialised commissioning to implement the radiotherapy networks across the region along with the new service specification for children's and young people's cancers.

The Genomics Project is an innovative enabler for improving diagnostics and treatments and we will continue to work with our partners to implement whole genome sequencing. This will enable more personalised cancer treatments, ensuring better outcomes for patients and translating innovations into practice.

As described at the start of the cancer plan, there are challenges with capacity and demand. We will therefore support the work of the Cancer Alliance to balance supply and demand and their proposals to complete a system-wide review of diagnostics as a starting point.

Digital innovation is also a key factor in addressing some of the capacity and demand issues. We will therefore continue to support delivery of an integrated pathology network to form a regional digitalised pathology diagnostic service. This will help maximise efficiency and effectiveness, enable new ways of working and help address some of the workforce reduction challenges.

We will also work to reduce the variation in access to diagnosis and treatment making cancer diagnosis, care and support easily accessible to all to assist in reducing health inequalities.

Living with and beyond cancer (personalised care)

The expansion of personalised care and support is important for patient experience, improving outcomes, and making sure people receive care in the right setting. Out of hospital care, such as introducing and supporting personalised follow-up, enable patients to take charge of their own care after treatment is completed. Patients therefore feel more empowered and involved in decisions about their care post treatment. To enable this, we will continue to implement personalised follow-up pathways for breast, prostate, and colorectal. This will include the roll out and improvement in the quality of personalised care interventions including needs assessment, a care plan, and health and wellbeing information and support.

Workforce

The challenges that exist within Birmingham and Solihull are mirrored across the region. It is therefore recognised that any solutions need to be at a sufficient scale. The West Midlands Cancer Alliance is developing a workforce plan to address the seven key occupational areas identified as key priorities within phase one of the Cancer Workforce Plan. The focus will be to address:

- Improvements in retention, postponing retirements, recruiting from non-NHS sectors of employment and international recruitment

- Building on sustainable short and long-term solutions such as upskilling, new roles, and new ways of working
- Investing in areas of identified need such as increasing diagnostic capacity i.e. clinical endoscopy and reporting radiography.

Within our area specifically, we recognise the workforce needs to be integrated and interconnected across all sectors to use skills across the whole scope of services. Changes to the scope of current roles are required along with the provision of opportunities for the development of different health and care professional roles (including apprentices) to provide more timely and responsive care.

As referenced in the Empowering Our Workforce section there are demand and supply challenges around specific roles, which are key to delivering improvements in earlier diagnosis and improved outcomes. Work will continue with partners to understand the predicted shortfalls and address identified workforce issues and progress the delivery of workforce plans.

One-year survival rates

We will deliver an improvement in the one-year survival rates by improving public education of signs and symptoms of cancer and generate “readiness to act”; improving education in primary care; improved screening uptake (especially in areas where uptake is poor). We have set the following trajectory:

One-year survival trajectory

Year	2019/20	2020/21	2021/22	2022/23	2023/24
Survival index	**71.5%**	**71.7%**	**71.9%**	**72.1%**	**72.3%**

With regards to improvements in early diagnosis, we will undertake more local awareness campaigns particularly aimed at localities with the poorest outcomes, where diagnosis is often late and results in an emergency admission. For this, we have set the following trajectory:

Early diagnosis – stages 1 and 2

Year	2019/20	2020/21	2021/22	2022/23	2023/24
% of cancer diagnosed at stages 1 & 2	**45%**	**45.2%**	**45.4%**	**45.6%**	**45.8%**

How does this deliver the STP aspirations?

Independence and resilience

- ✓ Delivers enhanced prevention and earlier detection and diagnosis of cancer
- ✓ Provides improved rehabilitation, self-care and promotion of independence for all patients
- ✓ Enables more personalised support for people to take charge of their own self-management after treatment is complete
- ✓ Improves access to information on cancer prevention measures and risk factors

- ✓ Improves information on when and how to act if people have symptoms that could suggest cancer.

Equity, equality and inclusion

- ✓ Supports people to access cancer care faster to ensure earlier diagnosis no matter where they live
- ✓ Reduces health inequalities to ensure people have the opportunity to be diagnosed early, which improve chances of longer term survival for everyone but also for those people from specific communities who are not currently accessing services early
- ✓ Reduces variation
- ✓ Delivers more personalised care as screening is provided at a place and time that suits individual needs.

Integration and simplification

- ✓ Improve out-of-hospital care and invests in sustainable primary care, bringing care closer to people's homes
- ✓ Needs are addressed in a holistic way that delivers more seamless care
- ✓ Creates standardised practice across all hospital sites.

Promoting prosperity

- ✓ Enables our workforce to have the skills and expertise to respond to the challenges and changes in service delivery and incidence of cancer
- ✓ Provides improved quality of life for our patients
- ✓ Supports people to be able to work for longer, improving economic growth, prosperity and wellbeing.

Social value

- ✓ Maximises on opportunities to work with communities and the voluntary sector to enable citizens to live well as part of a holistic package of cancer care.

Delivering our commitments in practice

At a national, regional, and local level a number of priorities for cancer have been identified. We are already working together with partners to deliver these priorities. As described earlier, our local Cancer Programme Board will provide system leadership as well as oversight and scrutiny to ensure that progress against key deliverables is being made across the partnership. We will also continue to engage with the West Midlands Cancer Alliance, the Cancer Alliance Clinical Expert Advisory Groups, Primary Care Networks, local authorities, voluntary and community organisations, such as Cancer Research UK and Macmillan, as well as our patient advocates. This will ensure all voices are heard, in particular patient voices so these are central to any developments. The sections below describe the range of priorities and timescales for delivery against each sub-programme.

Prevention and screening

We will drive an improvement in screening uptake for **bowel screening** coverage (60-74-year-olds) screened in last 30 months, **breast screening** coverage (50-70-year-olds) screening in last 36 months, and **cervical screening** coverage (25-64-yea-olds) attending screening within target period (3.5 or 5.5. years) by 2023/24.

This work will be delivered through the system Cancer Screening and Early Diagnosis Group. The Universal Offer will allow opportunistic re-engagement of people who have not participated or responded to national screening programmes. We are also using cancer transformation funding to roll out the role of Cancer Champions in primary care to support these improvements. We will also work with Cancer Research UK to deliver Cancer Awareness Roadshows (in partnership with the Bowel Screening Hub). To ensure we have a wider role in screening improvement we will engage with and support work of Screening and Immunisations Partnership Forum. Over the five-year period of this plan, this will be supplemented with ongoing work with screening services, general practice/Primary Care Networks, Public Health England, and Cancer Research UK to increase and maintain uptake and delivery of local awareness campaigns.

From September 2019, all boys aged 12 and 13 will be offered the **HPV vaccination.** We will work with the Cancer Alliance and Public Health England to ensure regional roll out and full coverage in the West Midlands.

By 2020, **HPV primary screening for cervical cancer** will be implemented across England and we will support partners to ensure regional implementation across the West Midlands.

Faecal Immunochemical Testing (FIT) has been in place for use in bowel screening since summer 2019. We will utilise the support of cancer transformation funding to implement **FIT for symptomatic patients**. This will commence with a pilot in a group of Primary Care Networks in East Birmingham towards the end of 2019/20. Based upon the evaluation, a wider roll out plan will be developed for 2020/21 onwards.

There will be a key requirement to implement the findings of the **independent review of cancer screening**. Once the final report is published, we will work with in partnership with Public Health England, Health Education England, West Midlands Cancer Alliance, and Primary Care Networks through our Cancer Screening and Early Diagnosis Group.

Earlier and faster diagnosis

In 2019/20 we submitted a proposal to establish a **Rapid Diagnostic Centre** pilot in east Birmingham for non-specific symptoms. This proposal was accepted in principle and work is currently underway with the West Midlands Cancer Alliance to establish the pilot and evaluation arrangements with the University of Birmingham. It is planned to commence this pilot in the coming months and based on the findings and evaluation, a wider roll out plan will be developed.

Work is already underway to implement the **Faster Diagnosis Standard** by 2020. We are currently collecting shadow data and will commence full monitoring against the new target from 2020/21. This includes showing a demonstrable improvement in the number of lung, prostate, and colorectal cancer patients diagnosed in 28 days. We will also work with the Cancer Alliance to implement the timed pathways for oesophagogastric, breast, gynaecology, and head and neck cancers.

An important aspect to ensuring earlier and faster diagnosis is early detection in primary care and good quality referral practice. We have a **Primary Care Cancer Education and Development Group** in place. The remit of this group in 2019/20 is to promote the training and development offer including the use of GatewayC. This work will continue into 2020/21 and beyond supported by the development of education and development tools (podcasts, webinars etc.). We will also undertake regular two-week wait referral audits to highlight areas for improvement and monitor two-week wait referral data by Primary Care Networks and practices to identify trends in practice. We will also work with the Cancer Alliance via the Primary Care Expert Advisory Group to standardise referral criteria and **two-week wait referral forms** across all pathways. We will also support the work to enable Primary Care Networks to diagnose more cancers early.

Work is already underway in 2019/20 to improve early diagnosis by implementing the four **best practice pathways** for colorectal, lung, prostate, and upper GI. Cancer transformation funding is being used to support this work. From 2020/21 mechanisms will be embedded to allow monitoring of compliance against the pathways.

We are committed to ensuring sustainable operational performance through the delivery of the **eight waiting time standards.** As described earlier there are a number of challenges to meeting these targets. The wider transformational work should help support improvement.

Diagnostics and treatment

In 2019/20, specialised commissioning will be establishing **West Midlands Radiotherapy Operational Delivery Networks** (hosted by University Hospital Coventry and Warwickshire NHS Trust). We will work with specialised commissioning to support the Radiotherapy Network to effectively function and deliver the new service specification across the region.

We will also work with the Cancer Alliance and specialised commissioning to implement the new service specification for **children and young people's cancer services** by 2021.

As a national ambition, from 2019 **whole genome sequencing** to be offered to all children with cancer and we will support the work to proactively engage with the relevant Genomic Laboratory Hub and NHS Genomic Medicine Centre. This will ensure local strategies are in place to provide all eligible patients with access to appropriate cancer genomic testing. We will also work in partnership with the relevant Genomic Laboratory Hub to ensure all genomic testing requesting is consistent with the national genomic test directory and delivered by the designated providers. Expanding on this, from 2020/21 **more extensive genome testing** should be offered to patients who are newly-diagnosed with cancer. We have worked with partners over 2019/20 to establish the Genomic Tumour Advisory Boards. From 2020/21 we will support whole genomic sequencing for all eligible cancer indications and support implementation of cancer genomic research projects and ensure greater alignment across local research initiatives.

In 2019/20 and 2020/21 we will work with the Cancer Alliance to review colonoscopy, endoscopy, and radiology protocols. This will ensure alignment with cancer waiting times guidance and move towards **reducing variation** via the development of a common set of guidelines, pathways and standards. We will also engage with and support the work of the Cancer Alliance on **balancing supply and demand** more effectively across the system starting with a demand and capacity review covering all diagnostics including pathology.

Our partners are already playing a key role in the delivery of an integrated pathology network to form a regional networked **digitalised pathology** diagnostic service and we will continue to support this work.

Living with and beyond cancer (personalised care)

We are wholly-committed to supporting the national ambition of everyone diagnosed with cancer having access to **personalised care** by 2021 (including a holistic needs assessment, a care plan and access to wellbeing information and support). This echoes our overall focus on delivering more personalised care as a key enabler to transforming our services. In 2019/20, we will implement the remote monitoring module on Somerset, implement monitoring and assessment of the offer to patients, and roll out of health and wellbeing events with providers and other stakeholders.

The remote monitoring module on Somerset will also enable us to allow **breast cancer patients** to move onto a **personalised follow-up pathway** by 2020. We will monitor compliance using the living with and beyond cancer metrics. Building upon this work the personalised follow-up pathway will be rolled out to **colorectal and prostate cancer patients** by 2021.

From 2021 the new **quality of life metric** will be in use. In 2019/20 and 2020/21 we will work with our provider trusts and the Cancer Alliance Living with and Beyond Cancer Group to prepare for implementation (including IT systems) once the metrics have been confirmed. This will then be supplemented by data collection of the quality of life metrics.

Workforce

We will continue to work together as an STP to address the challenges relating to workforce shortages and also developments. This will involve Health Education England, the Cancer Alliance, Local Workforce Action Boards and system partners to deliver phase 1 workforce plans via comprehensive regional workforce mapping and workforce strategy. We will then continue to use workforce modelling and strategy to support STP workforce planning to address the cancer workforce challenges we currently face. Further information can be found in the empowering our workforce section.

How will services be different in 2023/24?

By 2023/24:

- Patients will benefit from more integrated services within primary, secondary and tertiary care throughout their cancer journey.
- More people will be accessing bowel, breast and cervical screening. This will also include new ways of screening such as the FIT test.
- All boys aged 12 and 13 will be offered the HPV vaccination and HPV primary screening for cervical cancer will be implemented.
- We will have established the Rapid Diagnostic Centre for non-specific symptoms and we will have made improvements for faster diagnosis, waiting times and treatment
- Genome sequencing will become the norm. Whole genome sequencing to be offered to all children with cancer and we will continually learn from evaluations to support further

improvements by working with the relevant Genomic Laboratory Hub and NHS Genomic Medicine Centre. There will also be more extensive genome testing offered to patients who are newly diagnosed with cancer.

- A number of services will be transformed through digital innovation, such as the regional networked digitalised pathology diagnostic service.
- Patients with cancer will be supported through personalised follow-up pathways. This will include breast, colorectal and prostate cancer patients.

Shorter Waits for Planned Care

Improving services for people needing planned, routine and non-urgent care through shorter waiting times and transformed services

Planned care is evidenced-based care which is agreed in advance of a visit or virtual contact. It is delivered by the clinician and their team to provide optimal care, support, and guidance for the patient. It can be provided through advice and guidance, treatment or a routine review or interventions to support people to manage their condition. It can be delivered face-to-face or virtually or through a number of digital interventions, and in a range or hospital, community, primary care or home settings.

We have made a number of improvements in planned care transformation across Birmingham and Solihull.

Until recently, we have consistently achieved the six-week from referrals diagnostic waiting time target. Remedial action is in place to recover performance before the end of 2019.

We have been able to provide support local eye providers with local alternative assessment and treatment capacity for more vulnerable eye patients to avoid excess waiting times.

Since summer 2018 we have introduced a range of new out of hospital services for eye assessment and treatment; adult non-complex audiology, non-complex anti-coagulation, vasectomy and pregnancy termination support.

We have been doing preparatory collaborative pathway re-design with local system providers for initiatives such as:

- Musculoskeletal hybrid triage model and first contact practitioner pilot proof of concept – these pilots have commenced with initial learning and evaluation documented
- Work to enhance the consultant and other clinician Advice and Guidance offer to GPs the highest volume specialties
- Ophthalmology high impact interventions including:
- Audit of patient follow up processes and reducing waiting times for follow-up appointments for eye patients to avoid risk of harm
- A full Birmingham and Solihull eye population health needs assessment
- A related initial eye providers' capacity review has been completed that looks at the next five years to 2023/24.
- Specialty specific pathway transformation has begun in areas such as: gastroenterology; bariatric surgery; dermatology; ear wax management and some gynaecology pathways.

In addition to this, whilst there are occasional 52-week breaches in waiting times, there is no systematic problem for a particular provider or specialty.

Why do we want to change?

Nationally the NHS is experiencing significant pressure and unprecedented levels of demand for elective care. The challenge is to reduce avoidable demand and ensure patients are referred to the most appropriate health and care setting, first time. We need to do this by redesigning planned care patient pathways across hospital, community and primary care primary settings.

Locally the challenges for planned care include:

- Workforce challenges:
- Clinical recruitment and retention of medical, nursing, therapy and other technical staff
- Retraining of some our workforce aligned with how services are changing, for instance, therapy staff in hospital or community setting. In certain specialties or services, a shortage of clinical capacity with the necessary competencies
- Some 17% of local NHS staff are over 55 and potentially fully or partly retiring from the system.
- Services and pathways are not always as integrated as they could be. We have a complex mix of planned care providers for acute and community services that have developed over time. There is a need to ensure that all providers for a given service are all working to the same contemporary best evidence-based specifications across all Birmingham and Solihull.
- There should be more focus on preventing ill health and also in supporting people to manage their own health and wellbeing, which might sometimes mean that a surgical intervention may not always be the best option for a patient. This is echoed in other chapters.
- As our population continues to get relatively older there is rising demographic demand for musculoskeletal services, sight and hearing impairment or loss condition, for example, with more people living with multiple co-morbidities including obesity and greater cardio, neuro and other vascular risk.

Priorities for change

Nationally there is an ambition to provide alternative models of care to avoid up to a third of face-to-face outpatient appointments. So, redesigning planned care (sometimes called elective) to achieve better management of referral demand which improves patient care quality, outcomes and experience, while also improving efficiency.

Where appropriate, e.g. obesity, better upstream prevention of avoidable illness and its exacerbations, including more accurate assessment of health inequalities and unmet need. This includes addressing the needs of local populations and targeting interventions for those people who are most vulnerable and at risk. Technology offers digitally-enabled possibilities in primary and outpatient care to support this transformation.

Our local plan for improving planned care services is shaped by the transformative enablers highlighted earlier in this plan. We have developed a number of strategic priorities for 2019-24, which focus on clinically safe and effective assessment, triage and treat services that can be

delivered by clinicians with appropriate competencies and experience including those outside of hospital settings, and closer to home.

How does this deliver the STP aspirations?

Independence and resilience

- ✓ Focuses on prevention to promote health and wellbeing
- ✓ Increases the physical and emotional resilience of individuals, communities and society as a whole through improvements to services e.g. sight loss, hearing, obesity to enable people to live well with their conditions
- ✓ Promotes self-care and management, where possible, at home or at a local GP practice linked in to the development of first contact practitioners or dietetic support for inflammatory bowel symptoms, or digital transformation (people with chronic conditions and complex care needs to be supported at home rather than hospital through digital safety nets, use of technology and point of care testing), for example
- ✓ Promotes independent living
- ✓ Digital transformation supports our frontline health and care practitioners to be change agents who can advocate for behaviour change confidently, supported by digital resources and promoting on-line and digital solutions locally. This empowers patients with shared decision making and self-management
- ✓ Reduces waiting time through the promotion and informed support of choice of appropriate and relevant alternative provider for patients who have waited 26 weeks for consultation, diagnosis or treatment
- ✓ Releases GP through the introduction of first contact practitioners in Primary Care Networks and enable the management of total clinical pathways before and after any secondary care interventions
- ✓ Promotes independent living and empowers patients with shared decision making and self-manage.

Equity, equality and inclusion

- ✓ Better supports the most vulnerable patients
- ✓ Offers greater availability of digital outpatient consultation and clinical advice
- ✓ Supports blind or partially-sighted people or people with musculoskeletal conditions who might face barriers to work, education, travel, leisure and the built environment through introduction of new roles such as the eye care liaison officer and first contact practitioner.

Integration and simplification

- ✓ Develops integrated pathways across the health and care system and reduces duplication
- ✓ Enables greater use of systems to manage overall capacity and delivery in health and care, creating alternative ways of managing health when needed.

Promoting prosperity

- ✓ Supports opportunities for work, education, travel, leisure.

Social value

- ✓ Promotes environmental sustainability, through the use of digital solutions.

Delivering our commitments in practice

To reduce the size of waiting lists and the time people wait (except through choice or clinical necessity). This will be enabled through the implementation of choice of alternative provider at 26-week waits which is a national pilot. This will be enabled through the implementation of national policy of choice of alternative provider at 26-week waits. The local implications of the draft operational guidance are being worked through with system providers until March 2020. This will include consideration of the patient and clinician guidance needed to enact the choice offer to each patient, and a practical NHS and independent sector waiting times tool with mileage from home filters.

The focus initially will be adult orthopaedics and from April 2020 the scope will progressively be broadened to include at least: general surgery, urology, ear, nose and throat, ophthalmology, gastroenterology, and gynaecology. There is no national target for waiting list size, remembering that our population in absolute size will continue to grow, but as a minimum the baseline size at March 2019 is 95,000 patients. In practice enablers to support waiting list management will include:

- Better information for patients and referrers about relative waiting times to first outpatient and then to procedure. An example of this is our work with cataract surgery providers across the economy to publicise monthly snapshot waiting times (**https://www.birminghamandsolihullccg.nhs.uk/your-health/eye-health**)
- Implementation of on 26-week wait choice of alternative provider or hospital site. This is a national policy where the first alternative choice should be an NHS provider where capacity exists for a speciality of procedure
- More virtual/video consultation and advice support for patients, and promoting more patient-initiated outpatient follow-ups, where clinically appropriate
- E-referral, telephone and clinical image transfer advice and guidance to primary care, as well as to patients and their families is both timely and informative enough to support shared decision making and key questions to ask about treatment and/or condition management options. This will be delivered by local and national accredited consultant and other specialist clinicians.

To transform specific pathways to support improvements in service quality and outcomes. These include:

- **Musculoskeletal services:** These include all therapy services and consultant-led orthopaedics, spinal surgery, rheumatology and pain management services. Local providers, commissioners and Primary Care Network teams are working collaboratively to redesign care and improve population health through greater integrated musculoskeletal first contact practitioners complementing and supporting general practice to provide easier

access to diagnosis, support, and where necessary, treatment for people with musculoskeletal conditions, and in particular to help in effectively self-managing their conditions. By the end of 2019/20 it is expected that around 19% of the Birmingham and Solihull population will be supported by a first contact practitioner service. Then between 2020/21 and 2023/24 the national expectation is to progressively increase first contact practitioner coverage to 100% of the population.

System providers, commissioners and Primary Care Networks are mapping the geographical competencies and availability of the local therapy workforce. In discussion with the Chartered Society of Physiotherapists and Health Education England. We are also developing a local training and competencies programme for Band 7 and above physiotherapists to meet the above population coverage ambition.

To complement this, our initial work with Versus Arthritis and our local musculoskeletal first contact practitioner teams in primary care is designing programmes to help patients manage their chronic and debilitating pain, improving individual movement and fitness that enable people to better support themselves and each other

- **Eye health/sight loss:** With local hospital, community and primary care providers we are redesigning eye pathways such as: cataracts, glaucoma, and macular degeneration and the related physical and virtual structure services to release capacity within hospitals so they can concentrate on more complex procedures. This includes more integrated pathways and referral refinement with GP/optometrist advice and guidance, and triage of referrals of non-urgent referrals for cataract, glaucoma, and other eye conditions. Much of this will be completed by or before 2022/23. Low vision patients will over that period be supported by new hospital eye care liaison officers in partnership with the Royal National Institute for the Blind and community low vision rehabilitative support to enabling people with poor vision to navigate health and care systems more easily.
- **Hearing Loss:** We are working to reduce the risk of hearing loss with accessible services for managing ear wax and other medical ear conditions. From October 2019 the age for accessing our community adult non-complex audiology services has reduced from 55 to 18 for our Birmingham patients (historically Solihull patients have been able to be referred from 18-years-old). Nationally, 18 is considered as the age threshold for degenerative/non-complex hearing loss rather than acute hearing loss before that age. More timely patient assessment of potential hearing loss under the age of 55 will reduce older person's demand on acute ear, nose and throat services and safely avoid unnecessary outpatient appointments. This means patients will not have to wait until their hearing has further deteriorated later in life which would then exacerbate the associated risks of hearing loss to physical health, mental health, dementia and falls.

  In addition to complement this lower age of access we are working to redesign ear wax management pathways to substantially move treatments such as ear wax micro suction from hospital to primary care hub settings
- **Managing obesity:** We will support this through re-designing a uniform offer of Tier 3 specialist weight management services for Birmingham and Solihull, for patients with more severe obesity and co-morbidities to improve quality of life for patients, some of whom will

not want or benefit from surgery. For those patients with a Body Mass Index of 35+ and a Type 2 diabetes diagnosis in the last ten years we are working with provider partners to expand bariatric surgical capacity with a faster-track surgical assessment and post-surgical support. For a high proportion of patients, evidence indicates they could experience a remission in their diabetes and reduced risk of cardiovascular or limb surgery emergency operations. The target is to complete this work by 2022/23.

This work complements the recently successful bid to NHS England for Birmingham and Solihull to become one of ten national pilot sites from April 2020 implementing a low calorie diet pilot programme detailed elsewhere in our plan. Medical research indicates that some people with Type 2 diabetes can achieve remission through adoption of a low calorie diet and nearly half of patients to stop taking anti diabetic drugs and achieve non-diabetic range glucose levels.

- **Skin conditions:** Hospital-based adult and paediatric dermatology are experiencing significant increase in referrals, whether for suspected cancer or non-cancer cases. There are local and national recruitment and retention issues for all clinical staff working in these services. Both services require transformation to appropriately reduce the number of people being referred to hospital services as many assessment and treatments for specific skin conditions can be undertaken by Royal College of GPs accredited clinician in primary care – closer to home and with a more personalised treatment pathway.

  To support this transformational change of management of less complex skin conditions, we can use Advice & Guidance and tele-dermatology solutions delivered directly to the GP or patient, rather than a referral to hospital service to protect hospital dermatology for more complex/urgent cases. A primary care dermatology service with Royal College of GPs extended role accredited staff also requires the expertise oversight and support of experienced hospital dermatology consultants with structured and regular multi-disciplinary teams to review more complex cases. The primary care dermatology service is a complement to, not a replacement for, hospital based services. Primary care dermatology service models vary but can include:

  - Advice & Guidance and tele-dermatology provided to GPs and potentially long term patients who have skin condition flare ups; or
  - Full primary care service as specified by the Primary Care Dermatology Association.

  Our STP already has a few of these models across the partnership either as proof of concept pilots or historically commissioned services. We want to ensure all the registered population is covered by clinically suitable alternatives to, and supporting, hospital based care during 2019/20-2020/21.

- **To transform outpatients** over a range of different specialties, developing digital solutions as described earlier. This will support the national priority to reduce the number of face-to-face consultations by one-third by 2023/24.

  Digital transformation of outpatients is part of the Digital First programme of work at University Hospitals Birmingham NHS Foundation Trust and is in its early phase at present to rollout more virtual outpatient consultations across specialties. Current hospital-based activity is being assessed to determine how many appointments could move wholly online

i.e. where there is no need to physically assess the patient. In addition, we are also exploring placing diagnostics, such as phlebotomy, in convenient community settings, which in turn would enable more patients to be monitored and seen virtually.

The use of technology will change the way that patients, carers and clinicians interact. The increased access to services through digital mediums that have already been discussed will enhance the experience of interactions and enable care to be designed and delivered to suit their needs. Technology will support the NHS to redesign clinical pathways and allow patients to be managed digitally through the use of virtual clinics and consultations, replacing traditional face to face follow up appointments, where appropriate. This would include patient initiated follow-up consultations where clinically appropriate, e.g. for gastroenterology/other inflammatory conditions where the patient might know when they need follow-up.

University Hospitals Birmingham NHS Foundation Trust has estimated that delivery of a 33% reduction in face-to-face outpatient appointments will be completed by 2022, supported by the Digital First programme of work. Further solutions to avoid or reduce outpatient referral demand include:

- Further development of the Advice & Guidance Offer to GP referrers including a number of specialty specific collaborations e.g:
    - Dietician-led gastroenterology irritable bowel syndrome referrer and patient advice and guidance. We have secured NHS England transformation support for a '100+100-day pilot' with University Hospitals Birmingham NHS Foundation Trust and Birmingham Community Healthcare NHS Foundation Trust partners. Initial testing of the service is expected to go live by the end of March 2020.
    - Paediatric dermatology telephone and tele-dermatology (using a secure cloud-based mobile GP app) NHS consultant advice and guidance service to support local hospital system consultant capacity pressure. Testing for 12 months from summer 2019
    - Liver medicine and endocrinology (University Hospitals Birmingham NHS Foundation Trust) specific pathway best practice guidance development for GPs to be completed before March 2020. Further specialties such as clinical haematology can then be jointly progressed during 2020/21.
- Increased use of Electronic Referral Systems Advice & Guidance – this is live with growing use by GPs across a wide range of specialties within agreed request response times
- Growing impact of more referral assessment service including referral Advice & Guidance. Across local providers the numbers of provider and specialty level referral assessment service functions is continuing to increase since October 2018.

- **NHS England evidence based interventions and local treatment policies** scope will continue to be further developed. We will work to ensure policy documents and supporting information is clear, accessible to patients and GPs. We will further review the accessibility

of our web based information at: **https://www.birminghamandsolihullccg.nhs.uk/your-health/treatment-policies**

NHS Birmingham and Solihull and NHS Sandwell and West Birmingham CCGs are also members of the NHS England evidence-based interventions national demonstrator community to promote and shape future waves of national treatment policy development

We are also working with the digital team to develop a way to seamlessly embed our treatment policies, summary clinical decision templates and our many treatment specific patient information leaflets into the primary care systems. We aim to complete this work during 2020/21.

For local treatment policies. These policies are reviewed over a three-year cycle for clinical relevance and population need. We will undertake greater audit of the impact of policies and any changes in clinical guidelines or future waves of the national NHS England evidence based intervention treatment policies and planned care patient decision support information such as Choosing Wisely UK (**https://www.choosingwisely.co.uk/about-choosing-wisely-uk/**).

Delivering our commitments in practice

We are already working together with our partners across the Birmingham and Solihull NHS economy through a shared Elective Care Transformation Plan developed in 2019/20. In addition, as well as informal discussion with third sector partners such as Verses Arthritis, Vision UK, Royal National Institute for the Blind, royal colleges and other clinical professional associations.

We will work with NHS England as it develops outpatient transformation resources to support each STP across England to review whether an additional overarching elective care transformation forum would strengthen delivery of our planned transformation priorities.

To support transformation a range of clinical led forums are in operation. This provides clinical oversight and it includes a range of GP, other primary care clinicians and provider specialty clinical service leads pathway input, calibration and validation. Examples of some of the active boards and working groups that feed into this programme include:

- **Musculoskeletal Transformation Board** – members include: Sandwell and West Birmingham CCG, West Midlands Right Care and Get It Right First Time, University Hospitals Birmingham NHS Foundation Trust, The Royal Orthopaedic Hospital NHS Foundation Trust, Birmingham Community Healthcare NHS Foundation Trust and Sandwell and West Birmingham Hospitals NHS Trust
- **Eye High Impact Interventions Providers Group** – members include representatives from all Birmingham and Solihull acute, community and primary care NHS and independent sector eye care providers
- **Eye Health Quality Board** – members include: NHS England Primary Eye Contracting, West Midlands GIRFT, Solihull Public Health, Birmingham and Solihull social care, Thomas Pilkington Trust and Vision UK
- **Treatment Policies Clinical Development Group** is a collaborative undertaking with NHS Sandwell and West Birmingham CCG, Birmingham Public Health, with Worcestershire and

Black Country CCGs in attendance. This group has a close relationship with the Clinical Prioritisation Advisory Group. NHS Birmingham and Solihull and NHS Sandwell and West Birmingham CCGs are also members of the NHS England Evidence Based Interventions national demonstrator community to promote and shape future waves of national treatment policy development.

Further detail on our joint work can be found at: **https://www.birminghamandsolihullccg.nhs.uk/your-health/treatment-policies**.

More information on the CCG's prioritisation process can be found at: **https://www.birminghamandsolihullccg.nhs.uk/our-work/clinical-prioritisation**.

- **Specialty/pathway re-design clinical working groups** including: Tier 3 and 4 obesity surgery, gastroenterology, dermatology, ear, nose and throat, gynaecology, diabetes and respiratory medicine/chronic obstructive pulmonary disease
- **Elective transfer of care and discharge protocol working group.** This group is about to be established as NHS Birmingham and Solihull CCG and University Hospitals Birmingham NHS Foundation Trust are reviewing and updating this key secondary care/primary care interface protocol. Progress on updating this protocol is being overseen the CCG/University Hospitals Birmingham NHS Foundation Trust/Primary Care Interface Group.
- **Advice & Guidance.** Progress on developing new approaches is overseen the CCG/University Hospitals Birmingham NHS Foundation Trust/Primary Care Interface Group
- **Referral to treatment and waiting times performance** is reviewed, with remedial action plans where necessary, at each provider specific contract review meeting.

How will services be different in 2023/24?

By 2023/24:

Waiting times and choice

- Planned care waiting lists and the time people wait (except through choice or clinical necessity) will be managed within 18-26 weeks
- Patients will be aware at time of referral that they can expect to be given a choice of a relevant alternative provider or providers should it be likely that their outpatient consultation, diagnostics or treatment will be longer than 26 weeks from time of referral.

Musculoskeletal conditions

- Local providers, commissioners and primary care network teams working collaboratively will have delivered improved population health and care through more integrated musculoskeletal first contact practitioners complementing and supporting general practice to provide easier access to diagnosis, support, and where necessary, treatment for people with musculoskeletal conditions, and in particular to help in effectively self-managing their conditions.

Eye health and sight loss

- Improved services will minimise avoidable sight loss for our population; and enable people with poor vision to navigate health and care systems more easily.

Hearing loss

- More timely patient assessment of potential hearing loss under the age of 55 will reduce older person's demand on acute hearing services and safely avoid unnecessary outpatient appointments. This means patients will not have to wait until their hearing has further deteriorated later in life, and so reduce risks to physical health, mental health, dementia and falls. In addition, we are working to re-design ear wax management pathways to substantially move treatments such as ear wax micro suction from hospital to primary care hub settings.

Skin conditions

- Primary care dermatology services helping to appropriately reduce the number of people being referred to hospital services, with more assessment and treatments for specific skin conditions undertaken by Royal College of GPs accredited clinician in primary care, with consultant oversight, closer to home and with a more personalised treatment pathway
- To support this transformational change of management of less complex skin conditions, we can use Advice & Guidance and tele-dermatology solutions delivered directly to the GP.

Managing obesity

- A uniform offer of Tier 3 specialist weight management services for Birmingham and Solihull, for patients with more severe obesity and co-morbidities to improve quality of life for patients, some of whom will not want or benefit from surgery
- For those patients with a Body Mass Index of 35+ and a Type 2 diabetes diagnosis in the last ten years we are working with provider partners to expand bariatric surgical capacity with a faster-track surgical assessment and post-surgical support.

Digital Transformation of outpatients

- Digital transformation supports health and care practitioners to be able to an advocate for behaviour change confidently, supported by digital resources and promoting online and digital solutions locally. This empowers patients with shared decision making and self-management.

Risks to delivery

In developing this plan, we have carried out a triangulation exercise for each programme area to ensure we have appropriately considered the finance, workforce, digital and performance assumptions and how these are inter-related to other areas in the plan. As a result, our key overarching strategic risks are based on interdependencies given that, if one of our fundamental enablers is not delivered, this will have an impact on delivering the key service transformations.

These strategic risks will be considered alongside operational programme risks and will be managed and reviewed on a regular basis using a robust programme management methodology. They will be reviewed part of the STP's governance infrastructure.

Our strategic risks are as follows:

1. **Risk to achieving financial balance by 2023/24**

   In the delivering best financial value section, we have outlined a range of detailed financial risks, which are summarised below:

   - Risk of significant financial pressure, both in delivery of our control total and in our working capital arising from the exhaustion of non-recurrent funding sources. This includes; the withdrawal of PSF/FRF funding, uncertainty over future changes to tariff including specialist top-ups. This is coupled with our systems distance from target and combined with the on-going scale of challenge for social care demand and associated funding levels for our local authority partners.
   - Risk of not delivering a break-even position: this is within the provider sector, including the rectification of children's services issues in Birmingham. This is in addition to high levels of services commissioned by NHS England specialised commissioners, whilst this commissioner remains outside of the control total for our system.
   - Risk of delivery of elective waiting targets: this is in the context of non-elective pressures, and further impacted if we are unable to reduce the increasing demand for urgent care
   - Risk to pump priming workforce initiatives to meet challenges around the availability of staff, with the right skills and the management of sickness
   - Risk to not securing both capital funding and additional targeted revenue funding to enable us to deliver on our transformational schemes, particularly connected to our estate and digital agenda, is key
   - Risk of EU Exit, a risk for all STPs
   - System efficiency assumptions are not realised in practice: We have also factored in a range of assumptions for system efficiencies, but the risk is these are not realised in practice. Best estimates and forecasts have been undertaken at this point but will be subject to change as transformation programmes get underway.
   - Delays in transformation activities impact upon the proposed activity and performance trajectories outlined in other areas of the plan. These arise from funding constraints from

partner organisations, which result in changes in demand for care, potentially in higher cost settings to deliver safe service.

Mitigations:

For the specific risks outlined above, mitigations are described in detail in the delivering best financial section. A summary of mitigations is as follows:

- Regular review of all financial forecasts for each programme as they develop to support early identification of risks and issues, which compromise the financial position for the STP
- Appraisal of risks at each programme board governance forum, with escalation to the STP chief finance officers, as appropriate, so early action can be taken
- Monitor impacts of programmes as they deliver against forecasted financial activity, to support continual refinement of efficiency savings and identify mitigations elsewhere in the system
- Ongoing review and if necessary, re-prioritisation as a system of our delivery plans, estate plans and trajectories for improvement
- Working towards Integrated Care System status, which will include working more closely together as a system for delivery of the triple aim.

2. **Risk to attracting and retaining the workforce needed to support our planned transformations**

Our workforce, who work incredibly hard to deliver excellent standards of care, are our greatest asset, as described in the empowering our workforce section. This plan identifies a number of challenges based on the need for a long term plan to create a sustainable and dynamic workforce. Inevitably, this will take time to create in terms of new roles and opportunities, training and other programmes. In the meantime, however, this creates short and medium term challenges given:

- There are current and predicted shortages of staff
- Our workforce is highly-skilled and experienced but ageing, with many due to retire in five years
- There is a need to respond to changing expectations for standards of care, digital readiness and our ability to meet the needs of our diverse communities amongst others
- Whilst we have developed a range of robust solutions and strategies to overcome these challenges, we will be continually faced with the risks around how quickly we can deliver some of these solutions. This will be key in continuing to deliver safe and high quality care that will embrace other interventions, such as new ways of working and digital transformations. New programmes to recruit and attract staff will take time to materialise and delays in delivering these priorities or in creating attractive opportunities for our potential workforce may compromise our ability to realise the scale of our desired transformation. However, this is not just a risk for our STP; many of these challenges will be faced across the country, creating an even greater need for us to be competitive in creating attractive jobs for people.

Mitigations:

- The actions detailed in this plan promote, attract and retain our workforce now and in the future.
- Regular review of programme effectiveness needs to be undertaken in relation to workforce developments, learning from what works and expanding this at scale
- Ongoing dialogue with local, regional and national organisations to support workforce development, including teaching and training opportunities
- Ongoing review of recruitment and retention figures to continually manage shortages in vacancies, enabling system wide discussions on priority workforce groups. This should include review of implications arising from EU Exit
- Review of our workforce governance (Local Workforce Action Board) to enable greater system working, monitoring and action
- Promote the benefits of working in health and care, including why this is a great place to learn, work and develop both internally within our organisations and wider in our communities.

3. **Risk to delays on digital transformation across the partnership**

Whilst we are already well underway with our digital transformation, we cannot under-estimate the scale of transformation this will involve in creating new ways of interacting with services. There will be new risks to delivery arising from a digital first relationship with patients, deploying and reacting to and funding new and changing technology at speed, moving to serverless IT architecture and the provision of new service environments whilst maintaining safe and secure standards. There will be patients who choose not to use the digital front door and will need to access health and care in a traditional way. The organisational development and change management programmes when moving to new models of care and delivery isn't underestimated. As a system, with leaders across our system, we are doing our utmost to promote and support the transformation of our care model and digital approaches to embed this new way of working.

Mitigations:

- Promote to citizens that digital solutions will be there to enhance and support care and that access to traditional services will still exist
- Ensure an experienced based co-design approach with care professionals and citizens
- Ensure subject matter expertise in business change to scope, design, implement and scale digital approaches
- Monitor and continue to review the latest technology to ensure services and solutions remain responsive to public needs as well as technological advancements
- Work with suppliers to seek opportunities with novel technologies
- Take advantage of collective buying power and digital efficiencies
- Ensure we maximise the learning and opportunity associated with being a 5g testbed.

4. **Risk of lack of appropriate estate infrastructure to enable wider transformation to take place**

   - As described in the section Using our buildings to deliver change, we face a number of challenges in relation to; the condition of our current buildings, the need to use space effectively to maximise our finances, the need for new facilities to respond to our changing population needs, as well as enabling digital transformation to support new ways of providing services. If we are unable to realise our estates vision, this will compromise our ability to transform a range of services at both a primary, community and secondary care level. It will also hamper integration of services and the co-location of our collective workforce, which is a key enabler to our transformation.
   - Our requirement for investment into our estate has been prioritised and identified. However, without capital funding being forthcoming this will fundamentally impact on our ability to deliver transformation in a range of services and settings, identified in the chapter.

   Mitigations:

   - Continue to review void estate and make best use of current infrastructure
   - Prioritise capital developments, and review these on an ongoing basis subject to funding
   - Apply for funding to secure estate, when available.

5. **Risk of lack of engagement with our citizens and communities to support transformation**

   As we have described in the Introduction and throughout the plan, we have a number of complex challenges as well as exciting opportunities. This includes new ways of providing services to enable people to have choice and control over the decisions that affect their health and wellbeing, as well as new ways of interacting with services through integrated services, our Digital First approach and also through our place based approach. If we fail to engage effectively with our communities and explain the reasons for our proposed changes both now and as services develop, there may be resistance and negative impacts arising from this at a time when we need to foster a collaborative approach to conquer our challenges.

   This may be a particular challenge for citizens in west Birmingham given this area falls outside of our STP. There may be confusion in terms of public messaging of services across the whole of Birmingham and Solihull given people in this area largely use different facilities, such as Sandwell General Hospital or Birmingham City Hospital. In addition, we wish for people to have consistency of offer and care pathways across Birmingham and Solihull.

   Mitigations:

   - Identify a clear communications and engagement plan beyond the launch of this plan, working across organisations, using a range of communication and engagement channels. This will need to include specific targeted engagement with seldom-heard groups to understand the positive and negative impacts, with mitigations for how to manage these.
   - Continue the ongoing dialogue and strengthen governance between our STP and also the Black Country and West Birmingham STP to support the planning and implementation of transformation across both areas. This needs to recognise the differences and opportunities

of placed-based care. It also needs to strengthen and create joint approaches for communications in west Birmingham and Birmingham as a whole to create a coherent and consistent message for citizens.

- Develop ways to engage more people across Birmingham and Solihull as key enablers to this communications and engagement, creating opportunities for learning and community development, which in turn deliver against our social value aspirations.
- Ensure quality and equality impact assessments are carried out for all developments, and for these to be discussed at STP forums, health and wellbeing boards and where appropriate joint overview and scrutiny committees.

How we will monitor progress of the plan

STP Board

The STP Board has ultimate responsibility for assurance of delivery of this plan and realising the outcomes for local people, with statutory responsibility within individual partner organisations.

The STP Board comprises of the chief executives and chairs of all of the STP partner organisations, who meet regularly as a system partnership. Seeking assurance of key progress on outcomes, leadership action to support delivery or management of any escalated risks to delivery as well as the impacts on other areas as we work together in a more system focused way.

STP governance continues to evolve, as described earlier in the plan to ensure decision making structures are reflective of the STP programmes, with appropriate checks and balances to deliver services in accordance with statutory guidance.

Portfolio boards and operational boards

The STP Board is supported by three life course portfolio boards and enabling boards for finance, estates and digital. Each is supported by operational working groups to deliver the range of individual projects and programmes arising from this plan, which are already in existence. This include NHS organisations, the two local authorities and voluntary and community sector organisations to ensure an integrated approach.

Each of our portfolio boards is co-chaired by our chief executives.

For the portfolio boards, we have embedded a number of principles to support strategic and operational delivery:

- Engagement and involvement of senior executives and clinicians in the shaping, development and delivery of strategic and operational plans
- Development of a clear work plan, setting out delivery priorities
- Clear milestones and actions required to achieve delivery
- Measurable key performance indicators/outcomes, which will be monitored on a risk basis
- Assurance reports provides to the STP Board, detailing progress made and barriers to delivery or risk
- Strategic direction and decision making (within agreed delegated limits) related to Long Term Plan and STP priorities and delivery plans.

We are in the process, aligned to our Integrated Care System accelerator programme, of reviewing our governance arrangements going forward and in the context of a shadow Integrated Care System.

Oversight and scrutiny

This includes regular presentations to the Joint Overview and Scrutiny Committee for Birmingham and Solihull and each respective local authority health and wellbeing board. This ensures effective

public engagement and a shared understanding of the impact to the transformational changes outlined in this plan.

To ensure clinical engagement and scrutiny, we will ensure that where large scale plans are being developed there is engagement with our local Clinical Senate. These have been established to be a source of independent, strategic advice and guidance to commissioners and other stakeholders to assist them to make the best decisions about health and care for the populations they represent.

This combined approach will ensure plans are developed and consider the relevant public engagement and impact assessment and clinical scrutiny as part of our transformational approach to delivering services.

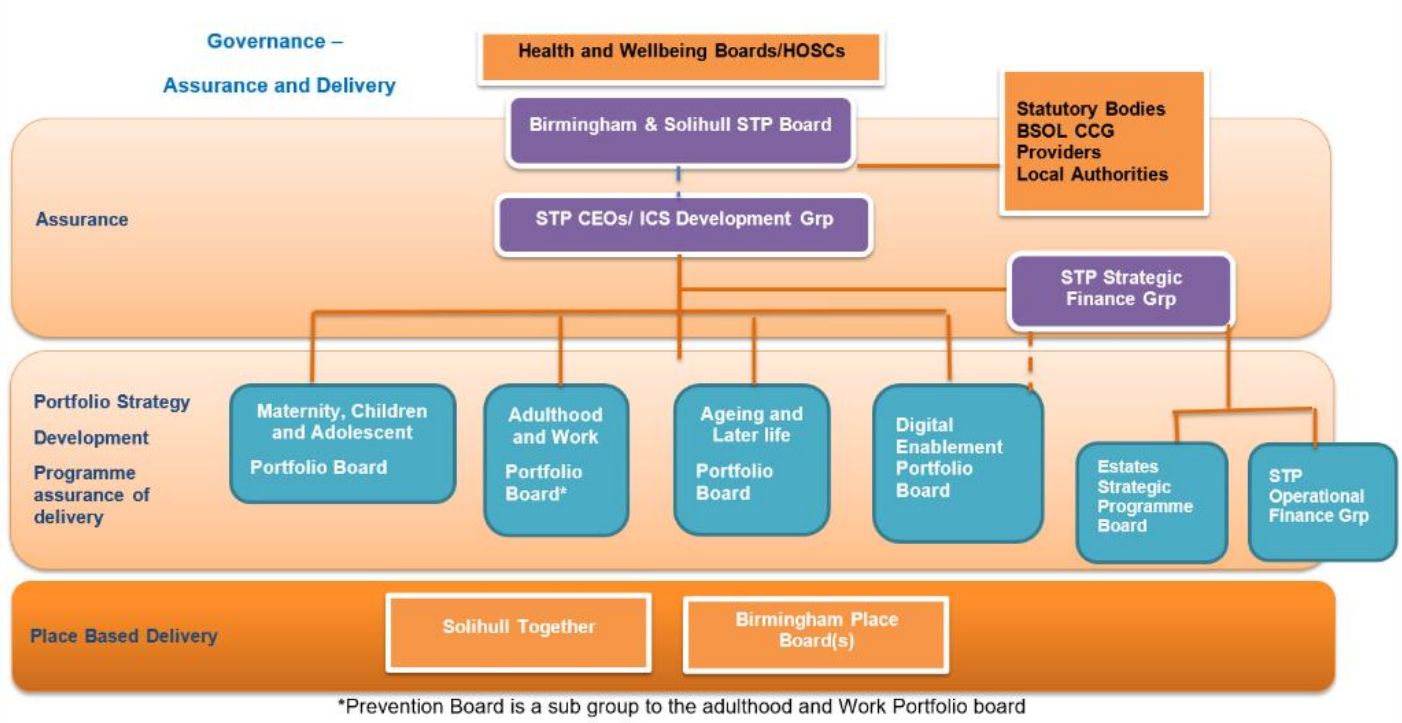

Figure 16: Governance model

Performance

As part of developing this plan, we have also estimated our future performance against a set of metrics. The performance of the plan will be monitored against these measures and they will assist in enabling us to continually improve the quality and effectiveness of our services. In addition to this, there are a number of other wider indicators of success that it will be valuable to assess ourselves against. These include changes to healthy life expectancy, levels of deprivation and health inequalities across the STP. Improvements against these indicators will result in changes to our needs overtime and impact future joint strategic needs assessments.

Communicating our plans

Creating a shared dialogue – engaging and communicating our plans

The NHS Long Term Plan provides us with exciting communication and engagement opportunities. However, the increasing and more complex demands from a population of 1.3 million people require us to take a different communications and engagement approach.

A key part of our vision is sharing the responsibility for local people's health and wellbeing with them, and people taking a more active role in keeping themselves well. We know that people are keen to do this, with the right support from health and social care organisations. This includes: helping to prevent people from becoming unwell; encouraging people to get help early; working in partnership with them to design the right solutions; as well as changing perceptions and behaviours along the way.

Using research and engagement that has already been undertaken as a solid foundation, as health and social care partners across Birmingham and Solihull, we need to continue to develop our collective approach to engaging, involving and communicating with people; this means using a range of different ways to reach people, speaking a common language and using a trusted voice. It may mean using trusted community sector partners to reach out to the communities they serve on our behalf, using tried and tested networks, and building on community assets. Regardless, any approach to communicate, engagement and involve must be built on previous successes, best practice, clear engagement principles, embedding processes to allow effective working practices and further developing organisational cultures, which continue to truly listen and respond to local people.

As the largest city outside of London, Birmingham and Solihull collectively are likely to attract more attention in political and health circles. Economic and social progress, and the increasing profile and awareness that comes with it, provides us with an opportunity to utilise this scale and strength to good effect, in terms of reputation and message impact.

Following the launch and awareness raising of our Long Term Plan locally, a longer-term communications and engagement plan will set out how in more detail how we will communicate, engage and involve local people, in different ways, across the priorities set out within the plan. This may include: co-production; marketing communications campaigns; encouraging and supporting behaviour change; providing information to support self-care and lifestyle choices; and statutory consultation, where necessary.

We will adopt a common language and will utilise different techniques, platforms and channels to reach as many people as possible, ensuring that this is meaningful and beneficial to the individual.

Quality and equality impact assessment findings

Quality and equality impact assessments were carried out by NHS Birmingham and Solihull CCG on behalf of the STP partnership. Overall both assessments scored **positively** against the impacts on residents and a summary of the key findings are below.

Considerations

Both impact assessments were carried out against the overall impact of the ambitions and commitments contained within the plan. As part of the ongoing approach to developing services, business cases will need to be developed, as appropriate, to ensure proposed services meet the objectives within this plan, national guidelines and provide positive outcomes for the population. Further quality and equality impacts assessments will be carried out on new services as part of this process to ensure inclusivity and full consideration of all impacts.

Quality impact assessment findings

The overall quality impact assessment was **positive**. The assessment was against a range of dimensions, which are described below, as follows:

- **Safety – POSITIVE IMPACT**

  Safety is a fundamental priority for the STP and all programmes are developed with patient safety at the core. The plan sets out the ambition to deliver services in a transformational way. This will require new ways of working and engagement with patients to ensure continued accessibility and people receive the right treatment at the right time. This will require further staff training, education and engagement (with both clinicians and public), across a variety of networks and contact points to ensure groups to ensure inclusivity across all groups. It will also require the assessment of appropriate infrastructure to deliver services in a new way.

- **Effectiveness – POSITIVE IMPACT**

  All programmes and service developments will continue to take into consideration NICE guidelines and national standards. Services will be provided in response to the local population needs to ensure they provide effective access, are appropriate, value for money and meet the ambitions within this plan. Innovation and transformation will be a key driver for service delivery and the STP is committed to providing appropriate resource and expertise to continue to develop services. Engagement with residents, clinicians and staff will continue.

- **Experience – NEUTRAL IMPACT**

  Transformation to services will require changes to the way we work and how services are delivered. It is clear that a range of people will benefit from the introduction of digital platforms and solutions for providing rapid response care which will give greater accessibility, information and improved response times, which will enable staff more time to care. However, it is equally acknowledged that change may result in some negative feedback as new services are embedded and pathways are (re)established or developed. In particular, this may affect vulnerable groups such as those who do not speak English, older

people and those with learning disabilities. To address this, the STP will need to continue to consider the impacts on different groups during programme development and engage through local networks and contact points to ensure accessibility remains at the forefront of service delivery.

- **Other impacts – POSITIVE IMPACT**

  It is recognised partners have made significant changes to the way they work to provide system savings, for example, merging three CCGs into one. However, it is recognised the system still faces significant financial challenges. We will continue to work closely with NHS England and NHS Improvement, partners across the STP and providers to continue to make efficiency savings where possible, for example, through estates. To deliver the ambitions across this plan, transformation of services will be a key driver. As a result, we will need to continue to develop the way we work including workforce recruitment and development to ensure we have the right workforce in place to meet patient needs.

Equality impact assessment findings

The equality impact assessment looks at the impact across the nine protected characteristics (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sex orientation) and well as carers and other disadvantaged groups. Overall, the assessment identified a **positive or neutral** impact on the health and care needs of these protected characteristics. In summary:

- **Age – POSITIVE IMPACT**

  The plan has a positive impact on age, considering all the life stages of a person from birth to death, and meeting health and care needs appropriately through each stage. There is significant positive impact on addressing health inequalities and associated age risks including infant mortality, dementia, cancer and other long term conditions associated with ageing, childhood obesity and long term impacts on health, poor mental health in adults and young people, and special educational needs and disabilities. The emphasis on right care, right time and providing care close to home will have a positive impact for all ages and in particular older people who may experience mobility difficulties, making it harder to travel to services. It is recognised that some groups may be at risk of digital exclusion including older people. Digitally inclusive approaches will need to be developed to meet the needs of people and groups who struggle to access digital, as these services are developed further.

- **Disability – POSITIVE IMPACT**

  The plan is likely to have a positive impact on the health and care needs of disabled people. It specifically sets out commitments to deliver services to meet the needs of disabled people through special educational needs and disability, improving the support to people with learning disabilities and autism, preventing ill health and long term conditions which limit life and cause disability, and investing in mental health services to keep people well. In addition, the plan sets out to reduce the stigma of mental health, disabilities and other conditions to support people to live well and self-care, provide information that is easy for everyone to understand, and improve access to the health and care services available to disabled people.

- **Gender reassignment (including transgender) – NEUTRAL IMPACT**

  The plan is likely to have an overall neutral impact on gender reassignment. It is recognised that as service streams are further developed across providers, equality and quality impact assessments will be undertaken to ensure inclusion for all protected characteristics.

- **Marriage and civil partnership – NEUTRAL IMPACT**

  The plan is likely to have an overall neutral impact on marriage and civil partnership. It is recognised that as service streams are further developed across providers, equality and quality impact assessments will be undertaken to ensure inclusion for all protected characteristics

- **Pregnancy and maternity – POSITIVE IMPACT**

  The plan will have a positive impact on pregnancy and maternity with a commitment to implement a single Local Maternity System for Birmingham and Solihull to increase choice, enhance maternity care and support, and improve the experience of mothers. This will help to reduce neonatal mortality rates and adverse childhood experiences and will give babies the best start in life. Birmingham and Solihull will build on the foundations of the national Better Births programme.

- **Race – POSITIVE IMPACT**

  The plan is likely to have a positive impact on the health and care needs of the protected characteristic of race and ethnicity. The plan sets the foundations for services to be delivered in a manner that supports cultural inclusion through personalisation, place-based, and choice to support the design of services to meet the needs of local communities, for example, personal health budgets and direct payments, primary care networks, place-based approaches and community assets, developing a workforce that is representative of the communities served through the Workforce Race Equality Standard. It is recognised further development is needed to ensure the impact on the health care needs of migrant communities is articulated in future plans.

- **Religion or belief – POSITIVE IMPACT**

  The plan is likely to have a positive impact on the health and care needs of the protected characteristic of religion or belief. The plan sets the foundations for services to be delivered in a manner that supports faith based inclusion through personalisation, place-based, and choice in services that meet the needs of local faith based communities including die well – enabling people to die at home, supporting open and honest conversations about death across the diverse communities we serve, use of community assets – faith communities to support the delivery of self-care, and Primary Care Networks, place based approaches and community assets.

- **Sex – POSITIVE IMPACT**

  The plan is likely to have a positive impact on the health care needs of the protected characteristic of gender for males and females. The plan sets the foundations for services to be delivered in a manner that supports gender inclusion through personalisation and choice including addressing domestic abuse and transforming maternity services and pathways.

- **Sexual orientation – POSITIVE IMPACT**

  The plan is likely to have a positive impact on the health and care needs of the protected characteristic of sexual orientation for the Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Plus population. The plan sets the foundations for services to be delivered in a manner that supports Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Plus inclusion through personalisation and choice. It is recognised further development is needed to ensure the impact on the health and care needs of the Lesbian Gay Bisexual Transgender Queer or Questioning Plus community is articulated in future plans.

- **Carers – POSITIVE IMPACT**

  The plan is likely to have a positive impact on the health and care needs of carers. The plan sets the foundations for services to be delivered in a manner that supports inclusion through personalisation and choice, specifically Primary Care Networks, social prescribing, mental health and wellbeing. It is recognised further development is needed to ensure the impact on the health and care needs of carers is articulated in future plans.

- **Other disadvantaged groups – POSITIVE IMPACT**

  In particular, the plan recognises homeless people and their health and care needs and seeks to address these needs through removing barriers to access to primary care registration, primary care networks, social prescribing, and prevention and self-care. Further work is needed to identify any other potential at risk groups and develop engagement mechanisms to ensure their needs are considered.

  The STP is committed to engaging with its residents to ensure their needs are addressed through future service development. All services will have a full quality and equality impact carried out to address any potential impact and steps taken to address any issues, where possible.

The full impact assessments can be found at Appendix 13.

Appendices

Appendix	Title
1.	Birmingham and Solihull STP Strategy (draft), Autumn 2018
2.	Healthwatch Birmingham and Healthwatch Solihull Findings Report
3.	Developing person-centre services: Detailed deliverables and performance trajectories
4.	Transforming services using digital innovation: • Priority Pillars for delivery by 2020 to 2024; • Delivered and proposed activity to support the Blueprint programme • Resources required
5.	Empowering our workforce: Metrics
6.	Delivering best financial value: Financial projections
7.	Born Well: Maternity services • Key deliverables • Workforce requirements • Digital requirements • Estates requirements • Finance requirements • Activity and performance
8.	Grow well: Children and young people • Key deliverables • Workforce requirements • Digital requirements • Estates requirements • Finance requirements • Activity and performance
9.	Mental health • Key deliverables • Rehabilitation Pathway • i-Thrive Model
10.	Birmingham Suicide Prevention Strategy (draft), 2019-2024
11.	Solihull Suicide Prevention Strategy 2017-2021
12.	Learning disabilities and autism key deliverables
13.	Quality and Equality Impact Assessment, October 2019
14.	Birmingham and Solihull Primary Care Strategy 2019/20 – 2023/24
15.	Strategic Planning Metrics Tool