CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

30 November 2016

Time 11.00 am **Public Meeting?** YES **Type of meeting** Oversight

Venue Committee Room 3 - 3rd Floor - Civic Centre

Councillor Roger Lawrence	(Chair) Labour
Councillor Val Gibson	Labour
Councillor Sandra Samuels OBE	Labour
Councillor Paul Singh	Conservative
Councillor Paul Sweet	Labour
Ros Jervis	Service Director Public Health & Wellbeing
Dr Helen Hibbs	Wolverhampton Clinical Commissioning Group
Trisha Curran	Wolverhampton Clinical Commissioning Group
David Jamieson	West Midlands Police and Crime Commissioner
Tim Johnson	Strategic Director - Place
Linda Sanders	Strategic Director - People
Dr Alexandra Hopkins	University of Wolverhampton
David Loughton	The Royal Wolverhampton Hospitals NHS Trust
Jeremy Vanes	The Royal Wolverhampton Hospitals NHS Trust
Tracy Taylor	Black Country Partnership NHS Foundation Trust
Donald McIntosh	Healthwatch Wolverhampton
Alistair McIntyre	Locality Director NHS England (West Midlands)
Robin Morrison	Healthwatch Wolverhampton
Alan Coe	Independent Chair Wolverhampton Safeguarding Children Board and Wolverhampton Safeguarding Adult Board

Information for the Public

If you have any queries about this meeting, please contact the democratic support team:

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Some items are discussed in private because of their confidential or commercial nature. These reports are not available to the public.

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 - 12)
[To approve the minutes of the previous meeting as a correct record]

5 **Matters arising**

6 **Health and Wellbeing Board - Forward Plan 2016/17** (Pages 13 - 18)
[To consider and comment on the items listed on the Forward Plan]

7 **Health and Wellbeing Board - Proposed changes to the terms of reference** (Pages 19 - 24)
[The board to consider proposed changes to the draft terms of reference and a request from West Midlands Fire Service for a representative to become a member]

ITEMS FOR DISCUSSION OR DECISION

8 **Better Care Fund (BCF): update report and 2017/18 programme** (Pages 25 - 32)
[David Watts, Service Director – Adults Community and Steven Marshall, Programme Manager: Adult Social Care Transformation/Better Care Fund, to jointly present a report**]**

9 **Draft NHS Black Country Sustainability and Transformation Plan** (Pages 33 - 130)
[Linda Sanders, Strategic Director - People and Steven Marshall, Director of Strategy & Transformation, Wolverhampton CCG, to jointly present a report]

10 **Dementia and Care Closer to Home** (Pages 131 - 138)
[David Watts, Service Director – Adults Community and Steven Marshall, Programme Manager: Adult Social Care Transformation/Better Care Fund, to jointly present a report**]**

11 **HeadStart Phase 3 Programme and Grant Update** (Pages 139 - 168)
[Kevin Pace, HeadStart Programme Manager, to present report]

12 **Wolverhampton Safeguarding Board Annual Reports 2015 – 2016** (Pages 169 - 172)
[Alan Coe, Independent Chair, to present Wolverhampton Safeguarding Adults and Wolverhampton Safeguarding Children Boards reports]

ITEMS FOR INFORMATION

13 **Joint Strategic Needs Assessment Update** (Pages 173 - 182)
[Ros Jervis, Service Director Public Health and Wellbeing, to present report]

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CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

Minutes - 19 October 2016 Agenda Item No: 4

Attendance

Members of the Health and Wellbeing Board

Councillor Val Gibson	City of Wolverhampton Council
Ros Jervis	Service Director - Public Health and Wellbeing
Councillor Roger Lawrence	Chair - City of Wolverhampton Council
Councillor Paul Sweet	City of Wolverhampton Council
Linda Sanders,	Strategic Director, People
David Loughton	Chief Executive The Royal Wolverhampton Hospital NHS Trust
Jeremy Vanes	Chairman The Royal Wolverhampton Hospital NHS Trust
Donald McIntosh	Healthwatch Wolverhampton
Robin Morrison	Healthwatch Wolverhampton
Alan Coe	Independent Chair Wolverhampton Safeguarding Boards
Steven Cartwright	Business Change Manager

Employees

Paul Smith	Interim Manager for Commissioning Older People
Earl Piggott-Smith	Scrutiny Officer
Steven Cartwright	Programme Manager, Transforming Adult Social Care

In attendance

Sara Fellows	NHS Wolverhampton CCG
Andrea Smith	NHS Wolverhampton CCG
Karen Evans	NHS Wolverhampton CCG
Tracey Cotterill	BCPFT
Chief Inspector Tracey Packham	West Midlands Police
Paul Smith	Head of Commissioning - Older People

Part 1 – items open to the press and public

Item No. *Title*

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

Apologies were received from the following members of the Board:

- Councillor Sandra Samuels
- Councillor Paul Singh
- Chief Superintendent Jayne Meir
- Tracy Taylor – Chief Executive - Black Country Partnership NHS Foundation Trust
- Dr Alexandra Hopkins – University of Wolverhampton

2 **Notification of substitute members (if any)**
Tracey Cotterill attended the meeting on behalf of Tracy Taylor – Black Country Partnerships Foundation Trust

Chief Superintendent Jayne Meir attended the meeting on behalf of Chief Inspector Tracey Packham

3 **Declarations of interest (if any)**
There were no declarations of interest.

4 **Minutes of the previous meeting**
That the minutes of the meeting held on 20 July 2016 be confirmed as a correct record and signed by the Chair.

5 **Matters arising**
There were no matters arising from the minutes.

6 **Summary of outstanding matters**
Resolved:

The summary of outstanding minutes was noted.

7 **Health and Wellbeing Board Forward Plan 2016/17**
Ros Jervis, Service Director Public Health and Wellbeing, introduced the report and explained that the new layout is an initial proposal to make the agenda planning process more inclusive and dynamic. The new form will include a short summary about each agenda item. The changes are intended to set out a rolling programme of issues that will be discussed by the Board. The plan will be updated at each meeting.

The Service Director encouraged representatives of partner organisations to submit items for the agenda. The Board were invited to comment on the draft forward plan.

The Board supported the proposed changes to the forward plan and welcomed the opportunity to submit agenda items.

Alan Coe, Wolverhampton Safeguarding Board, suggested that the annual reports for the Adult Safeguarding and Children's Safeguarding Boards should be added to the agenda for meeting on 30 November 2016.

Resolved

1. The Board agreed to merge the summary of outstanding matters into the new forward plan format for future meetings.
2. The annual Safeguarding Board reports to be presented to the Board on 30 November 2016 for consideration.

8 **Child and Adolescent Mental Health Services (CAMHS) Local Transformation Plan**
Sarah Fellows, Mental Health Commissioning Manager, Wolverhampton Clinical Commissioning Group, presented the report on behalf of Fred Gravestock who was unable to attend the meeting.

The Mental Health Commissioning Manager explained that the organisation is required to refresh its Wolverhampton Children & Young People's Mental Health and Wellbeing Local Transformation Plan and present it to the Board for sign off.

The Mental Health Commissioning Manager gave an overview of the vision in the plan to provide young people and children in Wolverhampton with access to timely, integrated and high quality mental health services that are accessible and responsive to their needs.

The Mental Health Commissioning Manager commented on the importance of delivering services that can respond to the growing need and increased demand upon the whole health service. The strategy is proposing to transform the delivery of the CAMHS service. The CCG is working with NHS England to deliver a more responsive service across Wolverhampton.

The Board were invited to comment on the plan. The Board made reference to other initiatives such as HeadStart which is aimed at improving the emotional health and wellbeing of children and young people and the link to the plan.

The panel requested an update on the Children's Outcomes Framework (Appendix A) so that it covers the same period as the GANTT chart (Appendix F) so that the Board can reach a more informed view about the plans for the service. The Mental Health Commissioning Manager agreed to bring a refreshed GANTT chart to a future meeting of the Board.

The Board discussed the reference in the document to tier 1 and 2 and stated aim in the same document to implement a tier-less whole system across health, education and social care. The Board suggested that the document needs to be more consistent and the language used needs to reflect the clear focus on partnership working. The Board suggested an alternative description of the service is needed.

The Mental Health Commissioning Manager accepted the continued use of Tier 1 and Tier 2 was confusing and the issue had already been highlighted in discussions with colleagues. The situation is complicated by the funding process used by NHS England which uses these terms to describe the level of services available. The Mental Health Commissioning Manager agreed to discuss this further with colleagues and report the outcome to a future meeting of the Board. The Mental Health Commissioning Manager advised the Board that a submission for funding has been submitted to NHS England.

The Board queried how the plan will better meet the needs of adult black males who are over represented in terms of accessing mental services, but much lower numbers are reported as accessing these services aimed at children and young people. The Mental Health Commissioning Manager accepted that there is an over representation of older male men in the service. This issue is a priority issue for the service and work is being with BCPFT to look at what the current provision is and how it is meeting the needs of black and minority groups. The review will also consider meeting the mental health needs of new arrivals to the City.

The Board queried the reference in the plan to the role of GPs and willingness to engage with other agencies in identifying young people who may need to be referred to appropiate wellbeing services. The Board discussed the recent findings of Children's Commissioner report detailing the poor experiences of users across England wanting to access mental health services.

The panel discussed the wider impact on the individual and society of not identifying and supporting young people, in particular vulnerable children, who need to be appropriately referred.

Resolved:

The Board agreed to sign-off the refresh of the Wolverhampton Children & Young People's Mental Health and Wellbeing Local Transformation Plan.

9 **Wolverhampton Integrated End of Life Care Strategy**

Karen Evans, Solutions and Development Manager (Wolverhampton CCG) introduced the report and explained that the report details the progress in developing an integrated strategy for end of life care. The strategy provides a whole pathway approach to end of life care. The Board were asked to consider and formally approve the final version of the strategy. The Solutions and Development Manager commented that the strategy puts the patient at the centre and ensures services are responsive and can support the needs and choices of patients and those closest to them.

The Solutions and Development Manager commented that the strategy has been informed by national guidance and also a recognition that the Strategy seeks to ensure that professionals and services deliver the best possible person centred care and support to people as they approach the end of life.

The Solutions and Development Manager outlined the vision for the new End of Life service and confirmed that the Strategy was co-produced with all partners to ensure support for the integrated strategy.

The Board discussed the importance of people having a choice about their care arrangements and being involved in key decisions. The Board supported the view that the strategy should take account of the wishes of the patient.

The Board discussed the challenges of people do not have the capacity to make informed decisions about their end of life care arrangements and the need for appropiate safeguarding arrangements. The issue of people dying in care homes and the need to ensure that plans are followed. The Board commented that Staffordshire have produced some interesting work in end of life which could be shared with members.

The Board discussed the statistics on the place of death – when compared to the England average the rate of Wolverhampton is higher than average in all categories of deaths in hospital. The rates for people that choose to die either in their own home or care home is lower in Wolverhampton when compared to the England average. The findings suggest that most people would prefer to die in their own home rather than in a clinical setting. The Board discussed the validity of the measure and extent to which people feel enough confident to make a choice.

Resolved:

The Board agreed to endorse the Wolverhampton Integrated End of Life Care Strategy.

10 **Workshop "Living Well, Feeling Safe"**

Linda Sanders, Strategic Director – People, outlined a proposal to host an event to raise the profile of the work of HWBB. The suggested date for the event is February 2017 and that it should involving community and voluntary groups in the steering group. The Board suggested that the event could be linked to Residents Week – this event is planned for March 2017 and how it can be supported. The Board discussed possible topics that could be included. The Board supported the idea that wellbeing could be a theme of the event.

Resolved:

1. The Board endorsed the idea of hosting a “Living Well, Feeling Safe” event in Wolverhampton during 2017.

2. Members of the Board were invited to either share their ideas for the event or to volunteer to be part of the working group.

11 **Wolverhampton CCG Commissioning Intentions 2017/18-2018/19**

Steven Marshall, Director of Strategy and Transformation, introduced the report. The report provides an update on progress across a range of health activities. The Director of Strategy and Transformation advised the Board that the CCG will become responsible for commissioning primary and medical services from 1.4.2017. The Director of Strategy and Transformation advised that it will take time to deliver programme of work detailed in the roadmaps.

The Board were invited to endorse the commissioning intentions of the CCG detailed in the report.

The Board queried the opportunities for the public to be involved in the developing and shaping the commissioning of services. The Director of Strategy and Transformation advised that the development of the strategy has involved public consultation in developing new models of care. The aim of the changes is to achieve the best outcome for patients.

Resolved:

The Board agreed to endorse the commissioning intentions of the CCG as detailed in the report.

12 **Primary Care Strategy - update**

Steven Marshall, Director of Strategy and Transformation, introduced the report and explained that this report is an update on progress. The Director of Strategy advised the Board about the programme about the list of activities aimed at delivering the Primary Care Strategy.

The Board commented on the level of fees charged by GPs for the provision of preventative and enhanced services and queried whether the planned changes will give the CCG greater control over this area. The Director of Strategy and Transformation commented that as GPs are independent contractors the issue of the fees will need to be negotiated as part of a future discussion about commissioning intentions.

The Director of Strategy advised the Board that Wolverhampton CCG is currently in the process of completing an application to NHS England for fully delegated responsibilities for the commissioning of primary medical services from 1 April 2017.

The delegated commissioning model delivers a number of benefits for the Wolverhampton population and allows CCGs greater ability to transform local primary care services.

Resolved:

The Board welcomed the report and noted the progress towards the implementation of the CCG Primary Care Strategy.

13 **Better Care Fund (BCF) update**

Paul Smith, Acting Head of People Commissioning, introduced the report and gave a summary of the progress made towards the delivery of the 2016/17 programme plan. The Acting Head of People Commissioning advised the Board that the rapid intervention teams had expanded from a Monday to Friday service to a seven day service to help prevent emergency admission.

The Acting Head of People Commissioning gave examples of recent work streams aimed at improving the patient experience funded by the BCF programme. For example, the dementia care work stream and the Memory Matters pilot. The project was launched in July 2016 and is based in Wednesfield Library. The Acting Head of People Commissioning advised that there are discussions about offering the service in other areas. The aim is have three co-located teams supporting this project. The Board welcomed the plans for the co-location of services. The Board queried the criteria that would be used to determine the sites and wanted an assurance that service users and carers will be involved in the decision. Linda Sanders confirmed that the public would be consulted about the location of sites.

Linda Sanders commented that the City of Wolverhampton Council had been nominated to be named Dementia Friendly Organisation of the Year at this year's Alzheimer's Society Dementia Friendly Awards.

The Board queried the rationale for using the system Graphnet as the Black Country standard in the medium term to support the sharing of data across the health and social care system, while planning to introduce the Fibonacci system locally, which is due to go live in December 2016. The Board were reassured of the plans to introduce a system can that can provide professionals with real time access to patient and social care records.

Resolved:

The Board welcomed the report and noted the progress towards the delivery of the 2016/17 programme plan.

14 **Public Health Lifestyle Survey 2016**

Ros Jervis, Service Director for Public Health and Wellbeing, introduced the report and outlined the key findings of the Wolverhampton Healthy Lifestyle Survey. The Service Director advised the Board of the methodology used to collect the survey data. The survey was based on interviews with 9000 residents and checks were done to ensure that the sample was representative of the demographic profile of the city.

The aim of the survey was to identify the level of lifestyle risk factors across the city and to provide better local intelligence. The Service Director advised the Board of the key headlines and the work done to map the impact of multiple risk health factors.

The information will be used to determine how resources will be targeted in the future.

The Board queried the methodology used to identify residents who took part in the doorstep survey and if the timing of visits would exclude some groups. The Service Director reassured the Board that the importance of getting a representative profile was part of the brief given to M-E-L Research, who were commissioned to conduct the survey.

Resolved:

The Board welcomed the report and supported the use of the survey findings to inform the planning and delivery of healthy lifestyle services for the City.

15 **Care Act 2014 Implementation: Stocktake Six Submission Summary - report to follow**

Steven Cartwright, Programme Manager, advised the Board that there has been a requirement as part of the implementation of the Care Act 2014 for all local authorities to submit a regular stocktake of progress in meeting its responsibilities. The Programme Manager gave a summary of Wolverhampton's sixth and final stocktake submission to the Local Government Association (LGA), noting the work undertaken to implement and embed the Care Act reforms in Wolverhampton.

The Board discussed the reference to care given to prisoners detailed in the summary findings and queried the low number of care and support assessments.

Resolved:

The Board welcomed the good progress and the positive comments by the LGA about the performance of the Council in meeting its responsibilities as detailed in the Care Act 2014.

16 **Exclusion of press and public**

To pass the following resolution:

That in accordance with Section 100A (4) of the Local Government Act 1972, the press and public be excluded from the meeting for the following item of business as it involves the likely disclosure of exempt information falling within paragraph 3 of Schedule 12A to the Act relating to the business affairs of particular persons.

17 **Sustainability and Transformation Plans (STP) 2016/17 - 2020/2021**

Steven Marshall, Director of Strategy and Transformation, gave a brief update on progress in developing the plan. The plan will be submitted to NHS England on 21 October 2016. The Board discussed the implications of the plan and the level of public consultation.

Resolved:

The Board noted the progress and agreed to receive a further update report at a future meeting.

The meeting closed at 14:25

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Agenda Item No: 6

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

30 November 2016

Report title	Health and Wellbeing Board - Forward Plan 2016/17	
Cabinet member with lead responsibility	Councillor Paul Sweet Public Health and Wellbeing	
Wards affected	All	
Accountable director	Ros Jervis, Service Director Public Health and Wellbeing	
Originating service	Governance	
Accountable employee(s)	Earl Piggott-Smith Tel Email	Scrutiny Officer 01902 551251 earl.piggott-smith@wolverhampton.gov.uk
Report to be/has been considered by		

Recommendations for noting:

The Health and Wellbeing Board is asked to:

1. Review the latest version of the forward plan and contribute to the planning of future agenda items.

1.0 Purpose

1.1 The purpose of this report is to present the forward plan to the Board for comment and discussion in order to jointly plan and prioritise future agenda items.

1.2 The forward plan will be a dynamic document and continually presented in order to support a key aim of the Board – to promote integration and partnership working between the NHS, social care, public health and other commissioning organisations.

2.0 Background

2.1 As agreed at the October 2016 Board meeting, the attached forward planning document seeks to enable a fluid, rolling programme of items for partners to manage (see attached).

3.0 Financial implications

3.1 None arising directly from this report.

4.0 Legal implications

4.1 None arising directly from this report.

5.0 Equalities implications

5.1 None arising directly from this report.

6.0 Environmental implications

6.1 None arising directly from this report.

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7.0 Human resources implications

7.1 No HR implications arising directly from this report.

8.0 Corporate landlord implications

8.1 None arising directly from this report.

9.0 Schedule of background papers

9.1 Minutes of previous meetings of the Health and Well Being Board regarding the forward planning agenda items.

Health and Wellbeing Board: Forward Plan

Updated 24 November 2016

Items in red are new or amended from the previous version.

Items ~~crossed out~~ have been rescheduled for a later date.

Items are highlighted where no report was received and there is currently no arrangement to reschedule.

Items are in **bold** that are regular or standing items.

Date	Title	Partner Org/Author	JHWBS Priority	Format	Notes/comments
30 Nov 2016	**Dementia and Care Closer to Home**	**CWC/David Watts and CCG/Steven Marshall**	Priority update paper	**Paper**	**Discussion paper as relates to JHWBS priority** **Deferred from last meeting.**
	Better Care Fund (BCF): update report and 2017/18 programme	**CCG/Steven Marshall and CWC/David Watts**		**Paper**	Discussion item Regular joint update paper.
	Sustainability and Transformation Plans (STP) 2016/17 to 2020/21	CCG/Steven Marshall and CWC/Linda Sanders		Plan and paper	Main agenda item Discussion paper Detailed plan previously embargoed. STP due to be published on 21.11.16. Plan will be shared and discussed by HWBB.
	Wolverhampton Safeguarding Children Board Annual Report 2015 – 2016	Alan Coe, Independent Chair, WSCB		Paper and report	Discussion item To seek assurance from HWBB

Key: JHWBS priorities

	Wolverhampton Safeguarding Adults Board Annual Report 2015 – 2016	Alan Coe, Independent Chair, WSAB		Paper and report	Discussion item To seek assurance from HWBB
	HeadStart Phase 3 Programme and Grant Update	Kevin Pace, HeadStart		Paper	Discussion item Pledges from HWBB members
	Joint Strategic Needs Assessment - update	CWC/Ros Jervis		Paper with links to website	Information item Last considered April 2016
15 Feb 2017	**Better Care Fund (BCF): Quarterly Report**	**CCG/Steven Marshall/CWC David Watts**		**Paper**	**Discussion item Regular joint update paper Last considered 30 November 2016**
	Mental Health Services: Revised Provider Trust Arrangements	BCPFT		Paper	Discussion item
	Public Health & Wellbeing Commissioning Intentions	CWC/Ros Jervis		Paper	Discussion item
	JHWBS Priority update		**Priority update paper**	**Paper**	**Discussion item**
	Mental Health Strategy 2017/19	CCG/Sarah Fellows		Paper and strategy	Discussion item Date when last considered
29 Mar 2016	**Better Care Fund (BCF): Update Report**	**CCG/Steven Marshall/CWC David Watts**		**Paper**	**Discussion item Last considered 15 Feb 2017**
	NHS Capital Programme - updates	NHS England		Paper	Quarterly reports to HWBB
	Quality and safety framework	CCG/Manjeet Garcha		Paper	Last considered February 2016
	JHWBS Priority update		**Priority update paper**	**Paper**	

Key: JHWBS priorities

May to July 2017 TBC	**Director of Public Health Annual Report 2016/17**	**CWC/Ros Jervis**		**Presentation**	
	Better Care Fund (BCF): Update Report	**CCG/Steven Marshall/CWC David Watts**		**Paper**	**Discussion item Last considered 29 Mar 2017**
	JHWBS Priority update		**Priority update paper**	**Paper**	

Key: JHWBS priorities

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Agenda Item No: 7

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

30 November 2016

Report title	Health and Wellbeing Board – Proposed changes to the terms of reference	
Cabinet member with lead responsibility	Councillor Paul Sweet Public Health and Wellbeing	
Wards affected	All	
Accountable director	Ros Jervis, Service Director Public Health and Wellbeing	
Originating service	Governance	
Accountable employee(s)	Earl Piggott-Smith Tel Email	Scrutiny Officer 01902 551251 earl.piggott-smith@wolverhampton.gov.uk
Report to be/has been considered by		

Recommendations for noting:

The Health and Wellbeing Board is asked to:

1. Consider and approve changes to the terms of reference of the Health and Wellbeing Board.

2. Agree to accept a request from West Midlands Fire Service for a representative to become a member of the Board.

1.0 Purpose

1.1 The Board is asked to consider and approve changes to the previous terms of reference that will contribute to supporting the priorities of the Wolverhampton Joint Health and Wellbeing Strategy – 2013-2018.

1.2 The Board is asked to approve the nomination of a representative of West Midlands Fire Service to become a member.

2.0 Background

2.1 The terms of reference of the Health and Wellbeing Board need to be updated to support its stated vision – **Ensuring good health and a longer life for all in Wolverhampton**.

2.2 A draft of the revised terms of reference is attached. Appendix 1

3.0 Financial implications

3.1 None arising directly from this report.
[GS/11102016/R]

4.0 Legal implications

4.1 None arising directly from this report.
[RB/11102016/V]

5.0 Equalities implications

5.1 None arising directly from this report.

6.0 Environmental implications

6.1 None arising directly from this report.
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7.0 Human resources implications

7.1 No HR implications arising directly from this report.
[HR/JF/RJ/030]

8.0 Corporate landlord implications

8.1 None arising directly from this report.

9.0 Schedule of background papers

9.1 None

Appendix 1: Health and Wellbeing Board – Revised terms of reference

TERMS OF REFERENCE HEALTH AND WELLBEING BOARD

Membership

- Leader of the Council (Chair)
- Wolverhampton CCG (Vice-chair)
- Strategic Director – People
- Director of Public Health
- Representative of Local Healthwatch
- Cabinet Member – Children and Families
- Cabinet Member – Adults
- Cabinet Member – Health & Wellbeing
- Shadow Cabinet Member – Health & Wellbeing
- Strategic Director – Place
- National Health Service England Representative
- University of Wolverhampton – Faculty of Education, Health and Wellbeing
- West Midlands Police – Wolverhampton Local Policing Unit
- Third Sector Partnership
- Independent Chair Children's and Adult Safeguarding Boards
- Royal Wolverhampton NHS Trust Representative
- Black Country Partnership NHS Foundation Trust Representative

Additional members will be considered by the Health and Wellbeing Board as appropriate. The overall size of the Board will, however, be kept at a level which is manageable and able to support efficient and effective decision-making.

A report will be presented by Democratic Services to the Health and Wellbeing Board with revisions to the membership to consider and approve.

Frequency of meetings

The Board will meet every other month.

An extraordinary meeting can be called when the Chair considers this necessary and or/ in the circumstances where the Chair receives a request in writing from 50% of the membership of the Board.

The Board may hold informal focus days / sessions on specific issues of interest to the Board.

The Board will establish its own forward planning programme of activity which will be reviewed at each meeting to ensure it remains both strategic and timely. The 'Forward Plan' will be used to facilitate discussion as to priority areas, new items and agenda timetabling. Any reports for a meeting of the Board should be submitted to the Democratic Services team no later than eleven days in advance of the meeting. No business will be conducted that is not on the agenda.

Agendas and papers for Board meetings will be made publicly available via the website unless covered by exempt information procedures.

Meetings of the Health and Wellbeing Board will be conducted in public.

The quorum for meetings will be 50% of the membership. There must be at least one Council and one CCG Board Member at each meeting.

Purpose

(a) To identify and act upon changes required under the enactment of the NHS Health and Social Care Act 2012 and subsequent related legislation.

The statutory health and wellbeing board will the following functions:

- To prepare and publish a joint strategic needs assessment
- To prepare and publish a health and wellbeing strategy based on
- the needs identified in the joint strategic needs assessment and to
- oversee the implementation of the strategy
- Discretion to give an opinion on whether the Council is discharging
- its statutory duty to have due regard to the joint strategic needs
- assessment and the health and wellbeing strategy
- To promote and encourage integrated working including joint
- commissioning in order to deliver cost effective services and
- appropriate choice. This includes providing assistance and advice
- and other support as appropriate, and joint working with services
- that impact on wider health determinants

Terms of Reference

a) To provide leadership and democratic / public accountability to improve health and wellbeing and reduce inequalities.

b) To promote integration and partnership working between the NHS, social care, public health and other commissioning organisations.

c) To assess the robustness of and continued development of the Joint Strategic Needs Assessment (JSNA) for the local population and to ensure that key commissioning decisions reflect local needs.

d) To receive the Director of Public Health's Annual Report and agree to performance manage the forward plan for Public Health priorities and to review progress.

e) To review and update in the light of the JSNA, a Wolverhampton Joint Health and Wellbeing Strategy. The strategy will set out how the health and well-being needs of the community will be addressed. To set an action plan to take forward the key priorities from the Joint Health and Wellbeing Strategy and to performance manage progress against defined targets.

f) To support and challenge, as appropriate joint commissioning integrated care and management and pooled budget arrangements as a means of delivering service priorities.

g) To determine appropriate partnership structures required to deliver the Board's responsibilities. To oversee and performance manage the work programmes of sub-groups To oversee major partnership service transformation programmes and to monitor the continued work of the Local Healthwatch and receive regular reports on work undertaken.

h) To oversee the governance and partnership arrangements for both Adults and Children's Safeguarding Boards.

i) Ensure the decisions of commissioners align with the JSNA and the Joint Health and Wellbeing Strategy and hold them to account for delivery.

j) To oversee the work of Public Health on health promotion and ill-health prevention campaigns.

k) Support local voice and patient choice by ensuring that the views of local people are used. to respond to major Government launched Inquiries into Health and Wellbeing.

l) Members have a responsibility to feed back to their respective organisations the deliberations and decisions of the Board as appropriate.

Accountability

There will be sovereignty around decision making processes. Members will be accountable through their own organisation's decision making processes for the decisions they take. It is expected that members of the Board will have delegated authority from their organisations to take decisions within the terms of reference.

Decisions within the terms of reference will be taken at meetings and will not normally be subject to ratification or a formal decision process by partner organisations (provided that at least 10 days notice of forthcoming decisions had been given).

However, where decisions are not within the delegated authority of the Board members, these will be subject to ratification by constituent bodies.

It is expected that decisions will be reached by consensus.

30.11.16

Agenda Item No: 8

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

30 November 2016

Report title	Better Care Fund (BCF):update report and 2017/18 programme
Cabinet member with lead responsibility	Councillor Roger Lawrence Health and Wellbeing
Wards affected	All
Accountable directors	David Watts, Service Director – Adults (City of Wolverhampton Council) Steven Marshall, Transformation and Strategy Director, (Wolverhampton Clinical Commissioning Group)
Originating service	Adult Services
Accountable employee(s)	Tony Marvell — People Directorate Tel — 01902 551461 Email — Tony.marvell@wolverhampton.gov.uk
Report to be/has been considered by	People Directorate Management Team — 21 November 2016

Recommendation(s) for noting:

1. To note the progress towards the delivery of the 2016/17 programme plan.
2. To note the progress towards the planning process for the 2017/18 programme.

1.0 Purpose

1.1 To advise Health and Wellbeing Board of the progress being made towards delivery of the 2016/17 programme plan, and progress towards establishing the 2017/18 programme.

1.2 The last report to the 19 October 2016 meeting of the Health and Wellbeing board provided a detailed update surrounding the pool fund arrangements, the Section 75 agreement, and a detailed summary of progress across the Better Care Fund projects.

1.3 This report provides the Health and Wellbeing Board with an update of current performance against financial plans and key indicators that are measured as part of the programme along with information and updates concerning the planning process for 2017/18.

2.0 Accident and Emergency admissions

2.1 Overall non-elective admissions show a decrease of 367 (based on data to September 2016) within Royal Wolverhampton Trust (RWT).

BCF Monitoring	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Full year
Baseline (15/16 Activity)	1990	1960	1966	1992	1833	2100	2326	2228	2161	2187	2064	2035	24842
16/17 Actual Activity - Total Emergencies	1977	1964	1970	1954	1752	1857							11474
Variance	-13	4	4	-38	-81	-243							-367
Variance (baseline v 16/17)	-1%	0%	0%	-2%	-4%	-12%							-1%
1617 Actual Activity - All Providers Total EM	2133	2149	2139	2164	1920	2028							

2.2 When analysing the HRG codes (Hospital Resource Groups) the impact of the BCF programme and associated work streams has been extremely positive with a reduction of 314 admissions directly attributable to the programme, whilst this is positive, it is 370 fewer than the 684 reductions that were planned in the current year (54% below target)

BCF Monitoring	Apr	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Full year
Baseline (15/16 Activity)	572	489	476	481	495	517	595	517	556	590	469	491	6248
16/17 Actual Activity - Total Emergencies	488	444	449	476	439	420							2716
Variance	-84	-45	-27	-5	-56	-97							-314
Variance (baseline v 16/17)	-15%	-9%	-6%	-1%	-11%	-19%							-5%

BCF Contribution to Admission reduction

BCF Monitoring	Apr	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Full year
Baseline - 15/16 Activity	**572**	**489**	**476**	**481**	**495**	**517**	**595**	**517**	**556**	**590**	**469**	**491**	**6,248**
Plan Reduction	111	115	115	115	115	111	115	111	115	113	104	113	1,356
16/17 Plan following BCF reduction	**461**	**374**	**361**	**366**	**380**	**406**	**480**	**406**	**441**	**477**	**365**	**378**	**4,892**
Actual Activity	488	444	449	476	439	420	0	0	0	0	0	0	
Actual Savings - 15/16 Baseline minus Actual Activity	**84**	**45**	**27**	**5**	**56**	**97**							**314**
Variance - Revised plan minus Actual Activity	-27	-70	-88	-110	-59	-14	480	406	441	477	365	378	2,176

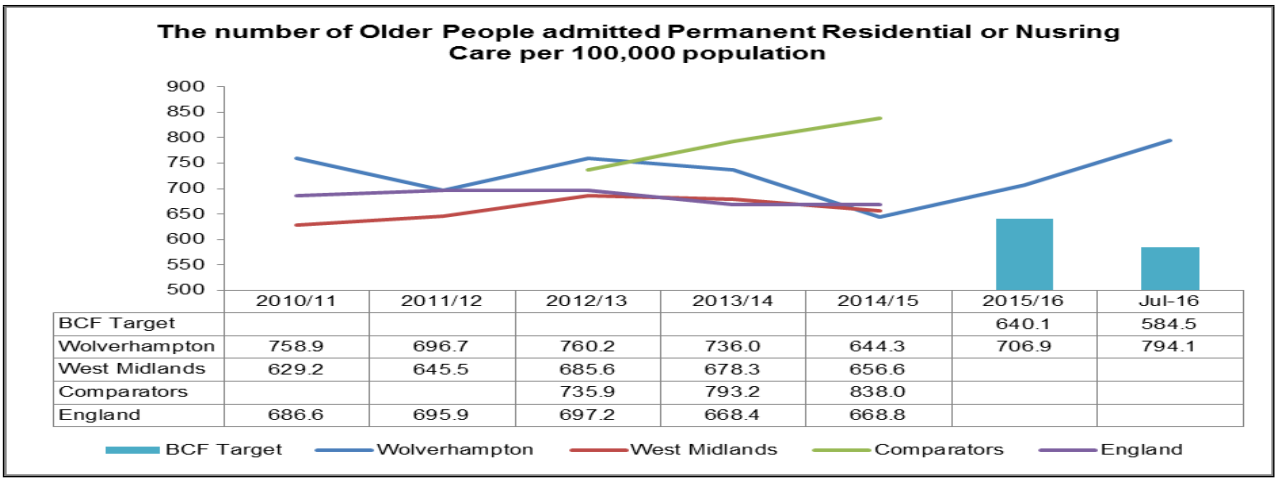
Notes:

1 From 01 April 2016, Emergency Admissions are being monitored via local Secondary Uses data (SUS) data rather than the nationally published hospital data (MAR) data that was used in 2015/16. Performance reporting shows overall admissions and performance against those HRG codes that are specifically affected by the work being undertaken by the Better Care Fund work streams.

2 Data and plans reported below reflects emergency admissions to RWT that are paid for by Wolverhampton CCG only. Admissions to other providers paid for by Wolverhampton CCG and admissions to RWT paid for by other CCG's are excluded. This means that data reported here will not fully reflect what will be reported in the quarterly returns.

3.0 Residential Admissions

3.1 In the 12 months up to October 2016 there were 339 admissions to permanent residential or nursing care against a target of 252 for 2016/17. This is a reduction of 15 compared with the 354 admissions in the 12 months up to the end of September. Pressures on residential and nursing admissions are under review, in particular the large amount of short term and respite placements that are made to relieve pressure on acute, which can often turn into long term residential placements.



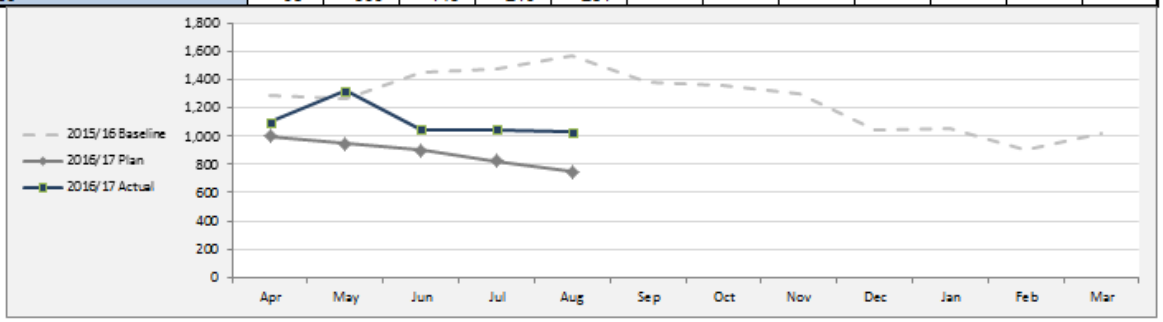
	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	Jul-16
BCF Target						640.1	584.5
Wolverhampton	758.9	696.7	760.2	736.0	644.3	706.9	794.1
West Midlands	629.2	645.5	685.6	678.3	656.6		
Comparators			735.9	793.2	838.0		
England	686.6	695.9	697.2	668.4	668.8		

4.0 Delayed Transfers of Care (DTOC)

4.1 Delayed transfers of care are now being reported against the new 16/17 plan. In August there were 1031 delayed days against a plan of 750. This is significantly lower than the number of delayed days in the same period last year.

4.2 Performance is currently 25.1% (1,112) above plan for the year but 21.4% (1,511) below last year's performance in the same period.

SUMMARY	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16 Baseline	1,290	1,261	1,454	1,472	1,571	1,380	1,360	1,301	1,042	1,050	904	1,020
2016/17 Plan	1,000	950	900	825	750							
2016/17 Actual	1,098	1,319	1,045	1,044	1,031							
Difference	+ 98	+ 369	+ 145	+ 219	+ 281							



4.3 The proportion of delays that are the responsibility of social care has fallen slightly since July (to 61% from 62%) but remains higher than when compared with 2015/16

	2016/17 Cumulative		2015/16 Baseline
Cause of DTOC (cumulative)	Number	Proportion	Proportion
NHS	1,661	30%	41%
Social Care	3,381	61%	50%
Both	495	9%	8%

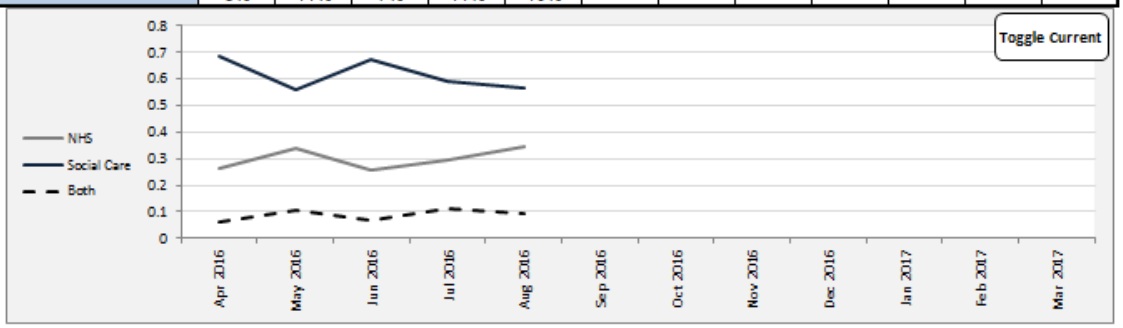
Cause of DTOC	Apr	May	Jun	Jul	Aug
NHS	286	443	271	309	352
Social Care	747	736	700	618	580
Both	65	140	74	117	99

4.4 In August the proportion of delays in the acute sector has fallen to more 'usual' levels from the spike seen in July.

	2016/17 Cumulative		2015/16 Baseline
Type of Care for DTOC	Number	Proportion	Proportion
Acute	3,133	57%	56%
Non-Acute	2,404	43%	44%

Type of Care for DTOC	Apr	May	Jun	Jul	Aug
Acute	581	673	604	750	525
Non-Acute	517	646	441	294	506

Cause of DTOC	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
NHS	26%	34%	26%	30%	34%							
Social Care	68%	56%	67%	59%	56%							
Both	6%	11%	7%	11%	10%							



4.5 The proportion of delays due to people waiting an assessment continues to decrease, whereas the proportion of delays caused by people waiting for a package of care in their own home, nursing home care or a residential placement continues to increase.

	2016/17 Cumulative		2015/16
Reason for DTOC	Number	Proportion	Proportion
Completion of Assessment	1,756	32%	41%
Patient or family choice	624	11%	17%
Awaiting package of care in own	1,113	20%	16%
Waiting Further non-NHS Acute	559	10%	9%
Housing patients not covered by	38	1%	5%
Awaiting community equipment	303	5%	5%
Public Funding	249	4%	3%
Awaiting Nursing Home	516	9%	2%
Awaiting Residential Placement or	379	7%	2%
Disputes	0	0%	2%

5.0 Financial implications

5.1 The 2016/17 revenue pooled budget is £56.7 million, of which £21.6 is a contribution from Council resources and £35.1 million from the CCG.

5.2 The BCF required the work streams to identify efficiencies to fund the demographic growth (£2 million).

5.3 The financial monitoring identified a cost pressure of £3 million across the pooled fund. This includes the £2 million demographic growth mentioned in 5.2. Based on the risk sharing arrangements in the Section 75 the forecast cost pressure for each organisation is £1.8 million for the CCG and £1.2 million for the Council. Both the CCG and CWC have the cost pressures reported and incorporated into their financial positions for 2016/17. In the event that efficiencies cannot be found to bring down the cost pressures, consideration will need to be given as to how the financial risk can be covered in future years.

6.0 2017/18 Programme update

6.1 Initial clarification has now been obtained from NHS England in relation to the national forward plans for Better Care Fund. For noting the main points are:

6.1.1 The BCF Planning and Assurance process will cover the next 2 business years i.e. (both 2017/18 and 2018/19 together).

6.1.2 It is anticipated that the current Better Care fund national conditions (Seven day health and care services, data sharing, joint assessments, role of the accountable professional, protecting social care, and impact on the acute care sector) will be reduced to around 3; and that the new national conditions will focus firmly around complete social care and health integration (jointly commissioned plans, multi-disciplinary teams etc.)

6.1.3 The Better Care Fund policy framework was due to be released by NHS England on 18 November 2016, with detailed planning guidance issued approximately two weeks later i.e. on or around 02 December. The guidance has now been delayed and we await confirmation as to when this will now be released.

6.1.4 Local plans will need to be fully approved (including regional moderation) before end of March 2017. The deadline for our first and subsequent submission has not been formally communicated but is likely that we will need to deliver a first Wolverhampton submission in early January 2017.

6.2 The Senior responsible owners for the programme and programme team are in the process of a lessons learned review, and are constructing options for the content of the 2017 pooled fund, and associated governance arrangements.

7.0 Legal implications

7.1 A Section 75 agreement was in place for the delivery of the BCF plan during 2015/16. A Section 75 agreement is currently being prepared for signature to cover the period 2016/17.

7.2 Section 75 of the NHS Act 2006 (the “Act”) allows local authorities and NHS bodies to enter into partnership arrangements to provide a more streamlined service and to pool resources, if such arrangements are likely to lead to an improvement in the way their functions are exercised. Section 75 of the Act permits the formation of a pooled budget made up of contributions by both the Council and the CCG out of which payments may be made towards expenditure incurred in the exercise of both prescribed functions of the NHS body and prescribed health-related functions of the local authority.

The Act precludes CCG's from delegating any functions relating to family health services, the commissioning of surgery, radiotherapy, termination of pregnancies, endoscopy, the use of certain laser treatments and other invasive treatments and emergency ambulance services.

8.0 Equalities implications

8.1 Each individual project within the work streams has identified equality implications, and a full equality impact analysis has been carried at work stream level.

9.0 Environmental implications

9.1 Each individual project within the work streams will identify environmental implications, such as the need to review estates for the co-location of teams and services.

10.0 Human resources implications

10.1 Each individual project within the work streams will identify HR implications. HR departments from both Local Authority and Acute Providers are already engaged in discussions regarding potential HR issues such as integrated working and change of base for staff.

11.0 Corporate landlord implications

11.1 Corporate Landlord (Estates Valuation and Disposals) meets regularly with the Task and Finish Team and is working with the Team to assist and evaluate if any of the assets within the existing NHS and Council Estate is suitable for reuse to support the BCF proposals The BCF programme has an Estates task and finish group in place to consider accommodation options on a city wide basis.

12.0 Schedule of background papers

None

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Agenda Item No: 9

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

30 November 2016

Report title	Draft NHS Black Country Sustainability and Transformation Plan
Cabinet member with lead responsibility	Cllr Lawrence; Cllr Samuels; Cllr Sweet; Cllr Gibson
Key decision	No
In forward plan	No
Wards affected	All
Accountable director	Linda Sanders – People
Originating service	People
Accountable employee(s)	Brendan Clifford Tel 01902 555370 Email brendan.clifford@wolverhampton.gov.uk
Report to be/has been considered by	Executive Team 14 November 2016 Health Scrutiny Panel 24 November 2016 Health and Well Being Board 30 November 2016

Recommendation(s) for action or decision:

The Health and Wellbeing Board is recommended to:

1. Consider the attached Black Country System Transformation Plan (BC STP)
2. Advise of any issues for feedback to NHS colleagues

1.0 Purpose

1.1 To share the NHS The Black Country Sustainability and Transformation Plan 2016-2021 Version with the Health and Well Being Board during its formal period for consultation.

1.2 Seek the views and direction of the Health and Well Being Board in formulating a consultation response as directed.

2.0 Background

2.1 The Government's NHS Five Year Forward View published in October 2014:

- set the direction for the next stage of development for the NHS in the light of current financial challenges. It stated that the NHS in 2016 is very different to that of 1948, therefore, the NHS needs to change.
- argues that the change should focus on systems. This refers to:
  (a) how different parts of the NHS work together – Clinical Commissioning Groups, Acute Hospitals, Mental Health and primary care; and
  (b) how the NHS works together with partners who are also part of the system such as local authority adult social care.
- emphasises the importance of the NHS coming together with partners in local areas in the interests of a local population. This is referred to as a "place-based" approach.
- recognises that localities are different, therefore there may be different solutions in different places.
- emphasises the importance of leadership by those responsible for the care and health system.

2.2 In December 2015, the NHS published guidance setting out the requirement to develop Black Country System Transformation Plan which are:

- five-year plans covering all areas of NHS spending in England. 44 areas have been identified as the geographical 'footprints' on which Sustainability and Transformation Plans are based with an average population size of 1.2 million. The Black Country has been identified as the relevant population for the local area but includes the area covered by the Sandwell and West Birmingham Clinical Commissioning Group which extends into the City of Birmingham area;
- More focused on collaboration and planning together rather than competition.

2.3 Andy Williams, Chief Officer of the Sandwell and West Birmingham Clinical Commissioning Group, is the named lead for the BC STP. Chief Executives from Black County NHS Clinical Commissioning Groups or Hospitals lead the main items of work to develop the plan.

2.4 The guidance on STPs also stated that local authorities should be engaged with developing the plans. Sarah Norman (Chief Executive, Dudley MBC) was designated as lead Chief Executive for the Black Country.

2.5 The draft plan is developed along four key themes as follows:

Local Place-based care – *to develop standardised locally-focussed integrated models of care to promote prevention and build resilient communities*	**Extended hospital collaboration** – *to build a network of excellent care services that deliver efficiencies and improve quality*	**Mental Health & Learning disability –** *embrace the opportunities provided by the West Midlands Combined Authority to become a single vision for effective mental health and*	**Maternity & Infant Health** – *robustly review capacity of maternity services across the Black Country and develop standardised pathways of care to improve maternal and child health*

BC STP also includes a detailed Programme Plan with the following items:

- New models of care across the whole Black Country
- A common prevention framework using public health interventions
- In Wolverhampton, developing a new model Ensuring Hospitals collaborate and the continued development of the Midland Metropolitan Hospital
- Ensuring more people with learning disabilities can live in community settings,
- Better commissioning of services for people with mental health needs including delivering the West Midlands Combined Authority challenges
- Improving maternal and infant health
- Supporting the workforce better and making better use of NHS estates
- Addressing the £512 million funding gap in the NHS in the Black Country
- Overall, commitment for Black Country NHS services to work more effectively together and with their partners, including Councils

2.6 A national communications and engagement approach was published in October 2016. This gives direction to local areas to develop their own arrangements for communication. This is a welcome development against the background where some had asked for more transparency and openness. NHS colleagues emphasize the intention to share the plan once it was at an appropriate stage of development.

3.0 Progress, options, discussion, etc.

3.1 Linda Sanders has been the City of Wolverhampton Council lead on engagement in the sponsorship group for this process. Linda Sanders has been supported by finance and other managers who have attended relevant meetings during 2016.

3.2 Wolverhampton Clinical Commissioning Group propose a model for development as part of the draft BC STP (pp. 31-34.) This model envisages the development of, firstly, a Primary and Acute Care System (PACS) pilot between the Royal Wolverhampton Hospital Trust and some General Practitioners; and, secondly, other Multi-Specialty

Community Provider (MCP) models bringing together a number of General Practitioners to improve primary care.

3.3 The BC STP was made public on 21 November 2016. Some STPs, e.g. Birmingham and Solihull, were made public before that date. Black Country NHS colleagues are proposing that now that the Plan is in the public domain, this offers an opportunity for local leaders to open a new phase of working together and collaboration as stated in the plan. A BC STP public engagement event has been arranged at the Bethel Convention Centre, Kelvin Way, West Bromwich, B70 7JW for 6 December 2016, 12:30-15:30.

3.4 A more detailed Programme Plan for the Black Country System Transformation Plan is included at p.106 in the attachment. (Unfortunately, no page number is inserted on the page itself.)

3.5 To work on the next stage of development of health, social care and voluntary sector organisations, with Healthwatch have established a Transition Board. This is still at an early development stage and the next formal development session is planned for mid-December.

3.6 Overall, the BC STP takes forward many challenges which are the subject of current work e.g. ensuring children have the best start in life, an overall prevention approach and ensuring that hospitals are used to best effect with a focus on primary and community care. At this stage, the draft BC STP is quite high level and does not specify detail about named resources where change might occur.

3.7 For the NHS £512 million funding gap to be delivered, NHS services provided for the City of Wolverhampton population will need to contribute to the way in which this benefit is realised.

4.0 Financial implications

4.1 CCGs, NHS providers and Local Authorities provided detail of their financial plans for health and social care over the five year period (up to 2020/21). A 'Do nothing' option which takes the recurrent starting position pre 2017/18 budget reduction plans and allowing for growth, this gives a potential cost pressure of £700 million across the Black Country footprint. £512 million in relation to health and £188 million across social care. A number of solutions were then identified across the footprint including demand management, cost efficiencies and service transformation to address this gap. This reduced the gap by 2020/21 to nil across the health system and £118 million across social care. Local Authority plans are currently being reviewed to take account on the 2017/18 Budget Reduction proposals and updated Medium Term Financial Strategies. These plans will be subject to review and revision.

5.0 Legal implications

5.1 There are no direct legal implications associated with this report at this stage.

6.0 Equalities implications

6.1 Re-assurance will be sought that the strategy of encouraging the development of a range of models of primary care development in the City is one which does not inadvertently create inequity in access to health care. Service leaders will ensure that any service re-design addresses equality issues as needed. For instance, where internet access is required, strategies will be developed to ensure that those without such access can be included within the improvement made.

7.0 Environmental implications

7.1 The draft BC STP includes early thinking about better use of the NHS estate. It is likely that Council staff may be part of this development through the creation of community hubs. Amongst other aims, environmental aims to minimise travel burden are included in this strategy.

8.0 Human resources implications

8.1 The draft BC STP sees the workforce as a key “enabler” to successful delivery of any change required. More workforce planning is proposed and it is envisaged that this will be undertaken from within existing resources.

9.0 Corporate landlord implications

9.1 The draft BC STP includes early thinking about better use of the NHS estate. It is likely that Council staff may be part of this development through the creation of community hubs. Appropriate liaison between colleagues will be undertaken as thinking develops and plans are formulated.

10.0 Schedule of background papers

10.1 None.

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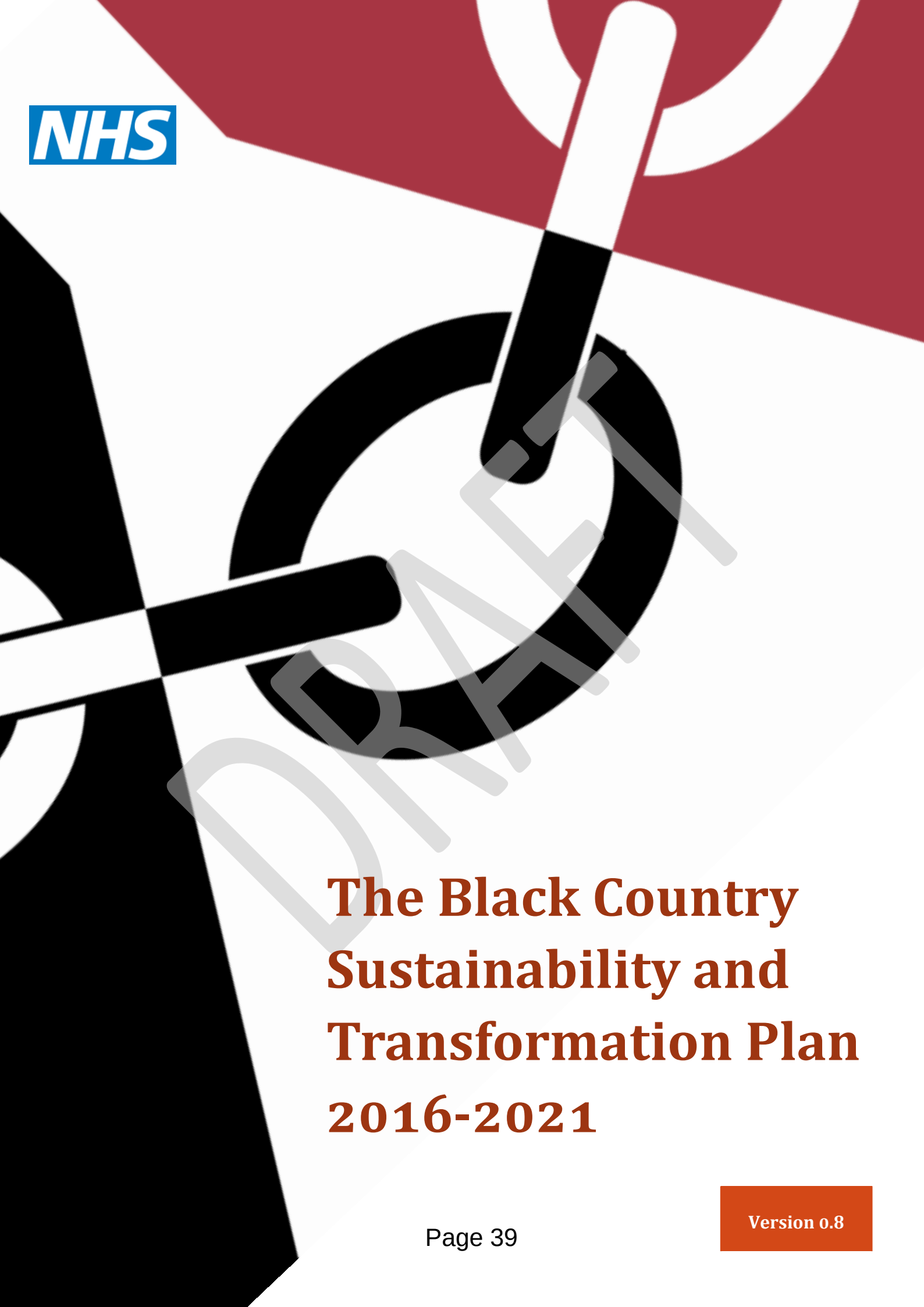


The Black Country Sustainability and Transformation Plan 2016-2021

Version 0.8

Version Control

Date	Version	Notes
15 August 2016	V0.1	Initial draft compiled from June STP submission, workstream updates and subsequent NHSI submissions
24 August 2016	V0.2	Update following review by Sponsoring Group
25 August 2016	V0.3	Annotated with further detail required from workstreams by 5th Sept
14 September 2016	V0.4	Further detail from VI, HI and Maternity workstreams
19 September 2016	V0.5	Revised financial narrative following 16 Sept template submission and input from specialized commissioners, plus changes from review by Sponsoring Group.
03/10/2016	V0.6	Further detail from VI workstream plus Mental Health and Economic impact studies
12/10/2016	V0.7	Full revision following review by Transformation Groups and Workstreams.
20/10/2016	V0.8	Changes as agreed following review by Sponsoring Group and to align with latest financial analysis.

The Black Country and West Birmingham

In order to develop this transformational plan for our local health and care system, eighteen local partner organizations have committed to a unique degree of collaborative working for the benefit of the Black Country and West Birmingham's 1.4 million population – 46% of whom live in the most deprived areas of England.

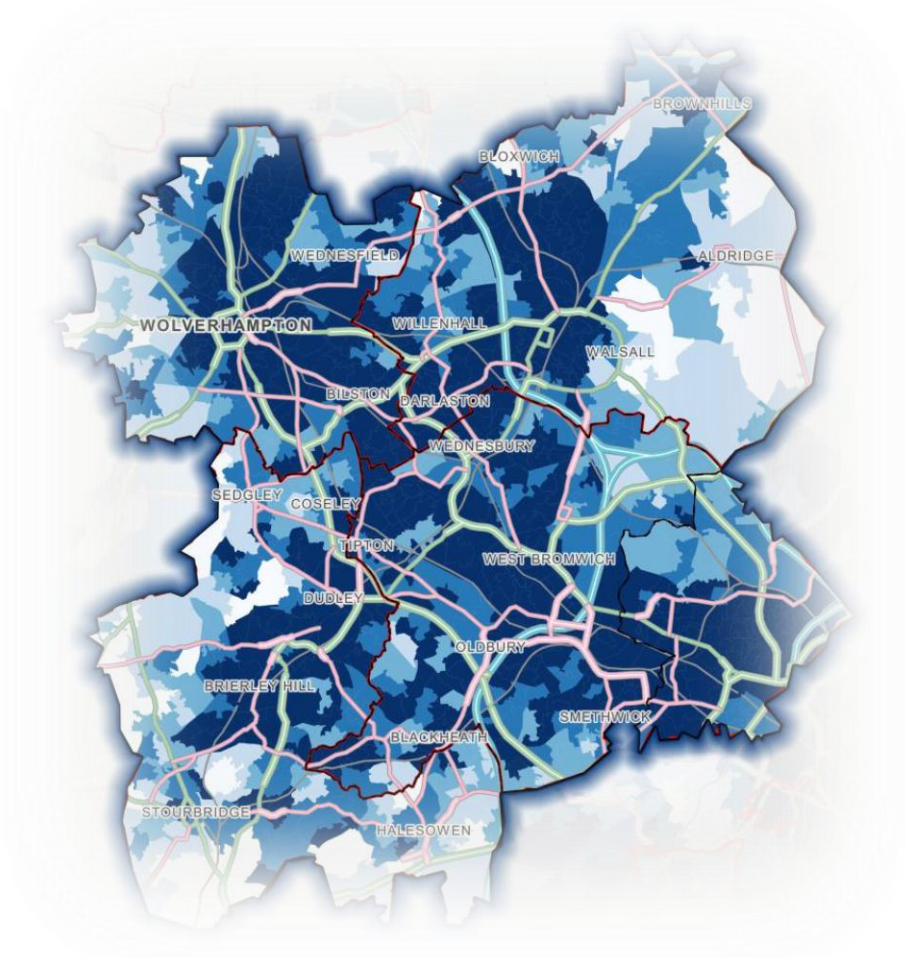


FIGURE 1 - THE BLACK COUNTRY STP FOOTPRINT (INCLUDING WEST BIRMINGHAM)

Some key principles shape our collaboration:

Subsidiarity

We serve five distinct local communities – Birmingham (West), Dudley, Sandwell, Walsall and Wolverhampton – each with their own unique histories, strengths and challenges. We will ensure that our collaboration does not undermine the existing excellence and innovation in each area. There is a very strong sense of place across Black Country and West Birmingham.

Collective Added Value

We believe that, through working together, we can build on our strengths, achieving a scale and pace of transformation that we cannot realise in isolation. In financial

terms, the added value to be delivered through coordinated action at STP level by NHS organisations is £413m (allowing for an additional £99m national funding). This is approximately £178m more than our NHS organisations would be expected to achieve without the STP.

Our partnership work has been advancing ahead of the formation of the STP through bodies such as the West Midlands Combined Authority, the Black Country Alliance and the Transforming Care Together partnership. Through the STP, we can now ensure that initiatives already being undertaken within Black Country and West Birmingham organisations are used to their greatest effect.

In addition:

- We have determined not to duplicate any processes or structures through our collaborative working; and
- Our functioning as an STP will not limit the way in which we liaise with neighbouring areas for patient benefit.

The following organisations have been invited to contribute to the development of this draft plan to date:

Black Country Partnership NHS Foundation Trust	NHS Walsall Clinical Commissioning Group
Dudley Metropolitan Borough Council	Wolverhampton City Council
Dudley Group NHS Foundation Trust	Royal Wolverhampton NHS Trust
Dudley and Walsall Mental Health Partnership NHS Trust	NHS Wolverhampton Clinical Commissioning Group
NHS Dudley Clinical Commissioning Group	Birmingham City Council
Sandwell Metropolitan Borough Council	Birmingham Community Healthcare NHS Foundation Trust
Sandwell and West Birmingham Hospitals NHS Trust	NHS England
NHS Sandwell & West Birmingham Clinical Commissioning Group	West Midlands Ambulance Service NHS Foundation trust
Walsall Metropolitan Borough Council	Local Government Association
Walsall Healthcare NHS Trust	Healthwatch
Black Country Partnership NHS Foundation Trust	Health Education England – West Midlands

Contents

Preface

This draft plan sets out an ambitious approach to transforming our local health and care system in the Black Country and West Birmingham.

Our aim is to materially improve the health, wellbeing and prosperity of the population through providing standardised, streamlined and more efficient services.

The STP's Sponsoring Group, formed of the local leaders of health and social care organisations, has prepared this draft plan to enable wider engagement. It proposes a number of critical recommendations:

- To implement **LOCAL PLACE-BASED MODELS OF CARE** for each community that deliver improved access to local services for the whole population, greater continuity of care for those with ongoing conditions and more coordinated care for those with the most complex needs. This work will build on the Multispecialty Community Provider (MCP) and Primary and Acute Care Systems (PACS) approaches which are already being developed with local communities, in order to deliver an 'Accountable Care Organisation'[1] model appropriate to each of our localities;

- To create, through **EXTENDED COLLABORATION BETWEEN SERVICE PROVIDERS**, a coordinated system of care across the Black Country and West Birmingham to improve quality and to deliver efficiencies on a scale not accessible to individual organizations. This will build on existing collaborations such as the Black Country Alliance and the Transforming Care Together Partnership for **MENTAL HEALTH AND LEARNING DISABILITY SERVICES**, and it includes the development of the new Midland Metropolitan Hospital (bringing together acute services from Sandwell and City hospitals) following Public Consultation in 2007;

- To take coordinated action to address the particular challenges faced by our population in terms of **MATERNAL AND INFANT HEALTH**, and to create a single Black Country and West Birmingham maternity plan that inter-relates with Birmingham and Solihull where necessary;

- To work together on **KEY ENABLERS** that will enable us to achieve significant workforce efficiency and transformation, to deliver the digital infrastructure required for modern patient-centred services, to rationalise public sector estate utilisation, and to streamline commissioning functions; and

- To act together, and in partnership with the West Midlands Combined Authority, to address the **WIDER DETERMINANTS OF HEALTH** such as employment, education and housing.

This document summarises how we can build on existing strengths, accelerating our learning from innovation, to create a sustainable health system with improved health outcomes and a better patient experience of services.

[1] http://www.kingsfund.org.uk/topics/integrated-care/accountable-care-organisations-explained

How our plan could benefit people in the Black Country and West Birmingham:

- With an extra £25m invested in GP services by 2021, an extra 25,000 primary care appointments a year will be made available. All children under 5 and adults over 75 will be guaranteed same day access to GP appointments, meaning 200,000 people will be able to see a family doctor when they need to.
- Over 1,000 people a month who turn up at A&E will be able to have their problem assessed and treated by a GP, reducing waits and improving care.
- Across the Black Country and West Birmingham, there will be at least 40,000 additional home visits, clinics and appointments offered in local surgeries and health centres, as close to home as possible.
- From November 2016, by ringing one telephone number the 1.4m people who live in the Black Country will be able to book a doctor's appointment, in the evening and at the weekend, get dental advice, order a repeat prescription, or get urgent advice.
- By 2021, over 100,000 people will be saved a trip to hospital for their outpatient care, with more treatment offered in local GP surgeries and health centres.
- By bringing all cancer services up to the standard of the best, cancer one year survival rates will reach over 70 per cent in the Black Country and West Birmingham.
- Common sense changes to the way our family doctors, hospitals and care services work together will reduce the number of people visiting A&E by 3,000 a week by 2021, meaning faster treatment and care for the most seriously ill.
- By 2021, instead of having to be admitted as an emergency to hospital, an extra 1,000 people each week will be cared for in their own home or local community by doctors, nurses and paramedics.
- Around 34,500 patients with long term conditions, such as diabetes or heart problems, will be given technology to monitor their heart rate and blood pressure remotely, alerting the doctor if there are any signs of deterioration so problems can be nipped in the bud early.
- Local clinical teams involving GPs, community nurses, mental health services and social care will provide better coordinated care for our most vulnerable patients with very complex needs.
- The new Midland Metropolitan Hospital will bring hospital services in Sandwell and West Birmingham together in one place to treat over 570,000 people in a state of the art building.
- By using our specialist NHS staff in a different way, patients who suffer major trauma, stroke, heart attack, or those who have cancer, kidney failure or breathing problems will receive the best treatment and care.
- Changes to how health and care services work together will mean those suffering early psychosis will get access to therapy within two weeks.
- The NHS in the Black Country and West Birmingham will reduce current high levels of infant mortality to bring it in line with the national average, avoiding the death of 34 babies a year - the equivalent of one child every eleven days.
- By tackling waste, improving standards and working together, we can avoid a potential increase in health costs of over £413 million per year by 2021. This will give better value to the taxpayer, equivalent to £680 a year for every household in the Black Country and West Birmingham.

Executive Summary

This document outlines our draft plans for transforming health and care services across the Black Country and West Birmingham. It is a 'work in progress' and we are now looking to engage and communicate effectively with our patients, public, partners, staff and stakeholders across the Black Country and West Birmingham in order to develop our plans further and to agree how to implement them in the best possible way.

The demands on health and care resources are rising year on year – people are living longer with ever more complex conditions; continuing progress in treatments and medical techniques comes with new costs and expectations; and modern lifestyle issues such as obesity are causing an increase in long term conditions. For the future, we must transform services to adapt to these rising demands. We must make the most of modern healthcare through innovation and best practice in order to change the way we spend money and use our limited resources. We must also focus on shifting demand away from our hospitals and to a more community-centred approach. When patients need hospital care, however, it should be of the highest quality, providing specialist interventions in the right place and at the right time with less variation in the care that patients receive.

Our vision is to transform health and care in the Black Country and West Birmingham. We need to bridge three critical gaps:

- **Our populations suffer significant deprivation, resulting in poor health and wellbeing;**
- **The quality of the care we offer varies unnecessarily from place to place, so not everyone has the best experience of care or the best possible outcome; and**
- **We risk not being able to afford all the services our populations need unless we take early action to avoid future costs, creating a sustainable health and care system that helps Black Country and West Birmingham lives to thrive.**

It is clear to us that our current ways of operating are unsustainable. 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 place-based models of care provided closer to home and through extended collaboration between hospitals and other organisations. Mental Health and Learning Disabilities services form part of this but are also identified as a discrete strand to reinforce parity of esteem, the necessity of which is confirmed by a study we commissioned that shows the much reduced life expectancy of mental health service users. Maternity and Infant Health is also an essential focus for us given our challenges around maternal health (in particular, maternal smoking) and its impact on neonatal death rates and other infant

outcomes. Maternity and neonatal service capacity also needs to be reviewed.

In addition to the challenges we face in terms of health and wellbeing outcomes and of variations in the quality of care, the local NHS is estimated to face a £512m financial gap by 2020/21 as increased funding is outstripped by rising demand. There is a parallel £188m challenge faced by Social Care services. Whilst local organisations retain individual responsibility to deliver savings, we know that standard existing demand reduction and efficiency measures will not be enough to bridge the NHS gap. As an STP, we need both to support individual organisations in achieving their regular savings targets and, through coordinated STP action at pace and scale, to avoid a further future costs.

Elements of our triple challenge (health and wellbeing, care and quality, finance and efficiency) 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 (commissioned through the Strategy Unit and ICF International) includes the economic impacts of health services defined in terms of both the economic benefits from improved healthcare and the opportunity costs of healthcare failures. It demonstrates how the NHS employs 6% of the Black Country and West Birmingham workforce and brings £2bn p.a. into the local economy, matched by an estimated similar value of informal care provided by friends and family members. It also models how improving infant mortality and mental health services could not only bring direct benefits to patients but could add c.£150m p.a. to the Black Country and West Birmingham economy. A summary of how we are taking forward our key initiatives can be found in the templates appended to this plan.

Aspects of these initiatives have been in development for some time (e.g. the Midland Metropolitan Hospital and the Dudley Multispecialty Community Provider model). Consequently they have already benefited from extensive public engagement and consultation. This plan, itself informed by the ongoing public and patient involvement by partner organisations, is now at the point at which coordinated engagement across the Black

Country and West Birmingham can be initiated, enabling the public to see (and to be able to contribute further to) how local plans relate to each other and how the benefits of working in partnership at scale can enhance the outcomes, experience and sustainability of Black Country and West Birmingham health services.

New Models of Care

Nationally, NHS England has been promoting a range of new models of care. These are designed to be locally appropriate ways of delivering the aims of its overarching strategy, the *Five Year Forward View*. The Black Country is active in developing a number of the new models:

- **Multispeciality Community Provider (MCP)**

  Building on and strengthening local GP services, MCPs will take a more integrated view of the needs of local populations, bringing together a wide range of services (including some traditionally provided in hospitals) and providing them closer to patients' homes. We are doing this is Dudley and in West Birmingham.

- **Primary Care Home (PCH)**

  Similar to MCPs, PCHs offer a different approach to strengthening and redesigning primary care, centred on the needs of local communities of around 50,000 people, and tapping into the expertise of a wide array of health professionals. This is the preferred model for most of Wolverhampton.

- **Primary and Acute Care Systems (PACS)**

  A local hospital also takes on a responsibility for local GP services. This is being developed in parts of Wolverhampton.

- **Acute Care Collaboration (ACC)**

  This is a model for NHS organisations offering acute care to share staff, services and resources. The Black Country is part of the Mental Health Alliance for Excellence, Resilience, Innovation and Training (MERIT), focusing on seven day working in acute services, crisis care and reduction of risk, and recovery and rehabilitation.

As we move towards a more sustainable, healthier and higher quality 2021, it is clear we already have a range of transformation initiatives underway across our patch. We will learn the lessons of these initiatives together. Through a programme of evaluation, we will reap vital learning from the seeds of innovation we have sown. This learning will be shared across the Black Country and West Birmingham and, where appropriate, across the NHS. We want to build a local health system that constantly improves itself and adapts as new learning emerges or needs change.

Public sector organisations are sometimes criticised for not doing enough to evaluate and learn from their new initiatives. In the Black Country and West Birmingham we are committed to making the sharing of knowledge and learning a powerful and accessible resource for our staff and patients. Empowering our staff, backed up with the right technology, we can make healthcare in the Black Country and West Birmingham a self-improving system that is constantly learning from what it is doing. Each aspect of our plan sets out to experiment – to test approaches, uncover effective practice, codify and spread it. Moreover, each of these initiatives is being evaluated and supported to varying degrees by the nationally regarded NHS Strategy Unit, based in the Black Country and West Birmingham, bringing a consistent discipline to both qualitative and quantitative measurement and understanding.

The Black Country and West Birmingham has the potential to transform its healthcare services and outcomes more quickly and more effectively than many other areas. Key areas of practical learning might include the following:

Local Place-based Models of Care

- There are two types of issue in this area -
  - Are there differences in the benefits that are delivered by the different models of care (MCPs, PCHs and PACS)?
  - What are the most effective ways for integrated local teams to deliver improved access, continuity and coordination of care to populations of 30,000 to 50,000? This could include evidence relating to the most effective Public Health interventions locally.

Extended Hospital Collaboration

- What level/type of joint working best enables the removal of unwarranted variation in care and outcomes?
- Does it help key hospital specialties to improve the benefits they bring to patients if they are provided in a joined-up way across more than one hospital?
- What are the key things that could most improve the quality of care in residential and nursing homes?

Mental Health & Learning Disabilities

- How can we best support service users to avoid crisis and manage their own care, improving health, social and economic outcomes?
- What level/type of specialist services can be sustained within the Black Country instead of further afield?
- Which interventions are best able to reduce unnecessary acute hospital usage by mental health service users?

Maternal & Infant Health

- What are the key things that would help us to reduce the number of unnecessary infant deaths in the Black Country?
- What mix of maternity services across the Black Country will best meet the needs of local mothers in the future?

Our 'Transformation Logic Model' overleaf sets out our rationale for why we believe that the things we are proposing to do will bring the benefits our patients and our communities need.

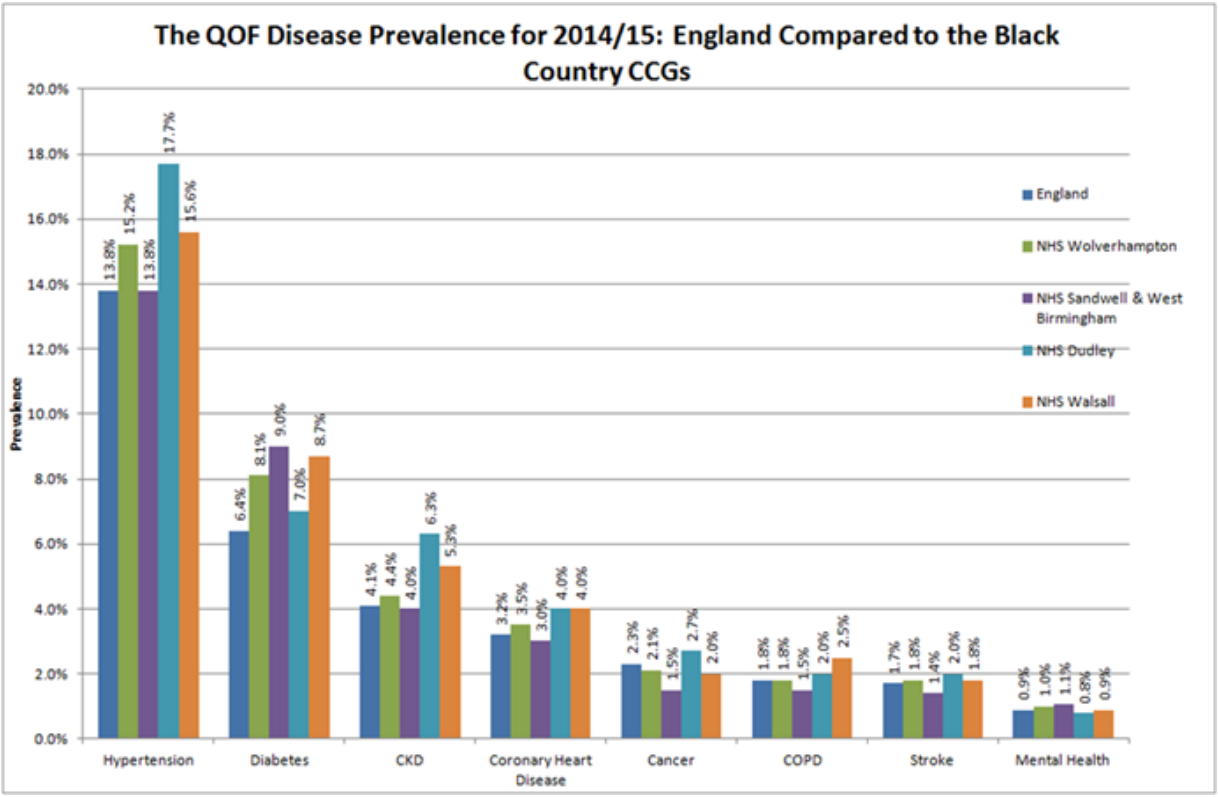
Our Transformation Logic Model

Rationale	The Black Country and West Birmingham 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	• In-kind contributions of all BC partners (including clinical and managerial resource) • Analytical inputs • Programme infrastructure • Additional funding allocations (including £99m Sustainability and Transformation Funding)
Activities	• 'Local Place-based Models of Care': Develop standardised place-based Integrated Care Models commissioned on the basis of outcomes; Promote the prevention agenda and build resilient communities; • 'Extended Collaboration between Service Providers': Build network of secondary care excellence; Deliver efficiencies in support services; Complete acute reconfiguration through Midland Metropolitan Hospital; Commission for quality in care homes; Deliver Cost Improvement Programmes; • 'Mental Health & Learning Disabilities': Become one commissioner for NHS services, Build the right support for Learning Disabilities in association with Council commissioning functions, Improve bed utilisation and stop out of area treatments, Deliver the WM Combined Authority Mental Health challenges, Deliver extended efficiencies through TCT partnership; • 'Maternity & Infant Health': Develop standardised pathways of care for maternal/infant health; Review maternity capacity • '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; Develop and implement future commissioning functions • 'Wider Determinants': Link to West Midlands Combined Authority to address wider determinants and maximise health contribution to economic impact
Outputs	• 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 and from the evidence
Outcomes	• 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, and reduced unplanned care • More engaged and productive workforce • Better use of available public sector infrastructure • Increased use of intelligence and insight
Impacts	• A more sustainable local health and care economy • Improved quality & experience of care for the population of the Black Country and West Birmingham • Improved population health: greater quality and quantity of life • A more capable local economy, equipped for self-improvement • A happier, more sustainable workforce

The Scale of the Challenge

Better Health

Directors of Public Health have examined data contained in local Joint Strategic Needs Assessments, STP data packs and Public Health England information in order to assess the Health and Wellbeing Gap in the Black Country and West Birmingham. This analysis demonstrates that not only are there gaps between STP and England averages but that there is also significant variation within the Black Country and West Birmingham. 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:

- Black Country and West Birmingham **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 and West Birmingham 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 and West Birmingham 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 and West Birmingham (linked to infant mortality) 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 and West Birmingham 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 level in the Black Country and West Birmingham (20.3%) is higher than the rest of England figure (18.4%). Walsall and Wolverhampton rates are 21.5% and 20.7%, respectively.

To achieve a step change going forward, we will implement a standardised, evidence-based approach to our prevention activities across the transformation areas we have identified. This includes:

- Co-ordinated action with all partners with a focus on improving healthy life expectancy;
- 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;
- Increasing our focus on the wider determinants of health and the impact the health and social care system can have on shaping the development of healthy, supportive environments

We have formed a Public Health Reference Group that has been focused on two key tasks:

a) Developing a common prevention framework

A common prevention framework is currently in development for use by STPs and the WMCA workstreams. For consistency this is being developed by the Association of Directors of Public Health Network (ADPH) for the West Midlands and Public Health England. The prevention framework aims to support STPs focus on prevention and early intervention to address variation and reduce the health and wellbeing gap. The framework is an enabler with a specific focus on the following three areas:

- **Changing Population Health Outcomes at Scale**. To address how to keep people healthier for longer and prevent the development of health risks;

- **Managing Individual Health Risks**. Focusing on early intervention to prevent health risks turning into ill-health and prevent escalation of existing health problems to the point where they require significant, complex and specialist health and care interventions; and

- **Better well-being by putting people at the centre of their care.** Improving quality of life and enhancing individual control by focusing on helping people to maintain good, happy, independent lives rather than being condition-focused.

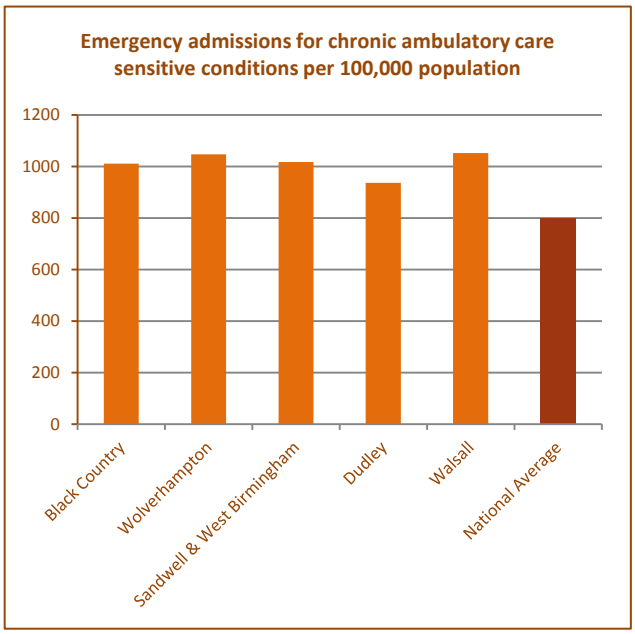
b) Providing advice and challenge across the Transformation Groups

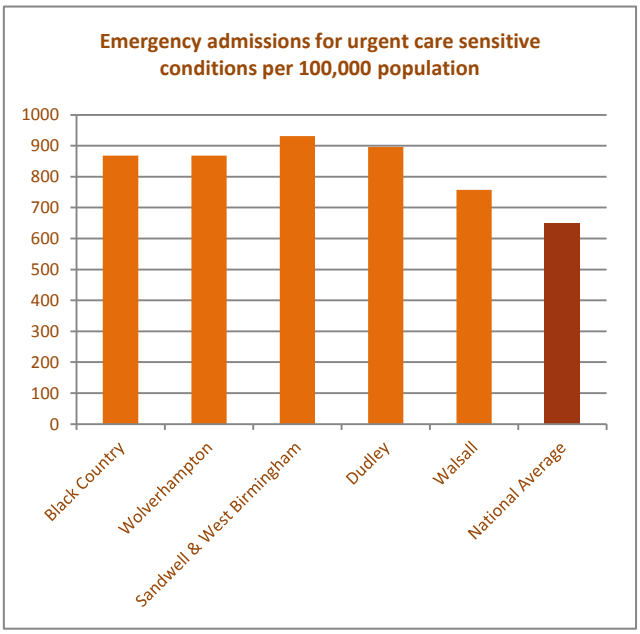
The Public Health Reference group is closely aligned to the Health and Wellbeing workstream of the West Midlands Combined Authority (WMCA) and directly links into the STP's Clinical Reference Group. In addition, it will also be closely linked to the Maternal & Infant Health and Mental Health Transformation Groups and to our joint work to address the wider determinants of health.

Better Care

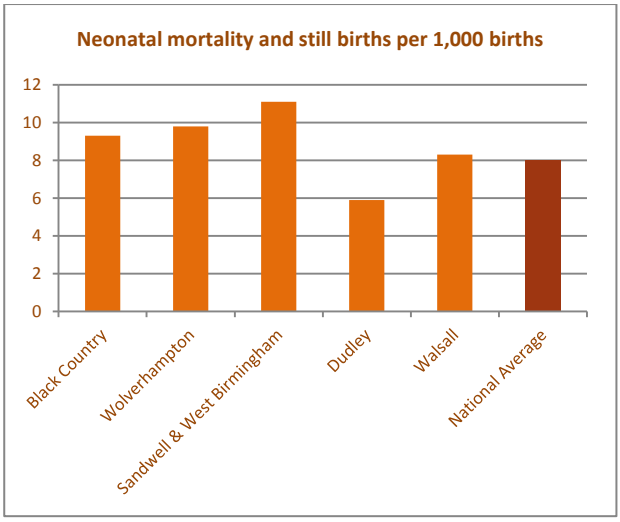
Our analysis of Care and Quality data indicates that there is unwarranted variation both between Black Country and West Birmingham performance and national performance, and also within our area.

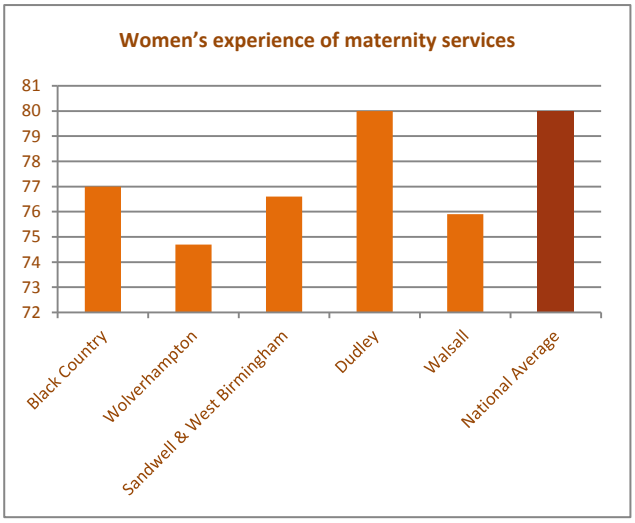
In terms of urgent and emergency care, for example, there is a 10% variation across our providers in terms of meeting the four hour waiting time target, with Black Country and West Birmingham performance in the 3rd quartile nationally (as it is for the number of emergency bed days). Emergency admissions for conditions that could be better treated in another way (i.e. through urgent care or ambulatory care) are in the bottom quartile.



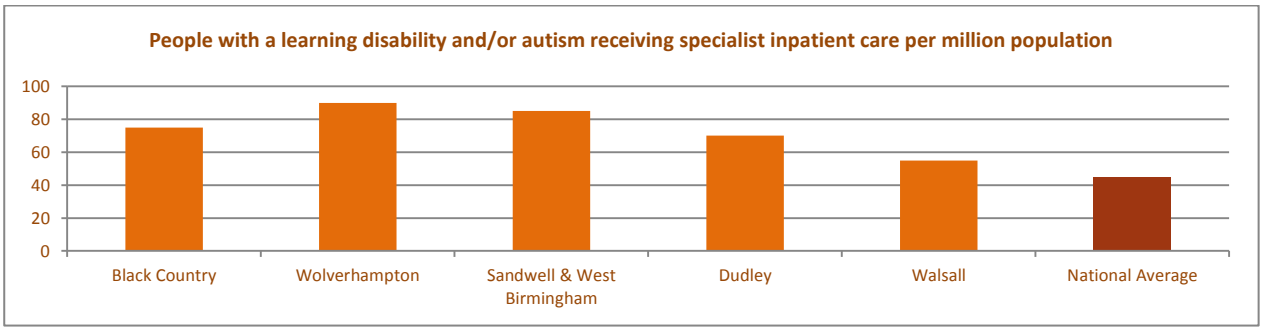


Maternity services are generally rated low in terms of mothers' experience, and the Health and Wellbeing Gap in relation to maternal smoking contributes to above average neonatal mortality. Both experience and mortality fall in the bottom quartile of STPs nationally.

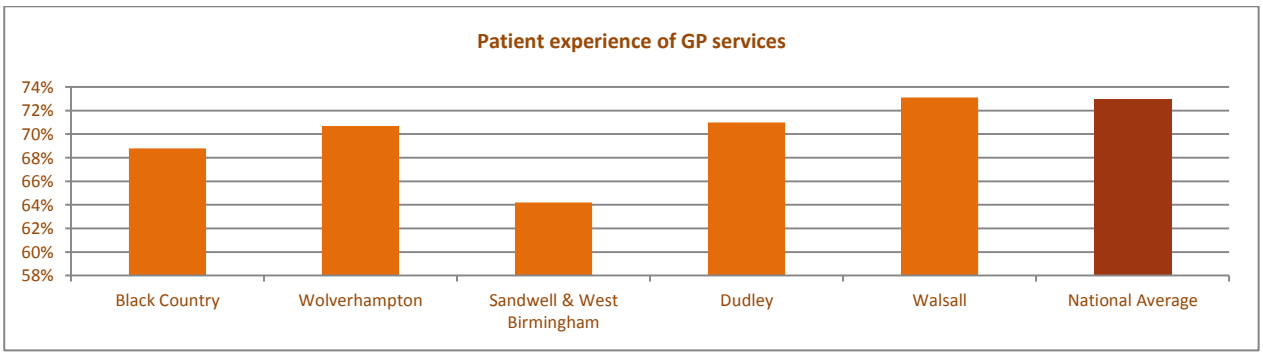




In Mental Health & Learning Disability services, there are also high rates for people with LD and/or autism receiving specialist inpatient care.



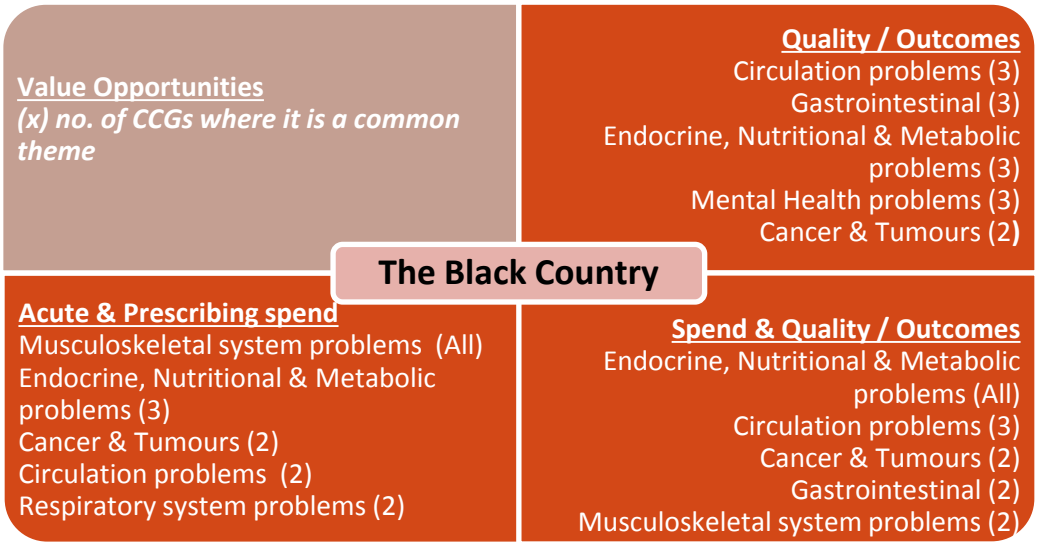
The need to standardise local place-based services is highlighted by relatively low patient satisfaction with experience of GP services.



Following this initial analysis, a Clinical Reference Group (CRG) has been formed for the STP in order to provide clinical support to our Transformation Groups in redesigning services and also to Quality Assure final clinical models, accessing external expertise where necessary. Membership of the CRG includes provider Medical Directors and Chief Nurses, CCG Clinical Leads and representatives from Public Health, Local Authorities and Pharmacists.

The CRG's work will be guided by the West Midlands Clinical Senate's Assurance Framework and will include the use of a standard template to facilitate a systematic and consistent approach. This will also enable integration with quality, equality and other impact assessment processes, as required by each proposal.

Following a review of Commissioning for Value (CfV) data and Public Health England (PHE) Health Profiles, the CRG has identified a number of clinical opportunities for improvement; key enablers and cross-cutting issues; and key challenges.



Comparison of Black Country CCGs (no.) with national averages	Significantly worse	Not significantly different	Significantly better
Hospital stays for alcohol-related harm	4		
Prevalence of opiate and/or crack use	4		
Recorded diabetes	4		
Obese children (Year 6)	4		
Under-18 conceptions	4		
Incidence of TB	3		1
Smoking status at time of delivery	3		1
Obese adults	3	1	
Excess weight in adults	3	1	
New STI (exc. Chlamydia <25)	2	1	1
Hip fractures – 65 and over	1	3	
Hospital stays for self-harm	1	2	1

a) Initial Focal Areas

- Avoidable emergency admissions:
  i. Alcohol / drug related
  ii. Frail / elderly related
- Musculoskeletal Conditions
- Long Term Conditions management

- End of Life care

b) Key Enablers and Cross-cutting Issues

- Patient engagement, activation and empowerment, and the need to help them better navigate what is often a complex health system
- Education, training & support of care home staff
- Workforce resilience & structure – use of new and/or different roles, and the potential 'sharing' of some workforce groups
- Information sharing between organisations
- Greater consistency and standardisation of social care referral processes
- Digital healthcare and access to records (with the need to address potential inequalities in access to technology)
- Linking with Mental Health and MCP vanguards in the STP
- Understanding costs to support sustainable changes.

c) Key Challenges

- Identifying the areas in which there are real opportunities for delivering a material improvement in the quality of care
- Defining key quality standards and the boundaries of what represents unacceptable variation
- Ensuring the robustness of proposals through evidence analysis, analytical modelling, etc.

To respond to these and other Care and Quality gaps, we are initiating a series of clinical service reviews that will, with appropriate public and patient engagement:

- Identify areas of best practice in the Black Country and West Birmingham 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 and West Birmingham to reduce duplication, facilitate repatriation and reduce Delayed Transfers of Care.

- Focus on clinical areas with particular challenge or opportunity such as Musculoskeletal conditions, Cardiovascular Disease and Frailty.

- Support the promotion of prevention activities in all settings and facilitate patient activation and engagement.

Sustainability

The NHS currently spends over £2 billion each year to meet the health needs of Black Country and West Birmingham communities. Even with this investment and planned funding increases over the coming years, the demand for services is expected to continue growing even faster. As a result, the total financial gap relating to health service organisations is projected to reach £512m by 2020/21.

Local Authority budgets are subject to different challenges and constraints but it is estimated that, in relation to social care costs, the challenge will be around £188m. As with health services, this is likely to involve a combination of demand management, cost efficiency and service transformation.

The table below sets out what we believe would happen over the next five years if we do nothing to provide services more effectively and efficiently and to reduce demand for services by helping people to stay healthier:

The Black Country		Do Nothing					
		2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Commissioner Surplus / (Deficit)	£000s	586	(10,154)	(76,713)	(142,758)	(208,699)	(273,318)
Provider Surplus / (Deficit)	£000s	(7,774)	(46,936)	(89,545)	(134,744)	(183,892)	(239,238)
Footprint NHS Surplus / (Deficit)	**£000s**	(7,188)	(57,090)	(166,258)	(277,502)	(392,591)	(512,556)
Indicative STF Allocation 2020/21	£000s						
Footprint NHS Surplus / (Deficit) after STF Allocation	**£000s**	(7,188)	(57,090)	(166,258)	(277,502)	(392,591)	(512,556)
Social Care And Other Surplus / (Deficit)	£000s	(0)	(0)	(67,631)	(115,428)	(155,064)	(187,698)

By contrast, if we were to successfully deliver the transformation of services described in this plan, we would not only improve the health of our populations but would also be living sustainably within our means (supported by additional Sustainability and Transformation Funds of £99m each year):

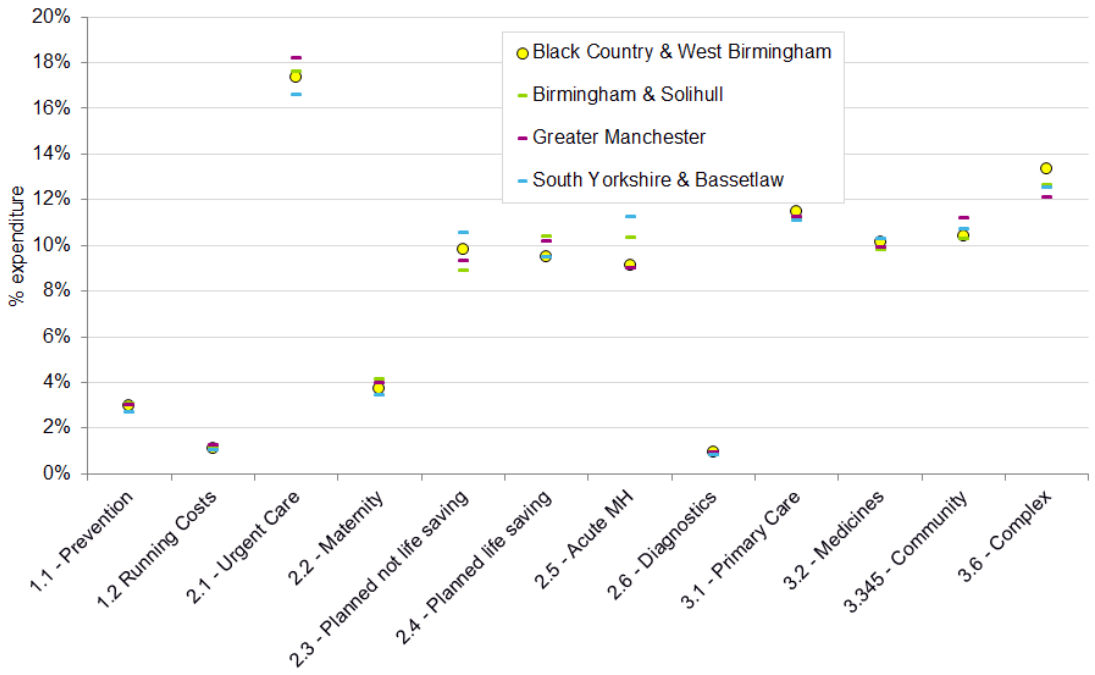
The Black Country		Do Something					
		2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Commissioner Surplus / (Deficit)	£000s	586	(10,154)	(0)	(0)	(0)	0
Provider Surplus / (Deficit)	£000s	(7,774)	(46,936)	(60,773)	(71,734)	(75,029)	(99,000)
Footprint NHS Surplus / (Deficit)	**£000s**	(7,188)	(57,090)	(60,773)	(71,734)	(75,029)	(99,000)
Indicative STF Allocation 2020/21	£000s			37,100	37,100	75,029	99,000
Footprint NHS Surplus / (Deficit) after STF Allocation	**£000s**	(7,188)	(57,090)	(23,673)	(34,634)	(0)	0
Social Care And Other Surplus / (Deficit)	£000s	(0)	(0)	(55,392)	(74,755)	(88,348)	(118,926)

We have also compared our levels of spending with other STP areas (including those with the most similar populations). This has shown us that how we allocate public funds is very similar to most other parts of the country including the most similar areas (see tables below). We will further explore this analysis in the next phase of our work – for example:

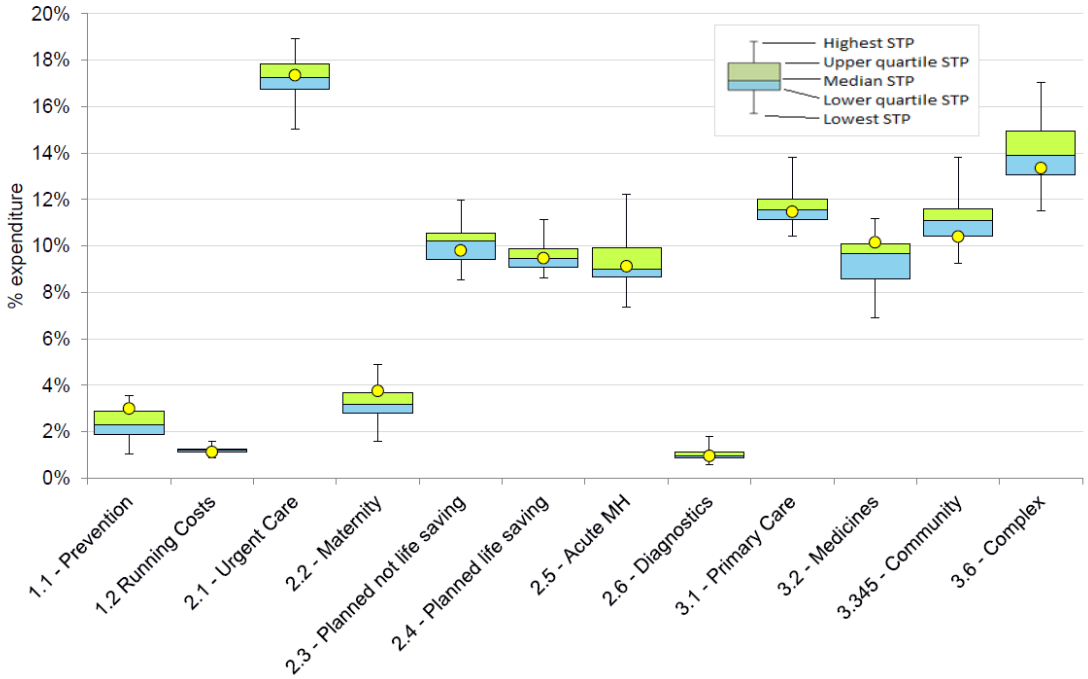
- Our administrative running costs are low;

- Our spending on complex health care needs and on primary care is high compared to our peers although we are not an outlier nationally;
- Our spending on prevention, maternity services and medicines is relatively high nationally but not unusual for our type of area; and
- Our spending on community services is relatively low, although our plans for local place-based care are expected to change this.

Distribution of Commissioning Resources 2015/16 – compared to most similar STPs



Distribution of Commissioning Resources – compared to all STPs 2015/16



When considering the sustainability of local health services, we are also very mindful that this not only relates to finance and efficiency but to some significant workforce challenges too.

- We know that a number of acute hospital specialties can be hard to recruit to across the country, and this is no different in our area. Where this is the case, we will address this as we consider how best to provide hospital services locally.

- We also know there are similar challenges faced in primary care. Delivery of the planned transformation across the Black Country and West Birmingham will provide challenges for all STP partners and success will depend upon genuine collective action. General Practice will be central to this and will play a key role designing the models for integrated delivery of services in the community and in ensuring that redesigned pathways work effectively. Current levels of manpower and capacity in General Practice increase the level of challenge. However, the STP partners are committed to an increased investment of £25m in primary care by 2020/21 to offset this challenge and to achieve the desired outcomes of the GP Forward View.

Demand Reduction through Local Place-based Models of Care

The way that health and care is provided has improved over the past fifteen years – thanks to the commitment of NHS and social care staff and, for the NHS, protected funding in recent years.

However, substantial challenges remain. The quality of care that people receive can be variable; preventable illness is common; and growing demands on the NHS means that local health and care organisations face financial pressure.

The needs and expectations of the public are also changing. Fortunately we are living longer, but we often require different, more complex care as a result. New treatment options are emerging, and we rightly expect better care closer to home.

People across the Black Country and West Birmingham are telling us that they want:

There is broad agreement that, in order to create a better future for the NHS, we have to adapt the way we do things. It means more preventative care; finding new ways to meet people's needs; and identifying ways to do things more efficiently.

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

Key actions we are taking include:

- The adoption of a developmental evaluation framework that will enable accelerated implementation from a robust evidence base, transferable to other STPs;
- Mapping current intentions and models in each borough to identify best practice;
- Developing standardised access to services utilising the full benefits of the new 111 service, integrated Out of Hours (OOH) services, new digital technologies and single points of access in each community;
- Improving long-term conditions care pathways with emphasis on prevention and self-care supported by Integrated Care Teams working to the same outcome objectives;

- Creating integrated place-based teams to achieve effective care coordination for a population (patient, registered with a practice, part of a community); and
- Accelerating the learning from our vanguard sites to implement new incentive and risk management models – long-term Whole Population Based (WPB) contracts that reward improvements in outcomes for patients.

Access, Continuity and Coordination Framework

The nature and scale of need is changing radically. Analytical work, alongside extensive engagement with patients, professionals and the public has shown us that different constituents of our population require different things:

1. **Enhanced access to care.** The percentage of people in the Black Country and West Birmingham 'able to get an appointment to see or speak to someone here' decreased from 81.8% in June 2013 to 79.1% in July 2016 (GP Practice Survey). The majority of our population wants enhanced access to care. They want more flexibility in the time and mode of access - to primary care based diagnostics and to analysis that identifies and solves problems as quickly as possible - and we need to create a sustainable primary care system to deliver this. The delivery of GP services will be redesigned to facilitate patient consultation through modern technologies and digital platforms to increase access, productivity and reducing barriers associated with traditional consulting systems.

2. **Improved support for people with a Long Term Condition.** The Black Country and West Birmingham has a high prevalence of Long Term Conditions (LTC) compared with England and West Midlands averages, especially in relation to hypertension, diabetes, chronic kidney disease, chronic heart disease, depression and dementia:

Condition	England	West Midlands	Dudley	Sandwell	Walsall	Wolver-hampton
CHD: Recorded prevalence (all ages)	3.20%	3.40%	4.00%	3.50%	4.00%	3.50%
CKD: QOF prevalence (18+)	4.10%	4.60%	6.30%	4.60%	5.20%	4.40%
Diabetes: Recorded prevalence (aged 17+)	6.40%	7.30%	7.00%	8.60%	8.70%	8.10%
Hypertension: Recorded prevalence (all ages)	13.80%	14.80%	17.70%	15.50%	15.60%	15.20%
Number of adults with dementia known to GPs: % on register	0.74%	0.73%	0.76%	0.69%	0.77%	0.82%
Number of adults with depression known to GPs: % on register	7.30%	7.60%	8.60%	6.90%	7.80%	7.90%
Stroke: Recorded prevalence (all ages)	1.70%	1.80%	2.00%	1.70%	1.80%	1.80%

Those being supported to live with a health condition (especially LTCs), need improved continuity of care. They need more consistent and proactive services that support them to manage their conditions and achieve their goals. They have needs (mental and physical) that are interdependent and that change, and they expect

services to reflect these needs. As a result of these factors (both prevalence and lack of continuity of care):

- Emergency admissions for chronic ambulatory care sensitive conditions per 100,000 population were 26% higher in the Black Country and West Birmingham than the England average (1,011 compared to 800) (STP Footprint data pack); and

- By moving to the upper quartile of comparable CCGs, savings of £4.6m could be made across the Black Country and West Birmingham (Identifying Potential QIPP Opportunities, Strategy Unit, 2015)

For these patients, self-care should be supported by enhanced primary care in order to keep patients better at home for longer by helping them to understand their condition and how it may exacerbate, and what to do about it if it does. Continuity of care embraces not only primary care but also community care (designing and delivering services closer to home), acute care (enabling hospital teams to discharge patients back to community care for rehabilitation or continuing care closer to home) and mental health services.

3. **Better Coordinated Care.** Some, notably those with complex care needs, multiple co-morbidities, those with frailty and those nearing the end of life, need better coordinated care. We know that the majority of health spending occurs in the last years of a person's life, when many have complex care needs:

    - The number of people with comorbidities is set to increase in England from 1.9 million in 2008 to 2.9 million by 2018 (Long Term Conditions Compendium of Information: Third Edition, Department of Health, 2012).

    - The number of people aged 75 and over is projected to increase by 10.4% between 2016 and 2021 from 105,000 to 116,000 (2014-based Subnational Population Projections for Clinical Commissioning Groups in England)

    - The cost of social care and inpatient admissions in the last year of life was £18,621 (£8,649 inpatient, £9,972 Social Care) (Social care and hospital use at the end of life, Nuffield Trust, 2010).

    These vulnerable people need the services that are supporting them to work closely together, integrating (rather than duplicating) care closer to home and improving the experience of it. Unfortunately, too many of these people are ending up in hospital in a crisis and being admitted to a hospital bed which potentially could be avoided with the right services in the community:

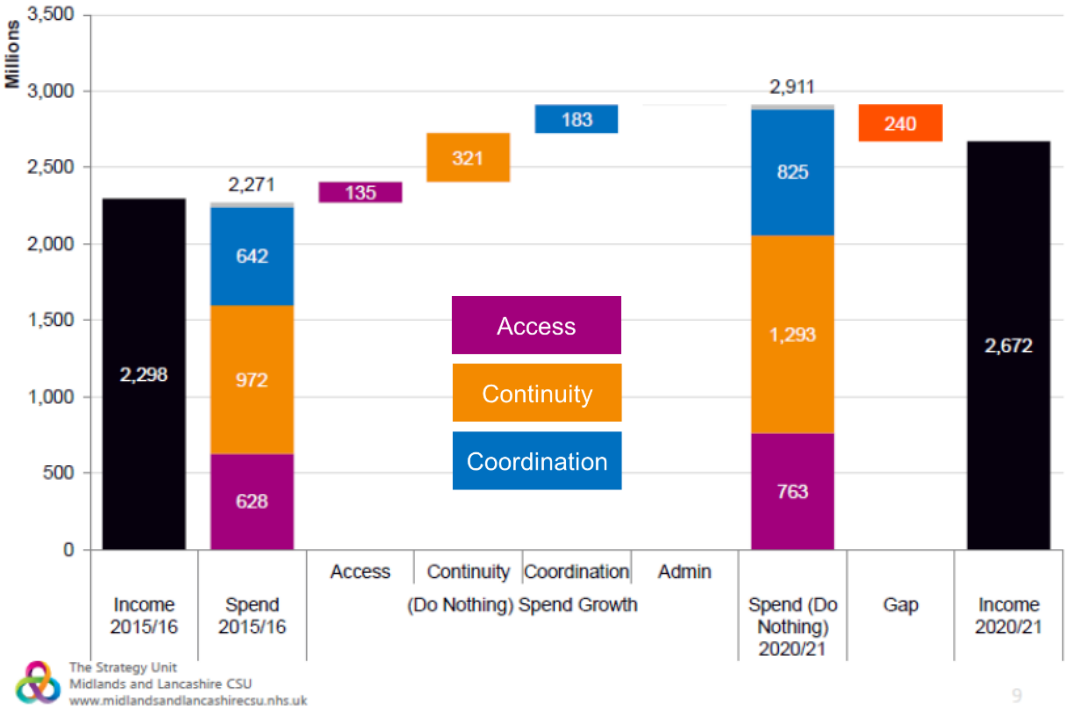
    - Across the Black Country and West Birmingham Emergency Admissions for frailty and ambulatory care sensitive conditions are amongst the worst in the country.

- In 2014/15, there were 28,530 admissions for ambulatory care sensitive conditions (acute, chronic and vaccine preventable) in the Black Country and West Birmingham costing £57.6m (Identifying Potential QIPP Opportunities, Strategy Unit, 2015).

Although this is a small cohort of patients, the current ways in which services are provided results in us spending a large proportion of our resources inefficiently. 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.

While the nature and scale of demand is changing, the supply of care is highly constrained and remains largely unreformed. The financial challenges facing the NHS are well documented; this places important limits on supply of care. But fundamentally, changes in the mode of provision have not kept up with changes in need. Providing care to an ageing population with multiple chronic conditions is a radically different proposition to supplying the predominantly episodic and curative interventions that typified the care of the past. Services are not configured to meet this fundamental shift. Nor are they sufficiently well integrated. With differing solutions to this problem in each place, Black Country and West Birmingham Health and Care organisations are working together to share best practice and experiences of addressing these challenges, in partnership with people who need us to address those most.

We have developed a framework that captures the scale of the local financial and activity challenge in relation to three key care areas. The following waterfall diagram sets out the challenge facing the STP's Clinical Commissioning Groups (CCGs) in terms of these areas:



Local Place-Based Care Models

The people of the Black Country and West Birmingham are at the heart of our plans. There may be different solutions in each of the four STP areas. This is the right thing to do, working with each community to shape what those solutions are. However, our collective aim is to help them flourish: to support them when they need support; to guide them when they need guidance; and to promote independence throughout. They are individuals and citizens first, patients and service users second. Our whole approach starts with this understanding.

Key enablers are the assets of the Black Country and West Birmingham People:

- Building on self-care in a more proactive manner by engaging and activating patients not only to contribute to their own health and wellbeing but also to support others to do the same;
- Building strong, resilient communities and connecting people together, reducing social isolation; and
- Maintaining a strong Voluntary Sector.

We will reprioritise prevention, to identify and focus on issues upstream rather than tackling them at the point of demand. This will include a renewed focus on population health measures such as smoking rates, obesity and mental health.

The place based care work stream addresses the imbalances in supply and demand. It rests upon the unique position of primary care - starting with the person, registered with the practice. The role of the GP is therefore fundamental. They take overall responsibility for the care provided by other services. Across the Black Country and West Birmingham these services include multi-disciplinary teams (MDTs), a wider network of community based and voluntary sector services organise around localities, and the services provided on referral to secondary care.

The delivery of GP services will be redesigned to facilitate patient consultation through modern technologies and digital platforms to increase access, productivity and reducing barriers associated with traditional consulting systems. All patients accessing health whether through acute minor ailments or more complex chronic pathways should have underpinning support.

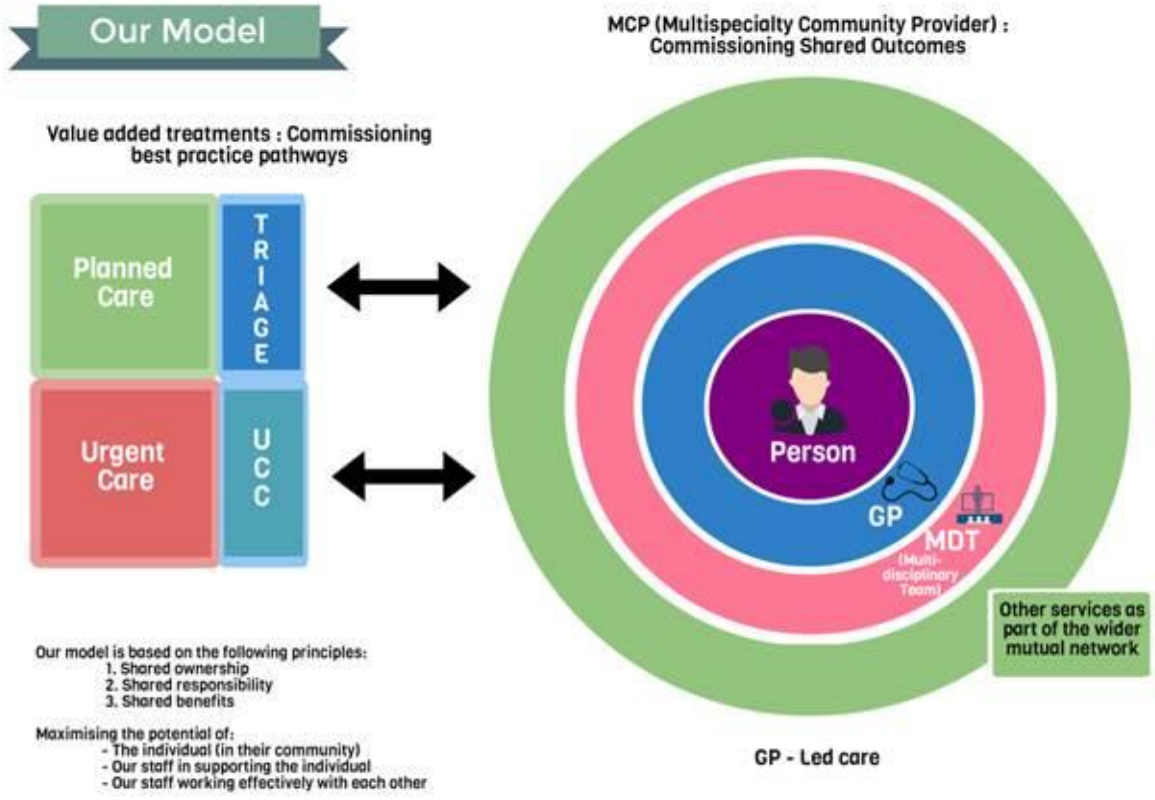
Supporting the benefits of modern hospital care, the new care models allows secondary care to focus on acute care of the unwell or injured, alongside appropriate elective activity for procedures which must be undertaken in a hospital environment. Hospital staff and teams can discharge patients back to community care in confidence of excellent local services delivering rehabilitation or continuing care closer to home.

The work stream will also tackle the variation in care, standardising pathways to best practice to deliver maximum efficiency of resources and delivering the highest quality 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 and more widely. Each model represents a locally-appropriate means of implanting an overarching, shared place-based model of care, in line with our principle of subsidiarity.

Dudley

Dudley's new care model proposes GP-led, integrated care in the community through the development of a Multi-specialty Community provider (MCP). A new approach to continuity of care and standardising access to services will provide a return on investment as it will improve the efficiency and effectiveness of primary care; improve self-determination by the public; contain the rising demand for emergency & planned secondary care - and thus improve efficiency of the overall system.



Our model rests upon the unique position of primary care - starting with the person, registered with the practice. The role of the GP is therefore fundamental. They take overall responsibility for the care provided by other services. In our model, these services include multi-disciplinary teams (MDTs), a wider network of community based and voluntary sector services organised around Dudley's five localities, and the services provided on referral to secondary care. Key actions planned include:

- Develop new ways of working to support the future MCP through:
    - Successful multi-disciplinary teams across all of our 46 General Practices;

- Voluntary sector Locality Link Workers, providing access to community-based support;
- Telehealth pilots in two practices covering 34,500 patients;
- Rollout of mobile devices to all GP practices, enabling remote access to core patient systems during home visits and better coordination at MDTs;
- A new Dudley Outcomes for Health long term conditions framework;
- An IT Local Delivery Roadmap towards integrated care records by 2020;
- Scoping of services, outcomes and characteristics of the MCP.

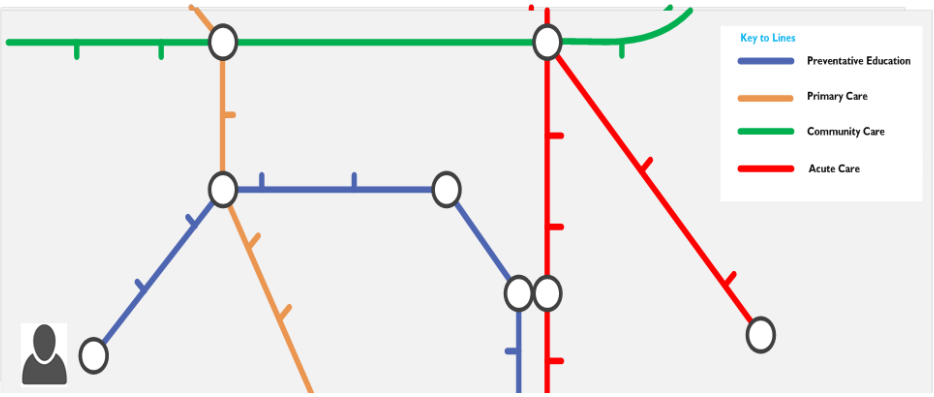
- Award a contract for Dudley MCP early 2017/18 which includes :
  - A meaningful outcomes framework to measure improvements in population health supported by a clear and robust evidence base, transferable to other STPs;
  - Standardised access to services utilising the full benefits of the new 111 service, integrated OOH, new digital technologies and single points of access in each community;
  - Improved long-term conditions care pathways with emphasis on prevention and self-care supported by Integrated Care Teams working to the same outcome objectives;
  - 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 site to implement new incentive and risk management models – long-term Whole Population Based contracts commissioning for outcomes across the STP footprint.

All of the above will be underpinned by on-going involvement and public consultation (where necessary) with local people, and we will fully engage with all staff involved in the transition to the MCP.

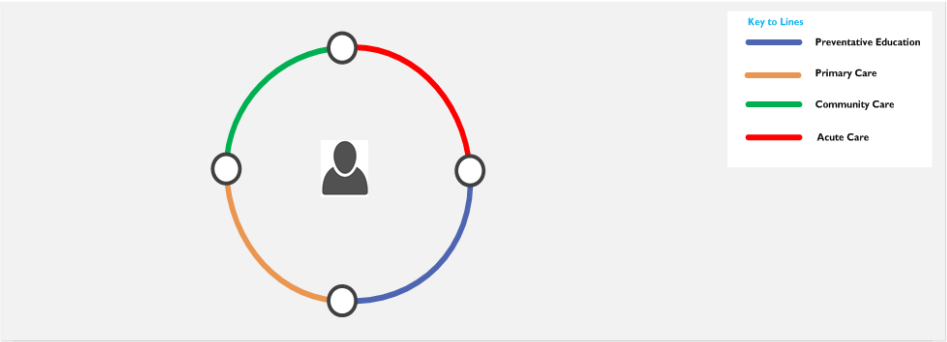
Sandwell and West Birmingham

The vision is to transition to outcomes based commissioning, which may take the form of a single, or multiple, accountable care organisations. These organisations will be accountable for both the costs and outcomes of their whole populations. The CCG will hold contracts with these organisations that will promote innovation and the delivery of effective and joined up care.

Patients travel through a system that is not designed around them, there are lots of changes and different routes and it can take a long time to the end point.



New Care Models provide the opportunity to design an approach where clinicians work together ensuring connections are made between care



Key actions planned include:

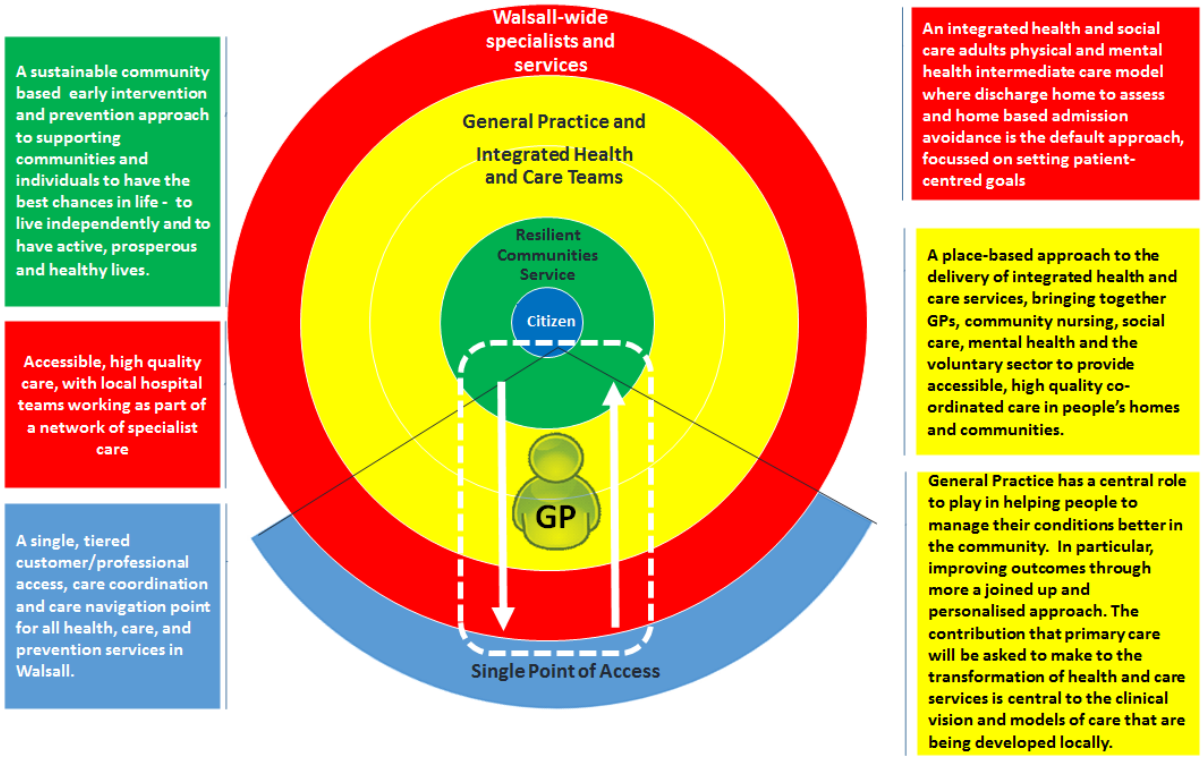
- Use the foundation of community nursing redesign and Primary Care Commissioning Framework to scope population coverage
- Develop the Whole Population Budget and the scope of services to be included
- Develop standardised access to services utilising the full benefits of the new 111 service, integrated OOH, new digital technologies and single points of access
- Improve long-term conditions care pathways with emphasis on prevention and self-care supported by Integrated Care Teams working to the same outcome objectives
- Accelerate the learning from our vanguard sites to implement new incentive and risk management models.

Walsall

Walsall aims to develop health and care services in the community that empower children, young people, adults and older people to live happier and healthier lives. Key actions planned include:

- We will support citizens to develop and harness the assets in communities to further develop a prevention and early intervention offer that keeps people well and independent in their own communities;

- We will simplify, integrate and standardise access to health and care services, ensuring quality and value through the commissioning of best practice pathways. This will include urgent care services (111 service, integrated OOH, new digital technologies and single points of access);
- We will tackle unwarranted variation in the care and treatment of people with on-going health and care needs;
- We will create integrated health and care teams, with general practice at the centre of care provision and supported by specialists working in the community, to provide multi-disciplinary co-ordinated care to people with complex health and care needs; and
- We will work together as system leaders to ensure that the resources and assets that we have in Walsall are most effectively deployed and have the necessary capabilities to deliver the new care model.



Wolverhampton

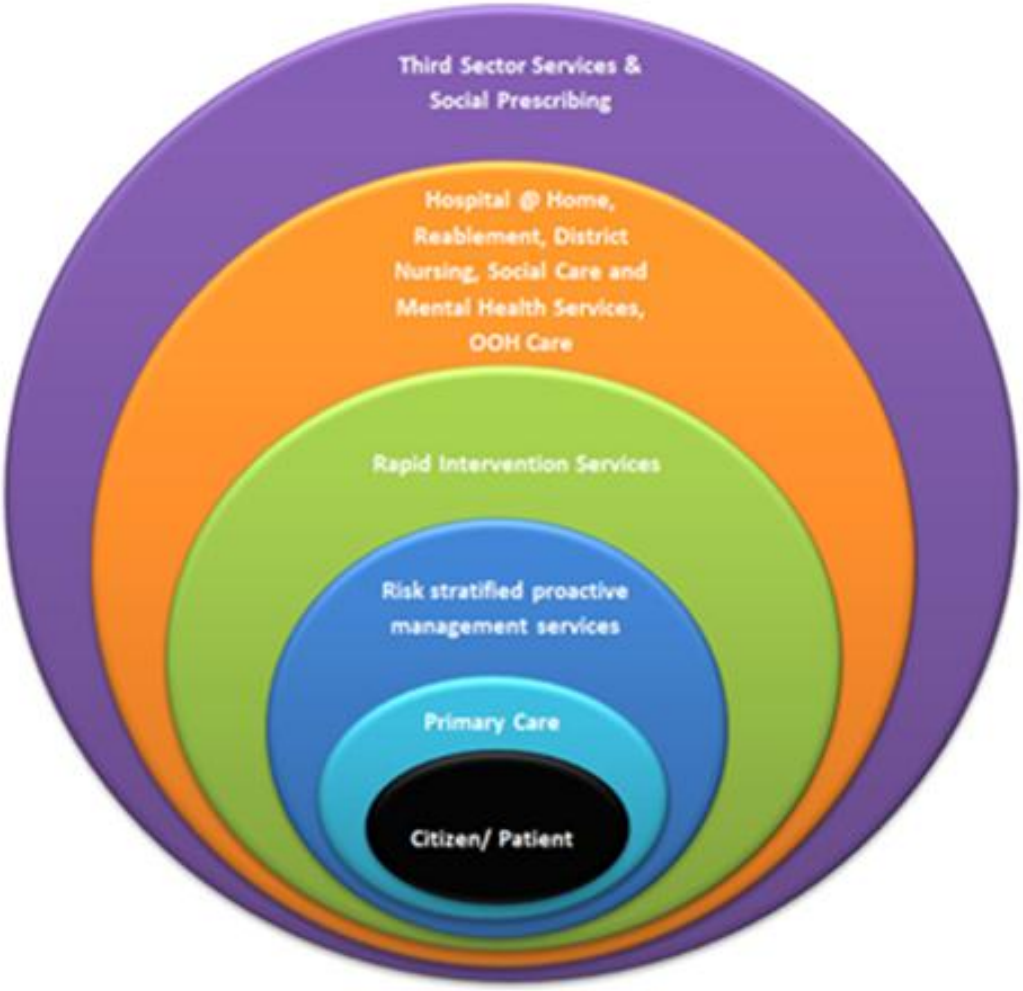
Wolverhampton CCG's aim is to promote the health and wellbeing of our local community that is standardised & commissioned in line with the registered list(s). We will do this by learning from models of care emerging both locally and nationally – including our local Primary Care Home (PCH) test site and Primary and Acute Care System (PACS) pilot. As we move into contracting year 2017/18, it is likely that an alliance-type MCP contract will become the vehicle through which community delivered services are commissioned.

The agreed approach will focus on health and care delivery models that are in the best interests of people living in the City.

There will be a greater focus on outcomes based commissioning including those that promote independence health and wellbeing but also be responsive to the needs of individuals with deteriorating independence.

We will reduce demand on services traditionally provided in the hospital setting and provision of alternatives to out-patient appointments to improve waiting times, diagnosis & treatment that can be achieved through shared decision making, advice and guidance and patient choice.

We will seek to ensure that our population receives the right treatment at the right time and in the right place. Care will be patient and population focused, reduce early deaths, improve quality of life of those living with long term conditions and reduce health inequalities. With Patient and GP Primary Care services at the core of the delivery model, many of the services are already in place.



Key actions planned include the development of new ways of working supported by integrated teams as the MCP or PACS model evolves, such as:

Access:

- Implement training for care navigators intercept & guide patients to the health & social care professional that best meets their needs whilst maximising social prescribing opportunities at primary care level;
- Improve access to services based in primary care including direct access to diagnostics identified through peer review, patient choice and shared decision making;
- Access to a full range of standard primary medical services during core hours and essential services 24 hours a day 7 days a week through a combination of primary care and extended out of hours service provision with access to central patient records and where feasible non face to face consultations using various media (skype, email, telephone); and
- Strengthen access to services utilising the full benefits of the new NHS 111 service, integrated out of hours, digital technologies and single points of access.

Care Co-ordination:

- Develop home based care including provision of hospital at home, community intermediate care, reablement, rapid response, therapy services and support from the third sector;
- Implementation of local strategies for Intermediate Care, End of Life, Ambulatory Care, Mental Health and Primary Care to maximise opportunities for place based care;
- Extended MDTs providing consultant outreach for diabetes, respiratory, mental health condition initially, extending a broader range of disease conditions; and
- Practices working together at scale with community neighbourhood teams that ensure coverage across the city for patients at highest risk of admission to hospital

Continuity:

- Ensure appropriate & timely support in line with our Integrated Care Strategy to support hospital discharge, prevent admission to hospital, avert potential care home admission, identify support that is suitable to meet the needs of individuals;
- Reduce demand on services traditionally provided in a hospital setting and provision of alternatives to out-patient appointments to improve waiting times, diagnosis & treatment achieved through shared decision making, advice and guidance and patient choice; and

- Improved long-term conditions care pathways with emphasis on prevention and self-care supported by Integrated Care Teams who are striving to achieve the same outcomes.

To support the above we will develop and implement a local Quality Outcomes Framework that seeks to achieve the highest standards of care quality, value for money & maximises opportunities for groups of practices to work at scale. This is work in progress and will be developed further with partner agencies and stakeholders.

Expected Impact

Each local area's implementation approach will contribute to the achievement of the overall benefits required in relation to access, continuity and coordination.

To support the delivery of these benefits we have identified £34m of capital investment in primary care premises over the planning period, with a further £16m capital to support the provision of services closer to patients' homes.

Pending confirmation of national metrics, the Black Country and West Birmingham expects its local, place-based plans to deliver the following benefits:

Category	Expected Benefit
Better Health	• Reduced LTC prevalence • Reduced mortality • Reduced social isolation • Increase in people dying in the place of their choice
Better Care	• Improved access, coordination of care, and patient experience of GP, community and other placed-based services • Clinical outcomes will be improved via MDTs, LTC care pathways and standardising access to care • Patient experience improves through co-production & patient activation; and by delivering more efficient & holistic care • Minimise harm (reduce number of incident per person / per practitioner). Safety/quality of the service will be safeguarded through standardised access and pathways; improved communication and reducing variation
Sustainability	• Reduction in emergency bed days, admissions for ACSC, and use of acute beds, nursing and social care placements • Resource sustainability will be realised through changing culture and behaviours, increased efficiency and improved staff retention • Reduction in emergency bed days, admissions for ACSC, and use of acute beds, nursing and social care placements • Improve staff efficiency, morale, patient contact time

Efficiency at Scale through Extended Hospital Collaboration

Our provider organisations have challenging Cost Improvement Plans (CIPs) in place for 2016-17. In order to meet the ongoing provider sustainability challenge beyond 2016-17 we will enable shared learning between providers so that individual CIPs can continue to be delivered. Much more than this, however, we will deliver a scale of efficiency beyond the reach of individual providers through coordinated action to develop networked and/or consolidated models of secondary care provision. As plans continue to develop, the impact on our hospitals of any new contracting models (e.g. Dudley MCP) will also be assessed.

We recognise that improving acute hospital services may require adjustments to be made to hospital sites, and we have allocated capital investment of £35m during the planning period to support this, along with a further £3m capital relating to organisational estates efficiencies of some £10m a year.

Creating Networks of Secondary Care Excellence

Reducing Variation

We have significant opportunities to share best practice and remove variation. Our initial analysis highlighted the following service areas:

1) Trauma & Orthopaedics – *Better Care, Better Value* (BCBV) indicates £2.7m could be saved through reducing first to 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).

We have a plan of action covering 6 phases (see table below), and these represent the sustainability challenge which is amenable to shared actions by the relevant organisations. Together they amount to a major programme of concerted change. We will build from extant clinical leadership arrangements to see it through and ensure learning from other systems that 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 supporting acute care operate to common standards we will tackle variation. By 2019 we will operate 4 A&E departments, ranging from 75k to 150k attendances 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 will have to deliver for us to succeed.

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

Service Sustainability

In addition, we have commenced a review of specialties and/or sub-specialties that face sustainability challenges and there may be opportunities to consolidate volumes. These include:

- **Rheumatology**. We have already well advanced discussions regarding Rheumatology service, unsustainable in Walsall due to small size of service making recruitment and retention of consultant rheumatologists really difficult. As a result of our network approach, we have collectively made available short term resources to sustain the service, and have been successful in recruiting 3 consultants who will join later this year. This will lead to a reduction in locum spend in the second half of the year. RWT already provides Rheumatology services for a large part of Staffordshire as well as Wolverhampton.

- **Urology**. While all Trusts have sustainable Urology services, this is a great example of where we have moved on to consider clinical and financial sustainability at a sub specialty level. Having comprehensively mapped services at a granular level, we are now defining specialised service pathway changes to consolidate volumes in particular areas. These will maximise certain consultant interests and make the best use of out of expensive treatment platforms. Discussions are taking place to widen this work to incorporate all Trusts within the Black Country and West Birmingham.

- **Neurology**. We have established a multi-disciplinary team to explore how we might improve sustainability of neurology services across the Black Country and West Birmingham. As well as exploring joint consultant posts to sustain current services, we are exploring together how we might make better use of sub specialty skills, how we might develop workforce to increase the provision of Nurse led services (MS, Complex Headache, Epilepsy) which in turn will we believe reduce pressure and

demand for acute, consultant led FU clinics. WHC is addressing current recruitment difficulties through a joint arrangement with UHB.

- **Out of Hours / 7-day services**. All Trusts are examining implementation of the four key standards by March 2017, RWT being an early implementer of these standards, and together we have begun to explore the opportunity to collaborate on closing 7-day service gaps and provide better out of hours cover. We have already established a joint rota for non-vascular interventional radiology (nephrostomy) and will examine extending to other areas. We will explore other areas where more specialised / lower volume services may benefit from a networked approach, for example ENT and Plastics and in particular, breast reconstruction.

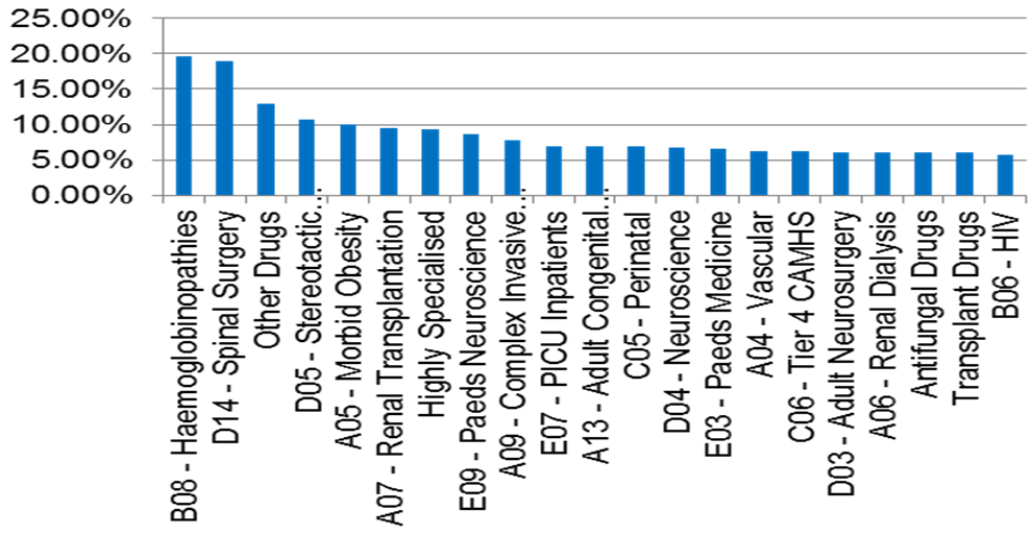
- Other areas include Upper Limb Trauma, Cardiology, Audiology, Children's and Community Services. We will also explore replicating some services across the path and scaling some services, both of which will enable improved clinical and financial sustainability.

Specialised Services

Certain services are commissioned directly by NHS England rather than through local CCGs. To support the integration of pathways and the devolution of some specialised services it is proposed that a Specialised Commissioning Board will be established for the West Midlands.

Midlands and East Specialised Commissioning will work with the Black Country and West Birmingham STP to plan for the development of new models of care to support specialised services. Over the five years of the STP this will involve looking at what is the appropriate level of planning and delivery for individual specialised services. Central to this process will be the development of networked models of care that allow geographically dependent services to be managed by Tier 1 and 2 providers.

The table below illustrates the demand and cost challenges faced in relation to fastest growing specialised services in the Black Country and West Birmingham:



To address these challenges in the current year, the West Midlands Specialised Commissioning hub has a QIPP target of £36.3 million. Schemes are split between 70% transactional and 30% transformational with 90% of these being local schemes and 10% nationally identified schemes. QIPP plans for 2016/17 are currently forecast to deliver a balanced plan. Moving into 2017/18, The QIPP target for the West Midlands in 2017/18 is: £36.9 million Schemes will be split 60% transactional and 40% transformational to reflect the national drive towards more transformational, whole system change. The proportion of this QIPP for the Black Country STP based on presumed population split is £9.23m. These plans are also expected to affect the STP's other Transformation Groups, as indicated in the table below:

STP Transformation Group	Specialised Commissioning Transformation Project		
	National	Regional	West Midlands
Local Place-based Models of Care			Spinal Pathfinder/ Future contracting at Level 1 and 2 providers
Extended Hospital Collaboration	Cancer Alliances	Vascular Review	Neonatal Review
Mental Health & Learning Disabilities Services	Transforming Care Mental Health Service Review		Adult Secure ACO CAMHS ACO
Maternity & Infant Health			Neonatal Review

Efficiency in Clinical and Non-Clinical Support Services

Pathology

The four integrated care trusts within the Black Country STP all currently provide a full range of pathology services covering inpatients, outpatients and local community GPs, both hot & cold, that include microbiology, histopathology, blood sciences, immunology, anticoagulation and clinical haematology. All departments are CPA accredited and are currently going through the UKAS accreditation. The Blood Banks have MHRA accreditation and the mortuaries hold HTA license for scheduled activities. All Trusts have in existence or are committed to entering into Managed Equipment Service arrangements which may constrain timing of consolidation. All 4 trusts will require continued access to 24/7 hot lab capabilities regardless of any other consideration.

The Black Country STP sets out a simple triple aim to improve health outcomes, healthcare experience and make the best use of the resources we have. We have an ambition to offer a first class UKAS, MHRA, HTA accredited pathology service across the Black Country and West Birmingham that ranks in the top quartile nationally on a range of quality, efficiency and outcome measures. This will include speed of access to results for inpatients to enable

earlier decisions on treatment and so reduce length of stay (LOS), improved turnaround times for all pathology tests and appropriate out of hours coverage to reduce 7 day service gaps.

We believe that IT will be an enabler to integration of services. Currently 3 of the four trusts use Sunquest ICE for requesting and results view. A common system would allow for sharing of results across the Black Country and West Birmingham. The procurement of a common LIS would allow the laboratory services to further integrate and create a virtual laboratory, which would be an enabler for further change; however this would require significant investment. All four trusts currently provide the full range of District General Hospital (DGH) pathology services locally along with some more specialist work for a larger area. The wider STP service strategy for the Black Country and West Birmingham commits to maintaining four acute sites (five currently – four following the opening of Midland Metropolitan Hospital), and so any solution proposed must be cognisant of and consistent with this baseline.

We are examining the case for a shared molecular laboratory and explore together Digital Pathology to support specialist and sub specialist reporting, improved (virtual) multi-disciplinary team (MDT) provision and deliver efficiencies from use of latest technologies. We believe this will enable some of the work we are doing across a range of services at a sub speciality level which we believe is a core part of the route to clinical and financial sustainability.

We have already established a team comprising clinical and operational colleagues who are currently working on collaborative solutions to the sustainability of Histopathology and Microbiology services initially. Initial focus has been on service level agreements (SLAs) to stabilise services and enable some joint recruitment to reduce locum demand and improve resilience.

We have commissioned an independent expert review of our pathology services. Trust Chief Executives have identified a suitable, credible, expert (Dr Mark Newbold) who is undertaking this work, and Terms of Reference have been agreed by all four Trusts. The STP has engaged fully with the national process around pathology integration.

All four Trusts are committed to considering all options that will lead to clinically and financially sustainable pathology services. All options will be fully considered. While examining various design principles and being open minded on solution options, we will in the meantime continue to build out on extant plans and focus on the functional changes that will enable sustainable services across the patch. Our review will include examining successful models from elsewhere as well as learning from unsuccessful lab mergers. Our outline plan is as follows:

- November – December
    - Build options and assess case for each, mobilise quick win delivery
    - Determine preferred option(s)

- Q1 2017
    - Deliver quick wins
    - Build detailed plan and business case for detailed options
    - Sign off business case
- Q2 2017 – Delivery / transition

Together in addition to the ambitions outline above, we will examine the case for further development of Managed Service Contracts (MSC) to allow new technologies to be introduced and more efficient procurement of consumables. We will accelerate possible consolidation of some referred tests to enable critical mass to be achieved to drive short term savings, and we will examine opportunity for consolidation of out of hours cover, i.e. Microbiology, as a route to short term benefit.

In seeking to move at pace and scale to realise maximal efficiencies in clinical support services, we are also mindful of the risks involved, including:

- The pace of change may be constrained by the financial and intellectual headroom to focus on planning and delivering the above at the same time as continuing work on STP, local vanguards, CIP and of course, seeing & treating ever increasing numbers of patients;

- As in other examples across the country, rushing to consolidate services may create more problems than are solved;

- Transactional costs associated with moving to consolidated models, dual running costs associated with changing service delivery models and the opportunity cost associated with distracting resources from other priorities will make the value case for change harder to make, and resulting in long period of pay back or inability to fund the change;

- Consolidation may have adverse morale impact on leaders & teams, which may lead to deterioration in service levels if colleagues leave as a result;

- Reconfiguring the use of PFI space for labs across the patch may lead to expensive change; and

- Pathology consolidation that is undertaken without full clinical engagement and without consideration of clinical strategy or which is not in alignment with patient pathways can result in (inter-provider) confusion, disruption in patient journey, delay in patient management, poor patient experience, transmission mistakes, repetition of tests with waste of resources, overall deterioration in quality of service and/or other clinical risks.

We believe we could mitigate the risks above and go further, faster if our work is supported by:

- Provision of national exemplars where consolidation was conceived, planned, delivered and sustained;
- Funding to increase project management office that can provide cohesion, grip and drive to accelerate the work;
- Funding for enablers that are identified during the assessment and planning phase of the work above. Examples being the technology to enable interoperability, digital reporting and molecular capability;
- Clarity on prioritising the sometimes conflicting requirements - short term versus long term targets; run rate reduction versus investment required to achieve; increase staffing to achieve Care Quality Commission (CQC) standards versus pressure to reduce staff to meet financial targets; quality versus value; pace versus perfection; and
- Time to make the changes in a considered way, building on extant initiatives like the Black Country Alliance, to enable change to made in a positive way that will be sustained and deliver long term clinical and financial sustainability rather than rushing to drive short term impacts that could unwind and cause more harm than good.

Back Office Functions

There is a broad range of back office service delivery across organisations within the Black Country and West Birmingham. The CCGs have differing levels of outsourcing already in place through Commissioning Support Units (CSUs) and other providers (particularly for payroll), alongside in-house provision; and Providers and Local Authorities largely have their services delivered by in-house teams and, in some cases, themselves deliver services to other organisations.

It is recognised that this will primarily focus upon the health partners of the STP, although Local Authority partners are active in the discussions and may contribute to some of the solutions which may be considered. Discussions already taking place across organisations have identified enthusiasm for delivering transactional excellence, driving efficiencies and sharing best practice to enable improved resilience and reduce reliance on temporary staffing. The trusts have been transparent in indicating that the delivery model for those services is open to determination, and are similarly clear that the journey of improvement and any new collaborative delivery model – in-source, joint-venture or out-source - has to start with resolving and aligning extant processes, procedures and their underpinning systems. Out-sourcing a problem will simply add to costs. Rushing to consolidate may simply incur transactional costs and raise concerns among those impacted without having a clear route to value.

By working at scale across the STP, there is significant potential to integrate the non-clinical support services across both provider and commissioner organisations. Building on the early work of the Black Country Alliance (BCA), 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, Human Resources (HR), telephony and legal services
- Common call centres
- Licensing of telephones, IT applications etc.
- Hotel services.

Our ambition is to move swiftly to identify which services may benefit from further collaboration, including an assessment of which service may be consolidated in 2016/17. In April 2016 the BCA Board established a comprehensive programme of work covering all back office functions across the three trusts. We are now devising a broader STP programme plan for services in 2016/17 and over the coming years (as some services are already under contract terms).

We have agreed the following principles:

- The efficiency we need by 2019 goes beyond what any part of the STP currently delivers, simply being among the current best is not good enough;
- Aggregation is not guaranteed to drive value - to get 'value' we know we need to know what we want and we will use a variant of our triple aim to guide us;
- Local employment matters and pay rates matter, we are not simply seeking the lowest possible cost model or we would, typically, outsource abroad;
- We recognise the potential to work towards a single 'virtual organisation' should the evidence support that but, first, we aim to build more securely on existing partnerships whilst keeping under review the opportunity for further consolidation;
- We approach this with a view to exploring closely the benefit of having strategic leadership across some of our functions, and in terms of opportunity to share transactional services. However, we are also mindful of the transactional costs associated with transitioning to shared service models, and the risks of impacting outcomes & experience of the service through disruption;

- We believe local business partnering and presence will continue to be a feature of most services; and
- We will seek where possible to ensure all organisations have an opportunity in this area, which enables broader engagement, capacity and will to take the work forward.

The first six-month wave of projects, mobilised in April, is reviewing potential for collaboration on a range of HR enabling processes including our use of Electronic Staff Records (ESR). We plan to reduce agency spend by working together on temporary staffing and administration, moving toward consistent admin, systems, processes and rates to establish a Black Country and West Birmingham Bank which will we think significantly reduce Agency spend. We are reviewing Clinical Coding, Information Governance, Legal Services, Research Governance, Contract Management and Procurement. Second phase will begin in October and will cover energy procurement, complaints handling, medical illustration / communication, emergency planning, mandatory training, disciplinary and conduct investigations, debtors and claims, safeguarding and recruitment.

As we mobilise a broader STP-wide programme to explore options, we will consider the merits of various delivery models, but will continue to focus in function rather form as we do so. Forms we may assess include but are not limited to:

- Use of CSUs to deliver across both CCGs and Providers
- Creation of an entity owned by the NHS bodies to deliver services to all partners
- Use of multiple providers to deliver services to NHS bodies

The quality and operational benefits will be assessed over the coming months but the following benefits are expected:

- Consistently high quality levels of service and improved resilience for those services, reducing the demand for temporary staff.
- Standardisation of service leading to fewer errors and improved efficiencies associated with fewer systems and economies of scale.
- Opportunities for more specialised level of service to be financial viable across a wider range of bodies
- Standardised ledger will lead to efficiencies in organisations, e.g. annual accounts process
- Potential for improved career opportunities for staff working in larger functions.

In advancing these plans, we are mindful of a range of issues and risks:

- Existing contract arrangements may be an impediment or delaying factor. CCGs in particular have recently entered into contracts with CSU providers. Consolidation may require termination payments, degrading the value for money case;

- In order to minimise risks of service disruption, a phased approach will need to be developed. Potential for consolidation may have adverse impact on morale that may lead to deterioration in service levels;

- Transactional costs associated with moving to consolidated models, dual running costs associated with changing service delivery models and the opportunity cost associated with distracting resources from other priorities will make the value case for change harder to make, and resulting in long period of pay back or inability to fund the change.

These risks would benefit from the same mitigations proposed in relation to clinical support services.

Midland Metropolitan Hospital Development

This project develops a new acute hospital and A&E department, merging two District General Hospitals into one – with associated community infrastructure – by October 2018.

Existing acute services are not sustainable: 60% of ED consultant roles remain vacant, and 50% of SWBH acute physicians; and Two-site services are not able to meet Keogh standards. Half of the Unitary Payment for the new hospital will be met through single-site 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. Acute bed capacity in the STP will then be within a range of 2.0-2.75 per 1,000 resident population. According to the NHS Confederation[2], the UK has 2.8 hospital beds per 1,000 people in 2013, compared to 8.3 in Germany, 6.3 in France, 3.1 in Denmark, 3.0 in Spain and 2.8 in New Zealand. Key to succeeding will be flexible capacity in intermediate care through existing arrangements and through our work on nursing home provision.

Capital investment will be required for additional ED attendances expected following the catchment changes of Walsall when MMH opens. The capital, which forms part of the Trust's investment planning, will be required to upgrade ED facilities on the Manor site together with additional inpatient facilities.

Commissioning for Quality in Care Homes

We have identified a number of opportunities for improving the commissioning of care home services across the Black Country and West Birmingham.

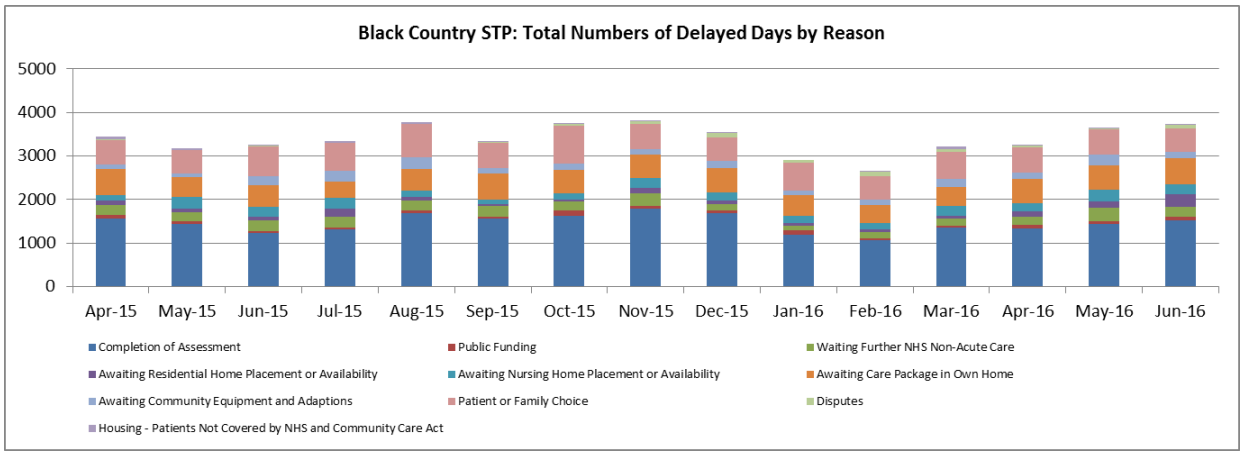
In their role as lead commissioner, Local Authorities will work with CCGs to explore how commissioning, such as enhancing primary care, can enhance the quality of services. This will

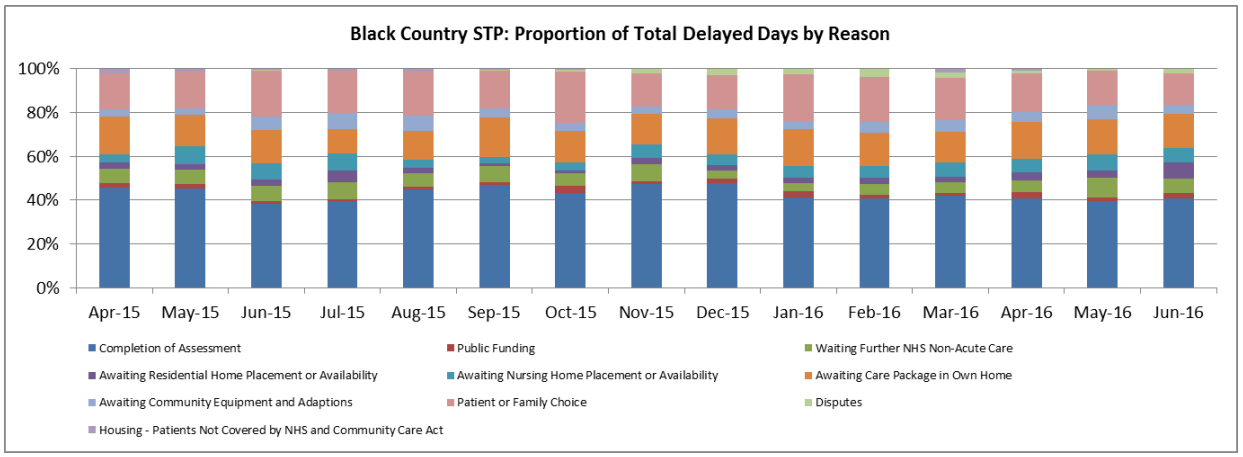
[2] http://www.nhsconfed.org/resources/key-statistics-on-the-nhs

build on work initiated by the West Midlands Association of Directors of Adult Social Services (ADASS) which is completing a region-wide analysis of residential and nursing home provision. The WM ADASS has undertaken a West Midlands-wide analysis of residential and nursing home provision. Data analysis can be made available on an STP-footprint and will be commercially sensitive. Councils already have responsibility for market-shaping and a workstream is underway. This will help us improve our health and social care system.

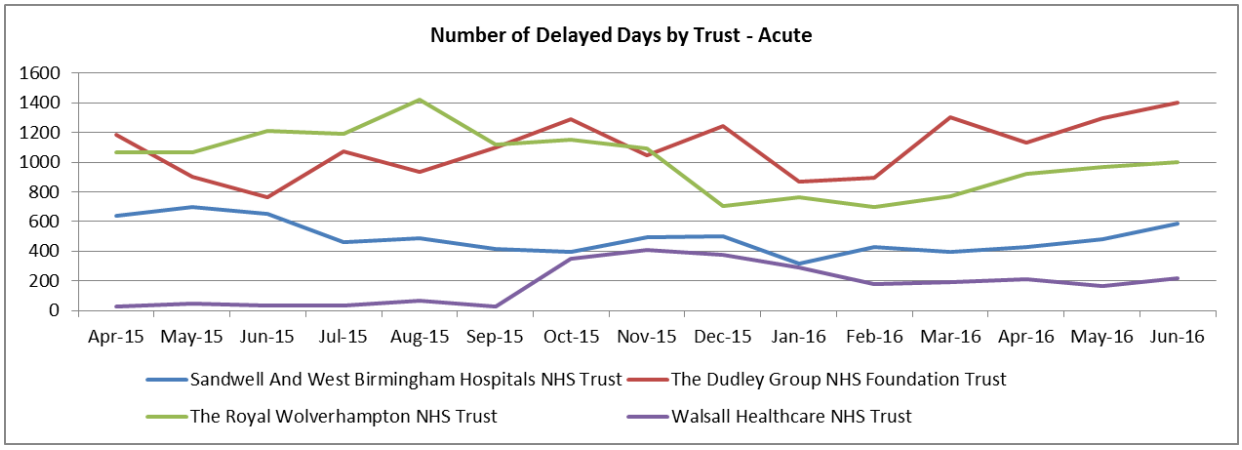
This will cover a wide range of care and support that adult social care commissions, such as residential and nursing care, care in the home, personal assistants, day opportunities, and more. It is important that, as care and health commissioners work closer together through this plan, we understand the impact of commissions on the market place so that we are moderating the costs of care across the boundaries of health and care, and across geographical areas. At present each commissioner will pay differential rates for the types of "placements" that they purchase. We can maximise the ability of new opportunities to commission and procure together for the best outcomes for people and for the value of the public purse.

There are also opportunities to reduce delayed transfers of care (DTOCs) from acute settings through improvement in the provision of care home services. The following tables summarise the causes of these delays:





An analysis by acute provider demonstrates variation across the STP:



In addition, we have modelled the potential for reducing spells and costs for Black Country and West Birmingham Patients aged 65+ who are in receipt of packages of care (residential or nursing home plus CHC services). By extrapolating detailed analysis undertaken for Dudley CCG across the Black Country and West Birmingham, we estimate that standardising models of care in relation to care packages could save around 3,000 spells and £7m p.a. (acknowledging the likelihood of double counting across areas of care).

Estimated Avoidable Activity and Costs	Spells	Cost
Readmissions within 30 days of discharge	660	£1,851,240
Falls related	660	£1,628,790
Frail Elderly - Usually managed elsewhere	544	£1,192,482
Ambulatory Care Sensitive - Vaccine Preventable Conditions	218	£699,049
Frail Elderly - Occasionally managed elsewhere	232	£655,449
Ambulatory Care Sensitive - Chronic Conditions	251	£593,175
End of Life Care long	104	£348,880
Ambulatory Care Sensitive - Acute Conditions	99	£209,548
End of Life Care short	101	£187,308
Zero length of stay, no procedure, discharged alive - adults	344	£174,036
Medicines related	55	£133,893
Medically unexplained symptoms	58	£69,355
TOTAL	**3,324**	**£7,743,205**

The main key to improving care home provision lies in the re-design and enhancement of community-based provision. This model can be complemented by effectively improved services across a continuum from re-ablement, 'step down' and care home services. Effective commissioning of community-based services is a first principle which needs to underpin the approach to use of care homes.

Effective Delivery of Cost Improvement Programmes

In order to deliver the existing Cost Improvement Programmes of our organisations (including Carter efficiencies, LOS reductions, and workforce re-design), we have agreed a set of key 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; and
- Track demand side efficiencies to ensure income impact is matched by real costs change.

Three quarters of our hospital-linked providers delivered surplus plans in 2015-16. Each has a CIP programme for 2016-17 of 2-4.5% for coming years, and has agreed STF financial control totals. Explicitly co-operating at scale will deliver added savings value beyond changes in organisational form.

We plan to:

- Scope a commercial offer to GP practices and other 3rd parties
- Explore NEWCO employment models
- Contract 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 and West Birmingham provider etc.

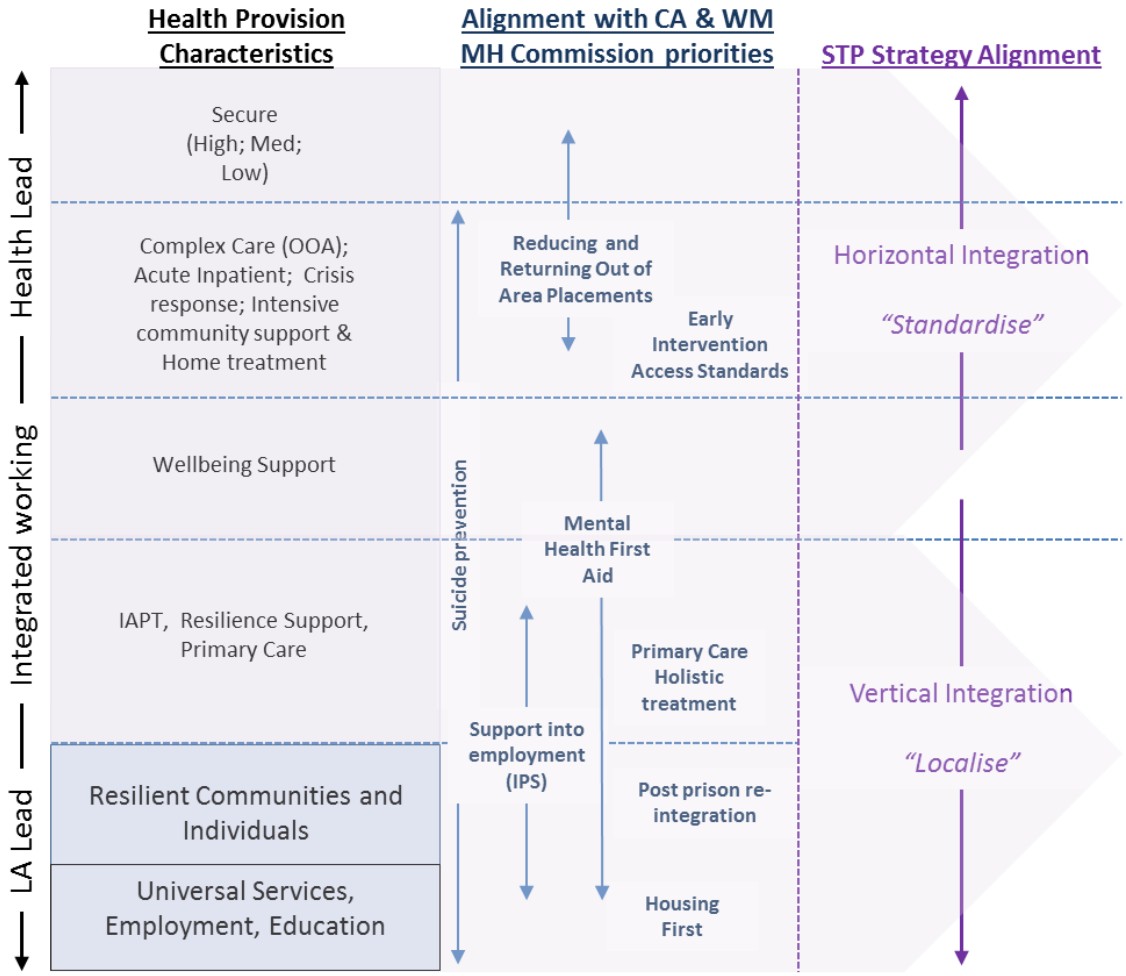
Improving Mental Health and Services for Learning Disabilities

Become One Commissioner

Our CCGs propose to operate as 'one commissioner' across the Black Country and West Birmingham, leading to a substantial reduction in the current unwarranted variations in the quality of care, standardised services, and the creation of an environment in which our providers can maximise resources and workforce through better skill mix utilisation. This will build on the Transforming Care Together (TCT) partnership vision to create synergies and improve the experience of Black Country and West Birmingham residents affected by Mental Health and Learning Disabilities (MHLD). By sharing best practice *and* aligning to the work of other agencies we will reduce variation; improve access, choice, quality and efficiency; and collaborate to develop new highly specialised services in the Black Country and West Birmingham (e.g. Children's Tier 4, secure services and personality disorder services).

By agreeing common specifications and models we will develop standardised and potentially more cost effective solutions, and minimise service variation, including putting in place 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. Additionally, there are opportunities to develop this across the West Midlands through the work in the MERIT vanguard (Mental Health Alliance for Excellence, Resilience, Innovation and Training). Overall, this approach to harmonization and standardisation will:

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



Principles

Parity of esteem for mental and physical health
Collaboration/partnership
Co-production
Standardisation of core specifications: single model/pathway/specification: specialized and acute services
Locally designed community services based on a core model/pathway
Evidence based commissioning
Maximise resource use: financial/workforce/estate

Build the Right Support for Learning Disabilities

The Black Country and West Birmingham Transforming Care Partnership (TCP) is a partnership of local authorities, CCGs and NHSE (Specialised Commissioning) 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.

We aim 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.

To date, as part of meeting the vision of TCP, ten inpatient beds have been decommissioned, with consultation currently taking place regarding the proposed closure of one Assessment and Treatment hospital; dependence on inpatient services has reduced by thirteen 13 beds (12%) across CCG and NHSE commissioned beds over the last six months; an Intensive Support Service has been commissioned as a pilot in Wolverhampton (2016) with a view to sharing learning across the footprint (January 2017); and revenue funding has been awarded from NHSE (£380,000).

Improve Bed Utilisation and Stop Out of Area Treatments

Inpatient provision is a key part of the whole system in support of people's mental health and wellbeing. It is resource heavy, but is only appropriate for a minority of people in contact with mental health services. Our ambition is to ensure that patients receive hospital care only when their health needs require it by commissioning appropriate consistent crisis services across the Black Country and West Birmingham. When admission is required it is (where possible) within the Black Country and West Birmingham ensuring that links are maintained with local support networks. We will determine the optimum bed requirement for existing services provided by NHS providers, which should support development of new highly specialised services.

We aim to retain Black Country and West Birmingham funding in the STP to deliver the right care in the right place for service users, working across current NHS providers, ensuring the right capacity of beds to meet the demand (numbers and service type). Although bed day costs are unlikely to deliver savings, efficiency should be delivered through reduced length of stay from strong local partnerships with social care, housing and family. This should reduce cost for Commissioners through existing out of area placements (savings only for services that can be provided from existing skilled staff). It will improve sustainability to existing providers by improved utilisation and profitability of inpatient units.

Deliver the West Midlands' Combined Authority Mental Health Challenges

Mental Health is an important issue nationally and in the Black Country and West Birmingham. The level of employment for individuals with mental health issues is significantly lower than the employment rate in the population.

In the Black Country and West Birmingham, the rate of employment for people with mental health issues is lower than the national average, and is particularly low in Wolverhampton.

Assuming the Black Country and West Birmingham could achieve the employment rate for people with mental health issues achieved in England (adjusted for the overall lower employment rate in the Black Country and West Birmingham) then an additional 4,000

people with mental health issues would be in employment in the Black Country and West Birmingham. At average full-time employment wage rates in the Black Country and West Birmingham, this would equate to an additional £100m of income less reductions in benefits.

Employment of individuals with mental health conditions, 2015[3]

	Number of people with mental health issues employed	Employment rate for people with mental health issues	Employment rate for whole population
Dudley	4,000	23.3%	69.5%
Sandwell	5,900	39.5%	70.2%
Walsall	4,200	28.2%	63.0%
Wolverhampton	2,600	21.7%	66.3%
Black Country	16,700	28.3%	67.5%
England	1,088,433	39.1%	74.2%

Labour Force Survey, Taken from the HSCIC indicator portal

Data is available for the number of people claiming Disability Living Allowance (DLA). This is presented below and shows that the percentage of the population claiming DLA in the Black Country and West Birmingham is similar to the national average. Using an average DLA payment of nearly £75 per week, the annual payments in the Black Country and West Birmingham are estimated to be nearly £44 million.

Disability Living Allowance claimants and payments for mental health issues in the Black Country, 2015

	No. of claimants (16-64)	% of population	Weekly value of benefits (£000)	Annual value of benefits (£000)
Dudley	2,615	1.4%	196	10,172
Sandwell	3,358	1.7%	251	13,060
Walsall	2,633	1.6%	197	10,240
Wolverhampton	2,618	1.6%	196	10,181
Black Country	11,223	1.6%	839	43,653
England	550,760	1.6%	41,199	2,142,333

ONS mid-year population estimates, DWP benefits claimant data

[3] This uses quarterly data. Data for 2015 Q2 was unavailable for Walsall and Wolverhampton, therefore the 2015 average is an average of Q1, Q3 and Q4 for all areas

Research suggests that employment and work is beneficial to mental health (Waddell and Burton, 2006). This improvement in health has a positive impact on the health service (as patients require fewer treatments) and can also help to move people off welfare payments, which is beneficial to the Government. If more people with mental health can return to employment then it will also improve the productive capacity of the Black Country and West Birmingham area.

The West Midlands Combined Authorities Mental Health Commission, chaired by Norman Lamb, 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 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.

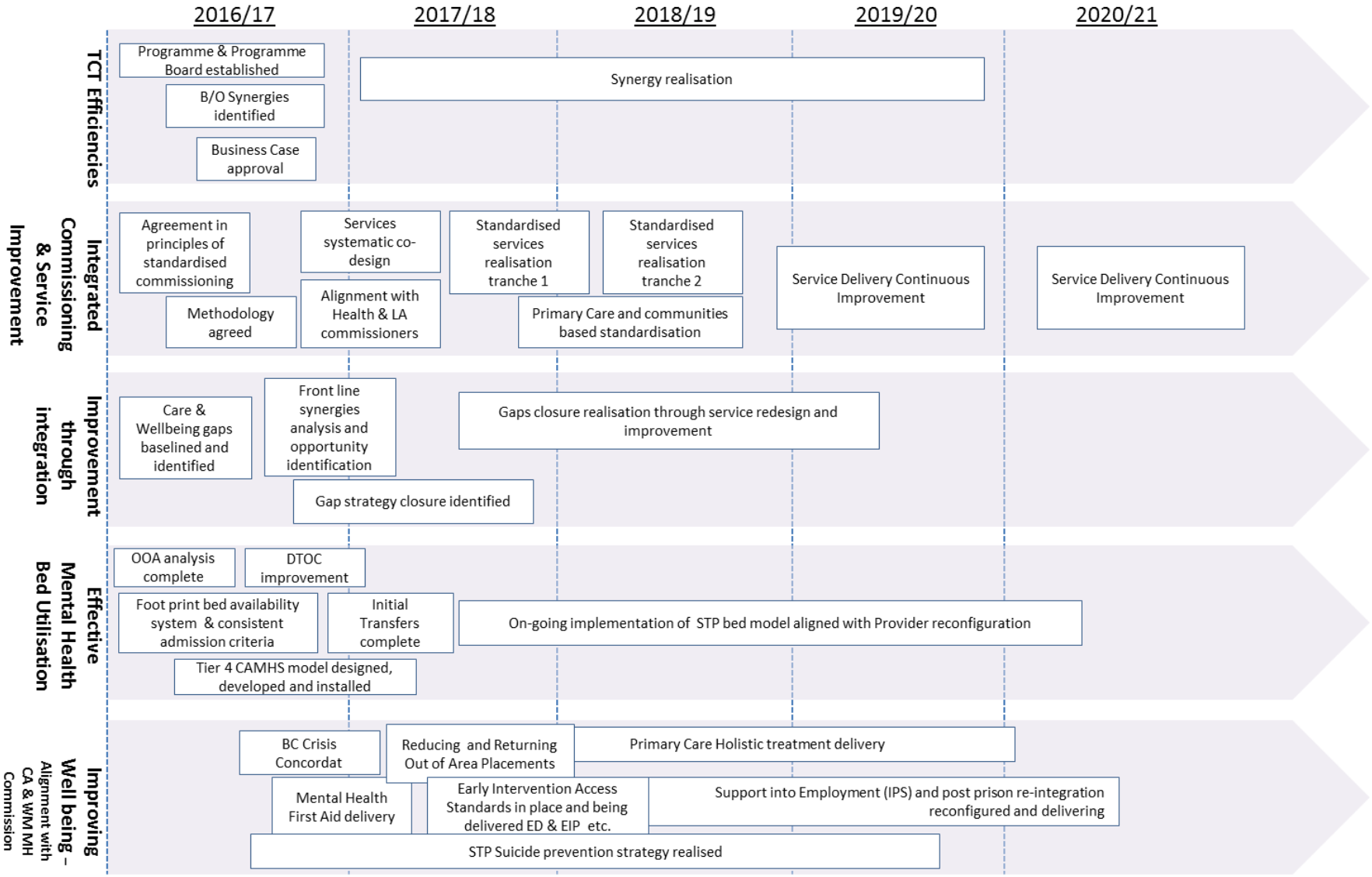
Deliver Extended Efficiencies through Transforming Care Together Partnership

Our vision for the Transforming Care Together (TCT) partnership is based on harnessing the strengths of three high performing NHS organisations, 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).

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.

Our overall delivery plan for Mental Health and Learning Disability Services is shown overleaf. It will be supported by £10m in capital investment to enable the changes to our estates required for service transformation.

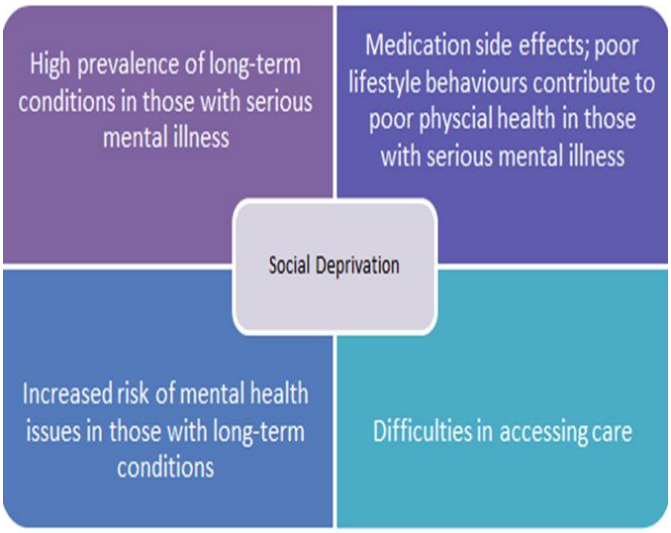
MH STP Delivery Timeline



Identifying and Addressing the Physical Health Needs of Mental Health Service Users

In addition to our established Mental Health and Learning Disability projects, the STP has commissioned analysis of how mental health service users' experience of physical healthcare services may vary from that of the rest of the population. That analysis is summarised below and we now aim to work with partners (service users, carers, and the West Midlands Combined Authority) to identify how best to respond to the challenges identified.

The health outcomes of individuals with mental health problems often fall short of the outcomes of the background population. Furthermore there is evidence that mental health service users present at acute hospitals in times of crisis. There are a number of factors that help to explain this:



In 2011 the Government launched its mental health strategy, *No Health Without Mental Health* (HM G, 2011) setting out its vision for mental health services to deliver on par with those for physical health. Building on this strategy the Mental Health Taskforce developed *The Five Year Forward View for Mental Health* (NHS England, 2016) which identified three key priorities;

- A 7 day NHS – right care, right time, right quality
- An integrated mental health and physical health approach
- Promoting good mental health and preventing poor mental health

New analysis commissioned by our STP from the Strategy Unit has found the following:

- The life expectancy of men in contact with mental health services in the Black Country and West Birmingham is 17 years lower than the rest of the male population. For women the gap is 14 years. This life expectancy gap, consistent with other international studies, is long standing and has closed only marginally since 2006.
- Mental health service users experience higher mortality rates across all major disease groups. Whereas cancer is the leading cause of death for the population as a whole, circulatory disease is the most common cause of death for mental health service users.
- Approximately 1 in 5 of all A&E attendances and emergency admissions relate to mental health service users whose A&E attendances and emergency hospital admission rates are three times those of the rest of the population.

- Outpatient DNA rates run at almost 15% for mental health service users; considerably higher than other patients and rates of diagnostic imaging are almost twice as high among mental health service users as the rest of the population.

The analysis also identifies opportunities for improving care for mental health service users:

- The STP could save up to £1.9m in A&E attendances and up to £17.7m in inpatient care, by reducing mental health patients' hospital activity, in subgroups which may be amenable to commissioner based QIPP schemes, to the same levels as the rest of the population. In practice, reducing acute healthcare utilisation of mental health service users to that of the rest of the population may not be wholly attainable, and clinical advice will be required concerning what is realistically achievable for each condition.

- Compared to England, the STP overall has higher utilisation for many of the opportunity subgroups. Patients conveyed by ambulance to A&E but discharged following no investigation and no treatment, frequent A&E attenders and patients admitted for self-harm are the exceptions to this.

- The overall mental health cohort had higher utilisation for each opportunity than the non mental health cohort. Almost without exception, those with cognitive impairment have the highest relative use of acute services of all mental health patients for all sub-groups of activity.

- The largest single potential saving (£16.7m) for the Black Country and West Birmingham is estimated to come from reducing admissions for those attending A&E with a primary diagnosis of mental health. The extension of psychiatric liaison services may impact on multiple opportunities – e.g. reducing admissions for mental health issues, self-harm and medicines adherence.

- These potentially avoidable hospital admissions represent an opportunity cost. Targeted investment in evidence-based interventions could release acute hospital costs whilst improving the physical health of mental health service users.

The following developments could help us to grasp these opportunities for users of mental health services, working in partnership with service users and carers:

- Mental health services could enhance annual health checks and make them effective as part of the individuals overall health care plan, review all prescribed medication for toxicity and side effects, work with partners to very significantly increase health improvement /risk reduction interventions (e.g. exercise on prescription, use of third sector community building opportunities) and staff in mental health services could develop a better understanding of physical health needs.

- Liaison and joint working between mental health and acute services could be strengthened (would a mental health service know if a services user had presented four times in the last week at A&E, and what would the mental health and the acute service do jointly about it?). Joint work between care homes, social care, voluntary services, mental and physical health could also be beneficial.

- Psychiatric liaison services are developing across the country but the outcomes achieved (and resource used) could be reviewed. For example, are integrated models for jointly managing the mental and physical implications of long term conditions and medically unexplained symptoms being developed?

- To enable an outcomes based approach to be implemented, there will need to be co-production of service models and feedback loops involving staff, users and carers. This could not only add knowledge and understanding but also make a real difference to the duration and quality of the lives of many Black Country and West Birmingham people.

- Local arrangements for integrating primary and community services on a place basis should always include mental health, social care and voluntary services. This represents the ideal opportunity to consider how this integrated team can develop innovative, locally sensitive options to address the physical health needs of their population in receipt of mental health services.

Getting the Best Start - Improving Maternal and Infant Health

The infant mortality rate in the Black Country and West Birmingham is much higher than the national average. Only Dudley has a rate lower than the national average, while the other local authorities in the Black Country and West Birmingham have a higher rate than the national average.

Annual infant mortality in the Black Country, 2011-13

	Number of infant mortalities per year	Infant mortality rate (deaths per 1,000 live births)	Best rate in England
Dudley	14	3.7	1.1
Sandwell	34	6.9	1.1
Walsall	26	6.8	1.1
Wolverhampton	24	6.8	1.1
Black Country	98	6.1	1.1
England	2,729	4.0	1.1

Public Health England Health profiles 2015, ONS Birth Summary tables

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 coordinated 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. In addition, if the infant mortality rate in the Black Country and West Birmingham can be reduced, this will provide an economic benefit to the Black Country and West Birmingham (through productive capacity in the future) and to society (the human costs of the Value of a Statistical Life).

Value of a Statistical Life, WebTAG

Element	Value (£000)
Productivity	591
Human Cost	1,126
Medical services	1
Total	**1,718**

Department for Transport, WebTAG databook, 2016; HM Treasury, GDP deflators

A reduction in Black Country and West Birmingham infant mortality rates to those achieved in England would deliver 34 fewer deaths, and an economic saving of £58m. However, improving infant mortality rates is also likely to have a positive impact on the number of children born with serious health conditions (through better screening and treatment of pregnant women and new-born children). The total economic saving from these measures is likely to be higher therefore.

We aim to improve maternity care and infant health outcomes across the Black Country and West Birmingham through the development of standardised pathways of care and quality improvement, involving:

- Implementing the recommendations of the Cumberledge report including improved cross boundary working and post/perinatal mental health services across the Black Country and West Birmingham;
- Public Health departments working 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 infant health;
- Local and strategic partners developing a Black Country and West Birmingham Healthy preconception and pregnancy pathway that addresses risk factors associated with poor maternal, infant and child health outcomes; delivers integrated maternal and neonatal health services, providing accessible care tailored to needs; improves the quality of care provision via Maternal and Neonatal networks reducing variation and standardising best practice; and ensures 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; and
- Model maternity capacity projections across the Black Country and West Birmingham and develop options for delivery.

To support the review of maternity services across the Black Country and West Birmingham, we have commissioned the Strategy Unit to develop, in partnership with neighbouring STPs, local estimates for the volume and type of inpatient birth episodes, maternal bed days and associated costs that might be expected in future. This work is due to complete by the end of Q1 2017/18.

The outcome of the West Midlands Neonatal Review has identified that capacity and demand is mismatched between maternity and neonatal services. Alongside the STP, NHS England specialised service commissioners will rebalance capacity across the footprint which is likely to lead to changes in capability and capacity within a number of units.

Three key themes have been identified:

- Infant mortality (health gap)
    - Defining a set of agreed metrics to support improved performance outcomes
    - Maternal mental health pathway
- A sustainable model for maternity and neonatal services (sustainability gap)
    - Effective pre-conception care
    - Healthy pregnancy pathway
    - Neo-natal pathway
    - Normalisation agenda for delivery
- National Better Birth agenda (quality of care gap)
    - Sustainable options for future delivery of standardised care
    - Reflective of national direction - Better Births: access, choice and empowerment.

Addressing the Wider Determinants of Health

We will build on existing partnerships with individual Local Authorities and the West Midlands Combined Authority to support the delivery of appropriate Local Authority efficiencies (the plan assumes application of the Social Care Precept and of the net Better Care Fund increase), to take effective action together on prevention and the wider determinants of health, to maximise the impact of health spending in the Black Country and West Birmingham and, as set out above, to implement the recommendations of the Mental Health Commission. The STP Plus agenda agreed by WMCA covers:

- The Mental Health Commission (see Improving Mental Health section)
- Best Start in Life (see Maternal and Infant Health section)
- One Public Estate (see Key Enablers – Infrastructure section)
- Place Based Regulation (see Future Commissioning section).

Reducing the Prevalence of Long Term Conditions

The healthy life expectancy of residents across the Black Country and West Birmingham is generally lower than the England average, indicating a considerable number of years is spent living with disability resulting from long term health conditions (LTCs). Care of people with LTCs 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 and West Birmingham, 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.

We aim to improve the healthy life expectancy of Black Country and West Birmingham residents by achieving a significant reduction in the prevalence of long term conditions (LTC) through promotion of the prevention agenda and building resilient communities. Public Health departments will work together to:

- Provide evidence based recommendations to support the prevention agenda; and
- Develop an STP-wide network of best practice and identify prevention resources & self-help tools.

Local partners will work together to:

- Deliver ambitious programmes across the Black Country and West Birmingham 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;
- Support the development of social capital to address social isolation and improve resilience, enhancing local knowledge of community resources and support whilst creating a culture where communities and groups can themselves identify gaps and develop solutions for local people;
- Promote independence through personalisation;
- Develop place-based models of care to improve management of LTC;
- Improve employability and skills development; and
- Encourage a wellbeing focus across all health and social care policies, planning and departments.

Maximizing the Impact of the Health Pound

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 lie mainly outside of the health and care system and relate to employment, wealth, education and housing.

Our STP commissioned a unique economic study through the Strategy Unit and ICF International in order to provide:

- An indicative assessment of the economic impacts in the Black Country and West Birmingham, that flow from spending by the NHS on health services
- A framework for assessing the wider impacts of changes in the scale and/or type of health services spending.

The study tracks healthcare expenditure and the subsequent effects on the demand for goods and services (through procurement) and for labour (skills and wages). The economic impacts associated with treating the population, especially, the working age population, with subsequent effects on levels of labour market output and productivity, have also be added. In both cases the focus is on the patients, health sector workforce and procurement located in the Black Country and West Birmingham. There is also brief analysis of services that have the potential to have significant economic impacts; informal care, infant care / mortality and mental health services. The more effective healthcare services are, the greater the economic as well as health benefits. The analysis seeks to distinguish between patients according to age and economic activity. The study has aimed to:

- Quantify the health and wellbeing benefit of the economic redevelopment proposals associated with the Combined Authority's proposals;
- Address through the Combined Authority the wider determinants of health including employment, housing, welfare and education; and
- 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.

Key findings to date include:

The NHS spends some £2 billion in the Black Country and West Birmingham each year.
The additional income (Gross Value Added) as a result of this NHS expenditure is £1 billion each year. This represents 5.5% of the GVA of the sub-region (representing £1 in every £17).
The multiplier effect of NHS spending (when NHS staff and suppliers spend money in the Black Country and West Birmingham) is estimated to be 1.43, increasing the total NHS-generated GVA to £1.53 billion.
The value of informal care undertaken by some 16% of the Black Country and West Birmingham population is estimated at a further £2 billion each year. The majority of carers provide between one and nineteen hours of care per week, rising to fifty hours for the economically inactive.
The Black Country and West Birmingham operates a small export surplus on NHS services with more non-Black Country residents treated in the Black Country and West Birmingham than local residents treated outside the area.
The NHS in the Black Country and West Birmingham also spends £1 billion on the purchase of goods and services, some supplied by local businesses.
The NHS is the largest single employer in the Black Country and West Birmingham. NHS expenditure supported 30,800 full-time equivalent (FTE) jobs in 2015, of which 24,000 FTE jobs (and some 29,000 people) were directly employed by the NHS. This represents 6.3% of total employment in the sub-region (1 job in every 14). Additional employment of 10,000 FTE jobs results from NHS spending on goods and services.
The NHS workforce is highly skilled, with average wages of the NHS workforce some 26% higher than the average wage for the Black Country and West Birmingham workforce.
The NHS in the Black Country and West Birmingham occupies 23 acute (hospital) sites, covering 125 hectares and over 511 million square metres of floorspace, with a notional land value of £188m. GP practices in the Black Country and West Birmingham were estimated to occupy 61 hectares of land, with an estimated value of £70 million.

Other work undertaken local to examine the economic impact of social care has found the following:

- Based on work undertaken in the City of Wolverhampton, the economic value of adult social care alone in the Black Country STP area is over £1 billion a year based on direct and indirect spend;
- Each locality's Director of Adult Social Services is accountable for the quality of the whole commissioned workforce in their area and there are approximately 30,000 staff in paid care roles working with adults in the Black Country STP area; and
- No calculation currently exists for the local or regional economic contribution of services supporting children, young people and their families but the economic value of social care services more broadly could be as high as £2 billion.

The second phase of the NHS study begins in November when the STP will seek to identify opportunities through which NHS spending could be used to further enhance the associated economic impact.

The following table identifies possible areas for discussion:

	Current activity	Discussion
Recruitment	With a direct workforce of over 24,000 the NHS is the largest employer and recruiter of labour in the BC. It is also one of the most skilled.	How can this recruitment activity be leveraged in support of wider recruitment plans? For example, offering incentives to the spouses of NHS applicants currently resident outside the sub-region
Training	Significant investment is made in the training of NHS staff, one of the largest training programmes in the BC	The training offered to the local NHS workforce, whilst specific to NHS occupations, offers a well-developed training infrastructure. How could this infrastructure be utilised for other employers, especially in the area of transferable skills?
Improved services to reduce the need for unpaid care	12% of those in employment provide some level of unpaid care, with an opportunity cost based on the value of (leisure) time of £0.6 billion each year	Providing informal care services has potential costs to carers in employment and employers. One possible option could be to mobilise the voluntary sector to take on some of this care. Is this feasible and what other options are available?
Adjustment to out-patient services	Half a million hospital out-patients from the local working population receive treatments each year	Even small reductions in the time taken off-work could have significant cost savings to local employers / employees. Transferring some out-patient treatments to primary care might be one approach, is this possible and what other options are available?

	Current activity	Discussion
Procurement	Over a £1 billion is spent each year. Much of this on employment services, pharmaceuticals and IT systems, but a wide range of goods and services are procured	The need for transparency and economies in procurement prevent any positive discrimination in favour of local firms. However, assistance for local firms to participate in NHS procurement procedures could be considered. How might this be achieved?
NHS estate management	The NHS occupies 125 hectares of land in the sub-region, with over 500 million m2 of floorspace. GP practices occupy (but do not necessarily own) some 60 hectares of land	NHS sites tend to be highly accessible and have limited development constraints compared to available development sites. Are there any opportunities for improving NHS services through reorganisation of the NHS estate, including sale/lease and relocation to non-NHS sites, and improving the supply of development land?
NHS resource management	Of total purchases (£1bn in the BC) 3% (£30m) is spent on energy, and 4% (£40m) on waste management and repair services Based on national figures half of purchases (£500m in the BC) are made on goods, mainly pharmaceuticals and computer equipment, but also including a wide range of other goods.	Given the scale of spending, there is the possibility of substantial savings from improved resource efficiency. Social benefits might also be realised from the recycling of pharmaceuticals, and the reuse of unwanted computer equipment. How can these opportunities be identified and what support can be provided to the NHS to realise benefits?

Key Enablers

Workforce

Aim

Our aim is to ensure that we provide the workforce, now and in the future, that can ensure patients receive safe, sustainable, high quality care in the right place and at the right time. This will require us to be bolder and braver than before about how our workforce is shaped, provided and developed.

We want the Black Country and West Birmingham to be a great place to work and grow, with workforce transformation a core element of service transformation. New skills will be developed alongside new types of roles. We will have a reshaped workforce, working across professional boundaries, with proven competencies to ensure safety and quality of care.

A key driver for our staff will be providing 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 the health and care system, moving care closer to home, and encouraging staff to move to and remain in the Black Country and West Birmingham.

Context

Delivering the Forward View: NHS planning guidance states that:

Planning by individual institutions will increasingly be supplemented with planning by place for local populations [and] *success depends on having an open, engaging and iterative process that harnesses the energy of clinicians, patients, carers, citizens, and local community partners including independent and voluntary sectors and local government.*

It is clearly evidenced that high performing organisations have integrated workforce planning. There are 5 benefits to strategic workforce planning:-

1. *Supports the budgeting process – good workforce planning, good understanding of the system needs*
2. *Supports the strategic/business planning process – it needs to be and iterative process*
3. *Identifies shortage of qualified talent to fill critical roles – good planning helps highlight talent gaps*
4. *Serves as a mechanism for identifying critical talent – improves the ability to identify and retain the most important talent*
5. *Identifies skills gaps in workforce*

We know that system workforce planning is easier said than done. However, the Black Country and West Birmingham has embraced the workforce opportunities provided by the STP. The Black Country Local Workforce Action Board (LWAB) is in place and will be the enabling mechanism. The STP has agreed that the majority of workforce efficiencies will be sought from the priorities ensuring there is no double counting or duplication of work.

The Health Education England (HEE) national data pack details a significant workforce across the Black Country and West Birmingham delivering health and care. This information does not include the unpaid workforce of carers and volunteers. The data pack reflects a Black Country and West Birmingham workforce of:

- c.30,800 FTE NHS staff including primary care
- c. 16,300 FTE social care.

Key Workforce Challenges

As we seek to better meet the needs of our patients, we also recognise that we are faced with same real challenges in terms of maintaining and developing the workforce patients need:

- We have an ageing workforce across the whole system (a significant proportion of the workforce are aged 55+ (15% in healthcare, 17% in social care, 11% in primary care);
- There are supply challenges as a result of the comprehensive spending review and also the implications of seven day services and out of hospital provision;
- There are a number of hotspot areas across the system including public health provision, social workers, adult nursing, Speech and Language Therapists, Operating Department Practitioners (ODPs), paramedics, sonographers, Primary Care both GPs and practice nursing, and the utilisation of enhanced and advanced role development across the system.
- We face financial challenges such as the delivery of the apprenticeship levy, living wage cost impact, changes in the LBR and tariff; and
- The provision of an integrated STP workforce plan requires data sharing agreements and also a common language, understanding and processing of the different “types” of workforce across the whole of the health and care services.

Workforce Strategy

Although currently in draft this strategy identifies five key strands for implementation:

1	**Engage sustainability and transformational leads to consider and implement workforce implications of system transformations**
	Within each of the transformational and sustainability plans people are the most important resource to ensure full implementation of the system change. The identification of the workforce implications, the mechanism for engagement and the full understanding of the proposed change is critical to the success of the priorities. It is the aim of the Workforce strategy to support and lead the detailed analysis of implications for each of the priorities. Early consideration of the workforce implications will ensure that the workforce enabler of transforming roles is connected into system change for programme development.
2	**Support and lead system leadership across organisational structures and professional boundaries**
	Collaboration across the whole system is the only possible and effective way to ensure better outcomes for people within a sustainable financial envelope and it is the strategy of the workforce leaders to ensure that the system will have the skills, knowledge and ability to lead, motivate, guide and support staff through the system change. The system leadership programme will work with regional and national partners across health and social care to: ➢ identify system leadership development programmes; ➢ Identify system leaders with experience of leading across boundaries; ➢ Develop system leadership skills through co-learning and a learning and reflective system of development
3	**Develop and deliver a workforce development plan across each of the sustainability and transformational programmes to achieve the aims of the priorities**
	Robust workforce data is essential in leading system change and redesign. Through detailed workforce data and intelligence across all partners will enable a full development plan for each of the transformation themes using the 5 step programme for workforce development. Workforce planning will include reviewing Skill mix, supply pipeline for future workforce and transforming roles. This will be fully supported by the agenda of the Local Workforce Advisory Board (LWAB)
4	**Ensure staff across all levels of the organisations are aware of the system changes and the reasons for change to enable positive responses to change**
	Working in full collaboration and partnership with the communications transformational programme to ensure all staff are educated, engaged and informed of the system changes and the rationale for these changes.
5	**Manage the system risk of people change management programmes to ensure sustainability programmes are delivered within timescales and ensuring continued high quality and safe patient care**
	To ensure successful implementation, staff must be identified as the most precious resource, ensuring their resilience to system change is maximised across both organisational and sector boundaries. The workforce strategy will oversee, manage and mitigate where possible the system risks of change management, providing advice, skills development and system solutions where possible.

Moving Forward

1. **A focus on bank and agency efficiency.** The HEE national data pack highlights that there is a vacancy proxy based on workforce plans submitted 2016 of 9.3%. The bank and agency (excluding locum) reflects a % of staff in post of 13% this indicates that there are some efficiencies to be made from this within the priority work stream. The Black Country Alliance (BCA) has already started to undertake work specifically around bank and agency and this will now be expanded to include other parts of the system. The group will start to look at the opportunities around consistency, negotiated fees, sharing resources and using technology to streamline the work (such as an app for bank staff to book directly on line).

2. **A focus on supply and demand challenges.** The HEE national data details student output versus organisational leavers for adult nurses reflects a -14 supply (on average the Black Country and West Birmingham has 271 leavers and the proxy value of students for the Black Country and West Birmingham is 257). The leavers' data does not include retirements which we know are significant in this particular staff group. Therefore we can conclude that the supply is not available with the commissioned education system so we do need to give careful consideration to placements, fast track routes for education, and recruitment and retention practices. Investing in training of a more readily available workforce which would support changes to team skill mix whilst maintaining safe care (e.g. Physicians' Associates, Band 4 Associate Nurses, Care Coordinators). There are also significant opportunities to continue building on the voluntary sector's contribution to effective patient care.

3. **A focus on standardisation.** We will also seek to move towards more standardised processes including recruiting and retaining staff for the Black Country and West Birmingham. Our Transformation Groups are working up the detailed workforce implications which will start to inform and develop a place based system for population system workforce plan.

4. **Utilisation of the LWAB.** The LWAB will be the driving mechanism for the workforce challenges and opportunities and will utilise the resources developed by HEE WM both via the STP offer, the transformational themes as well as connections with best practice across the health and care architecture.

To achieve this we are:

- Utilising the LWAB to lead and drive workforce development across the STP making extensive use of HEE resources;

- Using research and recognized evidence base to embed the principle that investing in developing our people will improve health outcomes, the experience of healthcare and make better use of our resources;

- Ensuring baseline data is collected from STP to inform forward planning and performance management;
- Adopting and spreading best practice across the system on managing turnover and reduction in bank/agency/locum;
- Considering the use of a single Black Country and West Birmingham Bank/Agency/Locum delivery function – to reduce costs and ensure consistency;
- Utilising the principles of the six step methodology to integrated workforce planning, we will employ a systematic and practical approach that supports the delivery of quality care, productivity and efficiency. It is both a scalable approach and joined up with social care; and
- Adopting and spreading best practice across the system.

Black Country and West Birmingham Digital Strategy

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, Big Data leads to meaningful information and so to insight, action and results and 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).

Our plan is to:

- Accelerate production and convergence of Local Digital Roadmaps, aligning existing plans;

- Form Black Country and West Birmingham Digital Transformation Board to lead, drive and 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 and support extant plans within organisation & LDR footprints, ensure one direction, avoid duplication, minimise 'risk of regret' & maximise triple aim benefits; and
- Rapidly identify & deliver 'quick wins' such as ePrescribing, ToC (electronic correspondence), network rationalisation, and procurement efficiencies. ePrescribing alone is expected to generate annual savings of £24m, supported by an initial capital investment of £5m.

One Public Estate

The Black Country and West Birmingham has invested heavily in new capital assets over the past decade and has a variety of capital asset funding models in place, included several Private Finance Initiative (PFI) and Local Improvement Finance Trust (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. As noted in relation to our hospital collaboration plans, we have allocated a one-off capital investment of £3m to this work in order to realise efficiencies of £10m each year going forward. A further £3m annual savings are expected in relation to voids in the primary care estate.

The evidence base for this project includes the Carter Review, Private Finance Unit (PFU) Forum survey and studies and Dudley CCG place-based assessments. We aim 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 through:

- Survey of current estate – LIFT & PFI – VOIDS
- Health & Local Authority opportunities
- Refinancing opportunities including Local Authority or Independent Trust Financing Facility (ITFF) 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.)

Future Commissioning

The future shape of service commissioning within and across the Black Country and West Birmingham needs to be aligned with the evolving nature of service provision. What is set out here reflects initial exploratory work by a number of our commissioning bodies. We will now test and refine our approach with all our commissioning partners.

The Black Country and West Birmingham is currently served by ten commissioning organisations across health and social care. This is likely to lead to:

- Duplication of activity and cost;
- Unnecessary complexity in models of care and in commissioning procedures (including procurement);
- Unwarranted variation in service delivery and outcomes.

Working together within the STP presents us with real opportunities to address these challenges and to look more strategically at the provision of services across the Black Country and West Birmingham, including how they interact with services in neighbouring areas. This work will be led through an STP commissioner group including NHS and Local Authority partners.

New ways of working together as commissioners are required to support the delivery of our local Accountable Care Organisation models, so we aim to simplify and standardise commissioning mechanisms across the Black Country and West Birmingham in order to support Better Health and Better Care, and to remove duplicated costs by:

- Identifying priority areas for streamlining and standardisation – both quick wins and major opportunities; and
- Identifying and evaluating alternative mechanisms through which streamlining and standardisation can best be enabled.

In addition, we aspire to invest an additional £82m annually in developing local healthcare services, subject to achieving an equivalent level of additional savings from our work to reduce demand.

The current NHS planning guidance requires NHS commissioners to agree two-year contracts with providers for 2017/19. This will not only create some medium-term stability for the system but will also afford the opportunity to review our commissioning arrangements in preparation for commissioning services for beyond April 2019.

Our STP sets out two main structures for the delivery of health and social care transformation across the Black Country and West Birmingham:

1. Local Place-based Delivery of Care
   This includes the implementation of the new care models such as the Multispecialty Community Provider (MCP) models in West Birmingham (Modality) and in Dudley Wolverhampton has implemented the Primary Care Home (PCH) model across the majority of practices and has also a Primary and Acute Care System (PACS) type model with the remainder of its practices. As set out above, each of our local areas will have its own locally-appropriate model for delivering place-based care.

2. Extended Provider Collaboration
   This includes the MERIT vanguard and Transforming Care Together Partnership for mental health services, and collaboration on service delivery and support services between the Trusts running our four acute hospitals.

There is, therefore, a clear benefit in organising commissioning arrangements across the Black Country and West Birmingham to enable and enhance the implementation of these two complementary strands. Further consideration also needs to be given to the consequential impact on CCGs once the new models of care have been fully commissioned. The key considerations for each of these issues are set out below, reflecting our core principles of subsidiarity and collective added value.

Local Place-based Commissioning

Each local place-based model shares key characteristics on the need for local public accountability, supporting local community resilience and public health and wellbeing, and the integration of health and social care. Commissioning local place-based care is therefore built on a foundation of partnership working between respective Local Authorities (LAs) and Clinical Commissioning Groups (CCGs). Each local system within the STP will continue to strengthen these partnerships as the basis for commissioning the local placed-based model.

Despite existing contractual arrangements and restrictions leading to services generally being commissioned independently from each other (and often without the right incentives to deliver the agreed model of care), current service delivery is largely being implemented through collaboration between providers and commissioners. To fully support providers in achieving the desired outcomes, however, it will be necessary to change future contracts. This will most likely include moving to Whole Population Based (WPB) arrangements that focus on the achievement of improved outcomes for patients in a local area. This represents a significant change from the current contracts, particularly in health services, that are largely based on activity measures for different items of service.

NHS England has recently issued new frameworks for new models of care, including MCPs and PACS models. These frameworks will subsequently lead to the development of new national contractual frameworks which will enable us to commission local services in a way that supports the preferred model of care. There are some common principles to these new frameworks, regardless of which model is adopted, and these give a clear emphasis on local

population delivery and a priority on achieving improvements in outcomes. It will therefore be desirable to implement these new forms of contracts from April 2019. We are already actively engaged in supporting the development of these new contractual models, providing one of the six national test sites via the Dudley MCP. This creates a further opportunity to use local learning from Dudley to establish a shared understanding and capability across Black Country and West Birmingham CCGs so that, subject to local determination on timing and methodology, we are able to progressively implement these new contractual models in each local system from April 2019.

Black Country and West Birmingham System-wide Commissioning

Earlier sections of our plan set out a clear need for collaboration between our acute service providers. In addition, our Clinical Reference Group (CRG) has reviewed the national Right Care evidence and determined that there are a number of services which would benefit from a strategic clinical review in order to determine the model of service delivery best placed to optimise patient outcomes, the quality of care, and efficiency in service delivery. Those services may include the following (subject to further analysis):

- Cardiovascular Disease (e.g. heart attacks, stroke);
- Endocrine conditions (e.g. Diabetes)
- Genito-urinary conditions (e.g. Chronic Kidney Disease)
- Musculoskeletal conditions (e.g. hip replacement); and
- Cancer.

Our shared objective is to commission acute service delivery so that everyone across the Black Country and West Birmingham can be assured that they will receive the same high quality standard of care regardless of which local hospital they attend. Consequently it will be important for the Black Country and West Birmingham CCGs to collaborate in commissioning these services to the same standards, particularly as our providers are themselves increasingly collaborating on service delivery. This approach will also help to provide a collective commissioning approach to the realisation of efficiencies across our system.

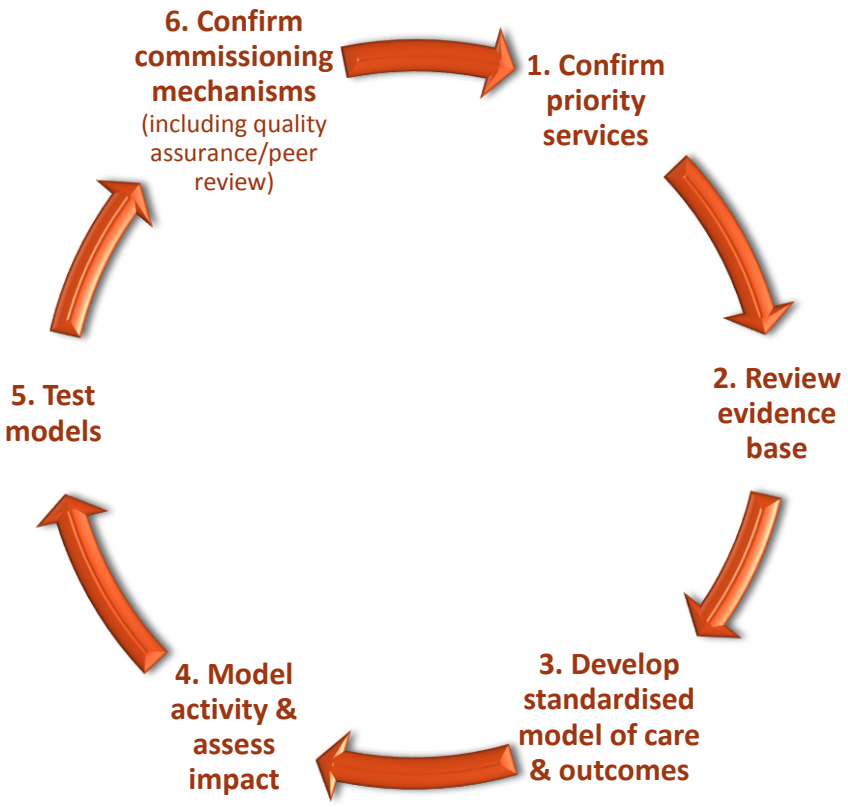
The first stage in this process would be to initiate the proposed clinically-led strategic review. This would be followed by establishing a shared approach to commissioning those services across the four Black Country and West Birmingham CCGs, so that from April 2019 the services can be commissioned through a single shared process across the whole of the Black Country and West Birmingham. The review process is expected to begin in early 2017 and is likely to be an iterative process (see diagram below).

In addition to our local-initiated work, NHSE Midlands and East's Specialised Commissioning Strategic Framework develops a vision to deliver services such as chemotherapy and renal dialysis through networks of provision based around larger specialist providers supporting local services. Specialised Commissioning teams will be working with providers and STPs to

identify opportunities for consolidating services and developing networks. In the Midlands and East region, the larger specialist providers can be categorised into two tiers:

- Tier 1 providers are those that have a large and diverse specialised commissioning portfolio and provide a number of level 1 national services; and
- Tier 2 providers are those which have a large and diverse specialised commissioning portfolio and are a sub-regional specialised centre for a number of services, or a Major Trauma Centre.

OUR CLINICAL REVIEW PROCESS



Although a substantial range of specialist services is provided in Black Country and West Birmingham hospitals, there are no resident Tier 1 providers (patients travel to Birmingham hospitals) and the Royal Wolverhampton NHS Trust is the only Tier 2 provider. This creates the need for a network of acute collaboration across the Black Country and West Birmingham. The framework specifies thirty-six specialised services which could be devolved through the West Midlands Specialised Commissioning Board to a Black Country and West Birmingham commissioning footprint.

Key drivers for commissioning at greater scale include where:

- Outcomes could be improved through service consolidation (e.g. to secure the appropriate clinical competencies)

- Services have interdependencies with other STP footprints (e.g. the configuration of specialist networks including emergency services, trauma care, PPCI)
- Services may not be sustainable as separate local entities (e.g. due to workforce shortage and/or high agency costs)
- Equity of access to high quality care can be improved.

This offers the opportunity to align a Black Country and West Birmingham CCG shared approach to commissioning acute services with the specialised services framework for commissioning through our local Tier 2 provider – to create an integrated Black Country and West Birmingham approach to the commissioning of all major acute services. Our intention would therefore be to work with NHS England to create a joint capacity and capability to commission all of these services from April 2019 on the basis of a single acute network of provision across the Black Country and West Birmingham working to the same standards of care.

This work will also include an independent assessment of the potential impact of the Midland Metropolitan Hospital on services across the Black Country and West Birmingham and, where necessary, the development of plans to address any adverse impact.

Impact of New Care Model Implementation

One aspect of the new care models programme is the opportunity for providers to take on responsibility for providing care to a whole population (e.g. through 'accountable care' type arrangements or Whole Population Budgets). This raises questions about the opportunities for CCGs to contract out some of their functions to providers in a way that has not been not possible before. Whilst the details on what is appropriate will be different for each local system and will be dependent upon the preferred model of care, each CCG Governing Body and its constituent members will need to consider the potential benefits this offers for enhancing the capabilities of local providers and the implementation of the new care models to drive better outcomes and efficiency.

As we move towards outcomes based commissioning and contracting which these new care models afford, the skills and capabilities of commissioners will also need to change. As the component parts of the commissioning system of the STP are addressing these challenges at different paces and with differing timescales, there exists the opportunity for greater collaboration between CCGs to facilitate and accelerate the adoption of new models.

As CCGs evolve to maximise their future effectiveness, it will also be important to consider opportunities for integration of some functions with the regulators, particularly NHS England and the Care Quality Commission, such as service assurance activities. As well as supporting the standardisation of care and the resulting improvement in patient outcomes, this may also enable additional cost savings through a reduction in the tiers of performance management and assurance processes.

A key area in which local commissioners have already been actively collaborating is in relation to urgent and emergency care. This work is summarized below.

Urgent and Emergency Care

The partners in the Black Country STP are committed to ensuring that high quality urgent and emergency care services are provided for patients. We have been working with the organisations that provide urgent and emergency care to make sure that these services are available when they are needed, from facilities as close to home as possible.

The provider organisations have been working together to identify ways to make sure that patients get treated in the right place by the right people. For those people with more serious or life threatening emergency needs we will develop a robust service offer to ensure they are treated 24 hours per day, 7 days per week in centres with the very best expertise and facilities in order to maximise their chances of survival and a good recovery

This work is going on across the whole of the West Midlands and the Black Country STP is playing a lead role. We have been focusing upon improving access to patient's records so that clinicians can be better informed when making decisions about treatment. In addition we have established NHS111 as a single point of entry into urgent care services and are also developing central points where calls from patients can be taken by doctors and other health professionals including pharmacy, dentist and mental health services. We want to clearly identify which services are available and from where and our work aims to make it as simple as possible for patients to find and get treatment from the service that they need 24 hours per day, 7 days per week.

We are aiming to reduce the need for patients to be transported to hospital by ambulance and we are doing this by making more advice and treatment available at the scene including in patients' homes.

There is developing work involving the providers of mental health services to make sure that patients receive consistent services and that those services are as close to home as possible.

We also want to encourage and support patients to manage their own conditions and to give them more information to help them understand what they can do to avoid the need to see a doctor or go to hospital.

Significant work has also been done to ensure that patients can get urgent treatment from their GP, dentist or pharmacist.

Patients and their carers have been heavily involved in the development of our work on urgent and emergency care from the beginning including co-design events, participation in the Urgent and Emergency Care Network and involvement in procurement processes.

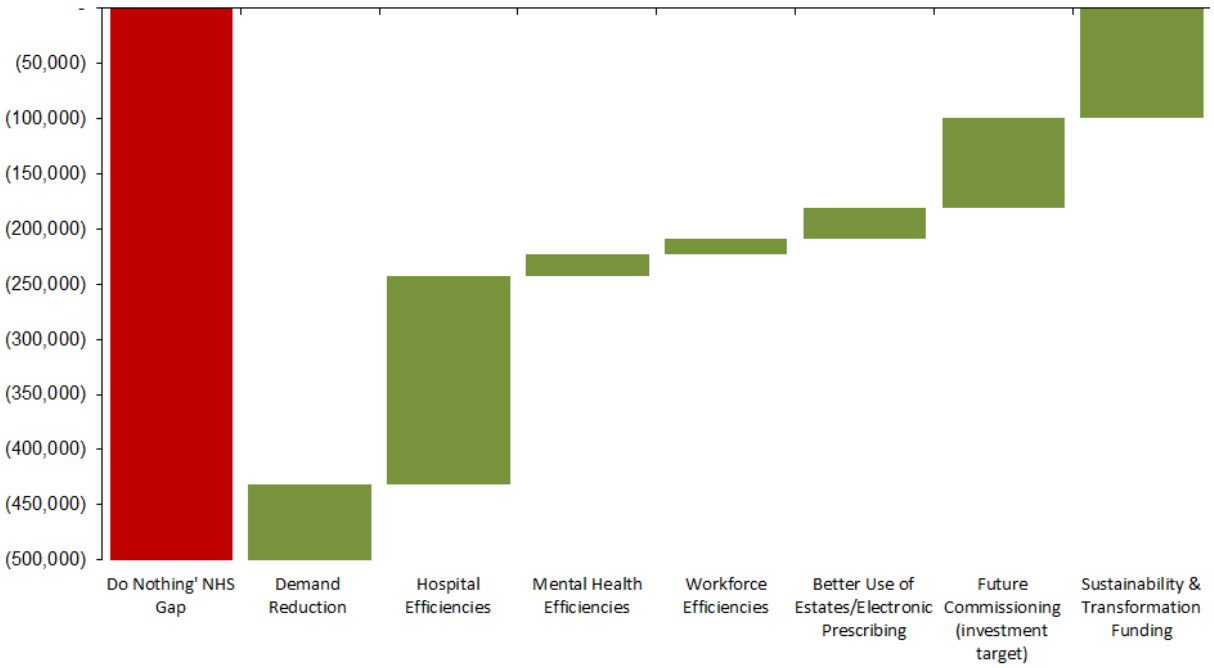
Financial Sustainability and Investment in Transformation

To achieve sustainability in local health services, the Black Country STP needs to take significant action to reduce both the projected growth in demand and the costs of the services provided. The challenge equates to avoiding spending of £512m by 2020/21. With an indicative national Sustainability and Transformation Fund allocation of £99m in 2020/21 that leaves a local challenge of £413m. The table below summarises how our transformation plans will contribute to building a financially sustainable healthcare system for the Black Country and West Birmingham. To be updated

The Gap		The Solutions
£700m 2020/21 STP 'Do Nothing' Gap	£512m Health £413m savings + £99m STF	£81m Demand Reduction through Local Place-based Models of Care
		£189m Efficiency at Scale through Extended Hospital Collaboration
		£20m Improving Mental Health and Learning Disabilities Services
		Getting the Best Start - Improving Maternal & Infant Health
		£14m Workforce Enabler
		£27m Infrastructure Enabler (estates and technology)
		£82m Future Commissioning
		Addressing the Wider Determinants of Health
	£188m Social Care	Local Authority Investment & Savings Plans

Individual organisations retain responsibility for delivering annual savings and efficiency targets, albeit with the increased mutual support available through STP structures and processes. There is currently a requirement for providers to deliver a 2% CIP and for CCGs to keep demand 1% under the average annual growth of 2.3%. Achieving against these challenges will deliver £235m out of the local £413m challenge. This makes it clear that we need the added value of increased collaboration through the STP to avoid future costs of a further £178m.

The diagram below sets out how sustainability will be achieved for Black Country and West Birmingham health services by 2020/21.



In order to achieve this, we will need to make some targeted capital investments. Our plan proposes the following allocations beyond what features in the separate investment plans of each of our organisations:

- £34m for primary care premises
- £16m for premises changes to support other closer to home services
- £35m to support networks of acute care excellence
- £10m for estates changes required to deliver Mental Health and Learning Disability services transformation
- £3m to enable the release of £10m annual efficiencies relating to estates
- £5m to enable the release of £24m annual efficiencies relating to prescribing.

Transformative Impact through Rapid Cycle Learning

We wish to become one of the most innovation-aware and adoption-ready health and care economies in the country. Our existing innovations (such as our Vanguard models of care) and the developments set out in this plan would give us the ability to systematically study and compare different approaches, to harvest and codify good practice and to actively support its adoption.

> **The single most important change in the NHS…. would be for it to become, more than ever before, a system devoted to continual learning and improvement of patient care, top to bottom and end to end.**
>
> *Berwick Report, 2013*

We intend to demonstrate the power of this approach to the wider NHS and to make practical learning central to what we do.

Maximising the value of knowledge exchange relies upon defining the right focus and questions. For example:

- Dudley is developing an MCP under the New Care Models programme (other areas have plans for them) and Wolverhampton is adopting PCH and PACS models. Marrying international and national evidence with local experience, we will be able to examine the arguments for the adoption of each model, the component parts of them, the practicalities of implementing them and the effects that result. In effect, we would treat the Black Country and West Birmingham as a microcosm of the New Care Models programme, with a rapid route to adoption;

- Whilst on one level there is a choice between types of new care models, it is likely that their component parts will be similar. Each typically includes some form of enhanced / scaled up primary care; each features community based teams over populations of thirty to fifty thousand; each makes use of more intensive multi-disciplinary teams focused on higher risk patients. This provides opportunities for cross-model learning. We will be able to select a common component and focus knowledge exchange on its design and operation. For example, how do we provide community based teams with the information they need to effectively manage 'their' populations?

- We, like most areas of the country, need rapidly to learn how best to take advantage of the unrealised opportunities for efficiency at scale and how best to deliver increasingly specialized services across a population of 1-2 million people. Should a service area focus be taken – urology has been identified as an example – this would allow knowledge exchange activity to use clinical peer review as a mechanism. Again,

involvement of clinicians would provide for rapid adoption of identified improvements;

- We have already identified the need to make rapid improvement in relation to MHLD and maternity services. In addition to learning about how services are best configured and operated, we also need to understand the potential impact of wider system drivers such as public health measures and the role of voluntary organisations, employers and the public. Such a breadth of approach is necessary given the wider determinants of problems as complex as infant mortality and mental health. Our approach here is likely to be more place-based, asking (for example) what each local area does on public mental health, what seems to work well and where improvements are needed.

Exploring questions such as these is no abstract exercise without urgency. In order to build a transformed and sustainable health and care system that makes an increased contribution to local wellbeing and prosperity, we need to learn rapidly from what we do. Every year, the NHS is the Black Country and West Birmingham has some nine million patient contacts undertaken by over 30,000 healthcare staff. This provides us with a vast live evidence base and a huge team of learners. With the right mechanisms in place we believe we can make the Black Country and West Birmingham a health and care system that quickly and continually adapts itself as a result of what it learns day by day.

The mechanisms we will be exploring include:

- Structured peer review cycle across the STP (e.g. between integrated community teams or acute specialty teams);
- 'Living Review' function (building on the current provision for the Dudley MCP Vanguard) to help our workforce learn from research and practice in a timely way. It would keep staff up to date with new evidence as it emerges, distilling key messages and translating them into a local context;
- How to use technology to enable the rapid spread of learning across both front line teams and the system as a whole. For example, it is feasible to envisage integrated community team members equipped with portable devices that:
    - Provide access to a shared care record;
    - Enable activity recording; and
    - Facilitate social media type comments about how services are working for patients and staff (new ideas, positive or negative feedback on developments, identification of system blockages).

  Potential benefits might include near real-time peer-to-peer learning for operational staff, ability for strategic evaluation through in-depth analysis of qualitative feedback,

cross-referenced to any changes in activity patterns and feedback from evaluation both to front-line staff and to other STPs/regulators for wider learning.

- Targeted local analytical reports designed to respond to identified team priorities with built in loops to measure improvement.

Communications and Engagement

Our Strategy outlines our plans on engaging and communicating effectively with our patients, public, partners, staff and stakeholders across the Black Country on how we will work with them to improve the health and care of people of the Black Country and west of Birmingham.

We recognise what people and communities want from their local health and care services and could do for themselves and by reorienting and reshaping health and other services to support them. This shift from a clinically and managerially led process to a coproduced approach to health and care is at the heart of our plans around communication and engagement.

Communication and engagement need to be at the heart of how we move forward if we are to transform local services in order to make them sustainable for the future and more responsive to the needs of the people we serve. In other words, the voice of the patient needs to be central to everything we do.

The way that health and care is provided has dramatically improved over the past fifteen years – thanks to the commitment of NHS staff and protected funding in recent years. However, some challenges remain. The quality of care that people receive can be variable; preventable illness is common; and growing demands on the NHS means that local health and care organisations face financial pressure.

The needs and expectations of the public are also changing. Fortunately we are living longer, but we often require different, more complex care as a result. New treatments options are emerging, and we rightly expect better care closer to home.

There is broad agreement that, in order to create a better future for the NHS, we have to adapt the way we do things. This doesn't mean doing less for patients or reducing the quality of care. It means more preventative care; finding new ways to meet people's needs; and identifying ways to do things more efficiently.

Two levels of activity are planned:

- STP programme level – high-level communications activity in support of the Programme, and the management of communication and engagement interfaces with contiguous strategic work programmes (including the Health Care Review; NHSI Financial Improvement Programme.)

- STP work stream level – supporting specific STP work streams to develop and implement a detailed, operationalised communications and engagement plan (or plans) to support their specific work programmes.

STP partners have committed to ensure all of our communications support local people to understand all of the issues which the programme seeks to balance. There will be many

different interests and only by working together, to discuss and debate the relative needs of local people, as well as the safety and quality of services proposed, can we fully ensure all interests are properly represented.

We will ensure we promote ways of working together which are in the interests of local people, who will remain at the heart of the development of this programme.

We will commit to communicate in a way that is:

- Open and transparent – our communication will be as open as we can be, ensuring that when the 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 in relation to structure, content and presentation at all times.

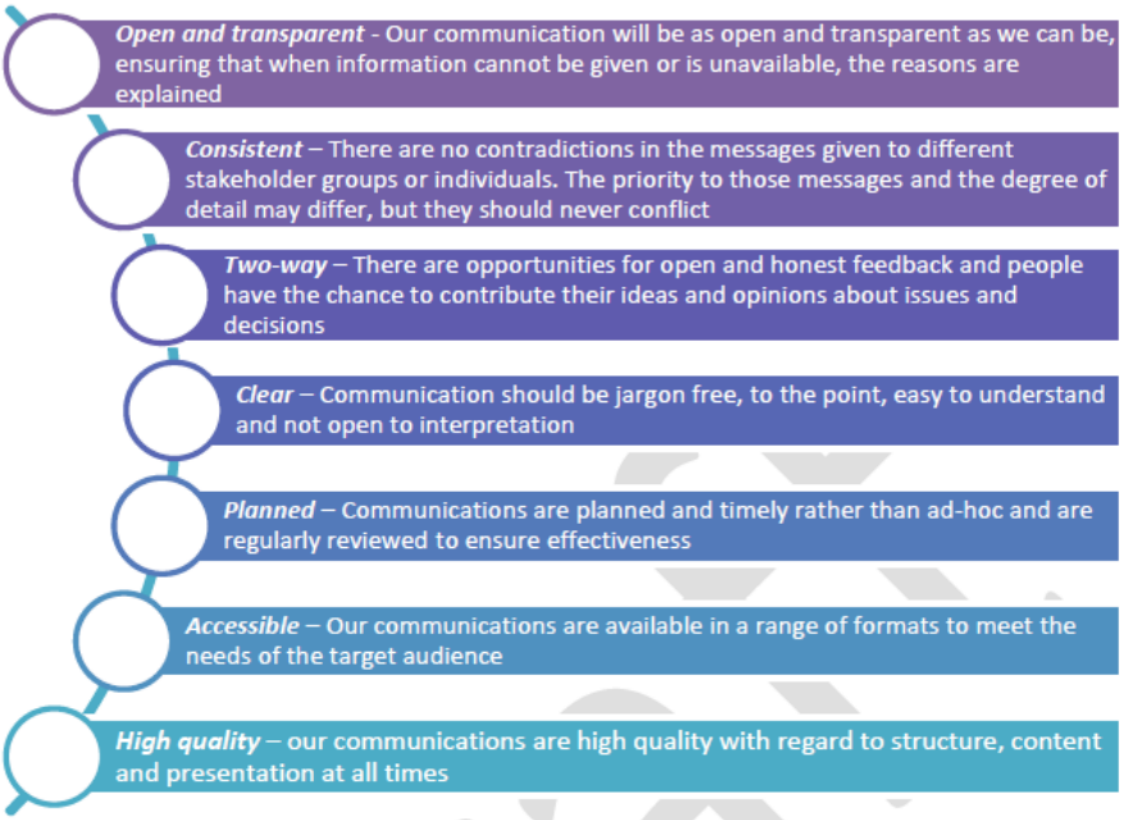
We will actively provide the following channels for communication, sharing, learning and strategic advice:

- Communications Concordat
- Local communications and engagement networks
- Communication and Engagement leads on each transformation work-stream
- Communications and Engagement lead to attend/report into the Operational Group
- Communications and Engagement lead to attend/advise Sponsoring Group

This concordat makes a commitment to publish a quarterly statement of programme progress as a minimum.

The five community empowerment dimensions above are helpful in thinking about how we work with people. Empowerment is not just about the people and communities, it is also about organisational structures and processes being empowering. When developing new ways of working we will take an empowering approach to engagement.

- By 'confident', we mean, working in a way which increases peoples skills, knowledge and confidence – and instills a belief that they can make a difference.
- By 'inclusive', we mean working in a way which recognises that discrimination exists, promotes equality of opportunity and good relations between groups and challenges inequality and exclusion.
- By 'organised', we mean working in a way which brings people together around common issues and concerns in organisations and groups that are open, democratic and accountable.
- By 'cooperative', we mean working a way which builds positive relationships across groups, identifies common messages, develops and maintains links to national bodies and promotes partnership working.
- By 'influential', we mean working in a way which encourages and equips communities to take part and influence decisions, services and activities.



Over the summer we have been working with partner organisations to refine our plans. During this time we have continued with a programme of communication and engagement events involving staff and other key stakeholders, to build understanding and support for our rationale and approach to change. Key aspects of our plans had themselves been subject to previous public engagement and, in some case, formal public consultation.

This engagement will continue and intensify following the publication of this plan, in a format that is accessible to our patients, public staff and wider stakeholders. We will be in a position to articulate the benefits for our patients in a way that they can understand and relate to through the publication of a document that gives the public a good understanding of the need to change. Throughout the Autumn we will be taking our plan through our partner organisations' governance processes. We will be presenting our plans to a wide range of key stakeholders, including:

- Health and Well-being Boards
- Overview and Scrutiny Committees
- Local Professional Committees, for example LMCs
- Healthwatch
- Patients and their carers through existing mechanism such as PPGs, FT Governors, Patient Advisory Groups etc.
- The public - through in-reach into Libraries, local housing forums, Citizen Forums etc.
- Reaching out through the local voluntary and community sector infrastructure organization to local community based organisations
- Utilising existing channels to communicate and engage staff and clinicians

We will take advantage of existing systems to capture patient and public insight, experience data in order to fully understand and inform the specific plans for change arising out of the workstreams. We will adopt a co-design and co-production approach to ensure that our plans for transforming the health and care of people across the Black Country and West Birmingham are sustainable and achieve real change.

It is important that we make best use of existing communication channels and build on place based relationships. We have undertaken a stakeholder analysis to understand who our stakeholders are and how we best communicate with them. For example we will continue to communicate with our patients, people who use our services, their carers and their communities by using existing forums, such as citizen panels, patient networks, patient participation groups, community events. Social media will also continue to feature in respect of how we get our messages out.

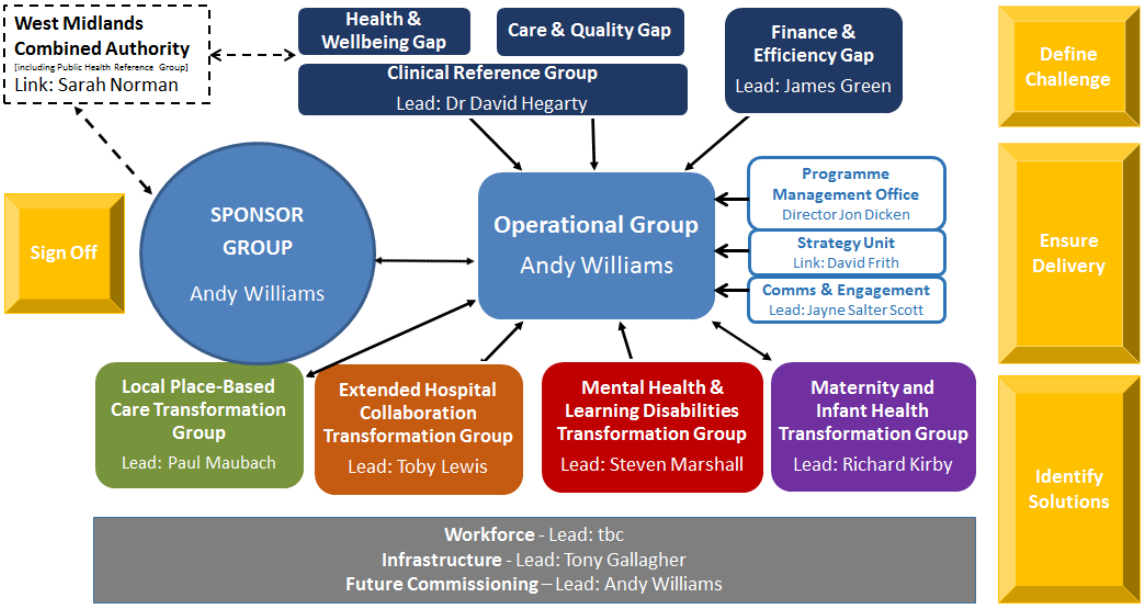
The success of our STP also relies on our relationship with our patients, people who use our services, our staff and clinicians. We will take an engaging and co-production approach to our STP by getting patients, people who use our services, our staff and clinicians to lead change. Taking decisions together, we will ensure that collective action can make a positive difference to the health and care of people across the Black Country and West Birmingham.

Ten Priority Questions

1	**How are you going to prevent ill health and moderate demand for healthcare?**	Our plans for local place-based models of care address the need for better health and will also serve to moderate demand.
2	**How are you engaging patients, communities and NHS staff?**	The communications concordat makes a commitment to publish a quarterly statement of programme progress as a minimum. Engagement with patients, communities and NHS staff will continue to be led by partner organisations in ways appropriate to local circumstances.
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.
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 and West Birmingham boroughs, and each area will implement a model which addresses access, continuity and coordination challenges. Our local evaluation methodology will enable rapid learning across all areas.
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?**	Balance will be achieved by 2020/21 through partner organisations delivering against their regulatory or statutory duties with an additional scale of savings delivered through collective opportunities at STP level.

Programme Governance

The sponsor organisations of the STP have agreed the following governance structure:



Oversight of the plan's development and implementation lies with the Sponsoring group which is constituted as follows:

Chair/Lead: Andy Williams

Organisation	Named Lead	Named Deputy
Black Country Partnership NHS Foundation Trust	Tracy Taylor	Tracey Cotterill
Dudley MBC	Sarah Norman	Matt Bowsher
Dudley Group NHS Foundation Trust	Paul Harrison	Anne Baines
Dudley and Walsall Mental Health Partnership NHS Trust	Mark Axcell	Mary Bytheway
Dudley CCG	Paul Maubach	Matt Hartland
Sandwell MBC	Jan Britton	David Stevens
Sandwell & West Birmingham Hospitals NHS Trust	Toby Lewis	
Sandwell & West Birmingham CCG	Andy Williams	
Walsall MBC	Paul Sheehan	
Walsall Healthcare NHS Trust	Richard Kirby	Daren Fradgley
Walsall CCG	Paul Maubach	Tony Gallagher
Wolverhampton City Council	Keith Ireland	Linda Sanders
Royal Wolverhampton NHS Trust	David Loughton	Mike Sharon

Organisation	Named Lead	Named Deputy
Wolverhampton CCG	Trisha Curran	Steven Marshall
Birmingham City Council	Alan Lotinga	
Birmingham Community Healthcare NHS Foundation Trust	Tracy Taylor	Lorraine Thomas
NHS England	Alison Tonge	Alastair McIntyre
West Midlands Ambulance Service	Anthony Marsh	Mark Docherty
Local Government Association	Joe Simpson	
Healthwatch	Jayne Emery	
Health Education England	Della Burgess	

Workstream and Transformation Group leads together form the Operational Group:

Transformation Group/Workstream	Named Lead	Named Deputy
Sponsoring Group	Andy Williams	
Local Place-based Care	Paul Maubach	Jo Taylor
Extended Hospital Collaboration	Toby Lewis	
Mental Health & Learning Disabilities	Steven Marshall	Mary Bytheway Sarah Fellows
Maternity & Infant Health	Richard Kirby	Sally Roberts
Workforce	tbc	Della Burgess
Infrastructure	Tony Gallagher	
Future Commissioning	Andy Williams	
Link to WMCA on Wider Determinants	Sarah Norman	Karen Jackson
Health & Well Being	David Hegarty	Jim Young
Care & Quality		
Finance & Efficiency	James Green	
Communications & Engagement	Jayne Salter Scott	
Programme Management	Jon Dicken	

A quality assurance function (QA) will be exercised by our CRG that will:

- Provide robust clinical assurance to each transformation group and workstream, supported by patient engagement;
- Be based on an evidence-based methodology developed in the Black Country and West Birmingham for the West Midlands Clinical Senate (and now endorsed by National Senate Chairs);

- Complement and provide evidence for any external assurance processes that may be required for aspects of our plan from time to time.

The partners to the STP have all worked collaboratively over recent months and have contributed to the development of the content of the plan for the Black Country and West Birmingham setting out aspirations for transformative and sustainable developments. The next stage will be to formally engage and consult with stakeholders on the plan. This will then facilitate formal sign off of the plan over the coming months.

Programme Plan

The STP has established a dedicated Programme Management Office which has developed a detailed programme plan and is monitoring workstream activity against this. The following table summarises key milestones for the STP during 2016. Summary plan templates for each main area of activity can be found in the appendix.

Subject to sign off and approval of the plan by the national sponsoring bodies we will move to implementation, this will see a review of our governance and leadership of the STP. Our intention is to place clinicians at the head of our governance so that the STP is a clinically led managerially supported process. It is essential that we build upon the advice and guidance provided through our Clinical Reference Group and effectively engage the clinical (and non-clinical) workforce.

Our clinical leaders will enhance the credibility of our plans when we consult and engage with patients and wider stakeholders as our plans mature and the implementation gathers momentum during the coming weeks, months and years.

The implementation of the STP rests firmly upon each of the localities and the constituent partners including patients, providers and commissioners. This approach recognises the principal of subsidiarity which has been central to the STP since its inception, it also recognises the wealth of existing work taking place across the Black Country and West Birmingham and ensures continuity whilst recognising the opportunities for further and wider collaboration and integration through the STP.

Agenda Item No: 10

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

30 November 2016

Report title	Dementia and Care Closer to Home	
Cabinet member with lead responsibility	Councillor Paul Sweet Public Health and Wellbeing	Councillor Sandra Samuels Adult Social Care
Wards affected	All	
Accountable director	Linda Sanders, People Directorate	
Originating service	People Directorate	
Accountable employee(s)	David Watts Tel Email	Service Director, Adult Social Care 01902 555310 david.watts@wolverhampton.gov.uk
	Steven Marshall Tel Email	Director of Strategy & Transformation 01902 444644 steven.marshall3@nhs.net
Report to be/has been considered by		

Recommendation(s) for action or decision:

The Health and Wellbeing Board is recommended to:

1. Receive the report on Dementia and Care Closer to Home in Wolverhampton.

1 Purpose

1.1 The purpose of this report is to provide Health and Wellbeing Board a report on Dementia and Care Closer to Home in Wolverhampton.

2.0 Background

2.1 The needs of a growing number of people with dementia are a high priority challenge for all public sector organisations. The Department of Health (2013) Mandate for 2014-15 required Public Bodies to make measurable progress towards enhancing the quality of life for people with dementia in the areas of diagnosis, treatment and care. Further, NHS England proposed a national ambition that by 2015 two-thirds of the estimated number of people with dementia in England should have a diagnosis, with appropriate post-diagnosis support.

2.2 A Wolverhampton Public Health Intelligence and Evidence Team Dementia Review (2014) highlighted the following:

- The 'Putting Dementia on the Map' tool estimates there are 3,600 people living with dementia in the city.
- It was estimated in 2014/15 that 1600+ (45%) people were registered with a formal diagnosis; this was similar to the national average at that time.
- The above figures resulted in approximately 2000 people with dementia living in the city without a formal diagnosis.
- Based on prevalence rates the population of people with dementia living in Wolverhampton will increase by approximately 60 people per year between 2015 and 2020.

2.3 In 2015 Central Govt. set a challenge to Councils to reach a diagnosis rate of 67%, this would equate to approximately 2400 people living with dementia in Wolverhampton having a confirmed diagnosis.

3.0 Progress – Joint Dementia Strategy for Wolverhampton 2015 – 2017

3.1 The Joint Dementia Strategy for Wolverhampton has six key objectives to deliver integrated dementia services across all pathways and journeys that retains and maintains independent living, raising awareness and an improved quality of response. This includes integrating health and social care services prioritising timely diagnosis and early intervention ensuring people living with dementia are engaged in advanced decisions about future care and treatment enabling them to maintain their independence for as long as possible. These six objectives are:

- Memory Aware Community, Early Diagnosis and Support
- Living Well with a Stable Condition
- Living Well with Complex co-morbidities

- Responding to Changing Needs
- Good Quality Secondary Care when needed
- End of Life

Below is a summary of the progression made since the launch of the Strategy in May 2015 which briefly comprises of the following:

3.2 Memory Aware Community, Early Diagnosis and Support

- Wolverhampton is fast becoming a 'Dementia Friendly City', people with dementia and their carers are more engaged with everyday life, living well and are remaining independent for as long as possible
- Wolverhampton Diagnosis rates in July 2016 were 78%
- Activities during the Dementia Awareness Week were extensive with the aim to raise public and professionals awareness
- A contract has been re-issued to Alzheimer's Society to provide six Dementia Cafes across the city and further such as 'Pop up Dementia Cafes' are being run to meet community diversity
- Organisations such as Waitrose have taken the initiative and now run their own Carers Cafes independent of the Council
- The launch of "Smart Posters" in partnership with the University of Wolverhampton was held in May 2016. The evaluation report on this project is due to be received from the University in the late Autumn

3.3 Living well with a stable condition

- Dementia Support – a contract has been re-issued to Alzheimer's Society to provide Dementia Support Workers.
- Carer Support - a refreshed Joint Carers Strategy has been developed inclusive of all ages with an implementation plan. This will provide opportunities for Carers of People with Dementia to develop a support group. The implementation of the strategy will be overseen and driven by a Strategy Steering Group made up of representatives of both Wolverhampton Council, Wolverhampton Clinical Commissioning Group and Carers.
- Integrated Community Services - a monthly information and advice surgery began on 05 July at the Wednesfield Community Hub.
- The expansion of the Better Care Technology offer across Wolverhampton is an integral part of the city's 'Promoting Independence policy' and the 'Home First Approach' to support people to remain independent with the objective of providing Telecare to 3000 new users by 2018

3.4 Living Well with Complex co-morbidities

- A cognitive clinic is being piloted by Consultant Geriatrician on a monthly basis with patients being identified by the RWT Dementia Outreach Service

- A review is underway of Older Adult Day Services provided by BCPFT, i.e. the Groves and the Joint day services at Blakenhall Resource Centre with a view to consolidate activity, possibly from one base and re-investing revenue from the current under activity elsewhere in the community model.

3.5 Responding to Changing Needs

- The preparatory work for a business case for the provision of a central, joint Dementia Hub (or 3 locality based hubs) in Wolverhampton has been developed following research by the multi-agency representatives of the Better Care dementia work stream and through consultation with broader interest groups. This is work in progress. The Dementia Hub will be responsible for ensuring the on-going development of services and interventions providing continued integration by developing a mix and match approach through commissioning arrangements with the public, private and third sector.

3.6 Good Quality Secondary Care when Needed

All patients admitted with a diagnosis of dementia will have an 'About Me' person-centred assessment document commenced within 24-hours of admission:

- Reading group established by RWT being piloted on C22 with plans to roll-out to other wards
- All RWT in-patient, out-patient, specialist teams and community services will have an identified lead professional with the responsibility for ensuring a person-centred approach to dementia care within their departments
- At least 1000 members of Trust will become 'dementia friends' in line with commitment to the Alzheimer's Society's national campaign

3.7 End of Life Care

- The Integrated End of Life care strategy is under development in partnership with the. CCG/WCC/RWT/Compton Hospice and Third sector grant recipients.
- There is a Strategic and Operational group with representation from all partners. The strategy focuses on a whole pathway approach to people approaching the end of life and those with Life Limiting Conditions (inc Dementia) although it is not condition specific.

3.8 Immediate areas of focus

- Advanced Care Planning (ACP)
- Earlier identification of people nearing end of life in primary care
- Central Register to hold these patients on with access across all sectors

3.9 BCF Adult Community Care (includes elements of Dementia)

The CCG is currently working with Local Authority under the BCF banner to co locate Community Nursing teams in each locality across Wolverhampton.These teams (Community Neighbourhood Teams) will be wrapped around Primary Care and support the shared care of the local population.

The teams will include:

- District Nursing
- Adult Social Care
- Rapid Intervention Teams
- Reablement teams
- Hospital @ Home
- Plans to include mental health are in development.

To facilitate and pull these together developments are in progress for a shared care record and have purchased a system to bolt on to current systems utilising the NHS number as the unique identifier across all agencies.

These teams will provide the following:

- Case Management of people identified at high risk through risk stratification
- Rapid Response service to avoid admissions to hospital
- Rapid Intervention service to care homes to avoid hospital admissions
- Community Intermediate Care Team (CICT) to provide re-ablement to avoid hospital admissions
- Hospital at home to support early discharge

The services will provide services to the whole population of each locality irrespective of condition, age, gender etc. and then coordinate services so that each person receives person centred care in the community.

4.0 Achievements

Key deliverables from the Strategy	Date
Current diagnosis rate for dementia in Wolverhampton is 78% in comparison to 57% at the launch of the Joint Dementia Strategy in 2015	On-going
Extensive awareness raising took place during the Dementia Awareness Week	May 2016
Contract issued to Alzheimer's Society to provide six Dementia Cafes following a tender process	April 2016
Contract issued to Alzheimer's Society to provide Dementia Support Workers following a diagnosis	April 2016
Smart Posters went live following a launch during the Dementia Awareness Week. The aim of the project is to improve awareness of dementia within the community, public and private sector workforce.	May 2016
A refreshed joint Carers Strategy has been developed providing opportunities for support group	July 2016

specifically for carers of people with dementia	
Assistive Technology has been expanded to support people to remain independent with the objective of providing Telecare to 3000 new users by 2018 which will include people with dementia	On-going
A monthly information and advice surgery has being provided at the Wednesfield Community Hub which will provide evidence of demand, activity and outcomes upon which data future localised and integrated services can be developed	July 2016
DAA continues to engage with citywide stakeholders to develop and implement initiatives to make Wolverhampton dementia-friendly	On-going
The development of Dementia Friends continues across all sectors. Figures for July 2016 showed 6247 Dementia Friends for Wolverhampton	On-going
Engagement with people with dementia and carers will be a continuous process in all areas of development.	On-going

5.0 Financial implications

5.1 The commissioning direction is consistent with the approved Medium Term Financial Strategy; therefore there are no financial implications arising from this report. Any additional actions ensuing from the strategy will be subject to the normal governance requirements, including if appropriate, budget approvals.

6.0 Legal implications

6.1 There are no legal implications associated at this stage with the report.

7.0 Equalities implications

7.1 This report has equality implications and Equality analysis has been undertaken. It will continue to be reviewed and monitored as part of the future implementation plan.

8.0 Environmental implications

8.1 There are no environmental implications associated at this stage with the report.

9.0 Human resources implications

9.1 There are no human resources implications associated at this stage with the report.

10.0 Corporate landlord implications

10.1 There are no corporate landlord implications associated at this stage with the report.

11.0 Schedule of background papers

11.1 None

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HeadStart Wolverhampton Phase 3 Programme – Key Milestones Plan

HeadStart Wolverhampton

LOTTERY FUNDED

Jul-16	Aug-16	Sept-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sept-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18

Workstream 1: Staffing, programme management and infrastructure

- Transition of phase 2 staff to phase 3
- Core and none core staff established
- Programme infrastructure established (accommodation, internal recharges and equipment)
- Award announcement event
- Award report to Cabinet
- Award report to Head teacher Conference presentation
- Communication to wider stakeholders and young people via www.headstart.fm begins
- Post award briefing at Partnership Board
- Agree existing and new membership of Board and negotiate roles and responsibilities
- Transition of HeadStarters Shadow Board from phase 2 to phase 3
- HeadStarters Shadow Board activity begins
- Procurement schedule agreed in partnership with young people
- Procurement process begins (VCS Consortium, additional intervention providers)
- Procurement process completed
- Transition of marketing and communications from phase 2 to phase 3 using existing channels
- 5 year Programme Marketing and Communications Strategy agreed
- Programme Marketing and Comms plan begins

Workstream 2: City Wide Offer

- Online Therapy Platform specification complete
- Online Therapy Platform tender process
- Online Therapy Platform implementation begins
- Recommence HeadStart.FM broadcasting schedule
- Mental wellbeing awareness and anti-stigma raising initial activity
- Mental wellbeing awareness and anti-stigma raising consultation and strategy for 5 year programme
- Mental wellbeing awareness and anti-stigma raising delivery

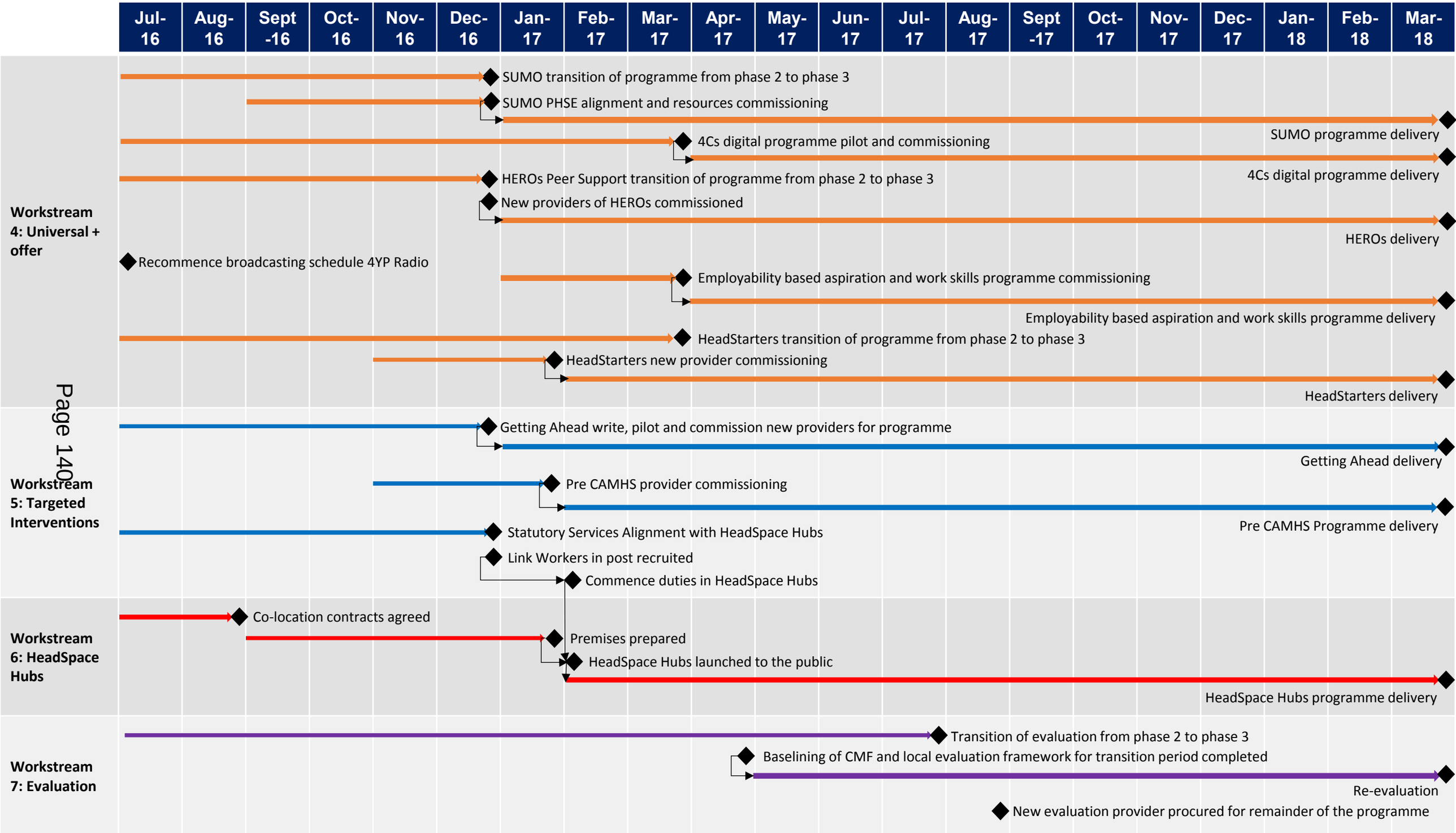
Workstream 3: Universal Offer

- Place to Go commissioning
- Place to Go delivery
- Parents and Families commissioning
- Parents and Families delivery
- Capacity and capability building and community empowerment transition of programme from phase 2 to phase 3
- Capacity and capability building and community empowerment planning, toolkit and training programme written
- Capacity and capability building and community empowerment delivery
- Mental and emotional wellbeing education and training programme written
- Mental and emotional wellbeing education and training programme delivery
- Accredited Digital awareness and online safety training programme written
- Accredited Digital awareness and online safety training delivery

HeadStart Wolverhampton Phase 3 Programme – Key Milestones Plan

HeadStart Wolverhampton

LOTTERY FUNDED



[Date]

Project ID: 0010284943

HeadStart
Grant offer

I am pleased to confirm that we would like to offer your organisation a grant of ££9,469,750 over 5 years to support the implementation of HeadStart Phase 3.

We hope this will help you to achieve your aim of improving the mental well-being of young people in your area.

The grant will be made up of the following amounts for each year as follows:

	Sept 2016-Mar 2017	2017/18	2018/19	2019/20	2020/21	Apr-Jul 2021	Total
Core staff & costs	394,990	666,100	476,270	405,330	280,000	97,620	**£ 2,320,310**
City Wide	30,000	210,000	210,000	50,000	25,000	5,000	**£ 530,000**
HeadSpace Hubs/ Schools & Community Support	332,360	798,600	784,600	790,280	105,440	15,160	**£ 2,826,440**
Universal	210,000	720,000	630,000	550,000	150,000	25,000	**£ 2,285,000**
Universal +	268,000	515,000	195,000	35,000	-	-	**£ 1,013,000**
Targeted	65,000	330,000	50,000	50,000	-	-	**£ 495,000**
Total	**£1,300,350**	**£3,239,700**	**£2,345,870**	**£1,880,610**	**£ 560,440**	**£ 142,780**	**£ 9,469,750**

The grant is to fund the Big Lottery Fund HeadStart programme which aims to improve the mental well-being of at-risk 10 to 16 year-olds through:

1. the implementation of a locally developed, cross-disciplinary, multi-layered and integrated prevention strategy, with the young person and their needs at its core
2. the development of the necessary local conditions to enable that strategy to become sustainable in time
3. the development of a more robust evidence-base around 'what works' in the area of mental well-being to be pro-actively shared beyond HeadStart with the aim of contributing to the national and local policy debate

HeadStart Wolverhampton's offer for young people, their parents, carers, communities and professionals who work with them consists of four components:

- **City-wide mental health well-being information and awareness raising for young people aged 10-16**. Comprising of:
    - Digital & Multi-Media platforms of information, advice and peer support for young people, parents & professionals

    - Mental well-being awareness raising events for young people, parents and professionals
    - Mental health anti-stigma campaigns and events with young people in the driving seat

- **An area-based universal offer for young people aged 10-16 in four geographical areas.** The areas selected are:
    - Area A: Low Hill, The Scotlands and Bushbury South
    - Area B: Springfield, Heath Town, Park Village, Old Heath / Eastfield
    - Area C: Bilston East
    - Area D: All Saints, Blakenhall, Parkfields and Ettingshall
- **A universal Plus offer for those aged 10-12 within the four geographical areas** to support transition of young people from primary to secondary school
- **Personalised, targeted interventions for young people aged 10-12 in the four geographical areas.** A number of categories have been highlighted that can make young people more at risk, these are:
    - Those identifying as LGBTQ
    - Those who have a family member with a history of mental health issues
    - Those who are young carers
    - Those at risk from or involvement in crime / gangs / youth violence
    - 'New arrivals' and/or ROMA
    - Black, Asian or other Minority Ethnic group(BAME)
    - Those who have / are witnessing domestic violence
    - Those with learning difficulties / disabilities

Terms and conditions of grant

Please read the terms and conditions of underpinning this grant attached to this letter.

Accepting the grant offer

If you accept our offer and agree to meet our terms and conditions of grant, a Senior Responsible Officer must sign the declaration at Annex D of this letter and all members of the partnership board must initial their understanding of the grant requirements. **Please append a list of partnership signatures to the declaration for this purpose.**

We expect a revised partnership agreement to be agreed and signed by all members of the partnership board within 6 months of the return of your accepted grant offer. This is included as a milestone within Annex E and will be subject to the progress reviews highlighted at Annex B.

You must return the signed offer letter attached to the terms and conditions, to the following address by **Monday 31 October**:

HeadStart
BIG Lottery Fund
Apex House
Birmingham
B15 1TR

The terms and conditions are part of the grant agreement between us, so we must receive them attached to the signed offer letter, with both documents in their original format.
If you detach the terms and conditions or alter either of the documents, we will be unable to accept them and will have to send you a new offer letter, which could lead to a delay in receiving your grant.

Keep the other copy of the offer letter and terms and conditions for your records.
If you have any questions about this offer or our terms and conditions, please call us as soon as possible.

By accepting our terms and conditions, you agree to meet our monitoring requirements. You can find out about these in the grant schedule attached at Annex B. Please read this to find out what you will be required to do during the life of the grant.

If you don't meet our requirements, including the monitoring requirements, we may withhold payments of this grant or any other grants that your organisation holds with us. We would also be unlikely to fund any further applications from your organisation until the situation is resolved. In some circumstances we might take legal action to recover all or part of the grant.

This also means that if your organisation does not meet our requirements for any other grant agreements with, or administered by, the Big Lottery Fund, payment of **this** grant might be affected.

We will not accept any responsibility for any consequences, whether direct or indirect, that come about from the suspension of any grant, even if any investigation we carry out finds no cause for concern.

Acknowledging our funding using the Big Lottery Fund beneficiary logo

It is a condition of your grant that you acknowledge funding from the Big Lottery Fund so people can see where Lottery money is going in their community.

The main, but not sole, means of acknowledging your grant is using the beneficiary logo as widely as possible. The beneficiary logo is made up of the Big Lottery Fund circle logo, the National Lottery crossed fingers and the words "Lottery Funded", these elements together all form one piece of artwork.

This section of your contract is formal in tone because it relates to intellectual property rights - the Gambling Commission own the trademarks for the crossed fingers and "Lottery Funded" artwork. If your project or activities are delivered in Wales you must use the bilingual version of the beneficiary logo.

The beneficiary logo is described in the enclosed grant acknowledgement requirements booklet, called *show*. This is also available, with further information, on our website www.biglotteryfund.org.uk/logos.

You must comply with these guidelines, or any future version of those guidelines which we send to you. This permission is personal to your project and you may not transfer any of your rights to another person or project.
We may share your details with the Gambling Commission to enable it to monitor your compliance with their guidelines and to take appropriate action if you are in breach of its terms.

We will have the right to end your permission straightaway to use the beneficiary logo, at any time and for any reason. This may be in the following circumstances:

if the Gambling Commission ends our permission to use it;
if you do not comply with the guidelines;
if your grant from National Lottery funds is withdrawn, suspended or terminated.

When this permission ends, you must stop using the beneficiary logo immediately.

If you have any questions regarding acknowledging your grant please contact us for advice at branding@biglotteryfund.org.uk

When you sign this offer letter, you are acknowledging that you have received this information and agree that we may give your details to the Gambling Commission. Please note that if you do not comply with the guidelines referred to here you will be in breach of the terms and conditions of your grant.

Starting the grant

We'll email you a bank or building society details form within the next five working days to complete, so that we can pay funds into your account. If we don't have an email address for you the bank or building society details form will be enclosed with this offer pack and you must return it with the signed offer letter.

After we've received your signed grant agreement and bank or building society details form, we'll get in touch to confirm your grant has started or to let you know if there is anything else you need to do.

Project outcomes and targets

We expect that you will achieve certain programme outcomes throughout the life of the grant.

The outcomes and targets for the next year are set out in the grant schedule at Annex B of this letter. We will work with you throughout the programme to understand your progress against these targets and how much change your project is making. As part of each annual review we will ask you to update the targets for the following year, reflecting the ongoing learning from the programme as well as potential changes in the environment in which you are operating.

Publicising the grant

Publicising your project is important so that people can learn about the fantastic work you're doing in your community. It's also good for people who play the National Lottery to see where their money is being spent and how people are benefiting from it. One of the easiest ways you can publicise your grant and promote the work that you do is on social media channels such as Twitter and Facebook. Guidance and information on this and other ways to publicise your grant can be found in Annex A and on our website www.biglotteryfund.org.uk/publicity.

Congratulations on receiving a grant. We wish you every success with your project.

Yours sincerely

Elly De Decker
Head of Funding

Enclosed:

Terms and Conditions (attached to this letter)

Grant Acknowledgement Requirements booklet

A copy of this offer letter and the Terms and Conditions for your records

Annex A – Communications protocol
Annex B – Engagement and grant review
Annex C – Data definitions
Annex D – Declaration
Annex E – Partnership milestones
Annex F – Partnership targets
Annex G – Partnership’s budget

Terms and conditions

Definitions

"We" and "our" refer to the organisation receiving the grant bound by these terms and conditions. "You" and "your" means the Big Lottery Fund (BLF) and includes BLF employees and those acting for BLF.

The "programme" means the programme that you are giving us the grant for as set out in our application form and any supporting documents, and/or as varied by the Grant Agreement.

The "Grant Agreement", which we have accepted and signed, includes and incorporates these standard terms and conditions and the grant offer letter together with any other conditions we have agreed.

1. In general

1.1 We will use the grant exclusively for the programme. We will hold any unused part of the grant on trust for you at all times, and we will repay any grant (including any unused grant) to you immediately upon demand.

1.2 During the period of the grant we will act in a fair and open manner without distinction as to race, religion, age, gender or disability, and in compliance with relevant legislation.

1.3 We will make sure that all current and future members of our partnership board, governing body (ies) and our executive team have received a copy of these terms and conditions before signature of the Grant Agreement / while it remains in force.

1.4 We will ensure that at all times while the Grant Agreement is in force, we are correctly constituted and regulated and that the receipt of the grant and the delivery of the programme are within the scope of our governing documents, and if asked by you we will provide a legal opinion from our solicitors confirming this.

2. The programme

2.1 We will get your written agreement before making any change to the programme, its name, governance structure and ownership.

2.2 We agree to use reasonable endeavours to deliver the programme according to the strategy and as per the implementation plan submitted. We agree to communicate openly with you about any changes we would like to make to our strategy and / or implementation plan based on on-going learning and accept we will need to get your written approval before implementing any change. We understand potential changes can be discussed during formal quarterly and annual reviews as per the regular monitoring cycle to be put in place (see Annex B – our relationship to you)

2.3 We will not use the grant to pay for any spending commitments we have made before the date of the Grant Agreement.

2.4 We will tell you immediately of any offer of funding for this programme from anyone else at any time during the project and engage in a constructive discussion on implications for your grant.

2.5 If we spend less than the whole grant on the programme, we will return the unspent amount to you promptly. If the grant part-funds the programme, we will return the appropriate share of the unspent amount to you promptly.

2.6 We will acknowledge the grant publicly as appropriate and as practical. We will follow your branding and publicity guidelines at all times. We will acknowledge your support in any published documents or any digital media that refer to the project, including job advertisements, accounts and public annual reports, or in written or spoken public presentations about the project.

2.7 We hereby consent to any publicity about the grant and the project as you may from time to time require. You can carry out any forms of publicity and marketing to promote the award of the grant as you see fit. We agree to do whatever you reasonably require in order to assist with any form of publicity and marketing, including any press or media related activities.

2.8 With regards to 2.6 and 2.7, we agree to adhere to the communication protocol as outlined in Appendix A, attached to the Grant Agreement.

2.9 We will tell you promptly about any changes to information we have provided and will make sure that the information you hold is always true, accurate and up to date at the time it is given and remains true, accurate and up to date whilst the Grant Agreement remains in force.

2.10 In our management of all personal information we will meet the requirements of the Data Protection Act 1998. We will tell you immediately if any of our key contacts or people whose salaries are funded by the grant change.

2.11 We agree to comply with all laws regulating the way we operate, the work we carry out, the staff we employ or the goods we buy. We will ensure that we have an equal opportunities policy in place at all times, to help us comply with all relevant laws and good practice whilst the Grant Agreement remains in force. We will obtain all approvals and licences required by law or by you

2.12 We will have an appropriate written policy in place to safeguard Vulnerable People We will carry out background checks with the Disclosure and Barring Service of all employees, volunteers, trustees or contractors who will have significant direct contact with Vulnerable People. We will also obtain written consent from the legal carer or guardian to work with them.

2.13 We will maintain adequate insurance at all times and if asked, will supply copies of the insurance policy to you. This includes employee and public liability insurance and insurance that covers the full replacement value of any assets you have funded.

2.14 You have the right to reproduce any of our submission or subsequent information supplied by us to you for any purpose as you see fit without any right of a claim by us in respect of copyright.

3. The lead organisation

3.1 We will write to you immediately if any legal claims are made or threatened against us and/or which would adversely affect the programme during the period of the grant (including any claims made against staff concerning the organisation).

3.2 We will tell you in writing immediately of any investigation concerning our organisation, directors, employees or volunteers carried out by any regulatory body.

3.3 We will be available for meetings with you and allow you or those acting for you or the National Audit Office full and free access to our records and any of our offices or buildings.

4. VAT

4.1 We acknowledge that the grant is not consideration for any taxable supply for VAT purposes by us to you. We understand your obligation does not extend to paying us any amounts in respect of VAT in addition to the grant and that the grant made by you is inclusive of VAT.

4.2 We agree to repay you immediately any VAT we recover whether by set-off, credit or repayment to the extent that any such VAT cost is included in the grant.

4.3 We will notify you immediately if any irrecoverable VAT claimed under the grant becomes recoverable.

4.4 We will keep proper and up to date records relating to VAT, and we will make such records available for you to look at and give you copies promptly when requested.

4.5 If you have funded all of the VAT costs for our project, we agree to refund immediately all of the VAT we recover to you.

4.6 If you have funded a proportion of the VAT costs for the project, we agree to refund immediately the same proportion of the VAT recovered to you

5. Our annual report and accounts

5.1 We will acknowledge your grant in our annual reports and accounts covering the period of the programme.

5.2 We will show your grant and related expenditure as a restricted fund under the description “Big Lottery Fund Grant” in our organisation’s annual accounts. If we have more than one restricted fund, or, as a statutory authority, cannot show restricted funds in our accounts, we will include a note to the accounts identifying each restricted fund separately. If we have more than one grant from you, we will record each grant separately in the notes to the accounts. We will identify unspent funds and assets in respect of the grant separately in our accounting records.

5.3 We will send you a copy of our annual accounts as soon as they have been approved in accordance with our governing document and in any event within ten months of the end of the financial year for each year in which grant payments are made. The accounts will be signed by a member of our management committee and externally audited or independently examined by a suitably qualified person if our annual income is over £10,000. We understand that if we are a statutory body, we are not required to send you our accounts.

However, if you require to see them, we will send you our accounts, signed and audited as required by the appropriate regulations.

5.4 We will keep proper and up to date accounts and records for at least seven years after the termination of our grant, including summary profit and loss accounts and management accounts, personnel and payroll records and invoices, which show how the grant has been spent. We will make these financial records available to you to look at and give you copies.

5.5 We will report regularly and fully to all members of our governing body on the financial position of our organisation and will put in place procedures to avoid any conflict of interest arising in the provision of goods and services or the employment of staff required to deliver the project.

6. Monitoring

6.1 We will monitor the progress of the project and complete regular reports as you require in the format you require

6.2 We will send you any further information you, or your evaluation and learning partners, may ask for about the project or about our organisation, and its activities, the number of jobs created by the project, the number of users and other beneficiaries and such other information to monitor the project and evaluate your grants programmes.

6.3 We will complete a final report about the project using the form you send us. We understand that the grant monitoring is complete only after we have completed this report and you have received annual accounts for the full period to your satisfaction.

6.4 We will inform you immediately in writing of anything that significantly delays, threatens or makes unlikely the project's completion.

6.5 We will inform you immediately in writing if there is to be any variation to or decrease in the project outcomes.

7. Grants for salaries

7.1 We will ensure that we have legally compliant employment policies and procedures in place at all times. Our policies will reflect the requirement of equalities in the recruitment and selection process and the need to ensure an appropriate balance of staff in our organisation.

7.2 If the grant is for a salary of a new post, we will advertise the vacancy externally, using appropriate media (including media that could attract disadvantaged groups). We will send you a copy of the text of every advertisement within a reasonable time before such advertising, which will be in accordance with all current best practice and will acknowledge that you are the funder of the post. This applies to any re-advertisement. We will keep the job description, a list of the publications where we placed the advertisements and a copy of the letter of appointment and send them to you if you ask for them. If we have an internal recruitment policy in place, you may waive the right to enforce this condition in writing at your discretion.

7.3 We will not pay grants for salaries until we have supplied you with the names of the staff to be employed, their salaries and their employment commencement date, and, if appropriate, employment termination date.

7.4 We will maintain all main financial records including personnel and payroll records for staff funded by you for seven years after the grant has ended. We will complete all statutory returns for employees and make all relevant payments to cover their pensions and salary deductions, such as income tax and National Insurance contributions.

8. Grants for assets and services

8.1 If any part of the grant is to buy or build, refurbish, extend or alter buildings or land then we will comply with the terms of the standard capital grant conditions attached to the grant offer letter or any other conditions which you have required of us.

8.2 If any part of the grant is used to buy services or a series of services or any other capital items including vehicles, or a series of related capital items costing more than £10,000, we will put out the order to competitive tender. If there are good reasons why we cannot tender, we will obtain your written agreement beforehand. We will comply with all anti-bribery and anti-corruption legislation. We understand that public bodies must meet the relevant UK and European procurement legislation together with the provisions of the World Trade Organisation General Procurement Agreement.

8.3 If any part of the grant is to buy a capital item including vehicles or series of capital items costing more than £10,000 we will keep all receipts and invoices and send them to you if you ask for them. If the cost of the item or items is less than £10,000 we will keep all receipts and invoices and make them available for inspection on request . If we buy a vehicle we will send you a copy of the registration documents no later than three months after you have sent us the money for the vehicle.

8.4 If any part of the grant is used directly or indirectly to purchase or develop any intellectual property rights then we will take all necessary steps to protect such rights against claims from third parties and we agree that we will not exploit such rights without your prior written consent. Exploitation includes use for any commercial purpose or any licence, sale, assignment, materials transfer or other transfer rights. We understand and accept that if you provide the consent it may be subject to conditions requiring us to repay or to share any money we receive.

8.5 We will keep all assets funded by the grant safely and in good repair and condition and will make sure we have adequate insurance cover for all of them. Any loss resulting from payments made for assets before delivery will be our responsibility. If the asset is damaged, destroyed or stolen, we must tell you in writing and we must repair or replace it as soon as reasonably practical.

8.6 We understand that you will monitor assets bought with the grant for a period of up to ten years after the grant has ended for assets purchased for over £100,000 unless varied by any capital conditions, which for the avoidance of doubt, will take precedence. If the assets were purchased for less than £100,000 you will monitor the assets for a period of five years or while the Grant Agreement remains in force, whichever is the shorter. We will supply you with information that you ask for and will allow you to inspect the assets for that period.

8.7 During the grant monitoring period, we will provide an annual statement that the assets are still held and insured by us. We will not sell, give away or borrow against the assets without first receiving your written consent.

As our grant has come from public funds, we understand and accept that if you provide written consent you may require that the sale is at full market value and/or subject to conditions requiring us to repay all or part of the money we receive.

9. Payment of grant

9.1 You will pay the grant by bank transfer (BACS) into a UK-based bank account or building society account in our name, which requires the signatures of at least two authorised people for every withdrawal. We will not use ATMs or debit cards to make cash withdrawals or payments from this account.

9.2 You will not be liable for any losses or costs (including, but not only, bank charges) if you do not make grant payments on the agreed date. We must take up the first instalment of the grant within 6 months of the date of the grant offer letter; otherwise it will automatically lapse, unless you agree in writing to an extension.

9.3 We understand that you will pay the grant in bi-annual instalments over the grant period, and that payment of each instalment will depend on a successful annual review. Failure of completing a successful annual review may result in further grant payments being suspended and/or withdrawn.

9.4 If you are not satisfied that we have met all the terms of our Grant Agreement, or you require extra information or documents, you may request this and may postpone payment of the grant until you decide that the terms are met or until you receive the information you want.

10. Length of grant agreement

10.1 These terms and conditions and the Grant Agreement remain in force for whichever of these is the longest time:

- For one year following the payment of the last instalment of the grant.
- As long as any part of the grant remains unspent.
- The expiry of the maximum period required under the grant for asset monitoring.
- As long as we are in breach of any of the terms and conditions of the Grant Agreement (this includes any outstanding reporting on grant expenditure or project delivery).

11. We understand that

11.1 You can only guarantee future instalments of the grant as long as funds from the National Lottery are available and you continue to operate.

11.2 You may share information about our grant with any parties of your choice as well as with members of the public who make a request for information under the Freedom of Information Act 2000. Details of the project may be broadcast on television, on your website, in newspapers and through other media.

11.3 You will not increase the grant if we spend more than the agreed budget.

11.4 You may suspend payment of the grant if you want to investigate any matters concerning the grant (or any other grants you have given to us). We understand that you accept no liability for any consequences, whether direct or indirect, that arise from a suspension even if the investigation finds no cause for concern.

11.5 You may withhold or demand repayment of all or part of the grant at your absolute discretion, in any of the following circumstances if:

- We fail to meet any of these terms and conditions, or the terms and conditions attached to any other grants from you for which a Grant Agreement is still in force.
- We submitted information within our strategy, implementation plan and/or budget that was dishonest or incorrect or misleading.
- We or any other person or organisation operating for us gave you any significantly misleading or inaccurate information, whether deliberate or accidental, during the application process, or during the period of the Grant Agreement.
- Members of our governing body, volunteers or staff have offered, given or agreed to give any person any money or gifts to bring about this Grant Agreement or act at any time during the project dishonestly or negligently or in any way, directly or indirectly, to our detriment or to the
- Our organisation, members of our governing body, employees or volunteers are subject to an investigation or formal enquiry by the Police, Charity Commission, HM Revenue and Customs or other regulatory body.
- We have match-funding withdrawn or receive duplicate funding from any other source for the same or any part of the project.
- We do not take positive steps to ensure equal opportunities in our own employment practices and the delivery of and access to our services.
- There is a significant change of purpose, ownership or recipient, either during the project or within a reasonable period after its completion, so that you judge that the grant is unlikely to fulfil the purpose for which you made it.
- At any stage during the period of the Grant Agreement we do not let you have information that would affect your decision to continue or withdraw all or part of the grant.
- We are or become legally ineligible to hold the grant.
- If you have reasonable grounds to believe that it is necessary to protect public money.

11.6 You may withhold or demand repayment of all or any of the grant if it is likely that our organisation is put into special measures which will impact significantly on delivery of the programme.

11.7 We acknowledge that the grant comes from public funds and we will not use the grant in a way that constitutes unapprovable State aid. In the event that it is deemed to be unapprovable State aid, then we will repay the entire grant immediately.

11.8 We may not transfer any part of the grant or this Grant Agreement or any rights under it to another organisation or individual, unless we have entered into an agreement which must have been authorised by you in writing, permitting us to work with another organisation in delivering the project.

11.9 We will ensure that no other organisation or individual acquires any third party rights under this Grant Agreement.

12. Additional conditions

12.1 You have the right to impose additional terms and conditions on the grant either in the offer letter and/or if:

- We are in breach of the Grant Agreement.
- You withdraw any part of the funding for the project.
- You judge that members of our governing body, volunteers or staff or any person or organisation closely involved in carrying out the project act in a way that may have a detrimental effect on the project or on your reputation as a distributor of public money or as a Government sponsored body.
- If you have reasonable grounds to believe that it is necessary to protect public money.
- You believe such conditions are necessary or desirable to make sure that the project is delivered as set out in our application or following any agreed changes.

Annex A – Communications protocol

Introduction

One of the aims of HeadStart is to contribute to the development of a more robust evidence-base around 'what works' in the area of mental health and wellbeing which will be shared beyond HeadStart with the aim of contributing to the national and local policy debate. As such, HeadStart partnerships should identify opportunities for sharing stories and achieving positive media coverage. They should also acknowledge the Big Lottery Fund's investment in HeadStart and share the learning and impact of the investment in external relations activities. This would include:

- Using the stories of those benefitting from the scheme to inspire other young people and encourage them to get the right support at the right time, raise awareness and combat stigma
- Using various channels to raise awareness amongst parents and front-line staff about partnerships in their local area
- Sharing the successes of the scheme with key stakeholders, including policy-makers and commissioners, to show the benefits of partnership working and preventative models of support.
- Working with us to maximise opportunities available including through Big Lottery Fund Channels.

Communication and dissemination strategy

All partnerships should develop a communication and dissemination strategy in collaboration with your Relationship Manager at the Big Lottery Fund. The plan will form part of the wider learning communications and dissemination strategy being developed by the Big Lottery Fund and the Learning Partnership led by Anna Freud. The plan will need to be flexible and reviewed on a regular basis. There is no set structure for this plan but we would expect it to include the following:

- A list of appropriate audiences and stakeholders
- A list of channels that will be used to communicate success stories
- Key findings and learning, targeted for appropriate audiences
- A timeline for when the activity will take place
- Early identification and notice of opportunities for the Big Lottery Fund or partners to support or be involved in.

Storytelling

The Big Lottery Fund believes that people should be in the lead in improving their lives and communities. This is consistent with HeadStart, which has young people at the heart of designing services delivered by local partnerships.

This is something we also look for in communications. We want to see people who benefit from HeadStart at the heart of stories which illustrate the positive impact of the programme. We hope to see the six HeadStart partnerships identifying and promoting appropriate inspiring case studies of young beneficiaries and real life success stories.

These case studies could feature in national newspapers, national television, radio, regional media, partners' social media channels, and blogs by experts and commentators.

The use of case studies should not be limited to media but also considered as speakers at conferences, websites and included in annual reports.

Success stories, best practice or positive results from evaluations, should be shared where appropriate with other local groups and organisations.

The partnerships should horizon scan for opportunities, awareness days, emerging debates and government measures in which success stories and case studies can be promoted.

Branding and logos

On all communications (print and online) relevant to HeadStart, please use the agreed lock-up logo (below). This includes reports, case studies and websites. Our Grant Acknowledgement Requirements booklet sets out how to use these elements correctly, including colour and minimum size and should be adhered to.

Media and public relations

All media releases and media briefing materials issued must acknowledge the Big Lottery Fund. This includes standard phrasing which should be included in the main body text and a standard 'Notes to Editors' which includes contact details for the Fund's press office, general enquiries and website.

Press materials must refer to the Big Lottery Fund. Do not use BLF or BIG.

Draft press releases for media events must be shared as early as possible to avoid clashes with media work being carried out by the Fund and ensure adequate support can be provided.

Significant coverage should be shared with the Fund so it can be circulated to colleagues and where appropriate, promoted through social media and other channels.

All materials for external audiences should be produced in plain English to ensure they are as accessible as possible.

Both Big Lottery Fund and the lead partners must inform each other of any significant media interest, particularly if that is potentially damaging, as soon as they know about it.

We expect the following to be included in all releases:

Notes to Editors:

- The Big Lottery Fund is the largest funder of community activity in the UK. It puts people in the lead to improve their lives and communities, often through small, local projects.
- It is responsible for giving out 40% of the money raised by National Lottery players for good causes. Every year it invests over £650 million and award around 12,000 grants across the UK for health, education, environment and charitable purposes.

Website: www.biglotteryfund.org.uk
Twitter: @biglotteryfund
#BigLottery
Facebook: www.facebook.com/BigLotteryFund

Social media

The Fund promotes and shares news, photos, films and stories of our projects on social media channels such as Twitter, Facebook and Instagram, as it is a great way to reach interested parties such as charities, local stakeholders, media and the public. HeadStart partnerships should also look for opportunities to share stories, activity and updates through social media.

You can find the Big Lottery Fund on social media at:

Facebook: https://www.facebook.com/BigLotteryFund
Twitter: www.twitter.com/BigLotteryFund
Instagram: https://www.instagram.com/big_lottery_fund/

Please use the handle @BigLotteryFund or the hashtag #BigLottery when mentioning us on Twitter, to make it as easy as possible to track and share content. The hashtag #HeadStartStories was used for the 2016 announcement and more general hashtags like #youngpeople and #mentalhealth are also useful for engaging in wider discussions.

Public affairs

The Big Lottery Fund seeks to communicate the impact of Big Lottery Fund's work to elected representatives and political opinion formers in a clear, consistent and coordinated way, in Parliament and at constituency level. In order to avoid duplication or contradiction, please let the Big Lottery Fund know if you are planning to undertake any significant stakeholder work. Please make sure the role of the Big Lottery Fund is acknowledged in all your communications with MPs and other elected representatives.

Annex B – Engagement and grant review

Introduction

HeadStart phase 3 will continue as a test and learn programme enabling the partnerships to develop and embed their approaches to building young people's resilience and supporting their emotional well-being. Co-production with young people will continue to be an essential component of the programme from design through to delivery and there will be a continued focus on improving engagement with key stakeholders including young people, parents, the voluntary and community sector as well as related statutory and non-statutory partners.

Our relationship with you

In line with the approach taken during the Phase 3 development process, the HeadStart team will seek to continue to have an open and transparent dialogue with you. Regular, ongoing engagement with your HeadStart Relationship Manager will be expected to ensure we develop and maintain a joint understanding of your strategy, progress on implementation and the impact on young people.

To facilitate this dialogue we envisage the following engagement and review schedule:

(1) Monthly touch-points: Strategic leads and programme managers to be available once a month for general updates with their relationship manager either via telephone or face-to-face

(2) Quarterly meetings: Strategic leads and programme managers be available for a face-to-face quarterly meeting to review progress against plans, milestones and targets and provide the information necessary to inform our progress updates to England Committee - we would expect a written report to be provided in advance of the quarterly meetings to guide the discussion

(3) Annual reviews: Partnership SROs, strategic leads and programme managers to be available for an annual face-to-face meeting, to serve as a formal review of progress achieved against plans, lessons learned, changes in context and the resulting implications for the programme going forward, in particular for the next financial year, including any potential changes to the strategy, the milestones, the targets and the resource requirements. The session is meant to provide an opportunity for formal sign-off of the plans and budget for the next financial year. It is the plan that the BLF relationship manager will be joined by one of the BLF committee members responsible for HeadStart.

The dates for these various catch-ups and meetings should be scheduled ideally for the entire financial year ahead.

In addition to these formal catch-ups and meetings, we aim to establish open lines of communication to ensure that any concern or query can be raised at any particular point, whether by yourself or by the BLF relationship manager, without having to wait for a pre-scheduled catch-up or meeting.

We fully expect that you will need to make changes and that everything will not always go according to plan. We expect and hope that you feel at ease to inform the Big Lottery Fund of anything which could impact on the programme at the earliest opportunity. In turn, we commit to working with you to mitigate any concerns and agree a way forward. Where this commitment is not reciprocated, we reserve the right to escalate our concerns and this may result in restrictions against the release of further funding.

Finally, we would ask you to invite your relationship manager to attend partnership board meetings, executive group meetings/task and finish group meetings, events etc. and to offer them the opportunity to engage with stakeholders in a variety of settings. Specifically with regards to the stakeholder event, we would ask that you inform us well in advance to give us the opportunity to potentially invite senior members of our executive and/or committee members to attend as and when appropriate.

What does 'good' progress look like?

We propose to base any review conversation on the following four items:

1. Progress against milestones
2. Progress against targets
3. Spent against budget
4. Assessment against the foundations

(1) Milestones:

As part of your submission, you were asked to develop an implementation plan for the HeadStart programme and specify the main milestones, with a focus on the first 18 months of implementation. We have included this plan in Appendix E. As part of the review cycle, we would like to understand how you're progressing against those milestones, understand where and why you might have deviated from the original plans and what the implications are for your plans going forward.

(2) Targets:

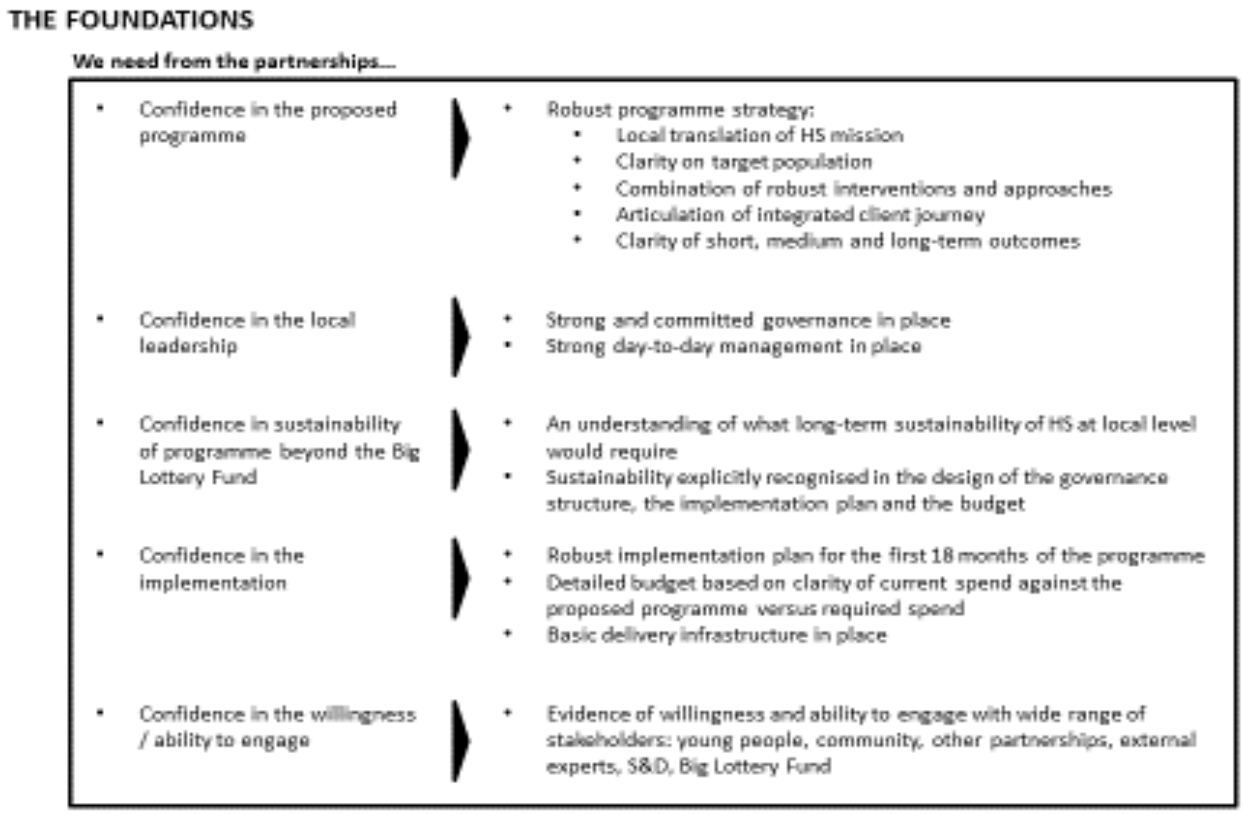
As part of your submission, you were asked to estimate the numbers of settings you would be working in as well as the numbers of young people, parents and professionals would benefit from the programme. Appendix C provides definitions for the different targets. We have included the targets you submitted in Appendix F. As part of the review cycle, we would like to understand whether you are actually reaching all the beneficiaries you thought you would and if not, why not and what the implications are for your plans going forward.

(3) Budget

As part of your submission, you were asked to develop a detailed budget for the HeadStart programme with a focus on the first 18 months. We have included this budget in Appendix G. As part of the review cycle, we would like to understand how your actual spending compares to what you had actually budgeted, understand where and why you might have deviated from the original budget and what the implications are for your budget going forward.

(4) The foundations

Finally, you know that we assess the strengths and areas of development for different partnerships against the foundations. Here again those foundations.



As part of the review cycle we would like to discuss with you how well you're performing against those foundations, where you have particular strengths, where action to further strengthen might be required and where BLF might be able to provide support.

Participating in the learning and development programme

HeadStart is meant to be a test and learn programme. It is therefore absolutely crucial to the success of the programme that all partnerships fully engage with the test and learn agenda, not only participate but take ownership of their own learning and pro-actively support the learning of others.

Specifically:

(1) We fully expect that all HeadStart partnerships fully implement the Common Measurement Framework as co-developed with them. This is a grant condition and failure to comply will result in a suspension of the grant;

(2) We fully expect that all HeadStart partnerships fully engage with all the elements of the learning agenda: e.g.;
   a. Capability building element
   b. Value for money
   c. Qualitative evaluation

   Again, this is a grant condition and failure to comply will result in a suspension of the grant.

(3) We fully expect that all HeadStart partnerships, as a rule, ensure that the relevant programme staff attend the learning sessions as organised by the learning team. We understand that, at times, dates might clash and that particular events might need to be missed. However, we expect all partnerships to make every reasonable effort to attend, especially where dates have been provided well in advance.

(4) We fully expect that all HeadStart partnerships take ownership not only of their own learning but also of the learning of the HeadStart collective. This includes amongst others:
    a. Pro-actively sharing learning with others – whether formally or informally
    b. Be willing to host other partnerships on learning events
    c. Volunteer to lead on particular strands of learning as and when appropriate, suggested by the Learning team

HeadStart offers a unique opportunity to develop the understanding of what works and doesn't work to support young people to develop their mental wellbeing and to make the case for much more investment in the appropriate support early on. It is our joint responsibility to ensure this opportunity is maximised.

Handling and escalation of any concerns

Regular communication, whether formal and/or informal should enable both the partnerships and the HeadStart team to highlight any potential concerns as soon as they arise and for both parties to agree a plan of action to address any such concern at the earliest opportunity.

The quarterly reviews, as standard, would provide the formal basis for any concern to be logged. Based on the written report provided by the partnerships in advance of that meeting, the relationship manager will produce a summary, highlighting their assessment of progress achieved by the partnership and of areas where specific action might be required - a plan of action should then be agreed during the meeting. The summary produced by the relationship manager, with the action plan attached, will be included in the formal quarterly HeadStart reporting to the England Committee.

Progress against the agreed action plan will be monitored and any significant delay to the plan might result in escalation of the matter as and when deemed appropriate by the relationship manager. Escalation would imply involvement of the BLF HeadStart programme lead and a specific conversation on the topic with the HeadStart strategic lead within the partnership.

If that escalation still does not result in the desired progress, a formal note will be send by the HeadStart programme lead to the strategic lead, the partnership board, copied to the HeadStart SRO.

Only as a last resort, BLF might consider a temporary suspension of the grant. This suspension will be decided upon by the England Committee on recommendation by the BLF HeadStart programme lead.

Annex C – Data definitions

Year-by-year partnership milestones, targets and budgets at the time of the grant agreement

Data	Definition	Since inception	Current year, budgeted projections	Current year, year-to-date	At the time of reporting
Number of schools engaged	Number of schools that directly benefit from one or more HeadStart programme elements at the time of reporting. N.B HeadStart programme elements refers to elements which deliver beyond awareness raising activity e.g. campaigns or accessing a website.	The total number of schools you have been working with since the start of Phase 3	The number of schools you had planned to work with by this point of the year	The total number of schools you have actually been working with at the time of reporting	The number of schools you are currently working with at the time of reporting
Number of community based organisations engaged	Number of community based organisations that directly benefit from one or more HeadStart programme element at the time of reporting. N.B HeadStart programme elements refers to elements which deliver beyond awareness raising activity eg campaigns or accessing a website.	The total number of community based organisations you have been working with since the start of Phase 3	The number of community based organisations had planned to work with by this point of the year	The total number of community based organisations you have been working with during the year at the time of reporting	The number of community based organisations you are currently working with at the time of reporting
Number of young people benefiting from HeadStart					
(1) Across the HS programme					
Number of young people benefiting from universal support	Number of young people involved in schools and / or community based organisations where the (or one of the) universal element of the programme is implemented AVOID DOUBLE-COUNTING OF YOUNG PEOPLE	Number since the start of Phase 3 – should go up if the number of young people in schools / community based organisations increase or if additional schools / community based organisations are benefiting from the programme	The number of young people you had planned would benefit by this point of the year	The total number of young people who have benefitted this year at the time of reporting	The number of young people who are benefiting at the time of reporting
Number of young people identified as requiring additional support (i.e. universal support alone has been identified as not being not enough for the young person so they have been signposted or referred to more targeted programme elements i.e. universal plus, targeted etc).	Number of young people who have been identified as requiring one or more elements of additional support – this includes self-referral where the 'threshold' is met AVOID DOUBLE-COUNTING OF YOUNG PEOPLE	Total number since the start of Phase 3	Number you had planned for by this point of the year	Actual total number identified for the year at the time of reporting	Actual number identified at the time of reporting

Number of young people recruited to the additional support (i.e. provider is satisfied that the support/intervention is appropriate for that young person)	A young person may be identified as requiring additional support but on assessment a practitioner or provider may decide that the support/activity/ intervention is not suitable or necessary. AVOID DOUBLE-COUNTING OF YOUNG PEOPLE	Number since the start of Phase 3	Number you had planned for by this point of the year	Actual number for the year at the time of reporting	Actual number at the time of reporting
Number of young people actually taking up the additional support (i.e. universal support alone has been identified as not being enough for the young people so they have taken up support from more targeted programme elements i.e. universal plus, targeted etc)	Number of young people who have attended at least one session of the additional support offered AVOID DOUBLE-COUNTING OF YOUNG PEOPLE	Total number since the start of Phase 3	Number you had planned for by this point of the year	Actual number for the year at the time of reporting	Actual number currently partaking at the time of reporting
Number of young people having completed the additional support in a planned way (i.e. universal support alone has been identified as not being enough for the young people and they have completed the support available from targeted programme elements i.e. universal plus, targeted etc)	Number of young people having completed one or more elements of additional support (planned is defined as where the children and young people identified that they no longer felt they needed the activity/ intervention or where the worker identified this. This can include face-to-face discussions or phone contacts AVOID DOUBLE-COUNTING OF YOUNG PEOPLE	Number since the start of Phase 3	Number you had planned for by this point of the year	Actual number for the year at the time of reporting	Actual number at the time of reporting
(2) For each programme element beyond the universal offer i.e. universal plus, targeted etc (reporting per programme element)					
Number of young people identified as requiring the additional/targeted programme element	Number of young people who have been identified as requiring the programme – this includes self-referral where the 'threshold' is met	Number since the start of Phase 3	Number you had planned for by this point of the year	Actual number for the year at the time of reporting	Actual number at the time of reporting
Number of young people actually recruited to the additional/ targeted programme element (i.e. provider is satisfied that the support/intervention is appropriate for that young person)	A young person may be identified as requiring additional support but on assessment a practitioner or provider may decide that the support/activity/ intervention is not suitable or necessary.	Number since the start of Phase 3	Number you had planned for by this point of the year	Actual number for the year at the time of reporting	Actual number at the time of reporting
Number of young people actually taking up the additional/targeted programme element	Number of young people who have attended at least one session / activity of the programme element	Number since the start of Phase 3	Number you had planned for by this point of the year	Actual number for the year at the time of reporting	Actual number at the time of reporting
Number of young people completing	Number of young people having completed the programme element in a planned way	Number since the start of	Number you had planned	Actual number for the year at	Actual number at the time of

the additional/targeted programme element in a planned way	which means that either the young person or the worker identified that the programme element was no longer required and this was agreed upon by both parties through face-to-face discussions or phone contacts	Phase 3	for by this point of the year	the time of reporting	reporting
Number of parents supported through HeadStart (parents of young people requiring additional/targeted programme beyond the universal offer i.e. universal plus, targeted etc)					
Number of parents / carers identified as requiring the programme element	Number of parents / carers who have been identified as requiring the programme – this includes self-referral where the 'threshold' is met. N.B mother and father to be counted separately	Number since the start of Phase 3	Number you had planned for by this point of the year	Actual number for the year at the time of reporting	Actual number at the time of reporting
Number of parents / carers recruited to the additional support (i.e. provider is satisfied that the support/intervention is appropriate for that young person)	A parent / carer may be identified as requiring additional support but on assessment a practitioner or provider may decide that the support/activity/ intervention is not suitable or necessary. AVOID DOUBLE-COUNTING OF YOUNG PEOPLE	Number since the start of Phase 3	Number you had planned for by this point of the year	Actual number for the year at the time of reporting	Actual number at the time of reporting
Number of parents / carers actually taking up the programme element	Number of parents / carers who attended at least one session / activity of the programme element	Number since the start of Phase 3	Number you had planned for by this point of the year	Actual number for the year at the time of reporting	Actual number at the time of reporting
Number of parents / carers completing the programme element in a planned way	Number of parents / carers having completed the programme element in a planned way which means that either the parent / carer or the worker identified that the programme element was no longer required and this was agreed upon by both parties through face-to-face discussions or phone contacts	Number since the start of Phase 3	Number you had planned for by this point of the year	Actual number for the year at the time of reporting	Actual number at the time of reporting
Number of professionals supported through HeadStart					
Number of professionals who take up training	N.B Take up is defined as where the professionals attend at least part of the training	Number since the start of Phase 3	Number you had planned for by this point of the year	Actual number for the year at the time of reporting	Actual number at the time of reporting
Number of professionals who complete the training	The actual number of professionals who complete the training for the agreed duration as defined in the training plan being utilised	Number since the start of Phase 3	Number you had planned for by this point of the year	Actual number for the year at the time of reporting	Actual number at the time of reporting

Annex D - Declaration

Wolverhampton City Council

Project ID: 0010284943

Project name: HeadStart Wolverhampton

Who must sign this offer letter?

The **senior** or **legally responsible contact** must sign this offer letter. They must be at least 18 years old and hold a senior position in your organisation as follows:

Organisation type	**Senior/legally responsible contact's role in your organisation**
Organisations incorporated under the Companies Act	Director or company secretary
Local authorities and statutory health bodies	Chief executive or director
All other types of organisation	Chair, vice chair or treasurer

Declaration
I am/we are authorised on behalf of the organisation named above to accept this offer of grant on the terms and conditions stated.

Senior/legally responsible contact

Title	**Forenames (in full)**	**Surname**

Position in organisation

Signed	**Date**

Annex E – Partnership Milestones

Foundation area	Sub area	Milestone	Deadline	Responsible person
Programme effectiveness	Programme strategy	Online Therapy Platform implementation	Nov 2016	##
		Place2Go programme delivery begins		
		Parents & Families programme delivery begins		
		Capacity and capability building and community empowerment toolkits and training established and implemented	Jan 17	
		Mental and emotional wellbeing education and training programme written and being implemented	Jan 17	
		Accredited Digital awareness and online safety training written and being implemented	Jan 17	
		Peer support network delivering in all geographical areas	Mar 17	
		Online Therapy Engagement workers delivering in target geographical areas	Jan 17	
		SUMO school curriculum being delivery in new schools	Jan 17	
		4 C's digital programme delivery begins	Apr 17	
		HEROs peer support programme delivery begins	Apr 17	
		HeadStarters programme delivery with new providers begins	Jan 17	
		Getting Ahead programme delivery begins	Jan 17	
		Pre-CAMHS programme delivery begins	Feb 17	
		HeadSpace Hubs launch programme of activity to community	Feb 17	
		CAMHS Link workers commence duties in Hubs	Feb 17	
	Implementation fidelity	Establish core and none core staff (admin and office staff, specialist support staff, HeadSpace and co-funded staff) - *Contracts issued* - *Staff in post*	Jan 2017 *Nov 2016* *Jan 2017*	HR

		Police and School panels in HeadStart areas and schools	Oct 16	
		Establish infrastructure - *Accommodation* - *Equipment* - *Internal SLAs(legal, IT, Finance, Audit Procurement, HR)*	Dec 2016 *Nov 2016* *Jan 2017* *July 2016*	Kevin Pace
		Completion of procurement - *Procurement plan??*		
		HeadSpace Hub - *activity aligned with statutory services* - *Protocols established for multi-agency partnership* - *Colocation contracts agreed in each hub area*	*Jan 17* *Sept 16* *Nov 16*	
	Performance management			
Governance/ leadership	Governance	Agree existing and new membership of Board and negotiate roles and responsibilities	##	Viv Griffin
		Partnership agreement revised and signed	##	##
		HeadStarters Shadow Board completes transition to Phase 3	Oct 2016	YPE Lead
Sustainability				
Engagement		Consultation – 'What does 5 year programme look like'	Mar 2017	M&C Officer

Annex F – Partnership targets

Annex G - Partnership budget

Agenda Item No: 12

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

30 November 2016

Report title	Wolverhampton Safeguarding Children Board Annual Report 2015-16
Decision designation	AMBER
Cabinet member with lead responsibility	Councillor Val Gibson Cabinet member for Children
Key decision	No
In forward plan	No
Wards affected	All
Accountable director	Linda Sanders People Directorate
Originating service	Safeguarding and Quality
Accountable employee(s)	Gillian Ming Children Board Manager Tel 01902 550640 Email Gillian.Ming@wolverhampton.gov.uk
Report to be/has been considered by	Wolverhampton Safeguarding Board 7 September 2016

Recommendation(s) for action or decision:

The Panel is recommended to:

1. Provide assurance to Wolverhampton Safeguarding Children Board that the respective agencies represented on the Health and Wellbeing Committee report annually to their respective boards on children's safeguarding;

2. Ensure all agencies represented at the Board have internal assurance mechanisms that can demonstrate their role and performance in relation to safeguarding arrangements for children and young people.

3. Note the report and support the areas for further development in 2016-17 contained in 3.3 and 3.4

1.0 Purpose

1.1 The purpose of this report is to report formally provide the health and Wellbeing Board with a copy of the Wolverhampton Safeguarding Children Board's (WSCB) Annual Report for 2015 -2016. The Report can be found using this link: WSCB Annual Report 2015-16 FINAL OCT.pdf or by going to the Wolverhampton Safeguarding Website.

1.2 In compliance to the statutory guidance; Working Together to Safeguarding Children, there is a requirement for the annual report from the Safeguarding Children Board to be presented to various bodies, including the Managing Director and leader of the Council, the Police and Crime Commissioner, the Department for Education, local strategic boards, and specifically the local Health and Wellbeing Board.

1.3 The report provides an overview of how board partners have discharged their safeguarding responsibilities over the preceding year, in this case, 2015 - 2016.

1.4 The Wolverhampton Safeguarding Children Board and the Health and Wellbeing Board together represent aspects of the partnership agenda within the City and have a responsibility to hold one another to account for safeguarding activities. This is exemplified by the introduction of a memorandum of agreement recently signed by the Chairs of a number of Boards and is included in the schedule of background papers.

1.5 The annual report of the Safeguarding Children Board offers a formal opportunity to ensure that this relationship in practice operates in accordance with the protocol. From the perspective of the Children's Safeguarding Board it provides an arena for challenge and an opportunity to seek assurances from members of the Health and Wellbeing Board that their constituent organisations discuss and review safeguarding at their respective Boards and, where relevant, scrutiny committees.

2.0 Background

2.1 Safeguarding Children's Boards are statutorily required to publish an annual report on the effectiveness of children's safeguarding and promoting the welfare of children in the local area. Its statutory objectives are to: Coordinate local work to safeguard and promote the welfare of children; and Ensure the effectiveness of its work.

2.2 The Chair of the Safeguarding Children Board through the Safeguarding Children Board Manager is responsible for ensuring there is an Annual Report on behalf of the Wolverhampton Safeguarding Children Board. The Annual Report contains contributions from the partner agencies who are members of the Board.

2.3 The report provides information regarding local safeguarding initiatives, the work and structure of the Safeguarding Board, progress against previous year priorities, partner achievements, and safeguarding data performance.

2.4 The Annual Report was presented as a final draft at the September Safeguarding Children Board where it was endorsed by Board members and is now available on the Joint Wolverhampton Safeguarding Boards Website.

2.5 The Annual Report reflects the complex and wide ranging agenda that the Board, its committee working groups and partner organisations have been addressing throughout the year. In line with statutory guidance we have a Strategic Plan that identifies our priorities and aspirations for the years ahead 2016 – 2017 and beyond.

2.6 The Board is a broad partnership of key agencies who have a collective responsibility for safeguarding children and providing mutual assurance that the practice and arrangements relating to safeguarding children, young people and families reflects jointly agreed policies and protocols. It meets four times a year with much of its business conducted through a range of committees that report into the Board.

2.7 The Board is independent of any of the partners, funded in the main by the three statutory lead partners, City of Wolverhampton Council, The CCG and West Midlands Police.

2.8 The Board does not deliver frontline services, but has a duty to monitor, quality assure and evaluate the quality and effectiveness of safeguarding function and arrangements of the key services commissioned and delivered via the board partners in the local area.

2.9 This report relates to the year 2015-16 and summarises the progress made during the stated period, and also identifies the challenges facing the Board in 2016/17.

3.0 Progress since last report

3.1 There is no progress unless we can show that the work we have done and the assurance processes we oversee have a positive impact on children. The examples below are a small number of the improvements we have made in protecting children through partnership:

3.2 We have created a new shared safeguarding website with social media presence for the public, staff and organisations in conjunction with the Wolverhampton Safeguarding Adults Board. This ensures there is more accurate an up to date information to help professionals and members of the public better protect children.

3.3 We have been instrumental in the formation of a joint safeguarding initiative with neighbouring Black Country Safeguarding Children's Boards which offers a unified Multi-agency training programme ensuring a better and more consistently trained workforce in an area of work where issues of safeguarding frequently cross municipal and NHS Boundaries.

3.4 A Head Teacher's Safeguarding Group was established in 2014 to strengthen the WSCB's relationship with schools, and this year we have managed to extend our work in this area by hosting a conference 'Keeping Children Safe in Education' which was well received by the sector.

3.5 While we will acknowledge and celebrate the strengths and successes of the Board, we recognise that there are some areas where further work and focus is required; examples include:

- The need to further strengthen the contribution and influence of young people in the work of the Board.
- Further embed the new approaches to tackling neglect.
- Further develop our approach to child sexual exploitation.

3.6 The report also recognises that abuse and exploitation does not end at the age of 18. Keeping people safe is an inter-generational issue. We must and do 'think family'. The impact of the misuse of drugs and alcohol by adults, for example, instantly raises concerns about the safety of children. Issues such as domestic abuse, trafficking or forced marriage do not fit into neat age-related compartments and our response has to demonstrate we do not think that way.

3.7 Going forward, we aim to build and sustain a strong safeguarding culture and arrangements where the focus is firmly on the experience of the child or young person and their journey to getting the right help and support at the right time. This report also seeks to summarise the journey of the Board to become more effective and to better evidence the impact it is having.

4.0 Equalities implications

4.1 How and in what ways we safeguard children must reflect the differing cultural values and norms within communities. Although the legal framework is universal, how we ensure children and parents understand, recognise and respond to potential safeguarding issues varies and is reflected for example in our work to reach out to faith communities and through our links with the Refugee and Migrant Centre.

5.0 Environmental implications

5.1 There are no direct environmental implications arising from this report.

6.0 Schedule of background papers

6.1 Report to Wolverhampton Safeguarding Children Report 07.09.2016.CYP Panel: 05.10.2016

Agenda Item No: 13

CITY OF WOLVERHAMPTON COUNCIL

Health and Wellbeing Board

30 November 2016

Report title	Joint Strategic Needs Assessment Update	
Cabinet member with lead responsibility	Councillor Paul Sweet Public Health and Wellbeing	
Wards affected	All	
Accountable director	Linda Sanders	People
Originating service	Public Health	
Accountable employee(s)	Ros Jervis	Director of Public Health
	Glenda Augustine	Consultant in Public Health - Evidence
	Tel	01902 558662
	Email	Glenda.augustine@wolverhampton.gov.uk
Report to be/has been considered by	Public Health Senior Management Team	3 November 2016
	People Leadership Team	14 November 2016
	Joint Strategic Needs Assessment Steering Group	23 November 2016

Recommendation(s) for action or decision:

The Health and Wellbeing Board is recommended to note:

1. The on-going development and completed sections of the Joint Strategic Needs Assessment (JSNA)
2. The findings of the topic specific JSNA report into children and young people with special educational needs and disability (SEN(D))

1.0 Purpose

1.1 The purpose of this paper is to provide the Health and Wellbeing Board (HWBB) with an update of progress on the Joint Strategic Needs Assessment (JSNA) and the specific JSNA report relating to children and young people with special educational needs and disability (SEN(D)).

2.0 Background

2.1 The JSNA is an integral part of improving population health and well-being and reducing local health inequalities. It aims to provide an assessment of the current and future health and social care needs of the local population. The identification of health and social care need will inform strategic planning alongside the commissioning of services across the whole system to address unmet need. The JSNA will also support the monitoring of trends and evaluation of performance data in relation to commissioned services.

2.2 In October 2015 the HWBB approved a large scale review and redesign of the JSNA. In April 2016, early developments were presented to demonstrate the 'new look' JSNA. This paper seeks to update the HWBB with the key highlights of an additional part to the 'overview' section of JSNA: causes of early death, a topic specific report relating to children and young people with special educational needs and disability (SEN(D)) and progress on further sections of and additional needs assessments relating to the JSNA.

3.0 JSNA Overview Report: Causes of Early Death

3.1 The JSNA overview section now includes a summary of the causes of early death, (premature mortality), before the age of 75 years. Data for Wolverhampton is presented in comparison to statistical neighbours and national outcomes. Ward level data and spend is provided for where available, with an explanation of the findings and indicative commissioning considerations.

3.2 In summary, there has been improvements in the following rates of early deaths in Wolverhampton between 2011-13 and 2012-14:

- Infant mortality
- Cardiovascular disease
- Coronary heart disease
- Liver disease
- Alcohol related mortality
- Respiratory disease
- Communicable disease
- Excess winter deaths (all ages; 85 years and over)

3.3 It should be noted that despite some improvement all the indicators above, with the exception of excess winter deaths aged 85 years and over, remain significantly worse than the England average. The rate of excess winter deaths for older adults is similar to the England average.

3.4 The following rates of early death in Wolverhampton between 2011-13 and 2012-14 have increased, remaining consistently worse than the England average:

- All causes of early death
- Cancer; Lung cancer
- Stroke
- Causes considered preventable
- Smoking attributable
- Serious mental illness
- Suicide and injury of undetermined intent

3.5 Early deaths in Wolverhampton due to excess winter deaths are higher in females. The rates of early death in Wolverhampton that have been consistently higher in males include cancer, cardiovascular diseases and liver diseases.

3.6 The rates of early deaths in Wolverhampton (2010-2014) due to following causes are more prevalent in most deprived areas of Wolverhampton:

- All causes of early death
- Infant Mortality
- Cancer; Lung cancer
- Coronary Heart Disease; Stroke; Circulatory Diseases
- Alcohol related deaths
- Suicides

4.0 SEN(D) JSNA

4.1 The recent reform of the Government's Children and Families Act (2014) and introduction SEN(D) code of practice: 0 to 25 years' (2015) is transforming the way children and young people with SEN(D) receive services across education, health and social care. In Wolverhampton, SEN(D) is a key priority for joint commissioning between the Council and the Wolverhampton Clinical Commissioning Group (CCG) and this topic was identified as the first deep-dive area for the JSNA.

4.2 The SEN(D) JSNA aims to collate and analyse national and local information and data to develop a comprehensive picture of education, health and social care needs of children and young people with SEN(D) in Wolverhampton. This needs assessment will particularly focus on children and young people aged 0 to 25 years with:

- Learning difficulties (specific learning difficulties, moderate learning difficulties, severe learning difficulties and profound and multiple learning difficulties)
- Special educational needs (that is, communication and interaction, cognition and learning, social, emotional and mental health and sensory and/or physical needs). This would include hearing impairment, visual impairment and multi-sensory impairment

- Physical disability
- Autistic spectrum disorder

4.3 The identified future needs for children and young people with SEN(D) in Wolverhampton are likely to be influenced by the following:

- Estimated increase in 0 - 24 year old population, particularly those in the age group 10 - 24 year olds
- Predicted increase in:
    - Specific learning difficulty and visual impairment in secondary schools
    - Speech, language and communication needs in secondary schools
    - Rate of autism
- Increasing complexity of need, including mental health

4.4 The key findings are:

- There are 6,935 pupils receiving SEN provision in Wolverhampton, of which 5,782 (83%) received SEN support, 972 (14%) received a SEN statement and 181 (2.6%) received an EHC plan in 2015/16
- 851 children with SEN or EHC Plans have accessed social care services and there were 1,030 children and young people in Wolverhampton recorded on CareFirst with learning disabilities in April 2015
- Boys with SEN/ EHCP, children aged 10-19 years with SEN or EHCP and those living in more deprived areas were more likely to access social care services
- The trend in the proportion of pupils receiving SEN support and SEN statements/ EHC plans in Wolverhampton is decreasing
- Educational attainment for children and young people with SEN in KS1, KS2 and at year 11 is improving
- In 2015, 87% of 16-17 year olds with SEN(D) were in education and training compared to 88.7% 16-17 year olds without SEN(D). The gap between children with and without SEN(D) has reduced from 9.4% in 2013 to 1.7% in 2015.
- Some of the gaps identified by parents/ carers and young people include:
    - Improved communication with parents and among services
    - Timely referral and diagnosis
    - Timely SEN assessments
- Some of the gaps identified by service providers / commissioners including education:
    - Support for children and young people with ASD and mental and behavioural problems
    - Increased independence and employment opportunities
    - Improved transition from children to adult services

4.5 41 stakeholder-led recommendations or actions were developed as a result of the SEN(D) JSNA stakeholder event. These can be categorised into the five following areas:

- Data for children and young people with SEN(D)
- Transition to adulthood
- Support for children and young people with SEN(D) with complex needs and mental health needs
- Promoting independence among children and young people with SEN(D)
- Organisational training needs

4.6 The Council is currently integrating health and social care data via a PI database. Should integrated data be made available through a future phase of the PI Project consideration should be given to updating of the SEN(D) JSNA.

5.0 Future development of the JSNA – in the pipeline

5.1 Over recent months' good partnership working has resulted in the collation of information to develop various sections of the JSNA. The following list provides an outline of further topic specific reports and additional life-course sections of the JSNA that are in progress and the proposed time to completion. These would include information about the current prevalence, trend analysis, national and regional comparisons as well as identifying any inequalities in terms of age, gender, ethnicity, deprivation, and variation between wards in Wolverhampton (where available). A summary of what can be expected is listed below:

- Start well section – due December 2016, to include:
  - Child Poverty
  - Pregnancy and post-natal care
  - Family life and parenting including obesity, physical health and oral health in children
  - Vaccination Coverage
- Develop well section – due January 2017, to include:
  - Safeguarding children and young people including Looked after Children, children in need and child protection
  - Child Abuse
  - CAMHS
  - Emergency admissions to hospital among children
  - Supporting young people including alcohol and substance misuse among young people, smoking and obesity in young people, youth violence, young carers, NEET, children with long term conditions, children with SEND and parental experience of services
  - Sexual health in young people
  - Education including GCSE's achieved and pupil absence
- Mental Health Needs Assessment - due February 2017
- Suicide Prevention Needs Assessment – due February 2017
- Headstart Needs Assessment – due March 2017
- Live well section due March 2017, to include:

    - Crime including violent crime, domestic abuse, anti-social behaviour, offending and re-offending
    - Housing
    - Employment
    - Lifestyle
    - Health Protection
    - Service Utilisation including dental services, A&E attendances, GP services, emergency admissions, uptake of cancer screening and NHS Health Checks
    - Resident Voice
- Age well section due April 2017, to include:
    - Hospital adimssions including hip fractures, falls, delayed transfer of care
    - Co-ordination of care including dementia, vaccination coverage for over 65s, people receiving direct payments
    - Management of long term conditions including diabetes, CVD, COPD, mental illness, adults with co-morbidites, cancer survival
    - End of life care
- Wolverhampton City section due April 2017, to include:
    - Local area
    - Population (including migration)
    - Ethnicity and Culture
    - Economy
    - Poverty and Deprivation
    - Housing
    - Transport

5.2 Over the recent months, various organisations including the Wolverhampton CCG, Royal Wolverhampton NHS Trust, Black Country Partnership Foundation Trust, University of Wolverhampton, Police and various departments within Wolverhampton Council such as social care, education, housing, transport and business intelligence have been involved in providing data and developing the JSNA. We would like to continue with this participatory approach to the JSNA across the whole system of health and social care.

5.3 The next update paper will be due for presentation post April 2017 following completion of all sections of the 'Overview' report of the JSNA.

6.0 Access to the JSNA

The causes of death report and the SEN(D) JSNA can be accessed via the following link. http://www.wolverhampton.gov.uk/Wolverhampton-Health-and-Wellbeing-Board. We are currently in conversation with the council digital transformation team and soon all the JSNA documents will be available on the council website.

7.0 Financial implications

7.1 There are no direct funding implications arising from the production of the JSNA. Any costs arising from implementation of the JSNA recommendations will be met from within existing resources in either Public Health or the SEN(D) service areas. [GS/31102016/F]

8.0 Legal implications

8.1 There are no anticipated legal implications to this report. [RB/07112016/B]

9.0 Equalities implications

9.1 The process of analysing health and social care need may highlight inequalities in service access or provision which could adversely affect people differently or not meet the needs of certain groups. There will be specific recommendations made regarding commissioned services, where applicable, to address any inequalities identified

10.0 Environmental implications

10.1 There are no environmental implications related to this report.

11.0 Human resources implications

11.1 There are no anticipated human resource implications related to this report.

12.0 Corporate landlord implications

12.1 This report does not have any implications for the Council's property portfolio.

13.0 Schedule of background papers

13.1 Wolverhampton Joint Strategic Needs Assessment: Policy and Process 2016 presented at JSNA Steering Group on 1 February 2016 and HWBB paper presented in October 2015.

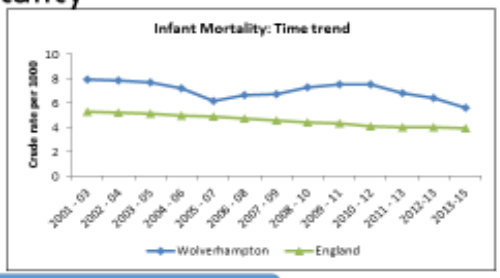
APPENDIX: Sample of JSNA Content

Infant Mortality

Infant Mortality rate is defined as number of deaths under the age of one year, per 1000 live births. It consists of 2 components:

- Neonatal mortality rate: rate of neonatal deaths (those occurring during the first 28 days of life) per 1000 live births
- Post-neonatal mortality rate: rate of infants death occurring between 28 days and less than one year per 1000 live births

Neonatal mortality is considered to reflect the health and care needs of both mother and new-born.

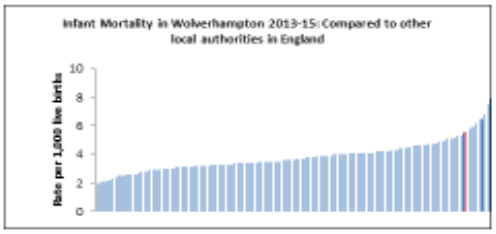


Infant Mortality in Wolverhampton is reducing

Wolverhampton 2013/15 (per 1000 live births)	England 2013/15 (per 1000 live births)
5.6	3.9

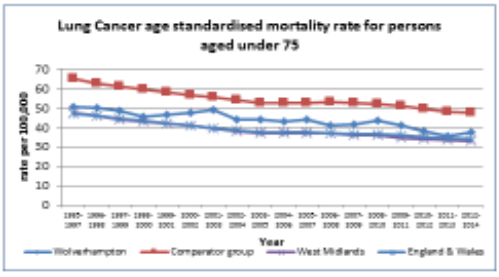
2.3 (per 1000 live births) 2001/03 → 2013/15

Infant mortality in Wolverhampton is 10th highest compared to other local authorities and is significantly higher compared to England.



Mortality rates in Under 75s from Lung Cancer

Premature mortality from lung cancer is an important public health concern in Wolverhampton



Premature mortality from Lung Cancer in Wolverhampton is improving

Wolverhampton 2012/14 (DSR per 100,000)	England 2012/14 (DSR per 100,000)
37.2	33.8

Wolverhampton (DSR per 100,000) 13.7 1995/97 → 2012/14

Wolverhampton (DSR per 100,000) 1.7 2011/13 → 2012/14

Premature mortality rate for lung cancer in 2010-14 is worst in most deprived areas of Wolverhampton

49.3 DSR per 100,000	16.9 DSR per 100,000
Most Deprived	Least Deprived

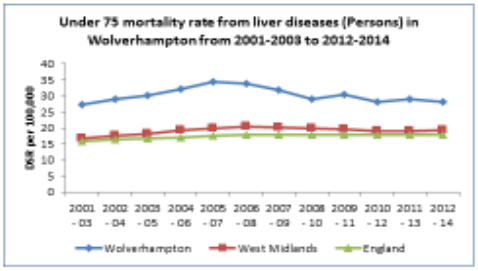
2010-2014

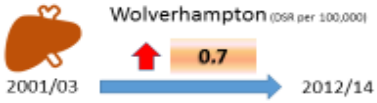
Mortality rates in Under 75s from Liver diseases

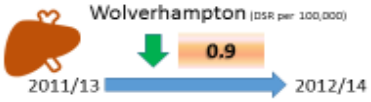
Premature mortality i.e. deaths occurring before a person reaches the age of 75 is a major public health concern. Liver diseases is one of the leading causes of premature mortality.

Premature mortality from Liver diseases in Wolverhampton is getting slightly worse compared to 2001/03

Wolverhampton 2012/14 (DSR per 100,000)	England 2012/14 (DSR per 100,000)
28	17.8





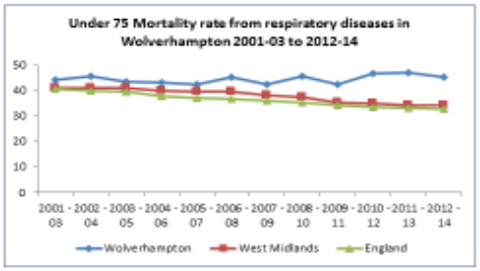


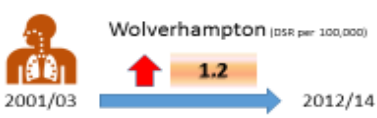
Mortality rates in Under 75s from Respiratory Diseases

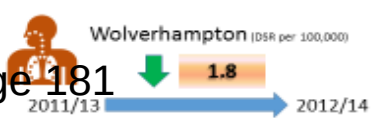
Respiratory disease is one of the top causes of death in England in under 75s and smoking is the major cause of chronic obstructive pulmonary disease (COPD), one of the major respiratory diseases

Premature mortality from respiratory disease in Wolverhampton has worsened since 2001-03 with peaks and troughs throughout

Wolverhampton 2012/14 (DSR per 100,000)	England 2012/14 (DSR per 100,000)
45.3	32.6







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