CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

20 July 2016

Time 12.30 pm **Public Meeting?** YES **Type of meeting** Oversight

Venue Committee Room 3 - 3rd Floor - Civic Centre

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Agenda

Part 1 – items open to the press and public

Item No. *Title*

MEETING BUSINESS ITEMS - PART 1

1 **Apologies for absence (if any)**

2 **Notification of substitute members (if any)**

3 **Declarations of interest (if any)**

4 **Minutes of the previous meeting** (Pages 5 - 14)
[To approve the minutes of the previous meeting as a correct record]

5 **Matters arising**

6 **Summary of outstanding matters**
[Viv Griffin, Service Director - Disability and Mental Health, to present report on summary of outstanding matters]

7 **Health and Wellbeing Board Forward Plan 2016/17** (Pages 15 - 16)
[Viv Griffin, Service Director - Disability and Mental Health, to present report]

8 **How can the Council, hospital and CCG work more effectively together? verbal report (Chair)**
[Cllr Roger Lawrence, The Leader, to give verbal report]

9 **Making prevention everyone's business - Public Health Overview** (Pages 17 - 20)
[Ros Jervis, Service Director Public Health & Wellbeing, to present report]

10 **Merit Vanguard - Black Country Partnership NHS Foundation Trust** (Pages 21 - 36)
[Karen Dowman/Jo Cadman,Black Country Partnership Foundation Trust, to present report]

11 **Wolverhampton Local Digital Map** (Pages 37 - 92)
[Stephen Cook, Senior IM & T Project Manager Wolverhampton CCG, present asking HWBB to approve a plan to integrate patient online records]

12 **Sustainability and Transformation Plans (STP) 2016/17 update - 2020/2021** (Pages 93 - 134)
[Steven Marshall, Director of Strategy & Transformation, Wolverhampton CCG, to present report]

13 **Revised Mission Statement** (Pages 135 - 138)

[Ros Jervis, Service Director Public Health & Wellbeing,to present joint report)

14 **Director of Public Health Annual Report 2015 16 - Presentation** (Pages 139 - 142)
[Ros Jervis, Service Director-Public Health and Wellbeing Public Health, to present report]

15 **Minutes from sub Group (Children's Trust Board)** (Pages 143 - 146)

[For information]

Information which is likely to reveal the identity of an individual. Para (2)

16 **Information and update item**

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CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

Agenda Item No: 4

Minutes - 27 April 2016

Attendance

Members of the Health and Wellbeing Board

Councillor Sandra Samuels OBE	Chair, Cabinet Member for Health and Wellbeing
Councillor Val Gibson	Cabinet Member for Children and Young People
Ros Jervis	Service Director - Public Health and Wellbeing
Councillor Paul Singh	Shadow Cabinet Member for Health and Wellbeing
Councillor Roger Lawrence	Leader of the Council
Dr Helen Hibbs	Wolverhampton Clinical Commissioning Group
Professor Linda Lang	Wolverhampton University

Employees

Carl Craney	Democratic Support Officer
Glenda Augustine	Consultant in Public Health, Community Directorate
Viv Griffin	Service Director - Disability and Mental Health
Emma Bennett	Service Director - Children and Young People
Helen Child	Chief Officer, Wolverhampton CAB
Donald McIntosh	Chief Officer
Tony Marvell	Transformation Programme Manager
Neeraj Malhotra	Consultant in Public Health
Kevin Pace	HeadStart Programme Manager
Steven Marshall	Director of Strategy & Transformation
David Martin	Wolverhampton Samaritan's
Sara Goodwin	Interim Democratic Services Manager

Part 1 – items open to the press and public

Item No. *Title*

1 **Apologies for absence (if any)**
Apologies for absence had been received from Cllr Elias Mattu (City of Wolverhampton Council), and Jeremy Vanes (Royal Wolverhampton NHS Trust) together with David Laughton CBE (Royal Wolverhampton NHS Trust).

2 **Notification of substitute members (if any)**
Mike Sharon attended as a substitute member for Jeremy Vanes (Royal Wolverhampton NHS Trust).

3 **Declarations of interest (if any)**
No declarations of interest were made relative to items under consideration at the meeting.

4 **Minutes of the previous meeting**

Resolved:

That the minutes of the meeting held on 10 February 2016 be confirmed as a correct record and signed by the Chair.

5 **Matters arising**

With reference to Minute No. 5 (Matters arising), the Chair, Cllr Sandra Samuels OBE enquired whether a copy of the hyperlink with a supply of fliers on the "Beat the Streets" initiative had been forwarded to Ian Darch for onward transmission to voluntary sector organisations. Ros Jervis, Service Director – Public Health and Wellbeing confirmed that the hyperlink and a supply of fliers had been forwarded on.

With reference to Minute No. 5 (Matters arising) and following a question from the Chair, the Service Director – Public Health and Wellbeing confirmed that the attention of the JSNA Working Group had been drawn to the possible inclusion of the issue of TB within the emerging JSNA.

With reference to Minute No.10 (Joint Strategy for Urgent Care – Equality Analysis – Implementation of recommendations), Steven Marshall, Wolverhampton City Clinical Commissioning Group undertook to ensure that the relevant data in relation to training on equality and diversity undertaken by employees of WCCCG and RWT was provided to the Independent Chair of the Children's and Adults Safeguarding Boards.

With reference to Minute No. 13 (Francis Inquiry – progress on implementing recommendations), Helen Hibbs, Wolverhampton City Clinical Commissioning Group reported that work was on-going on the development of a quality and safety framework and that the outcome would be reported to a future meeting with a view to quarterly reports being submitted to the Board.

With reference to Minute No. 15 (NHS Planning and Strategic Transformation Plan 2016/17), Linda Sanders, Strategic Director – People reported that the next meeting in connection with this matter was scheduled to be held on Friday 29 April 2016.

6 **Chair's Update**

i) Matters considered by the Health and Wellbeing Board during the 2015/16 Municipal Year

The Chair circulated a document which outlined the matters considered by the Health and Wellbeing Board during the current Municipal Year.

ii) Workplace Wellbeing Award

The Chair reported that the City of Wolverhampton Council had entered the Workplace Wellbeing Award in connection with the work undertaken to address obesity in the City. The Service Director – Public Health and Wellbeing advised that the City of Wolverhampton Council, the University of Wolverhampton and the Royal Wolverhampton NHS Trust were working together on this initiative and that the former two organisations had been awarded Chartermark status with the latter organisation undergoing its assessment currently.

iii) "Sugar Tax"

The Chair referred to the Chancellor of the Exchequer's recent announcement in connection with the imposition of a sugar tax which would lead to a levy of between 18p and 20p being introduced on sugary drinks during 2017.

iv) "Beat the Streets"

The Chair reminded the Board that the "Beat the Streets" initiative had been launched on 27 February 2016 for a period of seven weeks. 190 Beat Boxes had been erected around the city with some 60,000 cards being made available. 78 schools and 21 community organisations had registered to participate with a total of 27,000 players registered. A sum of 196,395 miles had been walked / run collectively. She reported that awards had been made to Dovecotes Primary School (414,580 points), St Lukes Church of England School (316,800 points) and D'Eyncourt Primary School (231,000 points). Prizes had also been awarded to teams with the highest points per player with the City Economy Division of the City of Wolverhampton Council finishing in first place with 2145 points per player, Walking for Health group finishing second and TLC College and Nursery finishing in third place. It was hoped to repeat the initiative again next year subject to funding being available.

v) Lord Bilston Challenge

The Chair reported that the son of the late Lord Bilston was organising a 5 kilometre walk around Hickman Park, Bilston to raise funds for Compton Hospice. Anyone wishing to take part should meet outside the office of Pat McFadden MP on Saturday 30 April 2016. Further details were available from her following the meeting.

vi) Partnership and Sport

The Chair reported that an event was being held on 10 June 2016 at Aldersley Stadium on "partnership and Sport" when elen different activities would be available. It was hoped that over 800 primary aged children would participate.

7 **Summary of outstanding matters**

Viv Griffin, Service Director – Disability and Mental Health presented a report on the current position with a variety of matters considered at previous meetings of the Board. Dr Helen Hibbs advised that responsibility for the NHS Capital Programme was now with the Wolverhampton City Clinical Commissioning Group and that the report should be amended accordingly.

Resolved:

That the summary of outstanding matters be noted subject to responsibility for future reports on the NHS Capital Programme – GP practices in Wolverhampton being marked as the responsibility of Mike Hastings at the Wolverhampton City Clinical Commissioning Group.

8 **Health and Wellbeing Board Forward Plan 2015/16**

The Service Director – Disability and Metal Health presented a report on the Forward Plan for the Board. She reported that the report would be refreshed for the forthcoming Municipal Year to include regular reports on matters such as: i) Better Care Fund and ii) NHS Planning Guidelines – Strategic Plan 2016/17 and 2020 Integration Plan. Steven Marshall, Wolverhampton City Clinical Commissioning Group suggested that the latter item be retitled as "Sustainable Transformation Plan"

Resolved:

That the report be received and noted.

9 **Health and Wellbeing Board - Mission Statement**

The Service Director – Disability and Mental Health presented a Mission Statement for the Board's consideration. She reported that the Joint Strategic Needs Assessment (JSNA) was to be considered later in the meeting with the revised Health and Wellbeing Strategy due for consideration at the next meeting. The Mission Statement, once adopted, would sit at the front of the Strategy. She explained that the Mission Statement was intended to reflect the life cycle and through strategic working would include prevention and integration issues. The Service Director – Public Health and Wellbeing circulated a further copy of the Mission Statement which set out the aspirations and intentions more clearly.

Mike Sharon suggested that the issue of "childhood Obesity" was given overdue prominence in the Mission Statement. The Strategic Director – People opined that this issue should, in any event, be re-badged as "Prevention of Childhood Obesity". Steven Marshall commented that a more holistic approach was required in terms of "Child and Adolescent Mental Health" as this currently did not appear to address the aspect of "wellbeing". Similarly, he suggested that "Dementia Care" should include reference to promoting independence. The Service Director – Public Health and Wellbeing reminded the Board that the main issues to be included within the Mission Statement had been identified at the Workshop Session held on 7 October 2015. Professor Linda Lang suggested that a link needed to be included with the "adult population" and the topic of "Dementia Care." The Service Director – Disability and Mental Health advised that the term "Mission" should be replaced with "Priorities". The Chair commented that the Mission Statement was in relation to health and social care generally and not solely the work of the Board.

Resolved:

That the Mission Statement be amended in accordance with the comments now made, re-circulated via email to Board Members and that a further report on the matter be submitted to the next meeting of the Board.

10 **Joint Strategic Needs Assessment (JSNA) - Update**

The Strategic Director – People reported that Strategic Joint Needs Assessments (JSNA's) had now been in existence for eight / nine years and that the aim with the refreshed JSNA for Wolverhampton was for it to be used pro-actively by Commissioners in the health and social care economy as an easily accessible point of reference available as an e.document. She suggested that there was a need for the document to include information regarding cultural and ethnicity issues together with details of sensory impairments both in terms of current and future trends. She thanked all those individuals and organisations who had been involved in the production of the refreshed document.

The Service Director – Public Health and Wellbeing presented a report which provided the Board with an update on the progress of the development of the JSNA. She commented that revising a comprehensive document such as the JSNA was a major piece of work and that every effort had been made to highlight gaps in the current document. She referred to Appendix 2 to the report and the following seven chapters. She explained that there was a need for the issue of "safeguarding" to be embedded in the refreshed JSNA and also for the topics in the various chapters to be covered fully. Inequalities needed to be readily acknowledged to enable them to be addressed and for commissioning processes to reflect the information within the JSNA.

Glenda Augustine, Advanced Health Improvement Specialist: Needs Assessment gave a PowerPoint presentation on the contents of Chapter 2 of the JSNA – Life Expectancy and invited comments on the visual contents of the document. She advised that the intention was for the JSNA to be the “go to” document i.e. the first point of reference for all health and social care professionals.

The Chair apologised for the small font in the document. The Strategic Director – People also suggested that blocks of text should be avoided and that there was a need for careful reflection on the content and order.

Donald McIntosh advised that he was happy with the process which had been used to update the document and suggested that it could benefit from the use of case studies or patient stories as examples of the patients journey, which could include examples of referral patterns. The Service Director – Public Health and Wellbeing commented that the term “Patient Voice” be amended to “Resident Voice”.

Alan Coe referred to Section 5.1 of the document and on the need for the same terminology to be used in Section 6 for the sake of consistency. With reference to Section 6.7 he commented that the term “Patient voice” be amended to “Citizen’s voice”.

Helen Child referred to Chapter 1 insofar as it referred to “Indebtedness in the City” and commented that reference needed to be made to the use of food banks and soup kitchens. With regard to Chapter 6.2.3 “Social isolation – Adult social care users and carers” she opined that as written the text referred only to service users and needed to be expanded in the broadest sense.

The Strategic Director – People was of the opinion that greater reference needed to be made to the University of Wolverhampton within the document given that many local authorities did not have such a resource to draw upon. She cited the assistance provided by the University on topics such as dementia, children and young people and connections with schools, inequalities, social wellbeing and obesity. She also opined that the section addressing “migration / immigration” should be expanded.

The Chair invited the Board to consider whether the membership of the JSNA Steering Group was adequate. It was generally felt that the University of Wolverhampton and the Third Sector Partnership should be invited to participate in the work of the Steering Group. Alan Coe advised that Stephen Dodd, as the Wolverhampton Voluntary Sector Council would also represent the Safeguarding Boards but suggested that a representative from the Regulatory Services of the Council should be included. The Strategic Director – People counselled caution on expanding the membership too widely especially as a lot of contributions were made to members of the Group from non-members. Donald McIntosh invited the Board to consider including a representative from the Inter Faith Group to join the Steering Group. The Advanced Health Improvement Specialist: Needs Assessment reminded the Board that a number of Task and Finish Groups would also be appointed to work on specific areas of the document.

Resolved:

That subject to the above points the progress and initial outputs of the Joint Strategic Needs Assessment (JSNA) be approved.

11 **Infant Mortality Scrutiny Review - Update**

The Service Director – Public Health and Wellbeing presented a report which updated the Board on the implementation of the recommendations of the Infant Mortality Scrutiny review which had been undertaken from July 2014 to March 2015 to gather evidence in relation to the high rate of infant mortality in Wolverhampton. She explained that this was an on-going process and that proxy measures had been put in place for issues such as smoking during pregnancy and encouraging pregnant ladies to stay in a smoke free environment.

A shared event with the Lullaby Trust was to be staged which would include participation from across all services and that a general willingness to take part had been evident. Work with the Royal Wolverhampton NHS Trust was continuing with a view to making the New Cross Hospital site smoke free and examples of best practice from other NHS Trusts were being sought. She advised that an annual report on Infant Mortality would be submitted to the Council's Scrutiny Board. The Chair referred to the whole system approach which had been adopted on this issue and thanked all those who had been involved in the work. Sher advised the Board that Infant Mortality rates had fallen from 7:1,000 between 2010 and 2012 to 6.4:1,000 in 2014 albeit that this was still ahead of the national average.

Mike Sharon acknowledged the comments made by the Service Director – Public Health and Wellbeing and confirmed that the staff of the Royal Wolverhampton NHS Trust were committed to the Strategy. He reported that a number of "Reducing Risks" programmes were being held with 1:1 sessions available. He confirmed that the experience of other NHS Trusts in introducing "smoke free" sites were being investigated. Dr Helen Hibbs commented that this was a positive piece of work but suggested that more work was required to be undertaken with General Practitioners and Health Visitors who were often the first point of contact in Primary Care. Donald McIntosh supported this suggestion and opined that similar work with Pharmacists would be equally beneficial. He referred to recommendation 8 and suggested that this be replicated and include examples of good practice.

Resolved:

1. That the progress in implementing the recommendations from the Infant Mortality Scrutiny Review that concluded in March 2015 be noted;
2. That the suggestions referred to above be included within the Strategy.

12 **Update on Suicide Prevention**

Neeraj Malhotra, Public Health Consultant (Transformation) presented a report and gave a PowerPoint presentation which informed the Board on the progress made in relation to the requirements outlined in the national suicide prevention strategy "Preventing Suicide in England: A Cross Government outcomes Strategy to Save Lives". In particular, the report detailed progress in relation to Mental Health and Suicide Prevention Needs Assessment" which had been completed jointly with Wolverhampton Samaritans, the establishment of a multi-agency Wolverhampton Suicide Prevention Stakeholder Forum and the development of a Suicide Prevention Action Plan for Wolverhampton. She confirmed that West Midlands Police and the Voluntary Sector had been involved actively in the production of the Action Plan.

She explained that there was an increasing need to reach out to white males and to some ethnic minority groups who were highly susceptible to suicide attempts. She advised that attempted suicide was often associated with social deprivation but was not so closely linked to this as some other health issues. She reported that the majority of cases had not been known previously to "Specialist Services".

Dr Helen Hibbs enquired as to whether any data was available as to if potential cases had made contact with Primary Health Care in order to seek support. The Public Health Consultant (Transformation) undertook to analyse the available data.

David Martin confirmed that the Wolverhampton Branch of The Samaritans confirmed that this organisation was committed fully to the Action Plan and explained the organisations involvement in its formulation. This included the adoption of Public Health England guidelines on suicide prevention. He reported that the cost to the local economy of cases of suicide exceeded £1 million. He reported further that there were six steps to reducing incidences of suicide and that the first three had now been addressed. The remaining three steps were being tackled robustly including working with Pharmacies, Network Rail and British Transport Police. Work was also on-going with the media with a view to positive messages being issued.

Cllr Roger Lawrence commended the work that had been undertaken on this issue and advised that it was a topic which was raised often with him during Councillor Surgeries and whilst conducting his role as Leader of the Council. Professor Linda Lang confirmed that the University of Wolverhampton worked closely with the Wolverhampton Branch of The Samaritans and other Charities in order to signpost individuals and groups to relevant services.

David Martin advised that his organisation also worked closely with other charitable organisations but commented that the “Mental Health Resource Directory” was not an easy tool to use, especially for those in desperate circumstances. He suggested that this was an issue which needed to be addressed.

The Public Health Consultant (Transformation) reported that 53 individuals had received training in respect of signposting to appropriate services. Donald McIntosh advised that Healthwatch Wolverhampton was also undertaking work on public wellbeing.

Resolved:

1. That the overall partnership approach taken to suicide prevention be endorsed;
2. That the establishment of a Suicide Prevention Stake holder Forum be approved and that the Forum be charged with improving the Mental Health Resource Directory;
3. That the Suicide Prevention Action Plan be approved;
4. That the inclusion of suicide prevention work as an additional workstream within the Crisis Concordat programme be approved;
5. That the Suicide Needs Assessment be noted;
6. That compliance with national requirements for a suicide audit / needs assessment stakeholder forum and action plan be noted;
7. That the early progress made to date on the action plan tasks be noted.

13 **Headstart Stage 3 Bid**

The Service Director – Metal Health and Disability explained the digital version of the bid for future funding for Headstart Stage 3. Kevin Pace, Headstart Programme Manager gave a PowerPoint presentation on the contents of the bid. He outlined a number of issues including:

- Currently the Children and Adolescent Mental Health Service (CAMHS) was overburdened with requests for assistance which placed many young people

in a position of believing that their case was not urgent enough to receive assistance;

- The need to identify those young people most at risk;
- The four geographical areas in the city would each have a Hub including a Police Community Support Officer (re-named as Community Support Worker) attached to it;
- The intention to build community and family capacity to respond to mental health issues;
- Undertaking work with schools on a whole system change approach in order to identify warning signs of potential problems.

The Service Director – Mental Health and Disability reported that a presentation would be made to the Bog Lottery Board in late May with the outcome being known in June 2016 with a potential award of £8.8 million. The Strategic Director – People informed the Board that work on this issue had been shortlisted for an award by the Municipal Journal. Professor Linda Lang advised that she was delighted that the University of Wolverhampton had been involved in this particular piece of partnership work. Cllr Val Gibson, on behalf of the Board, expressed her thanks to all those involved in the Headstart Stage 3 Bid.

Resolved:

That the report be received and noted.

14 **Better Care Fund 2016/17 outline plan**

The Service Director – Disability and Mental Health presented a report which updated the Board on the progress towards the establishment of a Section 75 Agreement between the City of Wolverhampton Council ("CWC") and the Wolverhampton City Clinical; Commissioning Group (WCCCG) for the purpose of delivering the Better Care Fund in the business year 2016/17. She reported also on progress for developing the 2016/17 delivery plan. She reminded the Board that it had been agreed previously that final approval of the 2016/17 Better Care Fund delivery plan had been delegated to the Chair, Cllr Mattu with advice from the Director of Strategy and Transformation, WCCCG (Steven Marshall) and Better Care Fund Leader for "CWC" (Service Director for Disability and Mental Healthy – Viv Griffin). She confirmed that the final bid was due for submission.

The Strategic Director – People reported that the report was commended by Cllr Elias Mattu. She suggested that the final bid included details of examples of end of life care and that this issue be looked at holistically during 2017/18. Steven Marshall, Director of Strategy and Transformation, WCCCG advised that end of life care was often provided by District Nurses but that a number of other individuals and organisations were also involved. He commented that a comprehensive review of end of life care and palliative care was required.

Donald McIntosh opined that there were risks associated with the achievement of some of the objectives within the Agreement. The Strategic Director – People reminded the Board that Healthwatch Wolverhampton was a member of the Better Care Fund Board. The Director of Strategy and Transformation commented on the need to recognise the involvement of the Royal Wolverhampton NHS Trust in the delivery of many of the services within the Agreement. The Strategic Director – People advised that she was of the opinion that the Agreement would be approved without any additional conditions being imposed by NHS England.

Resolved:

1. That subject to the above amendments, the progress towards the development of the Section 75 Agreement between the City of Wolverhampton Council (CWC) and Wolverhampton City Clinical Commissioning Group be noted;
2. That the arrangements for the final submission to NHS England of the Wolverhampton Better Care Fund 2016/17 delivery plan be noted.

15 **Children's Trust Board - Progress Report**

Cllr Val Gibson, Cabinet Member for Children and Young People presented a report which provided the Board with an update on progress with the Children, Young People and Families Plan (2015 – 25). She explained that the Plan had been aligned with the Health and Wellbeing Board Strategy and that the structure of the Children's Trust Board had been reviewed. The Plan now concentrated on early intervention. A Stakeholder Event had been held on 8 March 2016 which had been attended by over 80 delegates including representatives of young people. The Event had included a session with Wolverhampton Homes on the subject of homelessness and this matter would be considered further at a future meeting of the Children's Trust Board.

Dr Helen Hibbs enquired as to the position with recruitment of foster carers' in the city. Emma Bennett, Service Director – Children and Young People reported that some 20 additional foster carers' had been recruited during 2015/16 and a Workshop facilitated by iMPOWER was planned for week commencing 2 May 2016 on that issue. She advised that work was also on-going to align the recruitment process and terms and conditions across the Black Country. Cllr Val Gibson referred to "National Fostering Fortnight" which would include use of the promotional vehicle and also to the regular "Fostering Fridays'" events.

Resolved:

1. That the 2016/17 work programme of the Children's Trust Board be supported;
2. That the necessary reporting and governance arrangements that were in place to oversee progress of the Children, Young People and Families Plan (2015 – 25) be approved.

16 **Feedback on Shadow Combined Authority Mental Health Commission**

The Service Director – Disability and Mental Health presented a report which updated the Board on the progress to date of the Shadow Combined Authority – Mental Health Commission and which raised the profile of the work of the Commission. She advised that the Commission was looking to produce an evidence base with a view to reducing the costs to the public sector. Currently, this work was at the evidence gathering stage with a view to identifying best practice and how improvements could be made. She reported that a Steering Group had been established on which she had been invited to participate. She had been nominated to lead the Employment Sub Group which was seeking how to get people with mental health problems into work and to sustain their employment. A report on the outcomes from the Commission would be submitted to a future meeting.

The Chair referred to the role of Cllr Darren Cooper as the Shadow Combined Authority Leader Champion on the Commission and his recent untimely death.

Mike Sharon commented that the work of the Commission appeared to exclude the work of the Children and Adolescent Mental Health Service (CAMHS). The Strategic Director – People advised that this point had been raised already. The Leader of the Council undertook to follow up this matter and reported that schools and mental health was a further issue which had been identified for consideration.

Resolved:

That subject to the above comments the progress to date with regard to the Shadow Combined Authority – Mental Health Commission be noted.

17 **Consultation on Joint Autism Strategy**

The Service Director – Disability and Mental Health presented a report on the draft Joint Autism Strategy for consideration and comment as part of the consultation process. She explained that the draft Strategy would be subject to a three month consultation exercise and that the Strategy had deliberately crossed over between children and adults. Eight priorities had been identified in the Strategy and that a further report would be submitted to a future meeting.

Helen Child enquired as to whether sufferers of autism had been involved in the development of the Strategy. The Service Director – Disability and Mental Health confirmed this to be the case and, furthermore, that they would also be involved in the consultation exercise.

Resolved:

That the draft Autism Strategy be received.

18 **Minutes from Sub Groups**

Resolved:

That the minutes of the meetings of the Children's Trust Board held on 1 December 2015, the Integrated Commissioning and Partnership Board held on 10 March 2016 and the Public Health Delivery Board held on 15 March 2016 be received and noted.

19 **Chair's Remarks**

The Chair offered her thanks to all members, partners and officers for their contributions to the work of the Board during the current Municipal Year.

CITY OF WOLVERHAMPTON COUNCIL

Agenda Item No: 7

Health and Wellbeing Board Forward Plan 2016/17

19 October 2016:

- Revised Health and Wellbeing Strategy – Ros Jervis
- Headstart stage 3 bid outcome – Viv Griffin
- Better Care Fund overview and 2016/17 Q1 update – Steve Marshall / Head of Strategic Commissioning –
- Autism strategy – Head of Commissioning
- Sustainability and Transformation Plans 2016/17 update – 2020/2021 – Steven Marshall
- CAMHS Transformation and Headstart – priority focus – Viv Griffin / Steven Marshall
- Dementia and Care Closer to Home – priority focus – Tony Ivko
- Social Impact Bonds – Older People's Services – Steven Marshall
- Urgent Care – Integrated Service Model – Steven Marshall
- Primary care strategy update - CCG
- BCF Update - Tony Marvell/Andrea Smith

7 December 2016:

- JSNA Update – Ros Jervis
- Mental Health – Revised Provider Trust Arrangements - Black Country Partnership NHS Foundation Trust
- Sustainability and Transformation Plans 2016/17 – 2020/2021 – Steven Marshall
- Better Care Programme 17/18 – Plan – Viv Griffin / Steven Marshall

Future meeting dates

15 February 2017
12 April 2017

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Agenda Item No: 9

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

20 July 2016

Report title	**Making prevention everyone's business - Public Health overview**	
Decision designation	AMBER	
Cabinet member with lead responsibility	Councillor Paul Sweet Public Health and Wellbeing	
Key decision	No	
In forward plan	No	
Wards affected	All	
Accountable director	Linda Sanders, People Directorate	
Originating service	Public Health	
Accountable employee(s)	Ros Jervis	Service Director for Public Health and Wellbeing
	Tel	01902 550347
	Email	Ros.Jervis@wolverhampton.gov.uk
Report has been considered by	People Leadership Team	11 July 2016

Recommendation(s) for action or decision:

The Health and Wellbeing Board is recommended to:

1. Prioritise the discussion and debate of 'prevention' including the showcasing by all member partners their contribution to the promotion of good health through prevention activities.

1.0 Purpose

1.1 The purpose of this discussion paper is to raise the profile of the prevention agenda across the health and social care system and begin to understand how partners are contributing to health improvement across the City through prevention and how this might be maximised through the collective effort of the Health & wellbeing Board.

2.0 Background

2.1 Last year as members of the Health & Wellbeing Board (HWBB) were discussing a new mission statement it was agreed that 'Prevention' would form an over-arching principle.

2.2 Prevention of a condition or of poor outcomes can be interpreted a number of ways from preventing its occurrence, its progression or the consequences. The example in the table below describes different levels of prevention with regard to the prevention of disease.

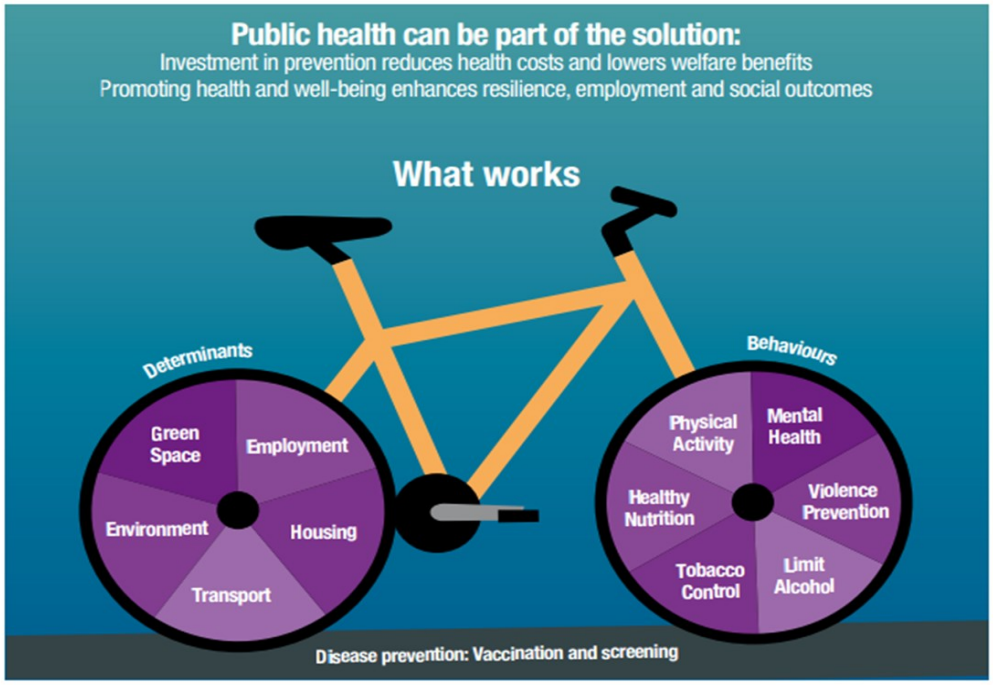
Table 1: Levels of Prevention

Level of Prevention	Definition	Example
Primary	Preventing the onset of disease by reducing risk **'stop it starting'**	Promoting healthy eating and physical activity to prevent obesity and conditions associated with excess weight
Secondary	Detecting asymptomatic disease at an early stage to slow or reverse disease progression **'catch it early and treat'**	Weight management programmes and promotion of physical activity for overweight and obese individuals to prevent development of conditions associated with excess weight
Tertiary	Reduce the damage of symptomatic disease to prevent progressive disability **'minimise consequences'**	Clinical management of obesity induced diabetes and liver disease

Adapted from: Goldston, S. E. (Ed.) (1987) Concepts of primary prevention: A framework for program development. Sacramento: California Department of Mental Health

2.3. Last year, in response to lower than national average life expectancy and healthy life expectancy figures across Wolverhampton the Director of Public Health's annual report launched a prevention plan with a particular focus on lifestyle choices.

It is estimated that around 80% of deaths from major diseases such as heart disease and cancer are attributable to lifestyle factors such as smoking, excess alcohol consumption, lack of physical exercise and an unhealthy diet. To improve life chances and reduce the burden of disease we collectively need to be looking at ways we can make an impact.



Source: WHO (2013)

2.4 The Health & Wellbeing Board holds a unique position across the local health and social care system to begin to bridge the divide between population-based behaviour change at scale (the non-NHS part of the system) and individual behaviour change (the NHS part of the system) and harness the capacity of the whole system to prevent ill health – both of which should be considered to be the front wheel of the bicycle. The HWBBs shared interest in people, families and communities provides the common ground on which collectively we can improve health outcomes in Wolverhampton.

3.0 Next steps for Wolverhampton

3.1 **Clear priorities**: last year's annual report highlighted priorities to reduce infant mortality, heart, lung and liver related disease through action on smoking, the harms caused by excess alcohol consumption, lack of exercise and a healthy diet. However we need to understand how this influences those factors that trigger the need for both adult and children's social care and overall how poor mental health effects the progression of poor health outcomes.

3.2 **Strategies for action**: dedicated prevention work streams that focus on reducing infant mortality, the obesity challenge, tobacco & substance misuse and suicide prevention do exist but could be enhanced through the system leadership of the HWBB.

3.3 **Understanding roles**: clarity of purpose and understanding how member organisations can contribute to and drive a radical upgrade in prevention across the whole system should be prioritised by the HWBB.

4.0 Financial implications

4.1 Any costs associated with the prioritisation of a radical upgrade in prevention will be met by member organisations of the HWBB.
[GS/11072016/N]

5.0 Legal implications

5.1 There are no legal implications related to this discussion paper.
[RB/11072016/F]

6.0 Equalities implications

6.1 Although this discussion paper does not highlight specific equalities issues the prevention agenda does provide opportunity to reduce inequalities particularly in health.

7.0 Environmental implications

7.1 There are no environmental implications of the discussion paper.

8.0 Human resources implications

8.1 There are no human resource implications related to this discussion paper.

9.0 Corporate landlord implications

9.1 There are no corporate landlord implications for the Council's property portfolio in relation to this discussion paper.

10.0 Schedule of background papers

10.1 There are no background papers in relation to this discussion paper.

MERIT

Mental Health Alliance for Excellence, Resilience, Innovation and Training

Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

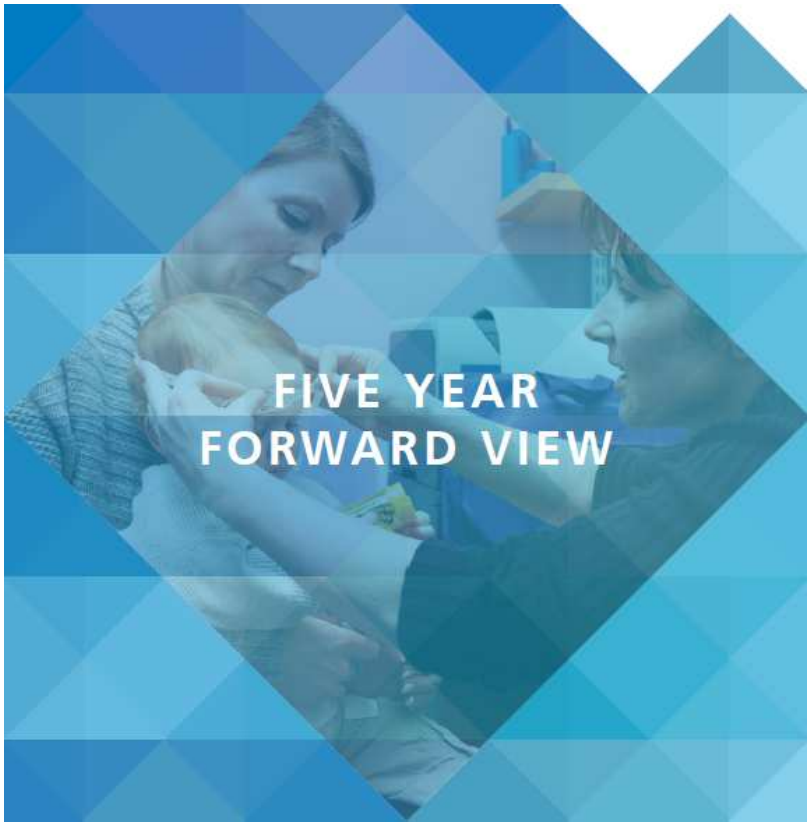
Coventry and Warwickshire Partnership NHS
NHS Trust

Black Country Partnership NHS
NHS Foundation Trust

Dudley and Walsall NHS
Mental Health Partnership NHS Trust

Background: The Five Year Forward View

- Published in October 2014
- A shared vision across seven national bodies
- New care models programme key to delivery
- Focuses on both NHS and care services



Care Quality Commission

Public Health England

NHS England

NHS Health Education England

NHS Trust Development Authority

Monitor

NICE National Institute for Health and Care Excellence

Five new care models

Multispecialty community providers

moving specialist care out of hospitals into the community

Enhanced health in care homes

offering older people better, joined up health, care and rehabilitation services

Integrated primary and acute care systems

joining up GP, hospital, community and mental health services

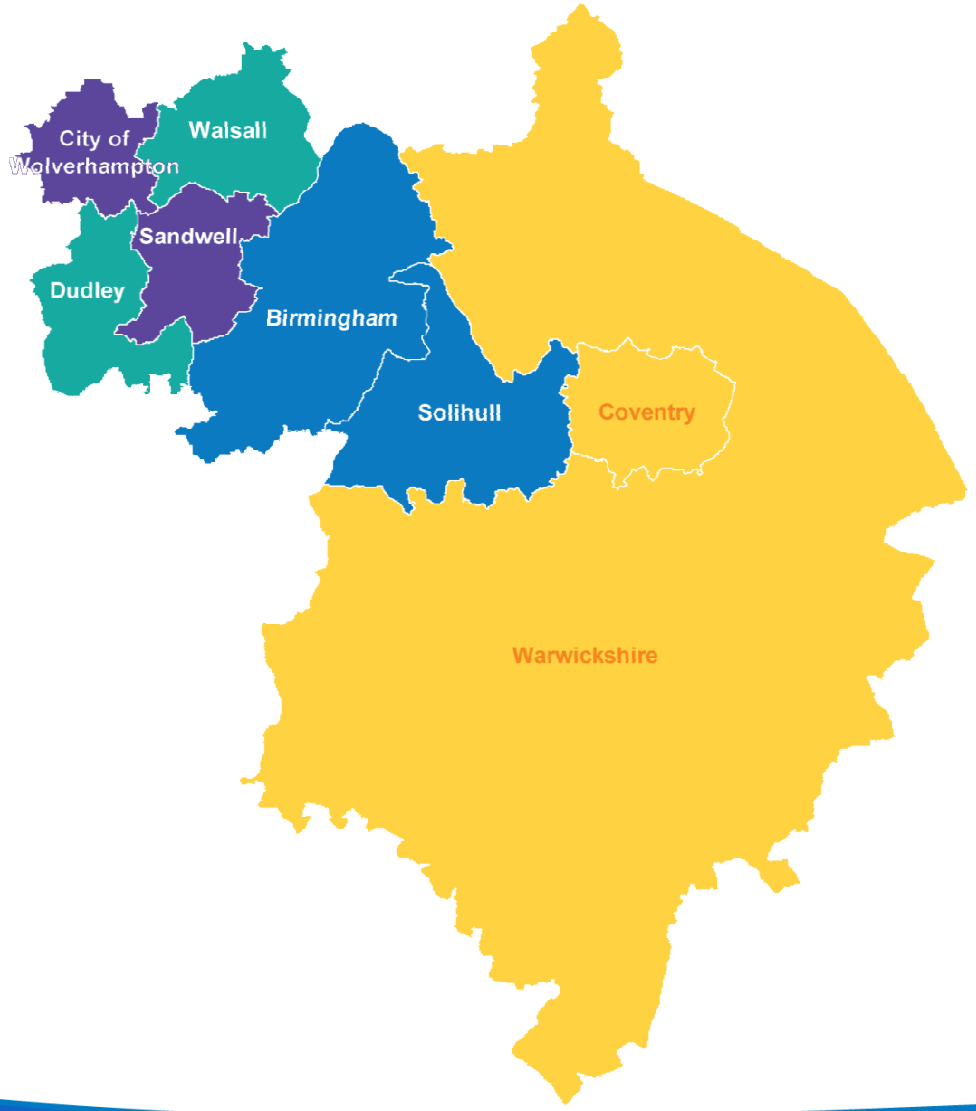
Acute care collaboration

local hospitals working together to enhance clinical and financial viability

Urgent and emergency care

8 new approaches to improve the coordination of services and reduce pressure on A&E departments announced in July 2015

Who is involved in MERIT?



- Birmingham and Solihull Mental Health NHS Foundation Trust
- Black Country Partnership NHS Foundation Trust
- Coventry and Warwickshire Partnership NHS Trust
- Dudley and Walsall Mental Health Partnership NHS Trust

Total population 3.4 million

Why have we come together?

2013 – Review into the death of 16 year old Christina Edkins.

Highlighted the need for:

- Better working together
- Consistency of practice
- Further improvement of quality standards

Why the West Midlands?

- Distinct geographical area
- Urban conurbation – need to make services fit people's lives rather than people fitting around our services
- Similar diverse populations
- West Midlands Combined Authority
- Good relationships
- Examples of current joint working

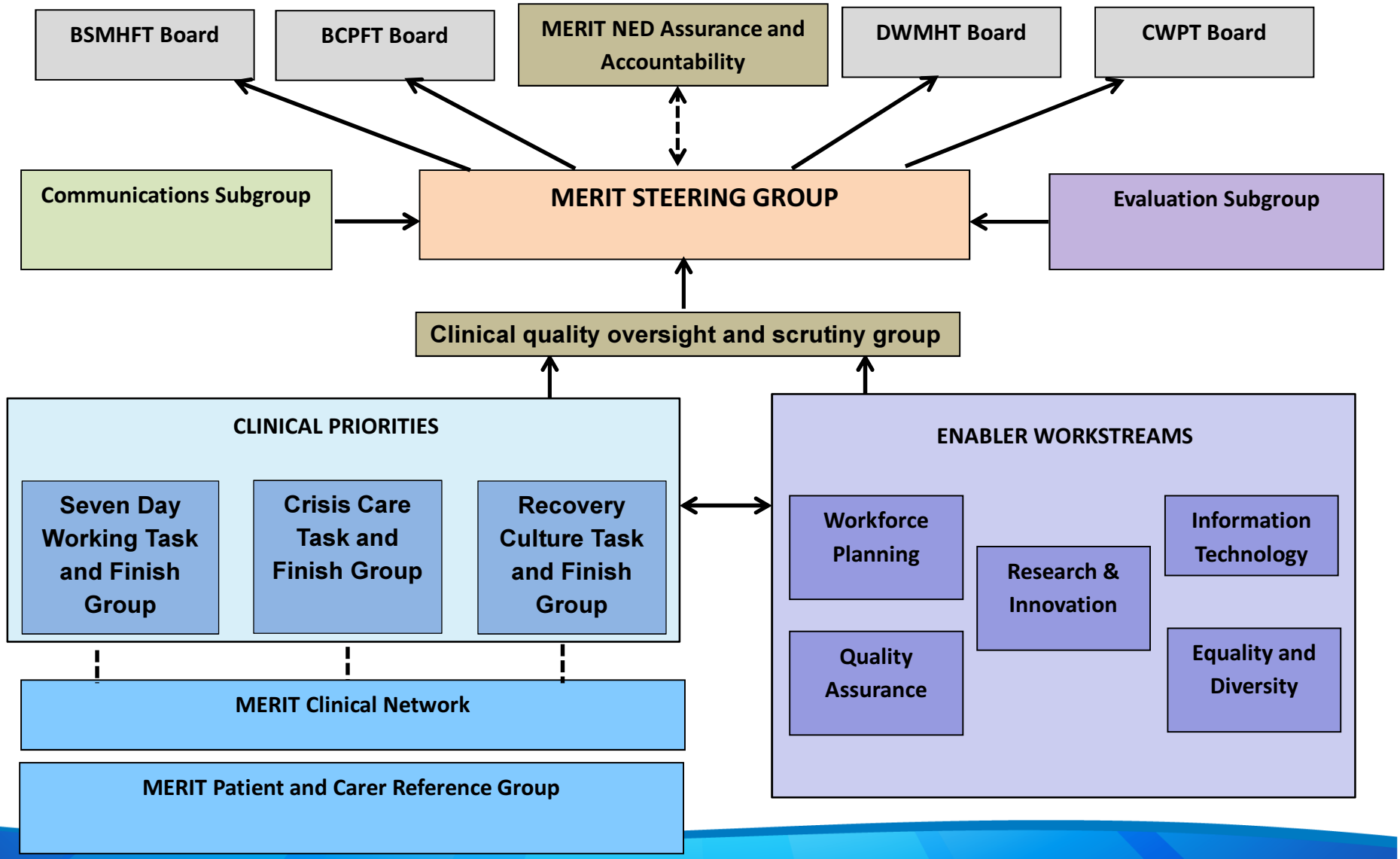
The way forward

- Sovereign organisations with local focus
- Urban model of care
- Reach potential through scale of developments
- Replicability
- Need for new commissioning structures
  - Accountable care?
  - Personal health budgets?

About us

Trust	Population	Income	Staff
Birmingham and Solihull Mental Health NHS Foundation Trust	c1.2 million	£240m	>4,100
Black Country Partnership NHS Foundation Trust	c600,000	£100m	>2,000
Coventry and Warwickshire Partnership NHS Trust	c1 million	£200m	>4,000
Dudley and Walsall Mental Health Partnership NHS Trust	c600,000	£65m	>1,100

Original Governance structure



Revised Plans – April 2016

- National funding reductions - Bid for £3.3m but offered £1.7m
- Funding for 2017/18 onwards through Sustainable Transformational Plans (STPs)
- Reviewed offer – combination of reduced scope, delayed delivery, postponed

Our workstreams

Crisis Care

Across our Alliance we have all of the recognised components of an urgent care system not operating consistently. We will develop a crisis care blueprint for a replicable clinical model that delivers the Crisis Care Concordat for those aged 16 plus. Implementing a single bed management function with streamlined, clear and efficient processes to maximise and increase flexibility of our bed utilisation. Technology used by users to assist clinicians identify those at risk of reaching a crisis

Recovery Culture

Our Alliance will explore different dynamic models/frameworks of rehabilitation and recovery, with a range of stakeholders, including users, carers , clinicians and communities We will review best practice with the aim of reducing dependency, preventing relapse/readmission back to secondary care, and support an increase in take up of personal social care and health budgets. We will work with third sector partners to ensure that our services are the best possible value for money and respond to local needs.

Our workstreams

Research and Innovation

Clinical Programmes will be evidence based through the utilisation of systematic reviews and the devising of a standard evaluation plan. This will lead to further investment of research activity, and thus increased income and publications.

Workforce

Carry out joint workforce planning to allow us to respond quicker and more effectively to national and local issues, including recruitment, retention and new roles.
To develop and deliver joint training programmes and implement shared flexible staffing arrangements to give critical mass and reduction of agency usage.

Quality Governance

Sharing experiences from CQC visits we can implement joint methodology for mock inspections, peer review and programmes of work to ensure all trusts achieve excellent feedback from reviews and patients.

Our workstreams

Information Technology

We will deliver a shared patient record system which will bring clinical benefits and support our standardised crisis and acute care systems.
We will support other workstreams to deliver coordinating contracts, procurement, technical support, knowledge sharing and training.

Equality, Diversity & Inclusion

We will pool our resources to coordinate our work plans, best practice and Equality Impact Assessments leading to greater engagement with mental health services from our communities to support the clinical emphasis on prevention and improved recovery outcomes. We can work jointly on responses to emerging issues.

Engagement

Clinical Network

The Clinical Network will ensure robust clinical engagement and input to the workstreams, ensuring that delivery implementation plans have a clear evidence base and reflect quality and safety principles.
It will contain a range of professional representatives including medical, nursing, psychology and allied health professionals.

Patient and Carer Reference Group

A forum through which the workstreams can engage with patients and carers to ensure ideas are shared and views represented in delivery implementation plans.

Communications Group

Will develop and implement a communications plan ensuring regular channels for internal and external communications to all stakeholders.

MERIT

A mental health trust alliance to transform acute care in the West Midlands

Birmingham and Solihull Mental Health NHS Foundation Trust

Coventry and Warwickshire Partnership NHS Trust

Black Country Partnership NHS Foundation Trust

Dudley and Walsall Mental Health Partnership NHS Trust

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Agenda Item No: 11

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

20 July 2016

Report title	Wolverhampton Local Digital Roadmap	
Cabinet member with lead responsibility	Councillor Sandra Samuels Health and Wellbeing	
Wards affected	All	
Accountable director	Ros Jervis, Wellbeing	
Originating service	NHS Wolverhampton CCG	
Accountable employee(s)	Mike Hastings Tel Email	Associate Director Operations 01902 441811 mike.hastings@nhs.net
Report to be/has been considered by	NHS Wolverhampton CCG Governing Body	12 July 2016

Recommendation(s) for action or decision:

The Health and Wellbeing Board is recommended to:

1. Approve the Wolverhampton Local Digital Roadmap

1.0 Purpose

1.1 NHS England has set out a number of criteria for the approval of Local Digital Roadmaps one of which is local approval at the Health and Wellbeing board. This will then allow the organisations within the LDR (Wolverhampton CCG, Wolverhampton City Council, Royal Wolverhampton Trust and Black Country Partnership Foundation Trust) to access technology enablement funds.

2.0 Background

2.1 In September 2015, a three-step process began to allow local health and care systems to produce Local Digital Roadmaps (LDRs) by 30 June 2016, setting out how they will achieve the ambition of 'paper-free at the point of care' by 2020.

The first step was the organisation of local commissioners, providers and social care partners into LDR footprints.

The second step was for NHS providers within LDR footprints to complete a Digital Maturity Self-assessment. Both of these steps have now been completed and each LDR footprint has been asked to develop and submit its own Local Digital Roadmap by the deadline of June 2016.

3.0 Current Situation.

3.1 NHS Wolverhampton CCG is the lead organisation for the Wolverhampton LDR. The other organisations involved are Royal Wolverhampton Trust, Black Country Partnership Foundation Trust, Wolverhampton City Council and West Midlands Ambulance Service.

The CCG has been working with our partner organisations to develop the Digital Roadmap based on the Universal Capabilities and the results of the Digital Maturity indexes that were completed by our partner organisations.

Wolverhampton CCG will present the Wolverhampton LDR to the NHS Local Area Team on the 20 July 2016 with representation from our partner organisations for review and sign off. A signed off LDR will be a condition for accessing investment for technology enabled transformation funds.

The Universal Capability Delivery Plan, Wolverhampton Information Sharing approach and the Wolverhampton Capability Trajectory are attached to this report, below overview of the key projects linked to the programme.

- The development of a shared care record across the whole health a social care economy within Wolverhampton

- The rollout of patient online services to Patients so they can access their own records, book appointments and order repeat prescriptions.

- The Continued development of e-referrals and the addition of referring to the mental health trust electronically formatting of electronic discharges along Royal College headings and the introduction of electronic discharges from BCPFT.

- The expansion of e-referrals to social care.

- The inclusion of Child Protection information within unscheduled care settings.

- A project to initially populate Graphnet with Patients end of life preferences which will then look to develop a shared end of life plan that can be accessed by clinicians linked to a patient with read and write access.

- Continued development of the existing EPS project to increase utilization within Wolverhampton.

4.0 Financial implications

4.1 The scale and scope of the programme of work will be dependent on the allocation of funds from NHS England. The organisations have committed to carry out a number of projects from existing resources additional projects will be dependent on Central funds becoming available.

5.0 Legal implications

5.1 There are no Legal and Policy Implications at this present time.

6.0 Equalities implications

6.1 Equality Impact Assessments will be carried out for all of the projects within the LDR Programme.

7.0 Environmental implications

7.1 There are no anticipated environmental implications and any that arise will be dealt with on a project basis

8.0 Human resources implications

8.1 There are no anticipated Human resource implications and any that arise will be dealt with on a project basis

9.0 Corporate landlord implications

9.1 There are no anticipated corporate Landlord implications and any that arise will be dealt with on a project basis

10.0 Schedule of background papers

10.1 Appendix 1 Wolverhampton Local Digital Roadmap v1_2

The Royal Wolverhampton NHS Trust

NHS Wolverhampton Clinical Commissioning Group

Wolverhampton Local Digital Roadmap

Version 1.1

Wolverhampton City Council

Black Country Partnership NHS Foundation Trust

West Midlands Ambulance Service NHS Trust

Contents

Vision

The vision for the Wolverhampton Local Digital Roadmap (LDR) is the development of a paper free NHS Service where local providers work in a cooperative way to better serve the patients within Wolverhampton. This will be achieved through the development of shared objectives and vision of the future requirements of patients within the NHS.

The Programme will be underpinned by the provision of a Shared Care Record across Wolverhampton that is accessible by both Health and Social Care. The solution will be developed to be fully interoperable to allow for greater integration across the Black Country or wider.

Roadmap Development/Involvement

The roadmap has been developed via a cooperative process involving the organisations who provide services within the Wolverhampton LDR footprint. The following organisations are within the boundaries and have inputted into the creation of the Wolverhampton LDR

NHS Wolverhampton CCG
Royal Wolverhampton Trust
Black Country Partnership Foundation Trust
Wolverhampton City Council
West Midlands Ambulance Service

Governance arrangements

The programme of work will be authorised within the individual trusts, with overall approval being given at the Wolverhampton Health and Wellbeing board. The individual organisations will gain additional approval from the following bodies/boards.

Wolverhampton CCG - Governance

CCG Governing Body
Wolverhampton LMC
GPIT Clinical Leads

BCPFT - Governance

EHR and PAS Project Board
Business Performance Board

Royal Wolverhampton NHS Trust Governance

RWT IEPR Governance Group
RWT Governance Steering Group.
RWT Trust Management Committee.

The continued Programme governance will be managed and monitored by the LDR Operations groups which will be chaired by the Chief Finance and Operating Officer for Wolverhampton CCG who also sits on the STP Board. The other members will be composed of members from the organisations within the Wolverhampton LDR.

LDR Programme Structure

The programme will be overseen via the LDR Operations/Programme Board made up of representatives from the organisations within the LDR Footprint. Individual Projects will be overseen by Project Boards within the organisations or across organisations dependent on the project but will also report to the LDR Operations Board.

All Projects within the LDR Programme of work will be run using PRINCE2 Project management methodology.

Projects within the programme will be required to complete Equality Impact Assessments to ensure that they are fully inclusive and take account of protected characteristics groups. Privacy Impact Assessments will be completed to ensure that information governance implications are fully analysed and action taken to ensure that any issues are resolved.

The LDR programme of work will be require robust change management processes involving Change request Board and Change advisory Boards.

To ensure that the benefits of the LDR Programme are realised, benefits trackers will be used for all projects within the programme of work to baseline the projects and to ensure that the benefits are realised and reported.

LDR and STP Alignment

The Sustainability and Transformation Plan (STP) in the Black Country is currently in early stages of development and is in discussion about potential joint opportunities that can be expanded across the footprint. Initial areas highlighted for discussions are around E-prescribing.

One of the key drivers for the Wolverhampton LDR will be to ensure that any solutions implemented will be fully interoperable so as to support the integration of solutions across the STP footprint.

The process for the alignment will be driven through the LDR Steering Group and the STP. The Chief Finance and Operating Officer for Wolverhampton CCG sits on both Groups and will act as the conduit for the alignment of the Groups and as the plans for the STP develop will oversee their implementation within the LDR.

Improvements in Co-operation and Resource Utilisation

The sharing of resources will be driven by the LDR Operations Board, STP Board and the project boards. An objective of the Wolverhampton LDR will be to promote improved levels of cooperation and to increase the levels of joint working both across the LDR Footprint and the wider STP Footprint.

A key factor will also be the sharing of skills, knowledge, ideas, technical expertise and good practice across the programme of work and the organisations taking part. The aim is for the experiences and expertise to be spread not just to the LDR footprint but also the STP footprint.

Shared infrastructure and mobile working infrastructure

Royal Wolverhampton NHS Trust host Wolverhampton CCG's IT infrastructure so although both organisations have their own domains the network and server infrastructure is joint. Additional links exist that connect both Black Country Partnership Foundation Trust and Wolverhampton City Council allowing for corporative working along secure private links. These connections not only support cooperative working but will aid in the development of greater integration and joint working.

Wolverhampton City Council has two connections into the NHS network. One is a direct link to the Royal Wolverhampton NHS Trust Network Infrastructure and the second is a N3 Connection allowing them to access the spine.

Royal Wolverhampton Trust and Wolverhampton CCG have Private corporate Wi-Fi Networks across a number of trust buildings within Wolverhampton. Work has also started on the development of a joint patient Wi-Fi network to include the acute hospital and all GP Practices within Wolverhampton.

Wolverhampton CCG and Royal Wolverhampton NHS Trust support secure mobile working via Trust laptops and a 2 factor authentication using the SWIVEL solution. The CCG have also rolled out the EMIS mobile solution using iPads and have now started a pilot to use EMIS Anywhere which allows Clinicians to access the full EMIS solution at Care Homes and Patients homes.

The use of briefcase technology is also utilised by both Black Country Partnership Foundation Trusts and Wolverhampton CCG who use it to support the Individual Care Team Nurses to input assessments in areas with poor signal strength.

Wolverhampton Council has also started the process of utilising mobile technology with a mixture of Microsoft Surface Pro's and Lenovo tablets.

Common information sharing agreement

To support greater cooperative working within the Wolverhampton LDR the partner organisations have started preliminary discussions on the development of a combined Information Sharing Agreement to cover all organisations within the footprint. The Wolverhampton Better Care Fund is also working on a common information sharing approach to cover all organisations within Wolverhampton

Wolverhampton CCG and Royal Wolverhampton NHS Trust have reciprocal agreement s to share data between the two organisations. The CCG's agreement also includes the sharing of information between the GP Practices and Black Country Partnership Foundation Trust.

The development of a combined data sharing agreement between all the partner organisations will be developed in conjunction with the development of the Wolverhampton Shared Care Record.

Shared Information Approach

Initial discussions have been held with both Black Country Partnership Foundation Trust and Wolverhampton City Council to include them in the Wolverhampton Shared Care Record Project.

A key factor in the sharing of information and the ability for systems and organisations to share records is the use of a common unique identifier. Wolverhampton LDR will use the Patient NHS Number as the unique identifier. The compliance of organisations within the LDR is detailed below with all organisations either at 100% or working towards 100% compliance.

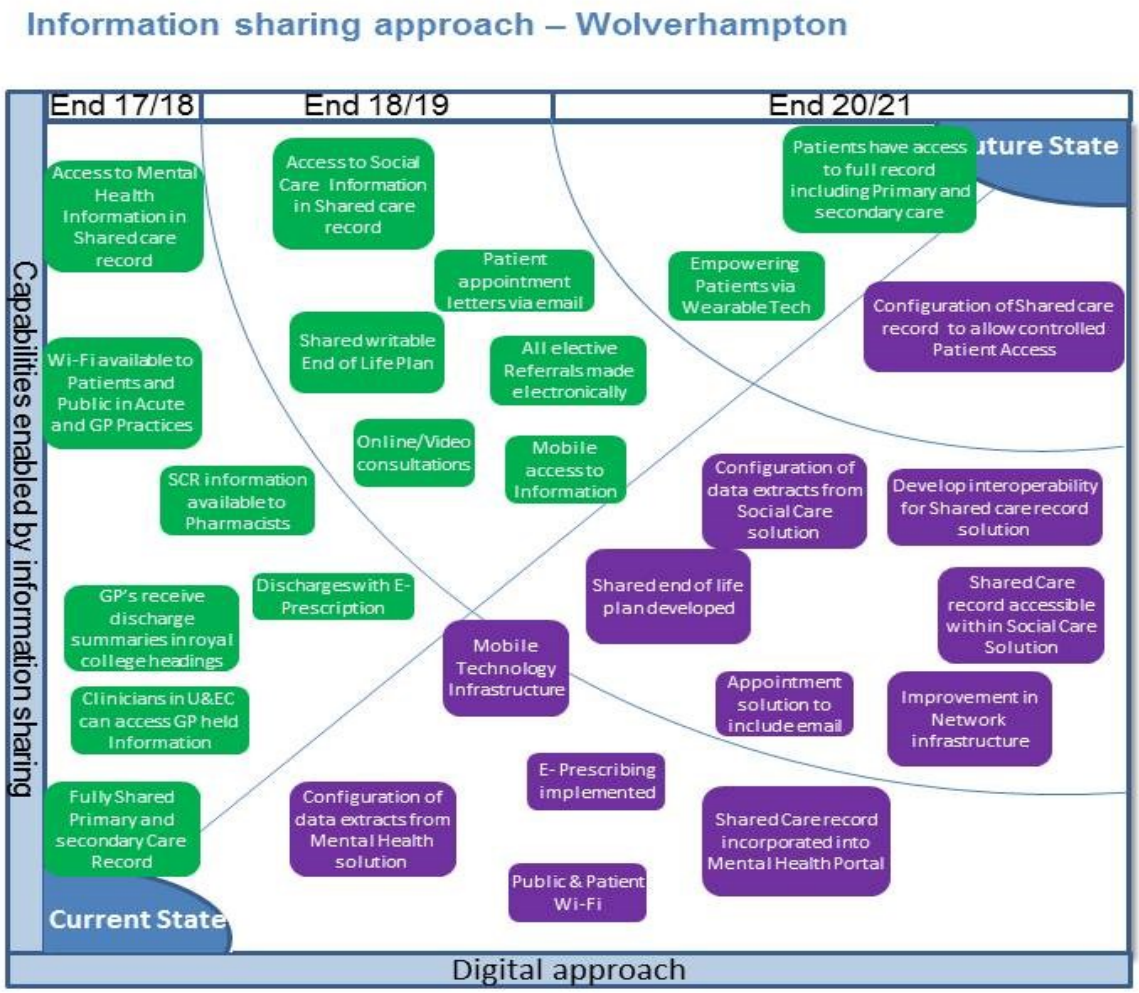
Wolverhampton CCG - 100% Compliant

Black Country Partnership Foundation Trust - 100% NHS compliant currently batch tracing but will be spine compliant in 2017

Wolverhampton City Council - 75% compliant - currently working to reach 100% compliance.

Royal Wolverhampton NHS Trust - Currently the Trust is NHS Number compliant across all of its key systems with around 99% compliance within the Data content. Currently the trust uses Batch Tracing, but once IPM Migration is complete in July 2016, Trust are moving forward with Spine rollout in August 2016.

The diagram below outlines the capabilities and associated solutions that have been identified to facilitate the organisations going paper free and using a Shared Care Record.



Interoperability

Wolverhampton LDR has interoperability as a key component in its development through use of the NHS Number which is a requirement for all Organisations. The requirement for interoperability and open APi's will be a precursor for all new systems that are developed as part of the LDR. This will support further joint working with other local Digital Roadmaps

Identification of rate limiting factors

To ensure the smooth development of the Wolverhampton LDR the factors that could impact on the programme have been identified and action will be taken to mitigate the effect. The identified factors are resource availability both Financial and Manpower, Information Governance relating to the sharing of patient data/information across organisations, Information Governance approval and finally technological constraints relating to hardware, software and interoperability.

Minimising risks to the LRD Programme

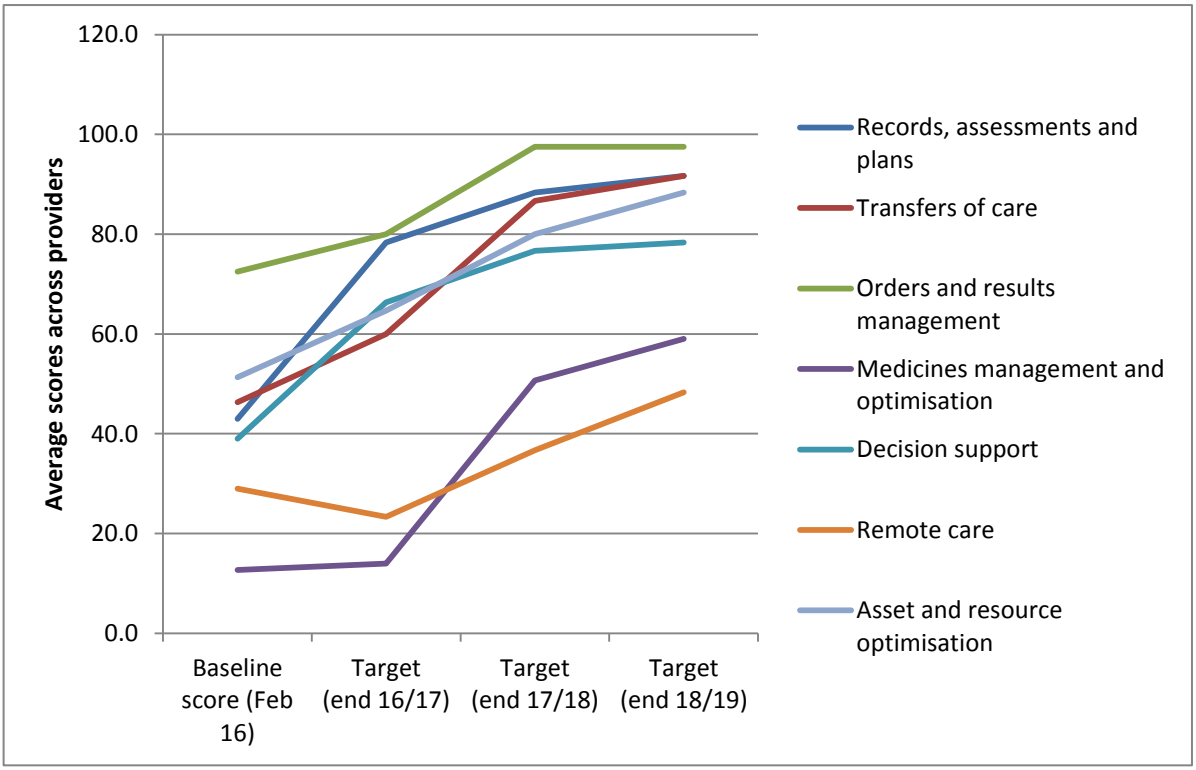
The LDR programme will be run using Managing Successful Programmes (MSP) methodology with individual projects run in accordance with PRINCE2 methodology and documentation. Workshops will be held to identify risks and issues as early as possible and these risks will be managed on both a programme and project level.

The projects will have oversight from each of the individual organisations and an overarching LDR Board will monitor performance and manage risks. The whole Programme will have Information Governance oversight and all organisations will amend their disaster recovery plans and Business Continuity plans to take account of the changes implemented as part of the LDR Programme.

Digital Maturity Trajectories

The Digital Maturity Trajectories of the Trusts within the Wolverhampton LDR are listed below the background data is available in Appendix 2 as are the Digital Maturity Baselines for all of the trusts.

	Average scores across providers			
Capability group	**Baseline score (Feb 16)**	**Target (end 16/17)**	**Target (end 17/18)**	**Target (end 18/19)**
Records, assessments and plans	43.0	78.3	88.3	91.7
Transfers of care	46.3	60.0	86.7	91.7
Orders and results management	72.5	80.0	97.5	97.5
Medicines management and optimisation	12.7	14.0	50.7	59.0
Decision support	39.0	66.3	76.7	78.3
Remote care	29.0	23.3	36.7	48.3
Asset and resource optimisation	51.3	64.7	80.0	88.3



Summary of key recent achievements

The organisations within The Wolverhampton LDR have implemented a large number of technology Projects, Key Projects are detailed below:

- The continued development of the Wolverhampton Shared Care record to provide information from the acute provider to GP's through their clinical system (EMIS).

- The provision of Primary Care data to Royal Wolverhampton Hospital including the Emergency Department, which is accessible via the Hospitals Clinical Portal.

- The replacement of aging infrastructure across the GP estate via provision of new server and network switches.

- The upgrade to Microsoft IE11 across both the CCG and Royal Wolverhampton Trust.

- Data sharing and provision of Acute Patient Record to neighbouring Cannock CCG GP Practices.

- Acute implementation of West Midlands Ambulance Service eHospital system for Ambulatory Handovers.

- Implementation of a 24/7 on call service for users of the EHR system at Black Country Partnership Foundation Trust.

- Review and Restructuring of ICT to consolidation the ICT and Information helpdesks, removing single points of failure and up skilling of key personnel at Black Country Partnership Foundation Trust.

- Black Country Partnership Foundation Trust instigated a Network/Mobile refreshment programme to replace Network Switches, expand the Wi-Fi coverage and replace firewalls.

Summary of key current initiatives

The Universal Capability Delivery Plan and Information Sharing approach outline the initiatives and projects. An overview of the key developments is detailed below:

- The development of a shared care record across the whole Health and Social Care economy within Wolverhampton, to include Primary, Secondary (Community, Acute and Mental Health) and Social Care.

- The rollout of patient online services to Patients so they can access their own records, book appointments, view test results, letters and order repeat prescriptions.

- The Continued development of e-referrals and the addition of referring to Black Country Partnership Foundation Trust electronically. The formatting of electronic discharges along Royal College headings.

- The expansion of e-referrals to Social Care

- The inclusion of Child Protection information within unscheduled care settings

- A project to initially populate the Wolverhampton Shared Care Record with Patients end of life preferences, then the development of a shared end of life plan.

- Continued development of the existing EPS project to increase utilisation within Wolverhampton.

- Utilisation of Electronic Performa's for Community Services

- Further expansion of Shared Care Record to Cannock CCG GP Practices (Royal Wolverhampton Trust initiative)

- Provision of Acute EPR Record and Electronic Discharge summaries to neighbouring care organisations.

- Expansion of SAN set-up to improve robustness of availability and to provide offsite and real time Disaster Recovery (DRS). Including building new server room system at Black Country Partnership Foundation Trust.

- VDI rollout scheduled for late 2016 (Black Country Partnership Foundation Trust).

- Deployment of VoIP IP at Quayside House system (Black Country Partnership Foundation Trust).

Funding Sources

The Wolverhampton LDR footprint will look to make use of existing resources within the organisations but to supplement this via the use of additional funding sources as they become available, with the organisations making bids either collectively or individually to support the LDR Programme of work. As part of the recent Primary Care Transformation Fund an IT bid has been submitted that would support the following projects.

Remote working EMIS Anywhere

EMIS Anywhere allows clinicians to access Patient data whilst at their GP Practice both as a desktop solution and on the move as a tablet solution. It provides GPs with a single solution that removing the need to use two devices. The solution supports paper free and has increased functionality, particularly around the areas of information governance and improved data collection. The solution enables GP to take their clinical system 'anywhere' with a single device.

Emis Community

To support a group of 8 GP Practices who have formed a horizontally integrated group work more effectively and increase capacity of services. Having the sites on a single clinical system provides them with ability to share records when providing shared care (enhanced services) and supports 7 working.

Wolverhampton Shared Care Record

The Project will be an upgrade and expansion to the existing Wolverhampton Shared Care Record between Wolverhampton CCG and Royal Wolverhampton Trust. The Scheme aims to facilitate joint working and improved information sharing, the net benefits of which will be to bring in both improved quality of treatment, Patient experience and cost savings through efficiency.
The solution will save time by reducing the need for clinicians to contact each other by phone or email as the information will be readily available. It will also reduce the need to use faxes.
The key benefit is that it will allow all clinicians to access the full record, which will support decision making and lead to improved treatment and diagnosis of conditions.
The addition of a data feed from Mental Health will be set up and then access to the Graphnet Care Centric portal will be incorporated into the Black Country Partnership Foundation trusts own portal.

Wolverhampton Auto- Arrival Solution
To standardise the entire estate within Wolverhampton to provide an enhanced patient experience through an all in one patient information LCD media screen patient calling-in solution with questionnaire module and self-checking-in facilities
Please see current state of 46 practices (61 sites including branch sites) in Wolverhampton:

New Models of Care

Wolverhampton has two new models of care being trialled within the LDR to improve cooperation and efficiency which are a Vertical model that integrates with the Acute/Community Trust and a Horizontal model that integrates Practices across Wolverhampton to provide services jointly.

Vertical Integration
Vertical Integration with Secondary Care providers is one of the new models of care outlined in the five year forward view. The Royal Wolverhampton Trust (RWT) has engaged in a pilot project with three Practices (Alfred Squire Medical Centre, MGS Medical Practice and Lea Road.

Horizontal Integration
Sites across the integration will be sharing Appointment books, delivering additional Enhanced Services and working towards increased numbers of consultations for patients who are registered within the 8 Practices. Furthermore, joining 8 Practices will open potential to provide 7 day care and increase the quality of care available to patients. The Practices that make up the group include (Tudor Medical Practice, Caerleon Surgery, Keats Grove Surgery, Fordhouses Medical Centre, The Newbridge Surgery, East Park Medical Practice, Church Street Surgery, Whitmore Reans Health Centre)

Appendix 1

Universal Capability:	A. Professionals across care settings can access GP-held information on GP-prescribed medications, patient allergies and adverse reactions
Capability Group:	Records, assessments and plans
Defined Aims:	• Information accessed for every patient presenting in an A&E, ambulance or 111 setting where this information may inform clinical decisions (including for out-of-area patients) • Information accessed in community pharmacy and acute pharmacy where it could inform clinical decisions

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

Wolverhampton has uploaded SCR records from all practices, allowing care professionals to access the information.

Wolverhampton CCG currently uses Graphnet Care centric solution to extract data and store GP data. This data is currently available via the Royal Wolverhampton Trust Portal which is available to authorised Clinical and non-Clinical staff within the Trust including Emergency Department.

The portal is also available in the Walk in centre and the Urgent Care Centre. Limited access to this portal is available to clinical staff (50 accounts) working as part of the Psychiatric Liaison Services based at the Royal Wolverhampton Trust's Walk in centre and the Urgent Care Centre.

The Portal has 8000 registered user accounts with over 1 million searches conducted annually (This includes searches for Primary and secondary care and test results)

Black Country Partnership NHS Foundation Trust will use SCR data in the short term but will look to integrate into the Graphnet Care centric solution for Wolverhampton patients.

WMAS do not currently access Summary Care Record as part of normal operational practice.

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	To start Project with Black Country Partnership NHS Foundation Trust to join Graphnet Care centric solution. To have SCR rolled out to all Pharmacies within Wolverhampton (Midlands and Lancs CSU Project) WMAS Deploy electronic patient record to provide platform for crew access
17/18	To include access to GP data through Black Country Partnership Foundation Trusts own portal Work with Graphnet to link the care centric portal with the Adastra solution used by West Midlands Ambulance service. To start project with Wolverhampton City Council to share information into the Graphnet CareCentric Portal WMAS SCR delivered as part of EPR solution

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points. At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	Secondary care data stored in the Longitudinal Patient Record Data Warehouse Pharmacy Summary Care Briefings WMAS Deploy EPR hardware, commence training
16/17 Q2	GP's able to Access Secondary Care data through Button/Tab within EMIS Web Clinical System. Emergency Department (ED) online Hold kick off meeting with BCPFT to scope requirements Pharmacy Summary Care Briefings Pharmacies complete the SCR2 Pharmacy Form Pharmacies complete CPPE e-learning WMAS Complete EPR training
16/17 Q3	Start Information Governance meeting with BCPFT and identify required data feeds and data set.
16/17 Q4	Identify method of Integrating Care centric Portal into BCPFT's ERP
17/18 Q1	Carry out testing of BCPFT ERP access to Care Centric Portal Finalise Information Governance BCPFT Initiate project with Wolverhampton City Council to link social care to shared patient record
17/18 Q2	Go Live with BCPFT ERP access to Care Centric Portal Agree information Governance with WCC WMAS SCR available through EPR application
17/18 Q3	Organise links with WCC to facilitate data sharing
17/18 Q4	Carry out testing of links WCC

D. National Services / Infrastructure / Standards

In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

NHS Wolverhampton CCG will supplement the use of Summary Care Records in care settings by providing access to the Wolverhampton Longitudinal Record which currently holds data from Primary Care and Secondary Care including A & E.

E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

Royal Wolverhampton Trusts Clinical Portal has 8000 registered user accounts with over 1 million searches conducted annually (This includes searches for Primary and secondary care and test results). The portal is also an access point to the CCG's Longitudinal patient record which has information on GP- prescribed medications, patient allergies and adverse reactions.

The CCG will provide evidence of the roll out of the Longitudinal Patient record to local care providers and statistics on the roll out of Summary Care record to Pharmacies (Project being carried out by Midland and Lancs CSU).

BCPFT's Electronic Heath Record Portal will become an access point for clinicians to the Longitudinal patient record which has information on GP-prescribed medications, patient allergies and adverse reactions. Evidence of using that information will be measured by the number of registered user accounts accessing that information.

Universal Capability:	B. Clinicians in U&EC settings can access key GP-held information for those patients previously identified by GPs as most likely to present (in U&EC)
Capability Group:	Records, assessments and plans
Defined Aims:	• Information available for all patients identified by GPs as most likely to present, subject to patient consent, encompassing reason for medication, significant medical history, anticipatory care information and immunisations • Information accessed for every applicable patient presenting in an A&E, ambulance or 111 setting (including for out-of-area patients)

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

Wolverhampton CCG with Graphnet has created a repository of data from GP Clinical Systems.

This data is extracted nightly from all EMIS Practices 37 Practices (80%) And currently Monthly from 9 TPP SystmOne Practices (20%)

This provides clinicians at ED, Urgent care Centre and Walk in centre with access to data on all Wolverhampton registered patients.

Out of Area Patient's information can be accessed via SCR.

This provides BCPFT clinical staff working at ED, Urgent care Centre and Walk in centre at Royal Wolverhampton Trust with access to data on all Wolverhampton registered patients.

The data from the repository is passed to Midlands and lancs CSU who run our Risk Stratification tool which then reports back to GPs on patients most at risk of presenting at A & E

WMAS 999 Command and Control System (aka CAD or Cleric) can register notes against address or patient. Typically this will be by address as this is a more robust search criteria on the 999 call however has a limitation when patient is not at home address. Notes are added manually.

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	To Move TPP SystmOne practices to daily uploads. WMAS Monitor local health economy (LHE) integrated care record (ICR) programmes
17/18	WMAS Review participation in LHE ICR

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points. At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	Initiate Daily uploads from TPP SystmOne into the Graphnet solution. Primary Care Data to be exported to Risk stratification tool offered by Midlands and Lancs CSU
16/17 Q2	Data Quality Check of TPP data uploads to ensure accuracy.
16/17 Q3	•
16/17 Q4	•
17/18 Q1	•
17/18 Q2	•
17/18 Q3	•
17/18 Q4	•

D. National Services / Infrastructure / Standards

In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

NHS Wolverhampton CCG uses the Graphnet Data extraction and Data warehouse solution to collect and store data which is then accessible through the CareCentric Portal. The Portal is integrated into the Royal Wolverhampton Trusts (RWT) own Clinical portal allowing RWT staff to access patient information in all care settings.

A Button/Tab is available within EMIS GP Clinical System to allow access to the CareCentric Portal for GP's to view Secondary Care Information.

This solution has the ability to be scalable and is planned to eventually include Social Care and Mental Health Data, thus providing the residents of Wolverhampton with an integrated care record.

E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

Information is collected on all Patients with Wolverhampton excluding patients who have opted out.

Graphnet contains Primary Care records on All Wolverhampton CCG patients who have not opted out. Exact data can be provided from the Graphnet solution.

Universal Capability:	C. Patients can access their GP record
Capability Group:	Records, assessments and plans
Defined Aims:	• Access to detailed coded GP records actively offered to patients who would benefit the most and where it supports their active management of a long term or complex condition • Patients who request it are given access to their detailed coded GP record

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

All practices within Wolverhampton have enable Enhanced Medical Record access.

Patients who wish to have access to enhanced records are able to request it from their GP and it will be made available subject to clinical discretion

Baseline Statistics March 2016 46 out of 46 (100%) Practices have Enhanced Patient Record access enabled on their Clinical system.

HSCIC Indicator Portal - Stats as at February 2016
Enhanced record usage for NHS Wolverhampton CCG was:

1,064 Patients enable to view record = 0.4% of the patient population
1,606 Records accessed

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	All Practices provide access to Enhanced Patient records 5% of patients have access to Enhanced Patient Record

Year	Ambition
17/18	7.5% of Patients have access to Enhanced Patient Records

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points. At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	• Carry out analysis of current position relating to patients signed up for Enhanced Patient Record. • Identify the practices with the lowest uptake. • Contact the identified practices and arrange practice visits • Develop Patient Information Literature. • Meet with first tranche of practices with low uptakes. • Liaise with HSCIC implementation lead. • Work with care homes to review possibility of using delegated access. • Contact Local Community Groups to raise awareness
16/17 Q2	• Review latest HSCIC Stats to confirm current position • Engage practice PPG's • Engage with locality leads • Arrange meetings with all remaining practices • Hold Practice Meetings • Distribute patient information literature • Attend PPG's and raise awareness and review if patients are being signed up for enhanced GP Record • Team W Event presentation on benefits of signing up patients with long term conditions to Enhanced Patient Record • Care Home Delegated access progress • Contact Local Community Groups to raise awareness
16/17 Q3	• Review HSCIC stats on uptake of Enhanced patient record and identify any practices where there are no or limited uptake. • Meet with PPG's to promote use of Enhanced Patient Records • Hold Practice Meetings • Attend and present at Practice managers forum • Care Home Delegated access progress

Quarter	Activities
	• Contact Local Community Groups to raise awareness
16/17 Q4	• Review latest HSCIC Stats to confirm current position • Hold Practice Meetings • Meet with PPG's to promote use of Enhanced Patient Records • Care Home Delegated access progress • Assess position in relation to targets and if uptake is below 5% ambition • Contact Local Community Groups to raise awareness
17/18 Q1	• Review latest HSCIC Stats to confirm current position • Hold Practice Meetings targeting practices with lowest uptake first. • Meet with PPG's to promote use of Enhanced Patient Records • Review and revise patient information literature • Care Home Delegated access progress • Carry out case study of benefits to patients and Clinicians both within Primary and Secondary care of providing access to Enhanced Patient Record • Contact Local Community Groups to raise awareness
17/18 Q2	• Review latest HSCIC Stats to confirm current position • Hold Practice Meetings • Meet with PPG's to promote use of Enhanced Patient Records • Distribute patient information literature • Care Home Delegated access progress • Contact Local Community Groups to raise awareness
17/18 Q3	• Review latest HSCIC Stats to confirm current position • Hold Practice Meetings • Meet with PPG's to promote use of Enhanced Patient Records • Team W Event presentation on benefits of signing up patients with long term conditions to Enhanced Patient Record • Care Home Delegated access progress • Carry out awareness check with practices to ensure that they know that patients have a right to review enhanced patient record.

Quarter	Activities
	• Contact Local Community Groups to raise awareness
17/18 Q4	• Review latest HSCIC Stats to confirm current position • Hold Practice Meetings • Meet with PPG's to promote use of Enhanced Patient Records • Care Home Delegated access progress • Assess position in relation to targets and if uptake is below 7.5% ambition • Contact Local Community Groups to raise awareness

D. National Services / Infrastructure / Standards

In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

Progress along the capability path will be monitored using nationally produced statistics from website below

https://indicators.hscic.gov.uk/webview/

E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

The progress made by the CCG will be evidenced in the HSCIC stats produced on the website below under the Patient online heading.

https://indicators.hscic.gov.uk/webview/

Universal Capability:	D. GPs can refer electronically to secondary care
Capability Group:	Transfers of care
Defined Aims:	• Every referral created and transferred electronically • Every patient presented with information to support their choice of provider • Every initial outpatient appointment booked for a date and time of the patient's choosing (subject to availability) • [By Sep 17 – 80% of elective referrals made electronically]

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

43 of 46 practices use E-RS

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	Get all practices to use E-RS Royal Wolverhampton Trust to increase capacity and improve issues around TAL WCC – Procuring a new Social Care system to support integrated Working to refer to Social Workers
17/18	Black Country Partnership Foundation Trust to start using E-RS or local e-referrals service as only 5% of referrals would come via E-RS.80% of elective referrals made electronically WCC – Social Care System in Place that allows referrals to Social Workers

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points. At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	• Identify Practices that are not using E-RS • Engage with practices to explain benefits of E-RS and National Requirements. • Update service design improvement plan in conjunction with our main service provider Royal Wolverhampton Trust (RWT) • Start liaison process with Black Country Partnership Foundation Trust to engage them to receive referrals using E-RS • Hold monthly meetings with BCPFT to review and monitor performance. • On-going review of practices processes in relation to E-RS • Hold monthly meetings with RWT to review and monitor performance • Liaise with HSCIC Local Implementation Lead • Review Royal Wolverhampton Trust's capacity and TAL
16/17 Q2	• Review Stats and assess CCG performance against targets • Hold monthly meetings with RWT to review and monitor performance • On-going review of practices processes in relation to E-RS • Liaise with HSCIC Local Implementation Lead • Attend Practice Managers forum to encourage use of E-RS • Review Royal Wolverhampton Trust's capacity and TAL • Hold monthly meetings with BCPFT to review and monitor performance.
16/17 Q3	• Review Stats and assess CCG performance against targets • Hold monthly meetings with RWT to review and monitor performance

Quarter	Activities
	• On-going review of practices processes in relation to E-RS • Liaise with HSCIC Local Implementation Lead • Review Royal Wolverhampton Trust's capacity and TAL • Hold monthly meetings with BCPFT to review and monitor performance.
16/17 Q4	• Review Stats and assess CCG performance against targets • Hold monthly meetings with RWT to review and monitor performance • On-going review of practices processes in relation to E-RS • Liaise with HSCIC Local Implementation Lead • Review Royal Wolverhampton Trust's capacity and TAL • Hold monthly meetings with BCPFT to review and monitor performance. • Hold monthly meetings with BCPFT to review and monitor performance. • WCC- Procurement of Social Care System Completed
17/18 Q1	• Review Stats and assess CCG performance against targets • Hold monthly meetings with RWT to review and monitor performance • On-going review of practices processes in relation to E-RS • Liaise with HSCIC Local Implementation Lead • Review Royal Wolverhampton Trust's capacity and TAL • Hold monthly meetings with BCPFT to review and monitor performance. • Hold monthly meetings with BCPFT to review and monitor performance.
17/18 Q2	• Review Stats and assess CCG performance against targets • Hold monthly meetings with RWT to review and monitor performance • On-going review of practices processes in relation to E-RS • Attend Practice Managers forum to encourage use of E-RS

Quarter	Activities
	• Liaise with HSCIC Local Implementation Lead • Review Royal Wolverhampton Trust's capacity and TAL • Hold monthly meetings with BCPFT to review and monitor performance.
17/18 Q3	• Review Stats and assess CCG performance against targets • Hold monthly meetings with RWT to review and monitor performance • On-going review of practices processes in relation to E-RS • Liaise with HSCIC Local Implementation Lead • Review Royal Wolverhampton Trust's capacity and TAL • Hold monthly meetings with BCPFT to review and monitor performance.
17/18 Q4	• Review Stats and assess CCG performance against targets • Hold monthly meetings with RWT to review and monitor performance • On-going review of practices processes in relation to E-RS • Liaise with HSCIC Local Implementation Lead • Review Royal Wolverhampton Trust's capacity and TAL • Hold monthly meetings with BCPFT to review and monitor performance. • WCC- New Social Care System installation Completed

D. National Services / Infrastructure / Standards

In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

NHS Wolverhampton CCG will use the National E-Referral solution to book appointments in conjunction with the organisations within the Local Digital Roadmap
Will use National Solution E-RS

BCPFT will use the National E-Referral solution to book appointments in conjunction with the organisations within the Local Digital Roadmap where applicable – expected uptake 5% of referrals. Remainder will use locally developed e-Referral Service.

E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

Evidence will be provided from HSCIC produced Statistics Relating to E-Referrals

Data from Council of numbers of referrals recorded in Social Care system.

Universal Capability:	E. GPs receive timely electronic discharge summaries from secondary care
Capability Group:	Transfers of care
Defined Aims:	• All discharge summaries sent electronically from all acute providers to the GP within 24 hours • All discharge summaries shared in the form of structured electronic documents • All discharge documentation aligned with Academy of Medical Royal Colleges headings

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

Discharge summaries sent electronically from acute Hospital to the GP's within 24 hours via use of the Docman Hub.

Discharge Summaries from the Community Hospital are currently nor electronic but a project is in place to move to the solution used at the Acute site.

Black Country Partnership Foundation Trust (BCPFT) are currently developing their own solution for release in 16/17 for Discharge summaries sent electronically from acute Hospital to the GP's within 24 hours, initially via local e-mail service but BCPFT to investigate the of the Docman Hub.

WMAS - This requirement relates to secondary care so could be viewed as not applicable however there could be benefit in passing care notification to GP from ambulance. WMAS do not currently pass information to GPs

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	BCPFT - To initiate E-discharge Project RWT – To send all discharge letters electronically from Community site WMAS - Send messages to GPs for incidents where ambulance attends (and NHS number matched) using Docman relay. Dependent upon support from other Docman hubs.
17/18	BCFPFT – To send all discharge letters Electronically

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points. At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	
16/17 Q2	BCPFT to initiate talks with supplier to explore use of DOCMAN Hub. WMAS - Establish Docman relay in Staffordshire
16/17 Q3	BCPFT to design, build and test E-Discharge Module for the Trust's EHR. WMAS - Establish Docman relay in supporting LHEs
16/17 Q4	BCPFT to complete the design, build and test E-Discharge Module for the Trust's EHR. Deploy at end of Q4. WMAS - Establish Docman relay in supporting LHEs
17/18 Q1	•
17/18 Q2	•
17/18 Q3	•
17/18 Q4	•

D. National Services / Infrastructure / Standards

In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

Messages are transmitted using the Docman hub from the Acute hospital to The Docman client on GP Clinical Systems. BCPFT – Messages are transmitted via local e-mail service to GP's DOCMAN solution initially but BCPFT to investigate using the Docman client on GP Clinical Systems.

E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

Stats will be provided from both providers Royal Wolverhampton Trust and Black Country Partnership Foundation Trust to evidence the volume and number of e-discharges sent.

Universal Capability:	F. Social care receive timely electronic Assessment, Discharge and Withdrawal Notices from acute care
Capability Group:	Transfers of care
Defined Aims:	• All Care Act 2014 compliant Assessment, Discharge and associated Withdrawal Notices sent electronically from the acute provider to local authority social care within the timescales specified in the Act

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

All patients as part of admission processes on the ward are considered whether there is a likely need for social services assessment, if there is then an assessment notification is completed 24-48 from admission.

Discharge notifications are only used for out of borough local authorities as there is a local agreement for them not to be used for Wolverhampton citizens.

All notifications sent electronically unless local authority asks for a phone (<5%)

WMAS - This requirement relates to acute care so could be viewed as not applicable however there could be benefit in passing care notification to social care from ambulance especially in the case of Safeguarding referrals. WMAS currently send Safeguarding referrals by email. This approach would use Docman.

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	All documentation used, to be Care Act compliant. Review sending electronic notices – exploring the use of TeleTracking to automate completion and sending WMAS - Pilot safeguarding referrals to supporting social care organisation
17/18	Sending notices via TeleTracking Notices to be discharge planning notices not just to local authority i.e. District Nurses, discharge to assess WMAS - Extend social care notification to other organisations

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points. At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	
16/17 Q2	RWT - Notices reviewed and updated to Care Act compliant Initial meetings with TeleTracking regarding sending of notices and multiple use of the notices
16/17 Q3	RWT - Review meeting with TeleTracking to establish timeframes if proposal is viable.
16/17 Q4	WMAS - Pilot social care communication
17/18 Q1	RWT - Following agreed timeframe including technology changes, process change management and implementation WMAS - Roll out social care communication
17/18 Q2	WMAS - Roll out social care communication
17/18 Q3	
17/18 Q4	

D. National Services / Infrastructure / Standards

In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

No

E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

Reported and monitored by the TeleTracking lead and board.

Universal Capability:	G. Clinicians in unscheduled care settings can access child protection information with social care professionals notified accordingly
Capability Group:	Decision support
Defined Aims:	• Child protection information checked for every child or pregnant mother presenting in an unscheduled care setting with a potential indicator of the child being at risk (including for out-of-area children) • Indication of child protection plan, looked after child or unborn child protection plan (where they exist) flagged to clinician, along with social care contact details • The social worker of a child on a child protection plan, looked after or on an unborn child protection plan receives a notification when that child presents at an unscheduled care setting and the clinician accesses the child protection alert in their record

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

RWT - Current technology presents risk flags within unscheduled care settings from the Patient Administration system. This is flowed through via integration engine to receiving systems such as ED and the Electronic Patient Record system. The attributes that present within the risk flag process is handled and managed as part of joint working teams, although this is very much a manual process for data entry and ongoing maintenance of the flags. Secondary care electronic patient record system is provisioned across 100 % of GP practices within the Wolverhampton area.

WMAS do not currently access CP-IS

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	RWT - To deploy automated functionality that negates the current need for manual intervention in terms of managing and maintaining current flagging process. Plans are in place to move towards full CP-IS functionality within the National SPINE, where child protection information can be recorded locally within social care. Initial upload sees the local authority uploading information on their cohort of Children to CP-IS, thereafter there will be an automatic submission to CP-IS, upon creation or amendment of status of child. Overnight updates will occur to NHS Spine when a child's information is looked up in the local health care setting and a check is made where any CP-IS information is automatically displayed. When the CP-IS record is looked at by the Health professional an audit of the event is recorded and returned to the local authority and other health workers looking at the child. This information is only held for children who are looked after or on a child protection plan, not for all children visiting unscheduled care. The above details are then made available to the local authority responsible for the child. They can also be accessed by subsequent NHS users viewing the child's child protection information. The access event log will help to highlight the children that have received unscheduled medical care across local authority boundaries. It will also help to provide clear and current indicator information to the NHS user viewing the child's details. CP-IS is not there to replace existing safeguarding policies and processes, but to support and provide up to date information which is not routinely available to aid in decision making and assessment
17/18	WMAS - Access CP-IS through SCR

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points. At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	RWT - Submit confirmation to National CPIS for plans to implement connectivity for interoperable solution. : - Complete

Quarter	Activities
	RWT- Initiate discussion and agreement with Patient Administration Systems suppliers for design of solution. : - Complete RWT - Start development of solution in partnership with supplier and national / local teams : - Complete
16/17 Q2	RWT - Complete development of solution in partnership with supplier and national / local teams. RWT - Instigate testing of integrated solution and sign-off with local, National and supplier partners. RWT - Deploy solution into live service and integrate within processes and systems for unscheduled care settings.
16/17 Q3	RWT - Expand solution within live services for further integration within processes and Electronic Patient Record systems for unscheduled care settings. RWT - Access workability / benefits from Go Live in Q2, deploy issue resolution for known problems.
16/17 Q4	RWT - Continue review with partners for future scope opportunities or expansion of solution.
17/18 Q1	•
17/18 Q2	WMAS - Available through SCR
17/18 Q3	•
17/18 Q4	•

D. National Services / Infrastructure / Standards

In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

Not applicable as all solutions deployed for universal capabilities will utilise National services. All Infrastructure and standards at local level will comply and align to those defined.

E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

RWT - Local, National and supplier sign-off for solution.

RWT - National CPIS statistics, records called regarding protection information.

RWT - Audit of events for return to local authority will be reviewed in conjunction with National team.

RWT - Reference to access event logs and appropriate reviews.

Universal Capability:	H. Professionals across care settings made aware of end-of-life preference information
Capability Group:	Decision support
Defined Aims:	• All patients at end-of-life able to express (and change) their preferences to their GP and know that this will be available to those involved in their care • All professionals from local providers involved in end-of-life care of patients (who are under the direct care of a GP) access recorded preference information where end-of-life status is flagged, known or suspected

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

Information is stored in the GP Clinical systems

The Clinical portal which will hold the information is currently used within Royal Wolverhampton Trust and by a limited number of Black Country Partnership Foundation Trust staff.

The portal is also available within Compton Hospice

WMAS 999 Command and Control System (aka CAD or Cleric) can register notes against address or patient. Typically this will be by address as this is a more robust search criteria on the 999 call however has a limitation when patient is not at home address. Notes are added manually

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	Work with Graphnet to scope getting End of Life Preference shown in the Clinical Portal WMAS - Develop interface between Black Pear and Cleric. Black Pear is in use in Worcestershire, Herefordshire, Coventry & Warwickshire
17/18	Work with Graphnet to create an EPaCCs solution with a shared End of Life plan that could be accessed by RWT, BCPFT, WMAS and WCC

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points. At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	Investigate data being collected via Graphnet extract.
16/17 Q2	Create new view within Graphnet Care Centric Portal to display end of life preference Carry out awareness exercise with GP's to ensure that they record end of life preferences WMAS - Development of Black Pear/Cleric Interface
16/17 Q3	Carry out testing of portal settings Carry out awareness exercise with GP's to ensure that they record end of life preferences WMAS - Deploy Black Pear/Cleric interface
16/17 Q4	Roll out new functionality within Portal Carry out awareness exercise with GP's to ensure that they record end of life preferences
17/18 Q1	Scope project to introduce shared end of life plan
17/18 Q2	Agree deliverables and finalise project plan Carry out awareness exercise with GP's to ensure that they record end of life preferences Carry out awareness exercise with GP's to ensure that they record end of life preferences
17/18 Q3	Create module and carry out testing
17/18 Q4	Go live with solution inside CareCentric Portal. Carry out awareness and training in the use of Plan

D. National Services / Infrastructure / Standards

In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

Will Use a solution from within the CCG's existing Graphnet solution, that will build on the existing shared care record that is used within Wolverhampton

E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

Will provide usage statistics from Graphnet to evidence the use of the functionality.

Universal Capability:	I. GPs and community pharmacists can utilise electronic prescriptions
Capability Group:	Medicines management and optimisation
Defined Aims:	• All permitted prescriptions electronic • All prescriptions electronic for patients with and without nominations - for the latter, the majority of tokens electronic • Repeat dispensing done electronically for all appropriate patients • [By end 16/17 – 80% of repeat prescriptions to be transmitted electronically]

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

42 of 46 Practices live with EPS

EPS April 2016 HSCIC stats for WCCG

Number of Practices Live	Practices Live %	% use in live practices
42	91.3	68.8%

HSCIC e-repeat dispensing EPS Percentage usage trends based on BSA data key = yellow actual figures

Practc Count	Live EPSr2 Practc Count	Apr-16	Apr-16 (RD)	Mar-16	Mar-16 (RD)	Feb-16	Feb-16 (RD)
46	42	64%	20.00%	57%	17.80%	60%	19.90%

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	80% of repeat prescriptions to be transmitted electronically
17/18	Roll out of Phase 4 of EPS to all GP Practices within NHS Wolverhampton CCG.

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points. At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	Review HSCIC Stats to identify low usage Practices Arrange Meetings with low usage practices Escalate to Locality Leads GP Practice to go live with EPS Reinvigorate Pharmacy Access Project currently being carried out with EMIS and RX
16/17 Q2	Review HSCIC Stats to identify low usage Practices GP Practice to go Live with EPS Encourage Pharmacies to continue to nominate patients thus increasing uptake of EPS in GP Practices Review progress of Pharmacy Access Project CCG Pharmacy Lead to Speak at Local Pharmacy Committee about EPS and Nominations
16/17 Q3	Review HSCIC Stats to identify low usage Practices and position against 80% repeat prescription target GP Practices to go live with EPS Target GP practices who have lower than 80% repeat prescription use Attend Practice Managers forum to encourage use of Repeat Dispensing Encourage Pharmacies to continue to nominate patients thus increasing uptake of EPS in GP Practices Review progress of Pharmacy Access Project
16/17 Q4	Review HSCIC Stats to identify low usage Practices Last Practice to go live with EPS Target GP practices who have lower than 80% repeat prescription use Encourage Pharmacies to continue to nominate patients thus increasing uptake of EPS in GP Practices Review progress of Pharmacy Access Project
17/18 Q1	Review HSCIC Stats to identify low usage Practices Arrange Meetings with low usage practices Escalate to Locality Leads Encourage Pharmacies to continue to nominate patients thus

Quarter	Activities
	increasing uptake of EPS in GP Practices
17/18 Q2	Review HSCIC Stats to identify low usage Practices Encourage Pharmacies to continue to nominate patients thus increasing uptake of EPS in GP Practices CCG Pharmacy Lead to Speak at Local Pharmacy Committee about EPS and Nominations
17/18 Q3	Review HSCIC Stats to identify low usage Practices Attend Practice Managers forum to encourage use of EPS Encourage Pharmacies to continue to nominate patients thus increasing uptake of EPS in GP Practices
17/18 Q4	Review HSCIC Stats to identify low usage Practices Encourage Pharmacies to continue to nominate patients thus increasing uptake of EPS in GP Practices

D. National Services / Infrastructure / Standards

In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

Will use national EPS Solution

E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

Progress will be evidenced by Nationally Provided stats from HSCIC on EPS Script requesting stats relating to Patient online

Poplars Medical Practice EPS story Fina

Wolverhampton_Pharmacy Access_10 11 15

Universal Capability:	J. Patients can book appointments and order repeat prescriptions from their GP practice
Capability Group:	Remote care
Defined Aims:	• [By end 16/17 – 10% of patients registered for one or more online services (repeat prescriptions, appointment booking or access to record)] • All patients registered for these online services use them above alternative channels

A. Baseline

Please summarise the current baseline across your local health and care system. The data may encompass deployment penetration (e.g. deployed in 80% of practices), volumetrics (e.g. accessed 2500 times in Q3) and take-up (e.g. accessed for 95% of prescriptions).

46 of 46 (100%) of GP Practices within Wolverhampton have enable Patient Online Access

HSCIC Indicator Portal - Stats as at February 2016
Enhanced record usage for NHS Wolverhampton CCG was:

Patients able to book online appointments
25,782 Patients 9.5% of population

Patients enabled to order Repeat prescription
24,318 Patients 9.0% of population

Patients enabled to View Letters
906 Patients 0.3% of population

Patients enabled to View Test Results
2,826 Patients 1.0% of population

B. Ambition

With reference to the defined aims set out above, please set out your ambition in the grid below. Remember that 'clear momentum' is expected in 16/17 and 'substantive delivery' in 17/18. Also note that you can go further than the defined aims – examples are provided in the Universal Capabilities Information and Resources document.

Year	Ambition
16/17	10% plus patients registered for online services at each GP Practice 20% of patients registered for online services for CCG as a whole
17/18	20% plus patients registered for online services at each GP Practice 35% of patients registered for online services for CCG as a whole

C. Activities

Please detail the activities you propose to undertake, by quarter, in the grid below. Separate activities should be separated out as separate bullet points. At the time of submission on 30 June 2016, any activities for 16/17 Q1 should be complete.

Quarter	Activities
16/17 Q1	• Carry out analysis of current position relating to patients signed up for online patient services. • Identify the practices with the lowest uptake. • Contact the identified practices and arrange practice visits • Develop Comms and scripts for reception staff to raise awareness. • Meet with initial 10 identified practices. • Liaise with HSCIC implementation lead. • Contact Local Community Groups to raise awareness
16/17 Q2	• Review latest HSCIC Stats to confirm current position • Engage practice PPG's • Engage with locality leads • Arrange meetings with all remaining practices • Hold Practice Meetings • Distribute patient information literature • Distribute scripts for reception staff to all practices. • Attend PPG's and raise awareness and review if patients are being signed up for enhanced GP Record • Contact Local Community Groups to raise awareness
16/17 Q3	• Review latest HSCIC Stats to confirm current position • Hold Practice Meetings • Attend and present at Practice managers forum • Review overall uptake of patient online service to identify if CCG is on track to hit 20% of patient population signed up

Quarter	Activities
	• HSCIC to attend Team W events (CCG to GP event) • Contact Local Community Groups to raise awareness • Review HSCIC stats on uptake of Enhanced patient record and identify any practices where there are no or limited uptake.
16/17 Q4	• Review latest HSCIC Stats to confirm current position • Hold Practice Meetings • Carry out awareness check with practices to ensure that they know that patients have a right to review enhanced patient record. • Assess position in relation to targets and if any site is still below 10% target resources to ensure that practice hits 10% by year end • Contact Local Community Groups to raise awareness
17/18 Q1	• Review latest HSCIC Stats to confirm current position • Identify Practices with uptake below 20% • Hold Practice Meetings targeting practices with lowest uptake first. • Contact Local Community Groups to raise awareness
17/18 Q2	• Review latest HSCIC Stats to confirm current position • Hold Practice Meetings • Review HSCIC stats on uptake of Enhanced patient record and identify any practices where there are no or limited uptake. • Contact Local Community Groups to raise awareness
17/18 Q3	• Review latest HSCIC Stats to confirm current position • Hold Practice Meetings • HSCIC to attend Team W events (CCG to GP event) • Carry out awareness check with practices to ensure that they know that patients have a right to review enhanced patient record. • Contact Local Community Groups to raise awareness
17/18 Q4	• Review latest HSCIC Stats to confirm current position • Hold Practice Meetings • Assess position in relation to targets and if any site is still below 20% target resources to ensure that practice hits 20% by year end. • Contact Local Community Groups to raise awareness

D. National Services / Infrastructure / Standards

In progressing the universal capabilities, if you are proposing to use alternative solutions to the national services, infrastructure and standards, please provide a rationale in the box below.

Progress along the capability path will be monitored using nationally produced statistics from website below https://indicators.hscic.gov.uk/webview/

E. Evidencing Progress

Please set out your proposals below for evidencing progress towards the defined aims for the universal capability, as set above. Your response should be informed by any national metrics available, as described in the Universal Capabilities Information and Resources document.

The progress made by the CCG will be evidenced in the HSCIC stats produced on the website below under the Patient online heading. https://indicators.hscic.gov.uk/webview/

Appendix 2

Documents and templates submitted for Wolverhampton LDR Submission

 Wolverhampton ldr-chcklist-submissior	LDR Checklist
 Wolverhampton LDR - Capability Trajector	LDR Capability Trajectory (Secondary Care)
 Wolverhampton ldr-info-sharing-apprc	Information Sharing Approach
 ldr-Wolverhampton-u nivrsl-capabl-delivery	Universal Cabability Delivery Plan
 Wolverhampton ldr-temp-capabl-deply	Universal Cabability Deployment Plan
 wolverhampton-foot print.xlsx  RYA WMAS DMA result.xlsx	Digital Maturity Index for Royal Wolverhampton NHS Trust, Black Country Partnership Foundation NHS Trust and West Midlands Ambulance Service.

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Agenda Item No: 12

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

20 July 2016

Report title	Submission of the Black Country (NHS) Sustainability and Transformation Plan (STP) – June 2016
Cabinet member with lead responsibility	Councillor Paul Sweet Health and Wellbeing
Wards affected	All
Accountable director	Vivienne Griffin - Director
Originating service	Disabilities and Mental Health
Accountable employee(s)	
Report to be/has been considered by	People Leadership Team 11 July 2016 Senior Executive Board 19 July 2016

Recommendation(s) for noting:

The Health and Wellbeing Board is recommended to:

Note the submission of the Black Country (NHS) Sustainability and Transformation Plan (STP - June 2016 to the NHS Executive.

1.0 Purpose

1.1 To inform the Health and Wellbeing Board of the content of the Black Country Sustainability and Transformation Plan(STP) June Submission to the NHS Executive.

2.0 Background

2.1 The STP within the Black Country footprint aims to bring together local health, care and community leaders to develop a local blueprint for improved health, care and finances over the next five years. The STP aim is to underpin and be the vehicle which realises the NHS Five Year Forward View. The STP Plans will address, over a five year period, what has been described as the 'triple-aim gap':

- Health and Well-Being
- Care and Quality
- Finance and Sustainability

The June submission was a 'checkpoint update' which outlined initial areas of work to deliver the Black Country STP. A much more detailed further submission is anticipated end September 2016 which will need to articulate in far greater detail the areas of work, deliverables, outcomes and timings.

3.0 Main Themes of the STP

3.1 The principle programmes of work include:

- Vertical integration on a place based basis using either PACS or MCP or a combination thereof approaches.

- Horizontal integration across the acute sector using single systems to create improved quality and economies of scale, including a reduction in acute Mental Health sites across the Black Country from 5 to 4.

- A single system of revised Mental Health and Learning Disability Services including revised commissioning arrangements.

- Development of maternal health and child health services, including the development of a single Black Country Maternity Plan.

- Consideration of public sector estate utilisation and the achievement of significant workforce efficiencies.

- Addressing the wider determinants of health through working together and in partnership with West Midlands Combined Authority.

3.2 **The Way Forward:**

As per above, there is a requirement for a far greater detailed submission by October 2016. Implementation plans for the individual work streams will be developed over the summer period and will be informed by commissioning partnerships and provider clinical networks.

The attached pack of slides (Appendix 1) gives more detail on each of the solutions outlined above.

4.0 Financial implications

4.1 CCGs, NHS providers and Local authorities provided details of their financial plans for health and social care over a five year period (2016/17 to 2020/21). A 'Do nothing' option was presented with took the recurrent starting position pre 2016/17 savings plans and allowing for growth to arrive at a financial challenge of £809.1 million across the Black Country footprint. A number of solutions were then identified across the footprint to address this gap, reducing the financial challenge to £124.2 million. The plan proposes that the balance of the challenge will be addressed through the work of the Combined Authority and wider determinants of health opportunities. These plans will be subject to review and revision.
{AS/08072016/L

5.0 Legal implications

5.1 There are no direct legal implications arising from this report.
[TS/07072016/W]

6.0 Equalities implications

6.1 As with any transformation programme there will be a number of equalities issues to consider. This report requires members simply to note the submission of the plan. At the time of the decision to approve the plan it will be critical that this plan is supported by a proportionate equalities analysis given the relevance of equalities to the anticipate contents. This will be undertaken as the plan develops.

7.0 Environmental implications

7.1 There are no immediate environmental implications arising from this report.

8.0 Human resources implications

8.1 There are no immediate human resources implications arising from this report.

9.0 Corporate landlord implications

9.1 There are no immediate landlord implications arising from this report.

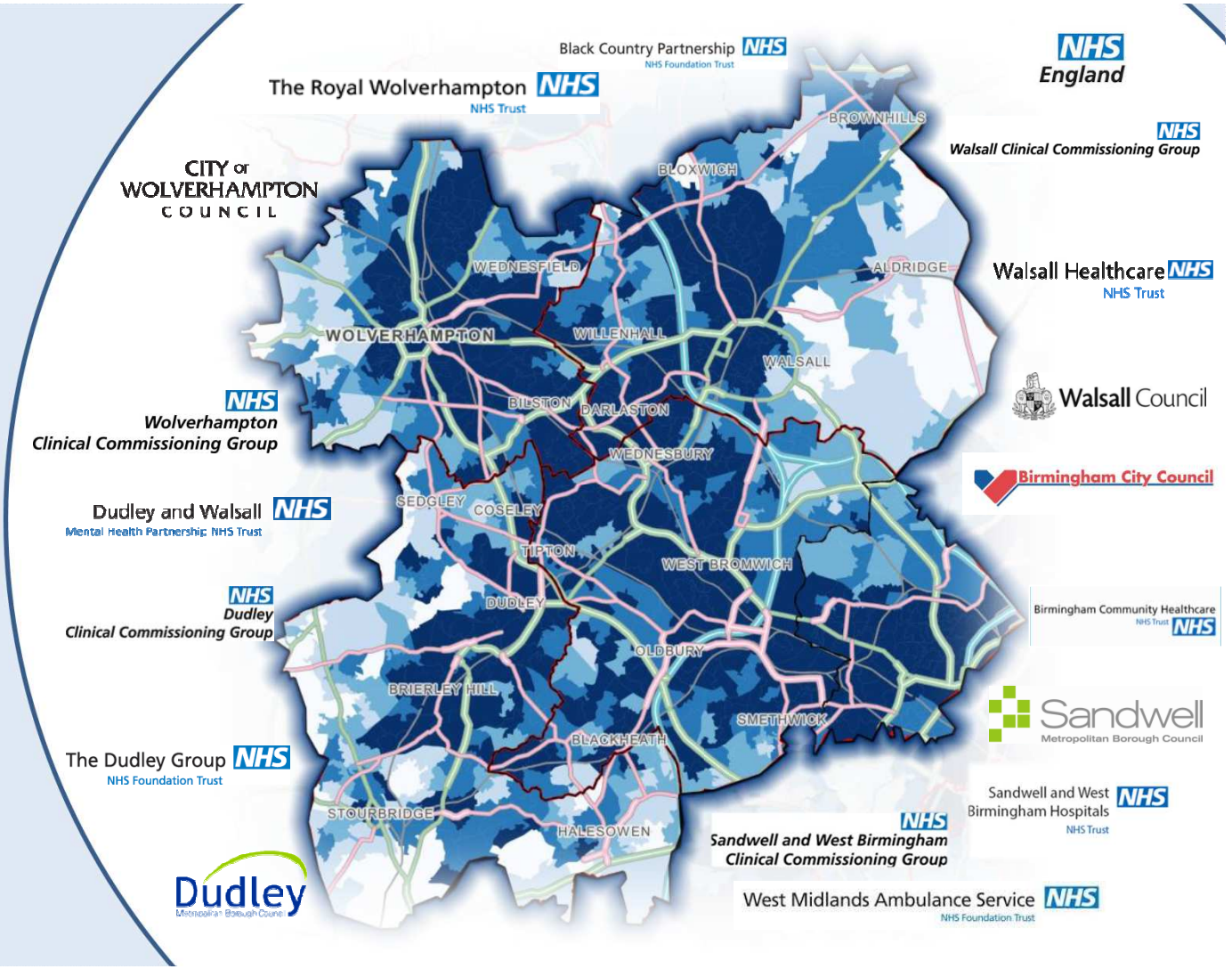
10.0 Schedule of background papers

10.1 Appendix 1 – Sustainability and Transformation Plan Submission – June 2016

The Black Country

Sustainability and Transformation Plan

June 2016



Executive Summary

Transforming Care Together

Birmingham Community Healthcare NHS Foundation Trust, Black Country Partnership NHS Foundation Trust and Dudley and Walsall Mental Health Partnership NHS Trust are working to:

- To enhance and improve our current services
- To develop high-quality, affordable services for the benefit of our communities
- To ensure our support services are efficient and effective
- To decide an appropriate organisational form to provide our services in the future

THE STRATEGY UNIT

The STP will work with the Strategy Unit and its partners to help develop its intelligence; create a positive learning culture; and implement that learning in practical applications at pace. Decisions will be based on high grade analysis and will result in better outcomes. This includes support for the evaluation of care models, analysis of the economic impact of healthcare, and scenario planning.

This plan sets out an ambitious approach to totally transforming our local health and care system in the Black Country. Through this transformation we will provide efficient, streamlined and standardised services that materially improve the health, wellbeing and prosperity of the population.

The Black Country has a strong track record of delivery and innovation. It hosts or directly interacts with a number of key nationally supported innovations: MCP Vanguards in Dudley and Sandwell & West Birmingham; and MERIT ACC vanguard. In addition, parallel innovations are underway in Walsall (integrated locality teams model) and in Wolverhampton (PACs–type integration). We are also in the process of reconfiguring from 5 to 4 acute hospitals through the Midland Metropolitan Hospital development. These innovations are summarised below. This submission sets out our year by year plan for building on this strong basis, accelerating our learning from innovation and creating a sustainable health system.

This plan has the full support of all its Sponsors who have agreed on a number of **critical decisions**:

1. We will implement a pattern of **vertical integration** on a place-based basis building on PACS and MCP approaches to deliver an Accountable Care Organisation model appropriate to each of our localities;
2. We will create, through **horizontal integration**, single systems to operate across the Black Country to improve quality and to deliver efficiencies on a scale not accessible to individual organizations, building on the Black Country Alliance and the Transforming Care Together Partnership for **Mental Health and Learning Disability Services**. This includes a reduction from 5 to 4 acute sites through the Midland Metropolitan Hospital development;
3. We have resolved to take coordinated action to address the particular challenges faced by our population in terms of **Maternal and Infant Health**, and we will create a single Black Country maternity plan that inter-relates with Birmingham and Solihull where necessary;
4. We will work together on key enablers that will enable us to achieve significant **workforce efficiencies**, to rationalise public sector **estate utilisation**, and to **streamline commissioning functions**; and
5. We will act together, and in partnership with the West Midlands Combined Authority, to address the **wider determinants of health**.

Our designated Transformation Groups will now flesh out the detail of how these critical strategic decisions will be

Executive Summary

The Black Country's 1.4m population, spanning 5 Local Authorities, is served by commissioner and provider organisations with a demonstrable commitment to leading in the transformation of health and care. But 46% of that population lives in the most deprived areas of the country. This creates some significant health challenges especially in relation to obesity, alcohol and smoking related illnesses. In addition to variation from national averages, there are also material differences in quality and outcomes across the footprint with each borough having areas of high performance and areas of particular challenge.

It is clear to us that our current ways of operating are unsustainable. As we move towards a more sustainable, healthier and higher quality 2021, we have the significant advantage of there being a range of transformation initiatives already active across our patch. Together we are committed to learning from all our initiatives through a programme of concurrent evaluation that will focus on harvesting learning that is transferable across models of care and organisational forms, locally and nationally. Under our plan, individual organisations and partnerships will continue to make the improvements and efficiencies that are directly within their own control but the overall scale of opportunity will be transformed by our working together as a single system with a common interest.

At the heart of our plan is a focus on **standardising service delivery and outcomes, reducing variation through horizontal and vertical integration**. Mental Health and Learning Disabilities services form part of this integration but are also identified as a discrete strand to reinforce parity of esteem. Maternity and Infant Health is also an essential focus for us given our challenges around maternal health, neonatal/infant outcomes and maternity capacity.

Elements of our triple challenge are unlikely to be addressed without taking action together on the wider determinants of health. To enable this we will be working closely with the West Midlands Combined Authority and have already commissioned a ground-breaking study on the economic impact of health spending. This study (commissioner through the Strategy Unit and ICF International) will include the economic impacts of health services defined in terms of both the economic benefits from improved healthcare and the opportunity costs of healthcare failures.

Evaluation and purposeful knowledge exchange is central to each of these innovations. Each programme sets out to experiment – to test approaches, uncover effective practice, codify and spread it. Each relies upon rapid-cycle learning and adaptation. Moreover, each of these initiatives is being evaluated and supported to varying degrees by the nationally regarded Strategy Unit, based in our patch, bringing a consistent discipline to both qualitative and quantitative measurement and understanding. The Black Country has the potential, with adequate resource, to transform more quickly and more effectively than many other areas.

The following slides set out our triple gaps and the key projects through which we will address those gaps.

WM URGENT & EMERGENCY CARE NETWORK

Network priorities includes a robust Integrated Urgent Care offer with single point of access, delivery of the clinical hub and interface to support direct booking; Paramedic at Home - Increased hear and treat and see and treat;- Urgent care Centres – delivering a consistent robust service offer; Highly responsive, comprehensive and safe Mental Health Crisis offer; Designing a 'sat nav' for patient self-navigation.

Transforming and Learning

MODALITY MCP VANGUARD

Modality has successfully transformed ways of working through innovative data-driven transformation plans, operating plans and outcomes frameworks. It has improved the health and experience of patients, built partnerships across Health and with Social Care, Community, Mental Health, Voluntary Sector and Public Health. It aims to become the first GP-led Accountable Care Organisation.

DUDLEY MCP VANGUARD

The model has developed a network of integrated multidisciplinary teams consisting of a GP, specialist nurses, social workers, mental health services and voluntary sector link workers. These teams work together for the benefit of their patients, taking shared responsibility to maximise the potential for individuals and communities to achieve better health and wellbeing.

MERIT ACC VANGUARD

Black Country residents with long term mental health conditions have life expectancies 20 years lower than the average. Young black men are over-represented in crisis services. Higher suicide rates are found amongst the LGBT population. Merit's 4 Trusts have three clinical priorities: crisis care, recovery culture and 7-day working in acute care. It aims to provide consistent, effective, efficient and equitable services.

MIDLAND METROPOLITAN HOSPITAL

Sandwell & West Birmingham partners are setting out to deliver improved physical, mental and social wellbeing, redesigning the whole local health and social care system. This requires a major change in service provision – namely, a substantial transfer of care into more local community and primary care settings and a significant improvement in performance in acute/emergency hospital services, enabled by the development of MMH and the associated change of use of existing sites.

RWT PILOT

The Royal Wolverhampton NHS Trust has commenced a ground breaking project with three Wolverhampton GP practices in which these practices are integrated into the Trust.

It is expected that this will increase access to services, provide more and better care out of hospital and improve team working between the surgeries and secondary care specialists.

Black Country Alliance
Better Care for All

The BCA, 12 months old and already making a difference, is a new model of acute care collaboration between DGFT, SWBH and WHC which will enable long term clinical & financial sustainability through reducing unwarranted variation, sharing best practice, improving resilience and maximising synergies through scale. Our triple aim; improve health outcomes; improve experience of healthcare; make best use of our resources.

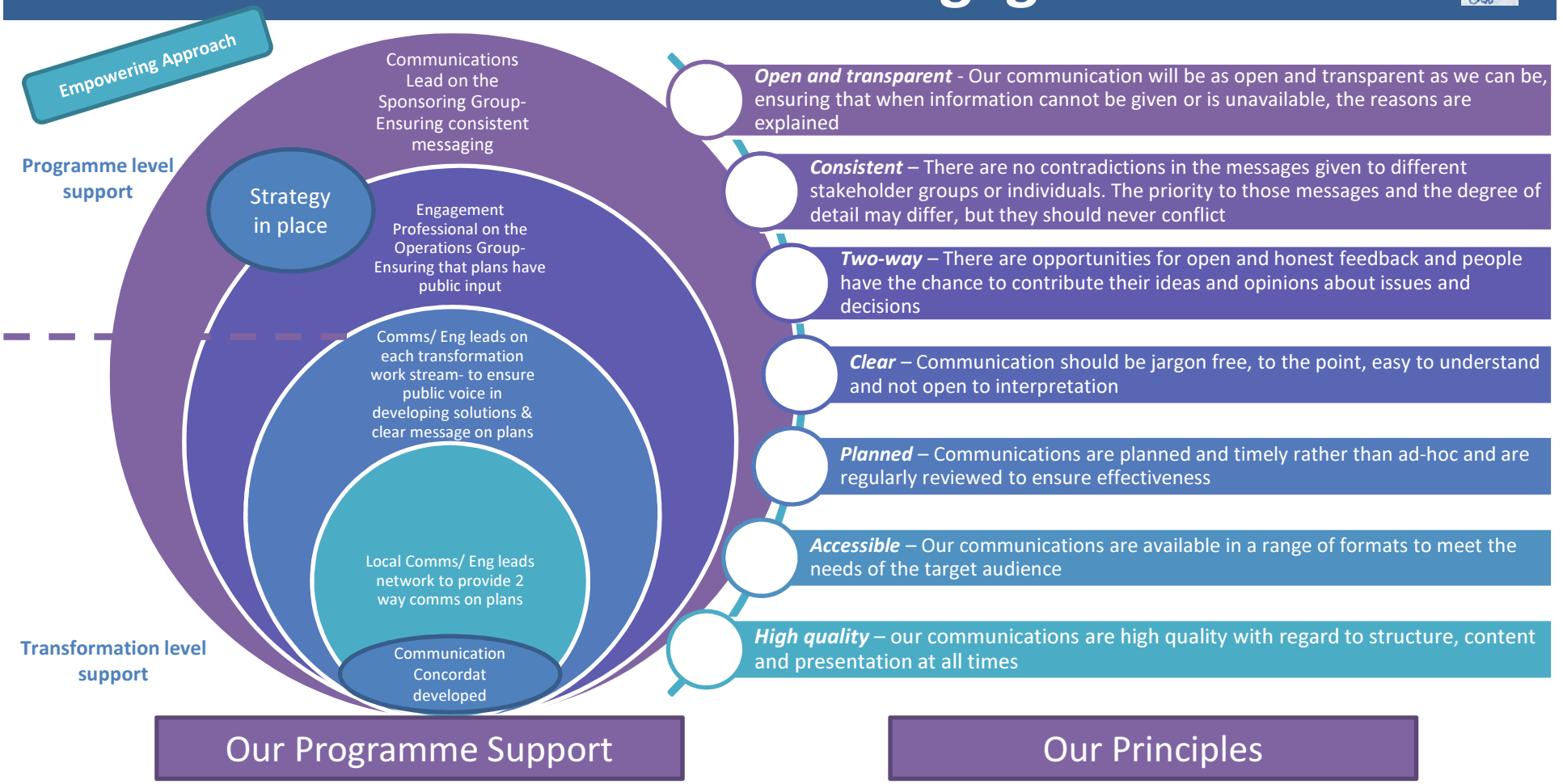
TRANSFORMATION AREAS

Over half of the STP footprint population is covered by designated Transformation Areas and we can demonstrate successes on extended primary care access, urgent and emergency care, mental health, technology and new care models. We will share learning and best practice from these successes across the Black Country to aid roll out which subject to appropriate resources will provide a sound base for further transformational initiatives at scale.

WALSALL TOGETHER PROGRAMME

Building on the existing Healthy Walsall Partnership, health and social care organisations have established Walsall Together, a transformation programme through which partners are working together to create a sustainable health and care system which delivers better outcomes for the people of Walsall. The programme is designing and implementing a model of place-based integrated care - bringing together community, mental health, primary care and social care services with good links into/support from specialist hospital provision. This work is a progression from the successful delivery of the 2013-16 Community Services Strategy which created 5 locality teams, developed rapid response and frail elderly services and is now aligned with adult social care Prevention and self-care is also a key priority for the programme, with a place-based focus on promoting independence/resilience.

Communication & Engagement



Open and transparent - Our communication will be as open and transparent as we can be, ensuring that when information cannot be given or is unavailable, the reasons are explained

Consistent – There are no contradictions in the messages given to different stakeholder groups or individuals. The priority to those messages and the degree of detail may differ, but they should never conflict

Two-way – There are opportunities for open and honest feedback and people have the chance to contribute their ideas and opinions about issues and decisions

Clear – Communication should be jargon free, to the point, easy to understand and not open to interpretation

Planned – Communications are planned and timely rather than ad-hoc and are regularly reviewed to ensure effectiveness

Accessible – Our communications are available in a range of formats to meet the needs of the target audience

High quality – our communications are high quality with regard to structure, content and presentation at all times

Better Health Gap

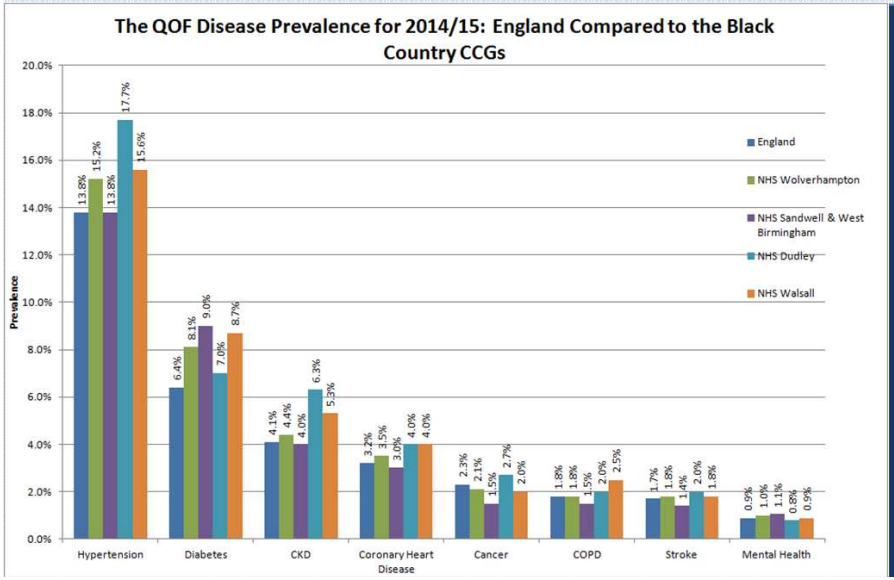
Directors of Public Health have examined data contained in JSNAs, STP data packs and supporting Public Health England information in order to assess the Health and Wellbeing Gap in the Black Country. This analysis demonstrates that not only are there gaps between the STP and England averages but that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

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

To achieve a step change going forward, however, we will implement a standardised, evidence-based approach to our prevention activities across the transformation areas we have identified. This will include: co-ordinated action with all partners; embedding critical prevention activities in place-based models of care and outcomes specifications; designing common acute care pathways that focus on broad health improvement not just narrow condition treatment; and tackling the rising challenge of Mental Health problems for communities through building resilience and promoting wellbeing, leading to health, social and economic benefits.

Key Actions will include:-

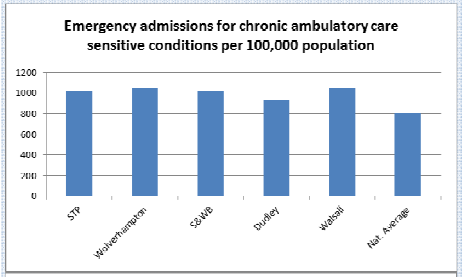
a) Forming a Public Health Reference Group: b) Developing a common prevention framework; and c) Providing advice and challenge across the Transformation Groups.

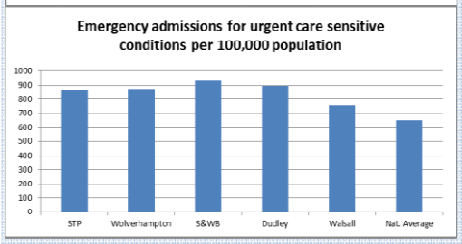


- Black Country **depression** rates (7.4%) are higher than the England average (7.3%), and are recorded at 8.6% in Dudley.
- **Diabetes** prevalence is much higher in the Black Country compared to the rest of England, with Sandwell and West Birmingham reaching over 9% (England 6.4%). The percentage of physically inactive adults is 32.6% (England 27.7%).
- The **Infant Mortality** rate is much higher in the Black Country compared to England rate of 4.0 deaths per 1000 - Walsall 6.8, Sandwell & West Birmingham 6.9, and Wolverhampton 6.8. The **Smoking in Pregnancy** rate across the Black Country is similar to the England average (11.1%) but Wolverhampton has a rate of 15.8%.
- The **Premature Mortality** rate for Respiratory Disease in the Black Country is higher than the England average rate of 28.1 per 100,000 - Sandwell & West Birmingham has a rate of 38.1 and Wolverhampton 40.9. The estimated smoking prevalence levels in the Black Country (20.3%) is higher than the rest of England figure (18.4%). Walsall and Wolverhampton rates are 21.5% and 20.7%, respectively.

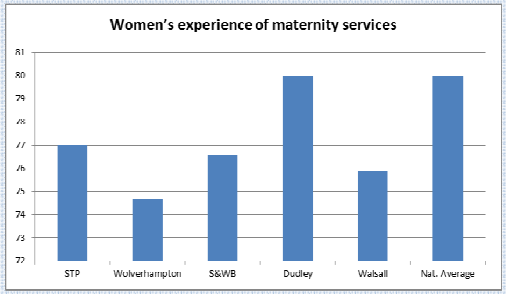
Better Care Gap

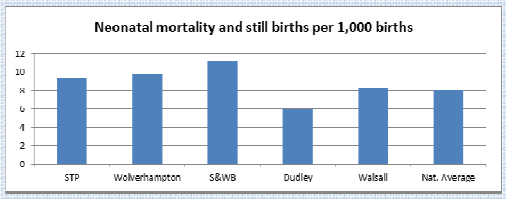
An analysis of Care & Quality data indicates unwarranted variation both between the Black Country and national performance and also across the footprint.





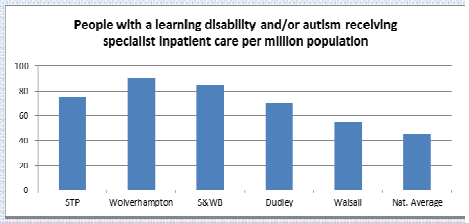
In terms of urgent and emergency care, there is a 10% variation across providers in terms of the 4 hour target with Black Country performance in the 3rd quartile nationally (as it is for emergency bed days). Emergency admissions from urgent care sensitive and chronic ambulatory care sensitive conditions are in the bottom quartile.





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

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



To respond to these and other Care and Quality gaps, our plan incorporates actions that:

- Identify areas of best practice in the Black Country and beyond which can inform the standardisation of care and quality both in localities and across hospital providers;
- Facilitate the development by commissioners, with providers, of consistent pathways and models of care across all care setting and locations
- Ensure the delivery of standardised enablers including common workforce competencies (especially in new roles); shared care records and other technology supportive of better care and self-management; and a common interface between health and social care across the Black Country to reduce duplication, facilitate repatriation and reduce DTOCs
- Focus on clinical areas with particular challenge or opportunity such as MSK, CVD, Frailty, etc.
- Support the promotion of prevention activities in all settings and facilitate patient activation and engagement.

Sustainability Gap

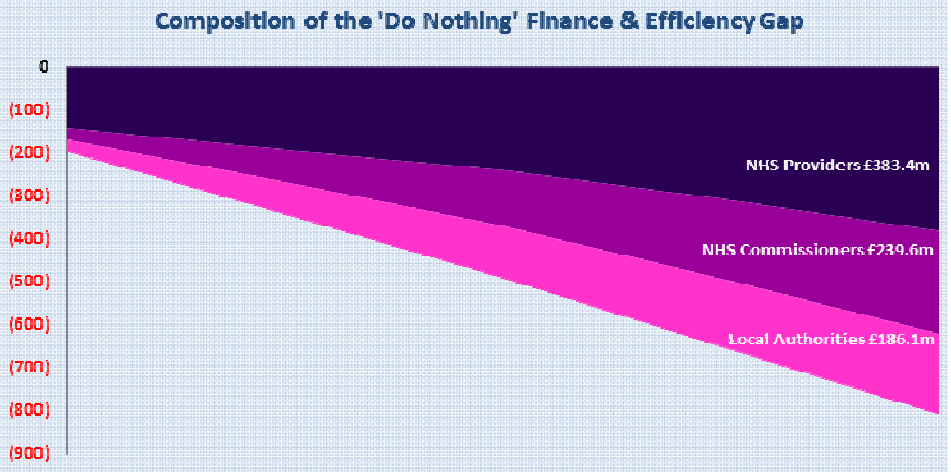
The total financial gap relating to health service organisations and the relevant elements of Local Authority budgets is projected to reach £809.1m by 2020/21, taking a recurrent starting position pre 2016/17QIPP and CIP plans.

We set out below the assumptions driving this projection, and the following slide sets out how we plan to bridge the gap.

Key Assumptions

1. NHS Commissioning
   - Secondary Care Sector (+1.2% for demographics & +1.2% for non-demographic pressures)
   - Community based services (+ 1.3% demographic & + 1.7% non-demographics)
   - Mental Health Services (+0.9% demographic and +1.3% non-demographics)
   - Continuing & Complex Care (+1.3% demographic & +6.7% non-demographics)
2. NHS & LA Providers
   - pay inflation of +2% pa for 2016/17 to 2018/19
   - additional pensions cost liability of 1%
   - non-pay costs of 2% each year
3. LA Commissioners
   - limited to adult and children's social care and health (including better care fund spending and the devolved public health functions)
   - driven by a combination of demographic driven (population levels, age profiles etc.) and non-demographic (linked to the availability of new interventions, regulation etc.) activity drivers
   - Social Care Sector (+1.2% for demographics & +1.2% for non-demographic pressures)

	Net Income & Expenditure gap				
Health & Social Care	2016/17	2017/18	2018/19	2019/20	2020/21
	£m	£m	£m	£m	£m
NHS Providers	(142.6)	(193.5)	(241.2)	(307.8)	(383.4)
NHS Clinical Commissioning Groups	(27.5)	(75.3)	(130.0)	(186.1)	(239.6)
Local Authorities	(25.2)	(73.3)	(119.8)	(157.0)	(186.1)
Total financial challenge	(195.3)	(342.1)	(491.0)	(650.9)	(809.1)



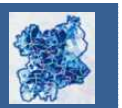
Sustainability Solutions

Place-based Vertical Integration	Horizontal Integration across the Black Country	Mental Health & Learning Disabilities	Workforce	Infrastructure
£108m	**£184m**	**£20m**	**£63m**	**£61m**
➢ Avoid demand growth ➢ Reduce existing unit cost of unscheduled ➢ Right care delivery	➢ Address variation in quality & outcomes ➢ Optimal configuration & distribution of services ➢ Clinical support efficiency benefits	➢ Reducing variation & improving access ➢ Improve early intervention ➢ Reduce out of area care ➢ Streamlining corporate services	➢ Reduce agency spending ➢ Control of pay cost pressures ➢ Improved efficiency of workforce	➢ Improve utilisation of estate ➢ Lower cost financing opportunities ➢ Technology solutions (e.g. E-Prescribing)

Gap closure schemes already underway - £90m
Sustainability & Transformation Funding - £97m
Social Care planned schemes - £62m

Addressing the Wider Determinants of Health with the West Midlands Combined Authority - £124m

Summary of Financial Position



The Financial template assesses the scale of the financial challenge and compares to the solutions identified across the STP footprint.

- This table shows the analysis of the financial challenge by sector in 2020/21
- The solutions shown on the previous slide are then attributed to either Health or Local Authority
- The analysis shows that the Health challenge is to be fully addressed through the solutions identified when incorporating the estimated STF allocation in 2020/21
- The Local Authority balance of challenge is £124.2m, and it is proposed that this will be addressed through the work of the Combined Authority / wider determinants of health opportunities

	Health £m	Local Authority £m	Total £m
Financial challenge 2020/21			
Providers	(383.4)		(383.4)
CCGs	(239.6)		(239.6)
L.A.s		(186.1)	(186.1)
Total Gap 2020/21	**(623.0)**	**(186.1)**	**(809.1)**
Solutions			
Existing gap closure schemes	90.5		90.5
Vertical Integration	107.9		107.9
Horizontal Integration	183.6		183.6
Mental Health & Learning Disabilities	20.0		20.0
Workforce	63.0		63.0
Infrastructure	61.0		61.0
Social Care planned schemes		61.9	61.9
Sustainability & Transformation Funds	97.0		97.0
Total Solutions 2020/21	**623.0**	**61.9**	**684.9**
Remaining challenge	**0.0**	**(124.2)**	**(124.2)**

Critical Transformation Areas

Place-based Vertical Integration	Horizontal Integration across the Black Country	Mental Health & Learning Disabilities	Maternity & Infant Health

Enablers

Workforce – Infrastructure – Streamlining Commissioning

Addressing the Wider Determinants of Health
with the West Midlands Combined Authority

Our Transformation Logic Model

Rationale for our STP

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

Inputs	Activities	Outputs	Outcomes	Impacts
In-kind contributions of all BC partners: clinical and managerial resources Analytical inputs Programme infrastructure National S&T funding	**1: 'Vertical integration'**: Develop standardised place-based Integrated Care Models commissioned on the basis of outcomes; Promote the prevention agenda and build resilient communities; **2: 'Horizontal integration'**: Build network of secondary care excellence; Deliver efficiencies in support services; Complete acute reconfiguration through Midland Metropolitan Hospital; Develop standardised models of care for nursing homes; Deliver CIPs; **3: 'Mental Health & Learning Disabilities'**: Integrated Commissioning & Service Improvement; Improving Services for People with Learning Disabilities; Mental Health and Regeneration; Effective Bed Utilisation and Management; TCT efficiencies; **4: 'Maternity & Infant Health':** Develop standardised pathways of care for maternal/child health; Review maternity capacity **5: 'Enablers'**: Systematically evaluate and learn from process of implementation and evidence based practice; Undertake workforce transformation and reduce agency use; Implement BC Digital Strategy; Rationalise public sector estate; Consolidate back office functions; Streamline commissioning functions **6: 'Wider Determinants':** Link to West Midlands Combined Authority to address wider determinants and maximise health contribution to economic impact	Proactive and efficient model of place-based care codified and commissioned Pathways codified and streamlined / standardised Back office / estates / supporting functions consolidated Digital Strategy implemented New workforce roles developed Lessons from implementation & from the evidence	Reduced unwarranted variation in care quality and outcomes Improved patient experience (and reduced variation in) Increased proportion of care provided in out of hospital settings Integrated service delivery Reduced per capita expenditure More proactive and risk stratified care; reduced unplanned care More engaged and productive workforce Better use of available public sector infrastructure Increased use of intelligence and insight	A more sustainable local health and care economy Improved quality & experience of care for the population of the Black Country Improved population health: greater quality and quantity of life A more capable local economy, equipped for self-improvement A happier, more sustainable workforce

1. Vertical Integration: Standardised Place-based Integrated Care Models

Project Lead – Paul Maubach

Ambition

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

Actions

- The adoption of a developmental evaluation framework will enable accelerated implementation from a robust evidence base, transferable to other STPs.
- Map current intentions and models in each borough to identify best practice
- Develop standardised access to services utilising the full benefits of the new 111 service, integrated OOH, new digital technologies and single points of access in each community
- Improve long-term conditions care pathways with emphasis on prevention and self-care supported by Integrated Care Teams working to the same outcome objectives
- Create integrated place-based teams to achieve effective care coordination for a population (patient, registered with a practice, part of a community).
- Accelerate the learning from our vanguard sites to implement new incentive and risk management models – long-term capitation based contracts commissioning for outcomes

Rationale

Population-based care needs to achieve three objectives:

• Improving timely **access** – to primary care based diagnostics and analysis to identify and then solve problems as quickly as possible.

• About one third of our population are living with at least one long-term condition. This cohort of the population, as well as good access, also want effective **continuity** of care with a professional they can trust. The Black Country has a high prevalence of LTCs and admissions for chronic ambulatory care sensitive conditions are currently in the bottom quartile.

• Within our population of people with long-term conditions we have an ever rising cohort of individuals living with frailty and complex co-morbidities (as evidenced in their utilisation of hospital-based care – emergency bed days are above the national average) who, in addition to access and continuity also need effective **co-ordination** of health and social care. Effective care planning, taking into account the whole needs of the person, is essential to ensure all individuals supporting a person's care work effectively together and help people maximise the use of their social networks in their community, reducing social isolation and reliance on statutory care.

Our STP has a high density of new care model initiatives from which initial learning can be shared to accelerate implementation across the whole STP.

Impact

Category	Type/Scale	Timing
Better Health	Reduction in LTC prevalence, % deaths in hospital & social isolation; increase in people with LTC feeling supported.	
Better Care	Improved access, coordination of care, and patient experience of GP, community and other placed-based services	
Sustainability	Reduction in emergency bed days, admissions for ACSC, and use of acute beds, nursing and social care placements	

Resources

- Partner resources (all sectors)
- National support for contracting model
- Transformation funding to support accelerated implementation and manage stranded costs
- Evaluation of care models with the Strategy Unit

Governance & Responsibility

Each CCG/LA area has its own transformation programme to deliver new models of integrated out of hospital care. Vertical Integration Transformation Group to ensure consistency and learning with critical links to pathway and workforce development groups.

2. Horizontal Integration: Collaborating to improve sustainability – 3 phase model

Project Lead – Toby Lewis

Ambition

To create networks of secondary care excellence through collaboration across the BCA Trusts working as needed with Royal Wolverhampton.

Actions

- Phase A1: Develop single service plans for less-acute surgical disciplines: including plastics, ophthalmology, and urology
- Phase A2: Complete extant work to get shared pathology vision including rationalisation of histopathology
- Phase B1: Develop shared collaboration plans for paediatric services on a network basis
- Phase B2: Create 2x2 model to support acute general surgery across 4 A&E departments
- Phase C1: Develop shared service plan for orthopaedics, based either on sub-specialised rationalisation or service relocation.
- Phase C2: Establish shared maternity and neonatal model of care to meet CQC / RCOG guidance

Rationale

There are significant opportunities to share best practice and remove variation:

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

These 6 Collaborative Network phases represent the sustainability challenge which is amenable to shared actions by the relevant organisations. Together this represents a major programme of concerted change. We will establish a governing clinical council to see it through and ensure learning from other systems who are ahead of us. We already have networked services in a number of areas – radiology, ENT, rheumatology, vascular surgery, and stroke. By ensuring that all services that support acute care operate to common standards we will tackle variation. By 2019 we will operate 4 A&E departments, ranging from 75k to 150k people in each. To succeed we may need to share expertise and increasingly to develop rotational programmes of learning and staffing across those sites. All 4 sites have to deliver for us to succeed.

Impact

Category	Type/Scale	Timing
Better Health	Potential to improve PNMR	
Better Care	Reduction in variation in outcomes for services covered by 6 phases of action	
Sustainability	Clinical and financial sustainability achieved	

Resources

Governance & Responsibility

Reports via Horizontal Integration Transformation Group. A clinical body will oversee work on the six phases, supported by a governance structure – if necessary with external independent clinical expertise: A clinical reference group is also in place across the STP

3. Horizontal Integration: Further consolidation of clinical & non-clinical support services

Project Lead – Toby Lewis

Ambition

To realise efficiency benefits from the horizontal integration of support services – including workforce sustainability and economies of scale

Actions

- Execute agreed Black Country Alliance back-office consolidation programme in 2016-2018
- Implement shared procurement programme across BCA and compare/contrast work with RWT
- Complete agreed work to create shared histopathology and microbiology functions by 2018
- Expand shared interventional radiology service (created 2016) to consider other elements of radiology and nuclear medicine

Rationale

Proposals to the timescale set out by NHSI will be developed.
RWT is already providing significant shared services into Staffordshire with UHNM. The other 3 Trusts have a shared change vehicle built around the Black Country Alliance collaboration – with a single board and programme office (and now a combined procurement function). We will work to deliver at the standard of the best on the patch.
By 2018-19 we would expect all back-office functions to have been optimised, merged or blended across Trusts, with shared services or leadership in place – but with business partners available at Trust level to support local clinical leadership.

Impact

Category	Type/Scale	Timing
Better Health	Approach consolidation on the basis of maintaining local employment	n/a
Better Care	Shared histopathology and microbiology functions will standardise outcomes	n/a
Sustainability	Estimated £10-£12m	17-20

Resources

Governance & Responsibility

Reports via Horizontal Integration Transformation Group. The Chairs and Chief executives form a BCA board, able to make decision about consolidation across three Trusts. RWT will determine which programmes of back office change it wishes to opt into.

4. Horizontal Integration: Major reconfiguration of acute services – Midland Metropolitan Hospital

Project Lead – Toby Lewis

Ambition

This project closes a major A&E and acute function, and merges two District General Hospitals into one – with associated community infrastructure – by October 2018

Actions

- Reduction of 75 acute beds vs. current state performance and flexing on intermediate care beds with hospital bed base
- Reduction in planned care demand from general practice to release medical manpower to deliver 7-day acute services
- Confirmation of NHSI approval of WHT Emergency Department capital – construction commences 2017
- Dudley Road housing land sale takes place early 2017 to create cash headroom to meet expectation of business case

Rationale

Existing acute services are not sustainable. 60% of ED consultant roles remain vacant. 50% of acute physicians. Two-site services are not able to meet Keogh standards. Half of the Unitary Payment is met through single-site only efficiencies in staffing, including rotas. The Trust will be able to eliminate much of its medical agency bill which is one of the highest in a metropolitan area in the country.
Beds per 100k population in the STP will then be within a range of 200-275 acute beds per 100,000 resident population. Key to succeeding is intermediate care flex capacity – which each integrated care/acute provider has, and our work on nursing homes.

Impact

Category	Type/Scale	Timing
Better Health	PI reductions in infection, mortality	20-21
Better Care	Keogh standards met, re-admissions reduced	19-20
Sustainability	£13m per annum recurrent	18-19

Resources

- Implementation is resourced by internal funds plus tariff adjustment non-recurrently 2016-2020 (aka NHS bank)

Governance & Responsibility

Reports via Horizontal Integration Transformation Group in addition to (a) Trust's Board governance b) NHSI/E quarterly programme board and c) SRG in SWB – includes dedicated out of hospital project taskforce chaired by SRO to ensure multi-agency response to acute changes

SC1 SC2 Horizontal Integration: Creating standardised models for nursing home care across the Black Country To be discussed and agreed			Project Lead – Toby Lewis
Ambition			**Rationale**
			To be discussed and agreed
Actions			
Impact			**Resources**
Category	**Type/Scale**	**Timing**	
Better Health			
Better Care			
Sustainability			
Governance & Responsibility			

Slide 17

SC1 Sarah Capewell, 06/07/16

SC2 Sarah Capewell, 06/07/16

6. Provider CIPs: Delivery of extant supply improvement efficiencies

Project Lead – Toby Lewis

Ambition

To deliver the existing Cost Improvement Programmes of the organisations, including Carter efficiencies, LOS reductions, and workforce re-design

Actions

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

Rationale

3 of 4 hospital-linked providers delivered surplus plans in 2015-16. Each have CIP programmes of 2-4.5% for coming years and have agreed STF control totals for 2016-17. Confusing accountabilities will detract from this work, which is the largest single component part of the stability of the Black Country STP. The Carter opportunities were:

- WH - £24m
- SWBH – £51m
- RWT - £28m
- DGH - £30m

Explicitly co-operating will deliver benefit beyond merger or organisational form changes

Impact

Category	Type/Scale	Timing
Better Health	Tbc	
Better Care	Improved pathways and patient experience	
Sustainability	Cost efficiency and cost effectiveness underpinning sustainability	

Resources

Governance & Responsibility

Reports via Horizontal Integration Transformation Group. Responsibility lies with individual Trusts who will provide monthly information on delivery into the central STP programme office.

7. MH & LD: Integrated Commissioning & Service Improvement

Project Lead – Steven Marshall

Ambition

To operate as 'one commissioner' across the Black Country, leading to: substantial reductions in care and service variations; standardised services; maximisation of resources/workforce through better use of skill mix; alignment with WM Combined Authority regeneration and MH Commission strategy. This will build on the Transforming Care Together (TCT) partnership vision to create synergies and improve the experience of Black Country residents affected by MH & LD. This opportunity focuses on developing an integrated commissioning and service delivery model. By sharing best practice and aligning to the work of other agencies we will reduce variation and improve access, choice, quality and efficiency.

Actions

- Agree governance arrangements across commissioning organisations (CCG and LA) Q1 2016/17
- Identify improvement opportunities Q1/Q2 2016/17 (provider workshops, Commissioner information, etc.)
- Agree '1CAMHS' integrated (with LAs) transformation model across the Black Country
- Agree programme of work – identify areas, prioritisation and leads – Q2 2016/17
- Development of robust business intelligence to support decision making and identification of best practice models; Benchmark across the West Midlands and nationally Q2 2016/17
- Identify opportunities across the Black Country and develop Outline Business Cases Q3 2016/17
- Identify opportunities in the West Midlands through the work of the MERIT vanguard Q3 2016/17
- Consultation with providers and any other relevant stakeholders – Q3 2016/17; FBCs developed Q4 2016/17
- Implementation - Q4 2016/17 / Q1 2017/18

Rationale

By agreeing common specifications and models we will be able to develop standardised and potentially more cost effective solutions, minimising 'differentiated' services and 'service flavours'. By comparing service delivery approaches and performance, opportunities to reduce variation can be identified including a recovery model that supports people to avoid crisis and manage their own care as much as possible, whilst supporting them at times of need. This will reduce role duplication, streamline service management and allow investment in front line staff development and up-skilling. There are opportunities to develop this across the West Midlands through the work in the MERIT vanguard. Standardisation will:

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

Impact

Category	Type/Scale	Timing
Better Health	All Community, Resilience, Wellbeing and IAPT services	
Better Care	Remove variation; Avoiding crisis; Providing services closer to home, reducing LOS,	2017/18
Sustainability	TBC	2017/18

Resources

- Programme management/back-fill
- Business Intelligence to support benchmarking
- Pump-priming to support transformational schemes and development of Early Intervention/employment support
- Non-recurrent/restructuring Costs requiring STP funding

Governance & Responsibility

Reports to the Mental Health & Learning Disability Transformation Group via existing governance arrangements for the TCT Partnership Board; Commissioning component TBC.

8. MH & LD: Delivering Services for People with Learning Disabilities

Project Lead: Steven Marshall

Ambition

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

Actions

To date as part of meeting the vision of TC:-

- 10 inpatient beds have been decommissioned, with consultation currently taking place regarding the proposed closure of one Assessment and Treatment hospital, reducing the TCP inpatient capacity by 5 beds and inpatient services provided across 3 sites.
- In the last 6 months dependence on inpatient services has reduced by 13 beds (12%) across CCG and NHSE commissioned beds
- An Intensive Support Service has been commissioned as a pilot in Wolverhampton (2016) with a view to sharing learning across the footprint (January 2017)
- Revenue funding has been awarded from NHSE (£380,000)

Future Plans

- Collaboratively commission future inpatient services across all tiers ensuring economies of scale and quality monitoring
- Embed a model of intensive support in line with Building the Right Support across the Black Country
- Develop a set of outcome measures validated for use across the TCP footprint
- Develop standardised care pathways across the TCP
- Align specialist service specifications wherever possible and ensure that there is a core offer for citizens which is standard across the footprint where service specifications are not aligned

Rationale

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

Impact

Category	Type/Scale	Timing
Better Health	• Improvement in co-produced set of Outcome Scores across 9 key areas of life	March 2017
Better Care	• Reduced admissions, Reduced length of stay, Joined-up care pathways across organisations, areas and services with a clear core offer, increase in uptake of personal budgets and use of creative alternatives to traditional service models	March 2018
Sustainability	• By reducing spend on inpatient services, the TCP will redirect resources to develop sustainable community alternatives that will be able to robustly support people with learning disabilities / autism in community settings	March 2019

Resources

- Current funding will be used differently to achieve better outcomes
- £380,000 awarded as revenue funding to the TCP in 2016/7
- Critical Path has clear working groups to facilitate delivery of the TCP Plan, with names leads
- Project Management Officer to be recruited to support the TCP

Governance & Responsibility

Reports to the Mental Health & LD Transformation Group.

9. MH & LD: Mental Health through Regeneration & Regeneration through Mental Health

Project Lead - Steven Marshall

Ambition

To build on the efforts of the Combined Authority Mental Health Commission and ensure that Mental Wellbeing is one of the core planks for regeneration across the Black Country

Actions

- Improve and Standardise Early Intervention Access as well as accelerating the time to treatment (Q3 2016/17)
- Design, develop, adopt and implement a Black Country Wide Primary Care Mental health strategy which ensures a holistic approach to both physical and mental health (Q2 2017/18)
- Roll out and standardise Support into Employment Service (IPS) and extend to include support into 3rd and voluntary sector organisations. Extend this service model to support post-prison reintegration when and where required (Q1 2017/18)
- Commission and Ensure provision for 'Mental Health First Aid' training and development in non MH Acute, Community and Primary Care settings (Q2 2017/18)
- Where 'Housing First' initiatives are in place, ensure that there are appropriate services available to draw on, with an integrate and collaborative support team (to align with Housing pilots)
- Adopt one Black Country wide suicide prevention strategy and start implementation (Q2 2017/18)

Rationale

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

Impact

Category	Type/Scale	Timing
Better Health	Black Country wide, across all Health and Social Care Sectors, aligned with WMCA MH Commission agenda	
Better Care		
Sustainability		

Resources

- Resources will be needed to fund additional services. Amount TBC
- Project Management resource for collaborative specification and development will be needed

Governance & Responsibility

Combined MH Commission action group need to be formed and planned to report to the Mental Health & LD Transformation Group.

10. MH & LD: Effective Bed Utilisation and Management

Project Lead - Steven Marshall

Ambition

To ensure that service users receive hospital care closest to home (no out of area placements) through optimised bed base management across the region. At the same time determine the optimum bed requirement, maximise the use of those beds, delivering new services for local people where that is appropriate e.g. Children's Tier 4, PICU, low secure, female services (personality disorders, perinatal).

Actions

- Identify all existing out of area placements Q1 2016/17 & Implement Tier 4 devolution in partnership with BCH Q4 16/17
- Set up live bed availability by providers to identify available beds with clear admission criteria Q2 2016/17
- Assess all patients and identify appropriate local alternatives and where there aren't local alternatives the reason (i.e. gap in service model or bed occupancy and what is causing the bottle-neck)
- Work in collaboration with whole system to reduce Delayed Transfers of Care if beds are unavailable Q2 2016/17
- Set up process for on-going/joint placement review commissioners and providers to avoid Out of Area Placements
- Transfers complete and care plans in place Q3 2016/17

Rationale

To ensure that users of services receive the most appropriate, best quality service provided as close to home as possible. This opportunity will ensure that people treated out of area are repatriated to the Black Country wherever possible. This will ensure Black Country funding is retained and bed provision is aligned to the appropriate level of demand resulting in savings for Commissioners through reduction of expensive (& less effective) out of area placements, improve profitability for providers of in-patient units and reduce length of stay through appropriate relationships with other partners required for recovery.

Impact

Category	Type/Scale	Timing
Better Health	• Improve user, carer & family wellbeing through care closer to home • Whole person care through closer relationships with social care	2017/18
Better Care	• Remove variation across the Black Country • Providing services closer to home, reducing LOS, better integration with wider system solutions • Agreed pathways developed with experts by experience • Opportunity to address gaps in service through management of the whole pathway of care	2017/18
Sustainability	• Reduction of out of area placements offset by spend in local area • Better contribution to overheads for providers through optimal occupancy, whilst retaining ability to respond to crisis	2017/18

Resources

- Clinical assessment team to review/back-fill support
- Systems to capture live bed availability
- Bed management co-ordinator
- Out of Area repatriation team to support transfers
- IT investment in system to capture available beds
- Potential costs to support reduction in DTOC
- Improved bed base information and data

Governance & Responsibility

Reports to the Mental Health Transformation Group via existing governance arrangements for the TCT Partnership Board and the MERIT Vanguard.

11. MH & LD: Transforming Care Together (TCT) Efficiencies

Project Lead - Steven Marshall

Ambition

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

Rationale

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

Actions

- Establishment of a programme board, governance structures and work streams Q1 2016/17
- Mobilise enabling work streams – IT & Informatics, Estates, HR & Workforce, Finance Q1 2016/17
- Outline business cases developed and approved (initial ideas expected to include estates rationalisation and efficiencies; procurement efficiencies; Electronic Health/Patient Record; using benchmarking data to ensure that best practice is identified) – Q2 2016/17
- Full business cases approved – Q3 2016/17
- 2016/17 projects commence – Q4 2016/17

Impact

Category	Type/Scale	Timing
Better Health	• N/A	N/A
Better Care	• Improved recruitment & retention and development opportunities for all staff • Reduction in sickness absence • Fit for purpose estate utilisation • Improved quality and safety through use of Electronic Patient/Health Record	2017/18
Sustainability	• Estimated 10% of current back office costs	2017/18

Resources

- Programme management costs including back-fill
- Backlog maintenance one-off capital investment
- Invest to save costs i.e. restructuring, alignment of infrastructure costs
- Legal advice and support
- Improved information and data to support decision making

Governance & Responsibility

Reports to the Mental Health Transformation Group via existing governance arrangements for the TCT Partnership Board.

12. Maternity & Infant Health: Improving Maternal and Infant Health

Project Lead – Salma Ali

Ambition

To improve the maternity care, infant and child health outcomes across the Black Country through the development of standardised pathways of care and quality improvement

Actions

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

Rationale

The rate of low birth weight infants, perinatal, neonatal and infant mortality across the STP is generally worse than the England average. There are high levels of deprivation, teenage conceptions and smoking at the time of delivery which contribute towards some of the poor maternal, infant and child outcomes. A co-ordinated maternity pathway alongside the provision of universal and targeted support will improve the quality of maternity care and prevent lifelong disability arising from poor outcomes at birth.

Impact

Category	Type/Scale	Timing
Better Health	Reduction in maternal smoking and child obesity	
Better Care	Reduction in still births/neonatal mortality; improvement in maternity experience	
Sustainability		

Resources

- Partner resources (all sectors)
- Investment in digital tools
- Contracting mechanisms which incentivise prevention activities and the achievement of improved health and wellbeing outcomes.
- Maternity capacity modelling

Governance & Responsibility

Reports via the Maternity & Infant Health Transformation Group. Liaison also required with Horizontal & Vertical Integration Transformation Groups.

13. Workforce: Reducing Substantive and Agency Spend

Project Lead – Paula Clark

Ambition

To make the Black Country the place of choice for all staff to live, work and develop by ensuring staff feel empowered, supported and valued, and have more flexibility and new opportunities. Investing in our people will lead to reduced turnover, significantly happier and more engaged staff leading to better care for patients and improved attendance, reducing turnover and the need for bank/agency & locum staff. Achieving a turnover level of 10% (reducing by up to 5.8%) creates an efficiency saving of £3m. Reducing dependency on non-substantive staff by 20% by March 2018 and a further 30% by March 2020 will save a total cumulative efficiency of £60m. Develop new roles in shortage areas with reduced lead times to employment. Invest in training of a more readily available workforce to change team skill mix whilst maintaining safe care e.g. Physicians' Associates, Band 4 Associate Nurses, Care Coordinators.

Actions

- Utilise the LWAB to lead and drive workforce development across the STP making extensive use of HEE resources
- Use research and recognised evidence base to embed principle that investing in developing our people will improve health outcomes, the experience of healthcare and make better use of our resources.
- Ensure baseline data is collected quarterly from STP to inform forward planning and performance management
- Adopt and spread best practice across the system on managing turnover and reduction in bank/agency/locum
- Consider the use of a single Black Country Bank/Agency/Locum delivery function – to reduce costs and ensure consistency

Rationale

With a total health care workforce of 28,000 FTE and 33,000 social care staff, the STP is a major employer across the region contributing substantially to the wider economy and is committed to ensuring the workforce reflects the community it serves. Untapped cost efficiencies identified around the existing workforce include bank/agency and locum costs, turnover, disciplinary management and recruitment to student placements. CIPD suggests an average replacement cost of £7k. There is an opportunity to promote the Black Country as a "Great place to work, live and grow", facilitating a more content and productive workforce with improved attendance.

Impact

Category	Type/Scale	Timing
Better Health	Improve workforce health, reducing sickness & absence	2017-21
Better Care	Happy and engaged workforce lead to better experience of healthcare	2017-21
Sustainability	Reduced turnover and reduced demand for temporary staff will generate £63m	2020

Resources

To utilise the HRDs across the STP to ensure a clear safe plan to facilitate the reductions.

Governance & Responsibility

Reports to the Workforce Workstream via the Local Workforce Action Board

14. Workforce: Transforming Roles

Project Lead – Paula Clark

Ambition

To ensure that the STP is bolder and braver about the shape, provision and development of the new and existing workforce to ensure the very best safe, sustainable, high quality patient care. The STP will be a great place to work and grow, with workforce transformation a core element of service transformation; new skills developed and new roles for current and future workforce; a reshaped workforce, working across professional boundaries, with proven competencies to ensure safety & quality of care; staff equipped to provide care closer to home, enabling more flexible working including remote working for non-clinical & clinical staff; a shift from treatment to prevention, from reactive to proactive care and to steady state rather than crisis care. This will reduce the cost of delivering care by equipping and uplifting skills across AfC bands, moving care closer to home, attracting and retaining colleagues and promoting the Black Country as a place to work and develop.

Actions

- Utilisation of the six steps methodology to integrated workforce planning - a systematic and practical approach that supports the delivery of quality patient care, productivity and efficiency. It is both a scalable approach and joined up with social care
- Development of Black Country wide vision of a new and transformed workforce at all levels.

Rationale

The Black Country has a number of key workforce challenges including social workers, living wage cost impact, adult nursing, Speech and Language Therapists, ODPs, paramedics, sonographers and Primary Care. With a significant proportion of the workforce aged 55+ (15% healthcare, 17% social care, 22% primary care), we need to utilise a different, highly capable workforce for the future (paid and voluntary) and to develop staff to be better equipped for providing integrate system care. There is also an opportunity to continue building on the voluntary sector's contribution to effective patient care. By changing the shape of the workforce, using technology to streamline processes, utilising roles such as physicians' associates, nursing associates, assistant practitioners, integrated health and social care apprentices, we can underpin the provision of high quality safe patient care. For example, the Black Country has c. 600 adult/community nursing vacancies. If we utilised assistant practitioners or nursing associates for 250 of those roles based on Band 4 & 5 there could be a saving of £1.2m.

Impact

Category	Type/Scale	Timing
Better Health	Better utilisation of the registered workforce to deliver complex provision	2017-21
Better Care	Better provision of care by a multi skilled, multi professional staff in the right place, right time	2017-21
Sustainability	With care in the right place and the right shape the best safe patient care will be delivered	2017-21

Resources

Project Delivery team: Workforce Analysts, Stakeholders to service redesign, HRDs and finance colleagues from across the STP

Governance & Responsibility

Reports to the Workforce Workstream via the Local Workforce Action Board

15. Infrastructure: Implementation of a Black Country Digital Strategy

Project Lead – Tony Gallagher

Ambition

To develop & implement an integrated Black Country digital strategy that enables self-care, remote-care, paperless care and population health management; accelerates and joins together extant Local Digital Roadmaps (LDR); supports development of new models of care; enables significant service transformation; increases public ability to self-manage; and strengthens our ability to aggregate and use big data, enabling a move from reactive treatment to proactive interventions that enable people to live healthier longer.

Actions

- Accelerate production & convergence of Local Digital Roadmaps, aligning existing plans
- Form Black Country Digital Transformation Board to lead, drive & own delivery
- Develop Digital Delivery Plans to take us from current state (16/17) to digitally enabled state (17/18) to connected state (18/19) to integrated state (19/20).
- Accelerate & support extant plans within organisation & LDR footprints, ensure one direction, avoid duplication, minimise 'risk of regret' & maximise triple aim benefits.
- Rapidly identify & deliver 'quick wins' such as ePrescribing, ToC (electronic correspondence), network rationalisation, procurement efficiencies.

Rationale

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

Person Centred Digital Health. Digital solutions must be 'person centred'; based on the needs of the end user and must be able to demonstrate measurable health and/or economic benefits.

Interoperability. 'If you're known to one of us, you're known to all of us'. Solutions must be capable of 'sharing by default' through the use of interoperability standards while at the same time respecting **trust** and **confidentiality.** Citizens and Users need to be confident that information is accurate, up to date and only shared legitimately.

Big data used properly leads to meaningful information and so to insight, action and results/further data. We will create this virtuous circle for our STP.

Prevention through digital enablement; risk stratification to target proactive interventions; remote monitoring and telemedicine to improve adherence to treatment, manage LTC closer to home and prevent crisis; move knowledge from specialists to those responsible for care (including patients).

Impact

Category	Type/Scale	Timing
Better Health	Reduction in antibiotic prescribing; proactive population health management	
Better Care	Improved transfers of care, admission avoidance, reduced acute Length of Stay	
Sustainability	ePrescribing alone could reduce drug spend by c.£47.5m in 2019/20 and £50m in 2020/21.	2019-21

Resources

- Local Digital Roadmaps & extant Plans (EPR, ePrescribing, Transfer of Care, Your Care Connected, Patient Knows Best)
- STP resources (e.g. Clinical, Finance, IT)
- Partners (e.g. WMAHSN, IBM, Cerner, ECHO)

Governance & Responsibility

Reports to Infrastructure Workstream via Black Country Digital Transformation Board (working closely with LDR Boards and STP Transformation Groups).

16. Infrastructure:
Refinancing and Better Utilisation of One Public Sector Estate

Project Lead – Tony Gallagher

Ambition

To ensure that the estates infrastructure required for service delivery and supporting functions is configured, financed and utilised in the most efficient way, contributing to a 10% reduction in STP estates costs.

Actions

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

Rationale

The Black Country has invested heavily in new capital assets over the past decade and has a variety of capital asset funding models in place, included several PFI and LIFT facilities, which have comparatively high occupation costs. We see two streams of opportunity in this cost area. Firstly, there may be opportunity to leverage the £3.8bn 'Sustainability & Transformation Fund' on a non-recurrent basis, to buy-out elements of PFI or Lift. Secondly, we see opportunities in the better utilisation of the estate that currently exists.
The evidence base for this project includes the Carter Review, PFU Forum survey and studies and Dudley CCG place-based assessments.

Impact

Category	Type/Scale	Timing
Sustainability	£0.5m £7.0m £13.5m £13.5m	2017/18 2018/19 2019/20 2020/21

Resources

- Partner resources (finance and estates teams)
- Financial modelling support (Strategy Unit/Provex)
- STP Trust Financial Model
- STP Provider Template returns
- Provider APRs & ERIC Returns
- CCG Void space returns/CHP & NHSPS

Governance & Responsibility

To be led by the Infrastructure enabler group, working closely with the Finance & Efficiency Workstream.

17. Infrastructure: Consolidation of Non-clinical Services

Project Lead – Tony Gallagher

Ambition

To magnify the impact of Cost Improvement Schemes by planning and delivering key schemes on an STP-wide basis, in order to deliver 2% year on year savings.

Actions

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

Rationale

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

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

Impact

Category	Type/Scale	Timing
Better Health	n/a	
Better Care	n/a	
Sustainability	Reduction in duplicated/back office costs	

Resources

- Partner resources (especially finance & HR)
- Black Country Alliance
- STP Trust Financial Model
- STP Provider Template returns
- Provider APRs

Governance & Responsibility

To be led by the Infrastructure enabler group, working closely with the Finance & Efficiency Workstream.

18. Infrastructure: Streamlining Commissioning Functions

Project Lead – Tony Gallagher

Ambition

To simplify and standardise commissioning mechanisms across the Black Country in order to support Better Health and Better Care, and to remove duplicated costs.

Actions

- To identify priority areas for streamlining and standardisation – both quick wins and major opportunities
- To identify and evaluate alternative mechanisms (including organisational forms) through which streamlining and standardisation can best be enabled, and efficiencies delivered.

Rationale

The Black Country is currently served by ten commissioning organisations. This is likely to lead to the duplication of activity and cost, to unnecessary complexity in models of care and commissioning procedures (including procurement) and to to the maintenance of unwarranted variation in service delivery and outcomes.

A single system of commissioning is required to support the delivery of our Accountable Care Organisation model.

Impact

Category	Type/Scale	Timing
Better Health	Improved outcomes through standardised commissioning	tbc
Better Care	Improved care quality through standardised commissioning	tbc
Sustainability	Remove duplicated costs.	tbc

Resources

- Partner resources (Chief Officers and Governing Bodies/relevant LA committees)
- Facilitation by the Strategy Unit
- Regulator support

Governance & Responsibility

To be led by the Infrastructure enabler group, working closely with the Finance & Efficiency Workstream.

19. Wider Determinants: Reducing Long Term Condition Prevalence

Project Lead – Glenda Augustine

Ambition

To improve the healthy life expectancy of Black Country residents by achieving a significant reduction in the prevalence of long term conditions (LTC) through promotion of the prevention agenda and building resilient communities.

Actions

- Public Health departments will work together to:
  - provide evidence based recommendations to support the prevention agenda,
  - develop an STP-wide network of best practice and identify prevention resources & self-help tools
- Local partners will work together and with the West Midlands Combined Authority to:
  - build social capital & map community resources to address social isolation & improve resilience
  - promote independence through personalisation
  - develop place-based models of care to improve management of LTC
  - improve employability and skills development
  - encourage a wellbeing focus across all health and social care policies, planning and departments
- Delivery of ambitious Public Health programmes across the Black Country to address key lifestyle risk factors, mobilising health and social care systems to deliver Making Every Contact Count. This will include promotion of workplace health initiatives across health, social care and local business

Rationale

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

Impact

Category	Type/Scale	Timing
Better Health	Improved healthy life expectancy, Wellbeing scores & diabetes education, carer quality of life	
Better Care	Increase in Making Every Contact Count & use of digital tools	
Sustainability	Reduction in activity attributable to lifestyle factors	

Resources

- Partner resources (all sectors)
- Investment in digital tools
- Contracting mechanisms which incentivise prevention activities and the achievement of improved health and wellbeing outcomes.

Governance & Responsibility

Reports to the Sponsor Group and the Public Health Reference Group of the West Midlands Combined Authority.

20. Wider Determinants: Health and Wellbeing

Project Lead – Sarah Norman

Ambition

To interact with the Combined Authority to contribute to and benefit from the health and wellbeing gain associated the Combined Authority's development plan.

Actions

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

Impact

Category	Type/Scale	Timing
Better Health	Improved health and wellbeing	
Better Care	Reduced demand on services	
Sustainability	Increased economic prosperity	

Rationale

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

Resources

The STP has already commissioned the SU with its partner ICF International to conduct and analysis of health service budgets (identifying expenditure on wages and on the procurement of goods and services) and of the patient population and the economic impacts of health services (defined either in terms of the economic benefits from improved healthcare or opportunity costs of healthcare failures, and taking existing targets / service activity as a baseline). The more effective healthcare services are, the greater the economic as well as health benefits. The analysis will seek to distinguish between patients according to age and economic activity.

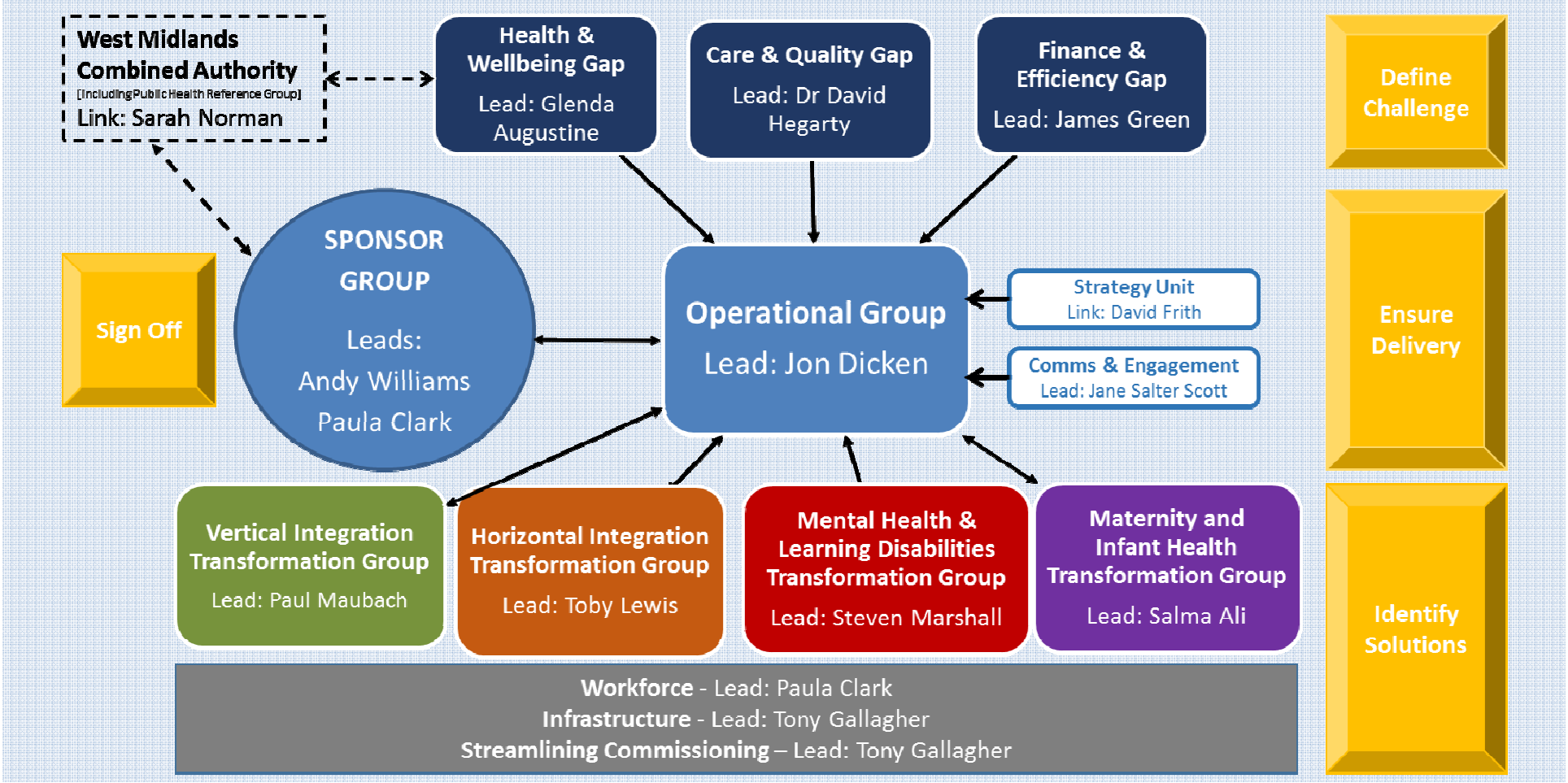
Governance & Responsibility

Reports to the Sponsor Group and the Public Health Reference Group of the West Midlands Combined Authority.

Ten Priority Questions

1	**How are you going to prevent ill health and moderate demand for healthcare?**	Our plans for vertical integration address the need for better health. Horizontal integration plans, including the standardisation of priority acute pathways will support the reduction of avoidable admissions. Total reduction of c.£224m.
2	**How are you engaging patients, communities and NHS staff?**	This is set out on the Communication and Engagement slide. More widely, place-based care models will increase patient activation (supported by the Digital Strategy) and the take up of Personal Health Budgets (especially for Maternity). The Workforce enabler group will lead on action to increase staff wellbeing and reduce employee sickness rates.
3	**How will you support, invest in and improve general practice?**	The development of place-based models of care, building on local Vanguards, will strengthen the resilience of primary care services and enable re-design appropriate to each locality. The Strategy Unit has developed an evidence-based approach to primary care development which has potential to be rolled out across the Black Country.
4	**How will you implement new care models that address local challenges?**	New models of care are already active within and across the four Black Country boroughs. Our local evaluation methodology will enable rapid learning and roll out of vertical integration across the Black Country.
5	**How will you achieve and maintain performance against core standards?**	Our plans for standardised best practice in place-based models of care will reduce the pressure on the urgent and emergency care system; and our analysis shows significant potential to reduce first:follow-up ratios, improving RTT.
6	**How will you achieve our 2020 ambitions on key clinical priorities?**	Standardisation of acute pathways will improve cancer survival; prioritisation of Mental Health transformation will improve access & outcomes; standardisation of maternity pathways will improve experience and outcomes; and Strategy Unit analysis will inform improved intervention along the Dementia pathway.
7	**How will you improve quality and safety?**	Improvements will be achieved through standardisation of place-based care models and of priority acute pathways. A system-wide ePrescribing system will support antimicrobial resistance through reducing inappropriate prescribing.
8	**How will you deploy technology to accelerate change?**	Our digital strategy will enable benefits in vertical and horizontal integration initiatives. These will both drive digital requirements and be partially shaped by digital potential (e.g. collaboration, analytics, big data, infrastructure).
9	**How will you develop the workforce you need to deliver?**	Our horizontal integration work will drive a new scale of workforce efficiency (including around agency spend). We are also initiating a discrete project to develop new roles (e.g. physicians associates, nursing associates, assistant practitioners, integrated health and social care apprentices) to underpin new models of care.
10	**How will you achieve and maintain financial balance?**	Our plan sets out how far we can go towards a sustainable health and care system. Critical to this is the horizontal and vertical integration that opens up transformational opportunities beyond those accessible through organisation -based QIPP/CIP. With the WM Combined Authority, we will seek to act on the wider determinants of health.

Well Led – STP Programme Structure



Well Led – Programme Plan

Year	2016			
Month	June	July	August	September
Comms & Engagement				
Develop Comms & Engagement Strategy				
Develop Comms & Engagement Plan				
Engagement - patient, public, partners, stakeholders, clinicians, staff				
Transformation Groups				
Vertical Integration				
Confirm membership				
Agree model for vertical integration				
Model impact of vertical integration				
Consultation with STP partners on the model				
Outline timescales for implementation				
Horizontal Integration				
Commence development of single service plans				
Commence Black Country Alliance back office consolidation programr				
Develop PMO arrangements to support delivery of CIPs				
Outline timescales for implementation				
Mental Health				
Agree governance arrangements across commissioning organisations				
Finalise work programme				
Consultation with STP partners				
Outline timescales for implementation				
Enablers				
Workforce				
Develop baseline for health and social care workforce				
Draft vision for new and improved workforce				
Consultation with STP partners				
Outline timescales				
Infrastructure				
Draft Digital Delivery Plan				
Commence survey of current estate (LIFT & PFI)				
Scope out opportunities for consolidation of non-clinical services				
Consultation with STP partners				
Outline timescales				
Links to Combined Authority				
Scope out opportunities for wider determinants of health				
Commissioning				
Identify opportunities for streamlining and standardisation				
Identify alternative models for commissioning				
Consultation for with STP partners				
Outline timescales				

Well Led – Key 5 Year Milestones

Year Transformation Group/Enabler	16/17	17/18	18/19	19/20	20/21
Vertical Integration	Integrated Urgent Care Model mobilised	New Care Models established in Dudley and Sandwell & West Birmingham	New Care Models established in Walsall and Wolverhampton		
Horizontal Integration			Midland Met Hospital opens – reduce from 5 acute sites to 4 across Black Country	Carter efficiencies delivered Right Care efficiencies delivered	Care home model established
Mental Health	Single commissioning approach agreed across the Black Country	Benefits of Transforming Care Together realised Black Country wide Primary Care Mental Health and Suicide Strategies in place			
Workforce	Vision for Black Country wide transformed workforce	Black Country wide integrated workforce planning model	Black Country as a place of choice for clinical and non clinical workforce		
Infrastructure		Options for possible NHS PFI estate refinancing confirmed		Local Digital Roadmap fully delivered	NHS PFI estate refinanced (subject to confirmation of viable option)
West Midlands Combined Authority		Black Country wide public health programmes established focusing on life style risk factors		Benefits realised from wider determinants of health	

Well Led - Investment

The Black Country

Estimated Investment Required To Deliver Five Year Forward View

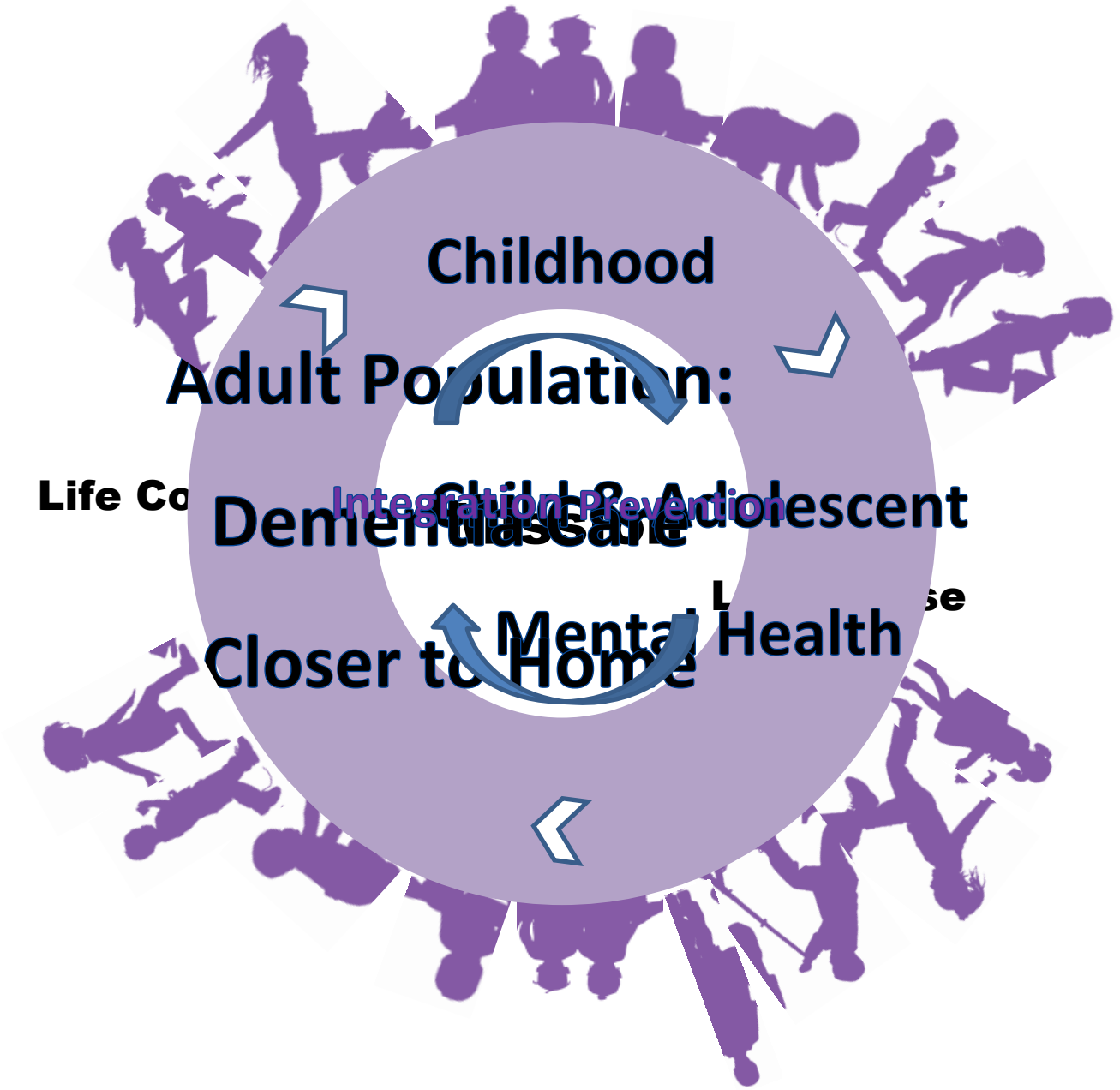
This is a memorandum worksheet and the data entered does not flow through elsewhere in the template.

		2017/18	2018/19	2019/20	2020/21
Enter the estimated non-recurrent revenue transformation costs required to develop each service in your STP footprint:					
Seven Day Services Roll Out Through To 2019/20	£000s	6,110	4,656	5,328	-
Taking Forward The Programmes Set Out In The General Practice Forward View and Delivering Extended GP Access	£000s	10,180	7,760	8,730	-
Increasing Capacity Of Children And Adolescent Mental Health Services And Implementing Access and Wait Targets For Eating Disorders Services	£000s	5,090	3,880	4,365	-
Implementing The Recommendations Of The Mental Health Taskforce	£000s	5,090	3,880	4,365	-
Cancer Taskforce Strategy	£000s	6,110	4,546	5,238	-
National Maternity Review	£000s	6,110	4,656	5,238	-
Investment In Prevention, Tackling Childhood Obesity, And Improving Diabetes Diagnosis and Care	£000s	4,070	3,104	3,640	-
Local Digital Roadmaps Supporting Paper Free At The Point Of Care And Electronic Health Records	£000s	8,150	6,208	6,984	-
Enter the estimated additional recurrent revenue costs (net of savings) required to develop each service in your footprint:					
Seven Day Services Roll Out Through To 2019/20	£000s	2,040	4,656	5,238	11,640
Taking Forward The Programmes Set Out In The General Practice Forward View and Delivering Extended GP Access	£000s	3,400	7,760	8,703	19,400
Increasing Capacity Of Children And Adolescent Mental Health Services And Implementing Access and Wait Targets For Eating Disorders Services	£000s	1,700	3,880	4,365	9,700
Implementing The Recommendations Of The Mental Health Taskforce	£000s	1,700	3,880	4,365	9,700
Cancer Taskforce Strategy	£000s	2,040	4,656	5,238	11,640
National Maternity Review	£000s	2,040	4,656	5,238	11,640
Investment In Prevention, Tackling Childhood Obesity, And Improving Diabetes Diagnosis and Care	£000s	1,360	3,104	3,640	7,760
Local Digital Roadmaps Supporting Paper Free At The Point Of Care And Electronic Health Records	£000s	2,710	6,208	6,984	15,520

Mission

Promoting health, wellbeing and resilience

across the life course



Vision

- **Best start in life**
- **Supporting positive transition into adulthood**
- **Promoting wellbeing throughout adulthood**
- **Supporting a good healthy life expectancy**

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Mission

Promoting health, wellbeing and resilience across the life course

Vision

- **Best start in life**
- **Supporting positive transition into adulthood**
- **Promoting wellbeing throughout adulthood**
- **Supporting a good healthy life expectancy**

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Agenda Item No: 14

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

20 July 2016

Report title	Director of Public Health Annual Report 2015/16	
Decision designation	AMBER	
Cabinet member with lead responsibility	Councillor Paul Sweet Public Health and Wellbeing	
Key decision	No	
In forward plan	No	
Wards affected	All	
Accountable director	Linda Sanders, People Directorate	
Originating service	Public Health	
Accountable employee(s)	Ros Jervis	Service Director for Public Health and Wellbeing
	Tel	01902 551372
	Email	Ros.Jervis@wolverhampton.gov.uk
Report has been considered by	Public Health Senior Management Team	30 June 2016
	People Leadership Team	4 July 2016

Recommendation for action or decision:

The Health and Wellbeing Board is recommended to:

1. Publish the Director of Public Health Annual Report for 2015/16.

1.0 Purpose

1.1 The Health and Social Care Act 2012 states that 'the Director of Public Health for a local authority must prepare an annual report on the health of the people in the area of the local authority…..the local authority must publish the report'.[1]

1.2 The purpose of this report is to present the Director of Public Health Annual Report for 2015/16 which illustrates Public Health related changes in the Wolverhampton population and place over the last 150 years.

2.0 Background

2.1 The year 2016 marks to the 150th anniversary of a statutorily recognised Public Health service in Wolverhampton. In 1866, Dr Vincent Jackson, a surgeon and councillor, was appointed as the first Medical Officer for Health in Wolverhampton Borough Council.

2.2 It was deemed opportune for the Director of Public Health this year to reflect on the Public Health achievements within the local population over the last 150 years.

3.0 Director of Public Health Annual Report 2015/16

3.1 The Director of Public Health Annual Report 2015/16 aims to illustrate the public health related changes to the population of Wolverhampton, focusing on the people and the place.

3.2 This historical overview of changes to the health of the local population provides an opportunity to celebrate the advances in health and social care over the past 150 years, influenced, initially, by the Medical Officers of Health. The 1974 health reforms saw the move of the main public health functions into the NHS and the role of the Director of Public Health emerged to continue population level improvements in health.

3.3 The passing of the Health and Social Care Act 2012, returned the responsibility for public health to local government, from the NHS in April 2013. This fourth Director of Public Health Annual Report since the return to local government highlights the significant historical journey of the local Public Health service. It will serve as a reminder of the advances made in local health and social care over the past 150 years, as well as a baseline at this point in our history, for the advancements yet to come for future generations.

[1] *Health and Social Care Act 2012 (c7) Part 1 – The health service in England* pg 60. The Stationery Office: London http://www.legislation.gov.uk/ukpga/2012/7/pdfs/ukpga_20120007_en.pdf [accessed 4th August 2015]

4.0 Financial implications

4.1 Funding for Public Health is provided to the Council by the Department of Health in the form of a ring-fenced grant. The final grant allocation for 2015/16 was £20.2 million which includes an in-year cut in funding of £1.3 million from the Department of Health. There are no direct financial implications related to the publication of the Director of Public Health Annual Report.
[GS/07072016/E]

5.0 Legal implications

5.1 There are no legal implications related to this report.
[TS/22062016/H]

6.0 Equalities implications

6.1 This report does highlight historical and current health inequalities that are known and addressed through services commissioned by Public Health.

7.0 Environmental implications

7.1 There are no environmental implications of the report.

8.0 Human resources implications

8.1 There are no human resource implications related to this report.

9.0 Corporate landlord implications

9.1 There are no corporate landlord implications for the Council's property portfolio in relation to this report.

10.0 Schedule of background papers

10.1 There are no background papers in relation to this report:

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