







BLACK COUNTRY AND WEST BIRMINGHAM

PROVIDER COLLABORATION BOARD UPDATE

Briefing Paper to Birmingham and Sandwell Joint Overview and Scrutiny Committee

- 1.1 The purpose of this briefing paper is to provide an overview of Provider Collaboratives, detailing the structure of the Black Country Acute Provider Collaborative Programme and timescales.
- 1.2 In August 2021, Interim guidance on the functions and governance of the integrated care board was published by NHSEI. In this document, The core aims of the Integrated care system are defined as
 - I. improve outcomes in population health and healthcare
 - II. tackle inequalities in outcomes, experience and access
 - III. enhance productivity and value for money
 - IV. help the NHS support broader social and economic development.
- 1.3 The guidance document refers to Providers and provider collaboratives and sets out the expectation that from April 2022, all trusts providing acute and or mental health services are to be part of one or more provider collaboratives.
- 1.4 A further document titled 'working together at scale: guidance on provider collaboratives' was also published. This specified that provider collaboratives are partnership arrangements involving at least two trusts working at scale across multiple places with shared purpose and decision making arrangements to
 - I. reduce unwarranted variation and inequality in health outcomes, access to services and experience
 - II. improve resilience by, for example, providing mutual aid
 - III. ensure that specialisation and consolidation occur where this will provide better outcomes and value.
- 1.5 A core driver for implementation of provider collaboratives is due to the ways providers have successfully worked together during the pandemic and demonstrated the types of benefits working at scale can have. This may be in reducing unwarranted variation in outcomes and access to services, or in creating greater resilience across systems by providing mutual aid and supporting where there may be workforce issues.
- 1.6 Development of a provider collaborative between the four acute hospital trusts in the Black Country and West Birmingham commenced in December 2020. Since then, a programme of work has developed centring on clinical services and back office as improvement programmes, with a range of enabling work streams covering IT, workforce, governance, intelligence and communications (appendix one).
- 1.7 During 2021 the programme went through an intelligence and data gathering phase where trusts highlighted the sustainability of a range of services on the basis of the following domains:
 - I. Quality and Safety
 - II. Performance









- III. Demand and Capacity
- IV. Workforce
- V. Financial Viability
- VI. Strategic Fit
- VII. Partnerships
- 1.8 A self-assessment process produced a range of outcomes between the four trusts. It identified fifteen clinical specialities, which would form the basis of the clinical service work stream going forward. From these specialities, the programme has appointed system wide clinical leads to drive forward a programme of change, improvement and collaboration. In some cases these networks are well established, such as urology however for many others this is a new way of working.
- 1.9 Engagement with clinicians within these specialities has been positive and the next stage of the programme is to identify areas where teams can make improvements through more detailed data analysis and trust GIRFT (Get It Right First Time) reports. It is envisaged that this will develop over the next six months into a clinical case for change in some specialities; in many others, it will simply focus on supporting clinical teams to produce more local improvements and changes.
- 1.10 Each Clinical Network has had their initial meetings and have started to develop their priority areas. One key theme is around stabilisation of workforce through advanced practice, workforce modelling, joint recruitment or local training programmes. There is clinical interest in ensuring services which are typically provided out of region are developed and supported within the Black Country so patients do not have to travel as far. There is also a strong focus on how teams can use surgical hubs or other models of delivery to reduce waiting times, which have risen since COVID was identified in 2020.
- 1.11 Over the next six months the focus will be to shape these priorities into a deliverable programme of improvement that is sustainable and grows services in the long term as well as identifying changes which could be implemented quickly and have an immediate impact.
- 1.12 Once the programme details have become more established, stakeholder and patient engagement will be a key element of the next phase of development.









Appendix 1- Programme Overview and Workstreams

	Diane Wake (DGFT)	Programme Board (Oversight & Accountability) Oversee delivery, assurance to sovereign Boards and STP/ICS Board; Hold programme leads to account; Challenge and drive ambition; Agree scope, priorities, plan and resources; Manage and mitigate overall risk; Align to and influence system priorities; Monthly meeting until established (review at 6 months)
	Simon Evans (RWT)	Governance & Implementation Sub-group (Delivery) Ensure all work programmes are well governed, planned, resourced and on-track and that all interdependencies are appropriately managed; communication and engagement is appropriate and that all risks are captured and mitigated. Ensure programme Director and PMO are held to account; Weekly meeting to include Programme Director and Executive Leads (Katherine Sheerin, Glenda Augustine, Simon Ev., and Dave Baker; PMO to be invited as established and required
	Jonathan Odum (RWT) and Diane Wake (DGFT)	Clinical improvement Programme (Transformation oversight; engage and empower clinicians) Drive clinically driven ambitious vision for collaboration which improves patient outcomes & experience, implementing evidence based pathways which reduces unwarranted variation, develop services and utilise peer review to implement evidence based pathways and drive forward quality improvement through clinical engagement & shared clinical leadership. Clinical priorities tbc: 1. Agree scope; essential place services aligned to ICPs; and sustainably vulnerable services (i.e. workforce or scale/demand) to develop centres of excellence and agree/implement plans and develop joint STP/ICS Clinical Strategy 2. Improve cancer pathways and outcomes (align to Cancer Board) 3. Clinical leadership; infrastructure and dedicated resources to support delivery i.e. Appropriate delivery workstreams & projects, Clinical Leadership, PMO, digital, estate, workforce, data, diagnostics etc
	Glenda Augustine (WHT)	Intelligence, Insight and Outcomes Programme (Support Clinical Transformation) Ensure systematic peer review process using data to improve through clinically engaged, evidence based programme to remove unwarranted variation in access, outcomes and experience and link to system partners e.g. public health/ICPs/Mental Health (demand & capacity review; waiting lists; performance variances; model hospital; GIRFT; Mutual aid; COVID recovery; CQC; Quality Improvement methodologies to empower clinicians etc.); monitor benefit realisation; support continuous evidence based improvement
sampled ook or	Alan Duffell (RWT)	Leadership/Workforce Programme (overseen by People Board – Alan Duffell) Compelling shared vision for the collaboration and consistent simple messaging for staff and stakeholder. Provide an inspiring collaboration for our current and future workforce; Invest in leadership relationships and culture; Shared value and behaviours; Support Clinical Improvement priorities with data & resources as required to improve sustainability; Leadership development – once established consideration of any dedicated Acute Care Collaboration work required
	Tom Jackson (DGFT)	Shared efficiency & infrastructure programme (overseen by System DoFs – James Green) Improve system working to enable clinical improvement and sustainability. Identify and jointly agree and implement priorities with biggest impact. Consider shared teams and resources to deliver STP/ICS priorities whilst maintaining BAU. Consider shared financial controls and opportunities. Oversight through DoFs and delivery through DDoFs and additional functions as required. Scope opportunities and benefits and put plans in place to deliver. Priorities for Acute Care Collaboration to resource programme, particularly PMO and analytical/BI resource. Utilise and link to existing digital, estates etc work programmes. Develop system-wide CIPs.









Appendix 2: Clinical Improvement Programme Timeline

