# Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Introduction</td>
<td>5</td>
</tr>
<tr>
<td>2 Context</td>
<td>6</td>
</tr>
<tr>
<td>3 Overview of System Plan</td>
<td>12</td>
</tr>
<tr>
<td>4 System Plan: our shared goals</td>
<td>20</td>
</tr>
<tr>
<td>5 Assuring safety and quality</td>
<td>24</td>
</tr>
<tr>
<td>6 Clinical leadership</td>
<td>25</td>
</tr>
<tr>
<td>7 Engaging providers, partners and the public</td>
<td>26</td>
</tr>
<tr>
<td>8 Making it happen: case studies</td>
<td>29</td>
</tr>
<tr>
<td>9 Appendices</td>
<td>54</td>
</tr>
</tbody>
</table>
The evidence is clear - we require a radical shift in how we deliver care.

We need to secure the right initiatives which ensure better use of resources with greater emphasis on quality and reducing health inequalities.
Foreword

Commissioners, providers and partners across Solihull and Birmingham have set out a common mission to **Unite for a healthier Birmingham and Solihull.**

The system plan marks a significant commitment of the NHS and wider health and social care system to work together to innovate and personalise care for patients. We have committed to work together to manage the rising pressures associated with an ageing population, advancing health care and sustaining good access to care for all.

The cluster is a highly complex system with a number of emerging clinical commissioning groups at varying stages of development, multiple providers including strong Foundation Trusts and two Local Authorities, all facing significant financial challenges. Change of this scale can only be achieved through a collaborative approach between all partners across the health and social care system.

In recognising the challenges and complexities, it is more important than ever to drive through changes at a strategic level as well as single organisations accountable for health and health care. The plan sets out a framework for working together as a system to ensure we are clear on partnership roles and responsibilities and focused on our ambitious end goals. Maintaining momentum for delivery is crucial. It needs focus and pace.

As commissioners, we will lever changes through our providers who in turn will make the necessary efficiencies around running costs. As partners, we will work together to redesign the system of care in key areas such as care for those with ongoing health care needs in particular the frail elderly and those with dementia, as well as to design access to care in the right setting for urgent and planned care.

The evidence is clear - we require a radical shift in how we deliver care, with an absolute focus on those who are most vulnerable. Together we are prepared to pool resources and redesign care so we make the service work for patients.

‘There needs to be more services in the community with hospital being the last resort if a person is too ill, or not safe, to remain at home. Hospital stays should be for the shortest time possible to secure good quality outcomes.’

**Jenni Ord, Cluster Chair**
1. Introduction

Commissioners and providers have agreed to work together to deliver improvements in the delivery of health and healthcare over the next five years.

The system plan steers a way forward for implementation in a changing health and care system, giving direction and leadership and encouraging true partnership and co-operation.

It identifies short term measures needed for financial balance across the health economy and commits towards longer term changes required to transform health care. The cluster will work closely with providers, emerging Clinical Commissioning Groups and local authorities around key challenges facing the NHS.

The plan brings together visions and plans across the cluster set out in the Five Year Strategic Plan 2009–2014 aimed at improving the health and well-being of their local population.

These plans set out strategic goals which were developed using a range of information including Joint Strategic Need Assessments (JSNAs) and views of the public, partners, clinicians and staff via stakeholder engagement. Analysis of these plans has been used to inform the three goals, priority initiatives and outcomes of the Cluster System Plan.

Partners across the cluster have signed up to a set of agreed principles to help strengthen and develop this work across the Birmingham and Solihull health economy. Working in partnership as part of a “one public sector” philosophy is a key factor in ensuring better use of our resources to address the broader determinants of health and tackle deep seated inequalities.

Commissioners, providers and partners will drive forward and effectively manage delivery, transition and transformation.
2. Context

Scale of the challenge - financial

The financial landscape across the health and local government sectors presents a significant challenge to many stakeholder organisations over the coming years. The NHS has largely been protected from budget cuts with a settlement that provides for an annual inflation uplift on existing budgets for the next three years; in the current climate, this is a comparatively good settlement.

However, we know that there are a number of factors that make this financial situation very challenging including:

- Rising demand from an ageing population
- Rising demands from increased ‘lifestyle’ diseases
- Increasing technological capability expanding the number of interventions but the actual cost of NHS inflation (driven by technological advances) running ahead of general inflation on which funding is based.
- Challenges to local government and other public sector partners resulting from real budget cuts

Assuming demand, activity and costs in the NHS increases in line with recent trends, it will be necessary to achieve productivity gains to ensure that spend remains within the available funding. This is shown in the graph below.

Assuming demand, activity and costs on the NHS increases in line with recent trends, it will be necessary to achieve productivity gains to ensure expenditure remains within the available funding. This is shown in the table below.

Birmingham and Solihull Cluster: Demand and funding by year

For the NHS the productivity target has been estimated at £15-20 billion by 2014/15. Based on local analysis and modelling, the estimate for Birmingham and Solihull NHS Cluster is a gap of around £539m over a five year period.

Forecast demand and funding gap for Birmingham and Solihull

<table>
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<th>Funding £m</th>
<th>Years</th>
<th>2010/11-2014/15</th>
</tr>
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<tr>
<td>£539m Total five year productivity gains</td>
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Funding

Productivity gap to meet demand
Cost of service without improved productivity
Key facts:

- Commissioners must deliver £69m productivity gain in 2011/12 to remain in financial balance.
- Provider efficiencies are based on our estimate of the impact of national price (tariff) framework changes.
- Commissioner productivity gain is based on changes in the way care is delivered, based on best practice i.e. care pathway changes.
- Commissioner budget of £2.3bn per annum; this equates to commissioners reducing costs by 10% over the next four years.
- £76m productivity gain already delivered to date.

**Estimate of Local Health Economy QIPP requirement 2010/11 to 2014/15**

(QIPP: Quality, Innovation, Productivity and Prevention)

<table>
<thead>
<tr>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
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<td>£34m</td>
<td>£69m</td>
<td>£66m</td>
<td>£51m</td>
<td>£15m</td>
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**Commissioner QIPP productivity target**

**Provider QIPP productivity target (provider efficiencies within tariff)**

Delivered

PCTs to cease and CCGs to start

- Total five year commissioner QIPP productivity target: £235m
- Total five year provider QIPP productivity target: £304m
- Total five year productivity gains: £304m
- Total five year commissioner QIPP productivity target: £462m to be delivered
- Total five year provider QIPP productivity target: £539m
Scale of the challenge - population and health outcomes

The Birmingham and Solihull NHS Cluster covers a wide and diverse population:

Birmingham

- Birmingham has a relatively young population compared to other cities in England, with a larger proportion of children and young people, and a smaller proportion of people in older age groups. However, Birmingham’s population is far from stable and the rate of growth for various age groups varies widely.
- Population characteristics across Birmingham vary: city centre areas have the highest growth and the youngest population while the south of the city has a sizeable 20-24 years population, due to the dominant student population, and a rising over 65s population.
- Ethnicity and the associated cultural and religious differences is a big factor in Birmingham, the most ethnically diverse city in the United Kingdom. 62.2% of Birmingham’s population is White British, but the White British share varies widely with age.
- Ethnic minority groups are very unevenly distributed within Birmingham. The heart of the city has the majority of the ‘non-white’ ethnic groups. Over half of the non-white population (51%) live in these areas, with only 18% in south Birmingham.
- Birmingham as a whole is the 10th most deprived Local Authority in England.

Solihull

- The Solihull population is relatively stable with the older population, 45 years + set to increase with the greatest increase in the 65+ population.
- Solihull is less ethnically diverse than Birmingham with over 90% of the population being white.
- As a whole Solihull is a relatively affluent borough, however wards in the north of Solihull are amongst the most deprived 10% in the country.

“**The biggest health challenge will be closing the inequalities gap in Solihull between deprived and more affluent communities. Overall we need to bring the NHS into the 21st century – a service that focuses on what the public want balanced against what clinicians believe they need.”** Dr Anand Chitnis

Birmingham and Solihull have to meet some important health challenges:

- Life expectancy in Birmingham is lower than regional and national average. There is variation across Birmingham wards of up to 10 years.
- Life expectancy in Solihull is higher than the national average, however the gap ranges by up to nearly 10 years between the best and the worst wards.
- Perinatal and infant mortality rates in Birmingham are amongst the highest in England, and are significantly above the national average.
- Teenage pregnancy remains high in Birmingham.
- Tackling the causes of premature death which are dominated by ‘diseases of lifestyle’, where smoking, unhealthy diet, excess alcohol consumption and sedentary lifestyles are contributory factors.
- Growing number of people with major complex and long-term health care needs.
- Growing elderly population living with dementia.
1. Birmingham Children's Hospital NHS Foundation Trust (A&E)
2. Heartlands Hospital (A&E) (Heart of England NHS Foundation Trust)
3. Queen Elizabeth Hospital Birmingham (A&E) (University Hospital Birmingham NHS Foundation Trust)
4. City Hospital (A&E) (Sandwell and West Birmingham Hospitals NHS Trust)
5. Good Hope Hospital (A&E) (Heart of England NHS Foundation Trust)
6. Solihull Hospital (A&E) (Heart of England NHS Foundation Trust)
7. Birmingham Dental Hospital (Birmingham Community Healthcare NHS Trust)
8. Moseley Hall Hospital (Birmingham Community Healthcare NHS Trust)
9. Birmingham Women's NHS Foundation Trust
10. Selly Oak Hospital (University Hospital Birmingham NHS Foundation Trust)
11. Royal Orthopaedic Hospital NHS Foundation Trust
12. West Heath Hospital (Birmingham Community Healthcare NHS Trust)
Scale of the challenge - Changing care

We need to change the way care is provided:

- There remains variations in quality of care and health and the use of health services
- In many instances improving quality can also reduce costs (for example, reducing rates of infection)
- The NHS is currently better at responding to ill health than preventing it
- With the assistance of new technologies, it is now possible to provide care at home or in the community; care previously only possible in hospital
- There are still many examples where the NHS is not maximising productivity in how it works (e.g. duplication of treatment or diagnostic processes) or how it buys things (procurement)
- Opportunities for health and social care to work together to streamline care are not being maximised
- Some of what the NHS provides to patients is of low clinical benefit and it is not appropriate that these activities crowd out others that offer greater clinical benefit

The financial, population and service challenges can be delivered through Quality, Innovation, Productivity and Prevention (QIPP).

Assessment of the QIPP challenge suggests that opportunities for improvement and the value associated with them can more than bridge the potential financial gap. However they require an enormous effort to manage substantial change simultaneously across several different fronts.

The same assessment suggests that as much as 75% of opportunities can only be achieved if all organisations in a local health and care system work together.

Options for change

There are only 3 actions available for commissioners:

- Reduce input costs
- Service redesign
- Same activity for less (price)
- Same demand for less (service change)
- Reduce demand (make people healthier)

Our key partners also face significant financial challenges:

- Birmingham City Council (BCC) must make savings of £138.5m in 2011/12; £975m over the next four years
- BCC savings will come from areas of non ring-fenced funding, including Adults and Communities and Children and Young People
- BCC Adults and Community to save £51m in 2011/12, £358 over the next four years
- Solihull Metropolitan Borough Council to deliver significant savings including £15.2m in 2011/12
Delivering together to address the challenges

The Birmingham and Solihull health and social care system is complex and consists of four PCTs across Birmingham and Solihull, two Local Authorities with some of the most deprived areas in England, multiple providers including NHS Foundation Trusts and emerging CCGs.

Through cluster arrangement, PCTs want to create a strong and positive platform for future commissioners, so they can build on financial balance and the right approach to improving services for patients. The Birmingham and Solihull NHS Cluster single executive team will have responsibility for helping to deliver objectives agreed across four key themes of delivery, transition, transformation and engagement and leadership (see Appendix 1). The Cluster System Plan will be a key document for the cluster executive team to work with partners in uniting for a healthier Birmingham and Solihull.

Delivering together - lessons learnt:

- **Integrated planning** - service and pathway development requires integrated planning across organisations particularly between primary and secondary care and local authority
- **Effective communication** - improving dialogue and processes with divisional and business managers in secondary care is necessary to ensure that clinical decisions for redesigning services, agreed in both primary and secondary care, proceed effectively to the contractual agreement
- **Sharing and learning** - sharing good practice and recognising that transformational change takes time and is highly dependent on successful relationships with partners
- **Clinical leadership** - clinically led changes are more successful than those that are managerially-led; this is very evident in areas of transformation

Delivering together to address the challenges
3. Overview of the System Plan

The Cluster System Plan is the key strategic document for the Birmingham and Solihull NHS Cluster and emerging clinical commissioners to ensure responsibilities are met and robust assurance processes are in place for delivery next year and in future years.

The plan:
- Sets out how we will manage the healthcare reform agenda whilst delivering balanced financial and performance figures and improving quality
- Gives direction and leadership to delivering improvements across the local NHS
- Informs our annual plan for the cluster
- Identifies the need for contractual and transformational accountabilities and responsibilities
- Encourages partnership and co-operation

The shape of the plan

The future care delivery system will provide high quality, safe services which are accessible for all and provided by well-trained, motivated staff in modern settings.

The focus will be on reducing hospital admission by integrating services. Two distinct forces will define the shape of the system:

- Greater provision of generalist services within communities or on a day-patient/out-patient basis. These will include primary care services, chronic disease management, social services maintaining and enhancing independence, and much of the surgery currently provided on an inpatient basis
- Greater specialisation, particularly within acute hospital services; this will promote the quality of services by ensuring that professionals deal with a ‘critical mass’ of similar cases to achieve sufficient expertise. New specialised medical technologies and techniques will keep more people alive who would otherwise die through illness or trauma

Strategy on a page

‘The strategy on a page’ (page 13) states the cluster mission as “Uniting for a healthier Birmingham and Solihull to get the best in care and quality of life”.

It captures the vision to maximise healthcare resources, improve patient experience and quality of life and to tackle health inequalities. This will be achieved through successful delivery of our strategic initiatives.

The strategy on a page summarises the broad approach agreed by providers and clinical commissioners in March 2011.

This emphasises by goal the importance of both a single agency and partnership approach to tackling health challenges and improving cost efficiency and quality of care. Some strategic initiatives are best driven directly by providers such as productive care whereas others such as stroke care are better delivered as pathway transformation between providers. Those requiring a greater degree of partnership, inter-dependency, payment barriers and risk will be led on a whole system basis coordinated by the cluster to begin with as responsibilities transfer to CCGs.
Uniting for a healthier Birmingham & Solihull to get the best in care and quality of life

**Cluster Vision**

- Better use of NHS resources
  - Reducing commissioner running costs
  - Strategic prioritisation
  - Improving provider efficiency
- Patient experience and quality of life
  - Redesigning care in key areas
- Tackling deep seated inequalities
  - Close the gap in life expectancy by 10%

**Goal 1**

Service development
- Planned care
- Medicines management
- Business efficiencies

**Goal 2**

Pathway transformation
- Maternity and children
- Mental health
- Urgent care and end of life

**Goal 3**

Healthier living and independence
- Ageing well, including dementia
- Alcohol and tobacco
- Continuing healthcare
- Long-term conditions

**Strategic initiatives**

- Planned care
- Medicines management
- Business efficiencies
- Maternity and children
- Mental health
- Urgent care and end of life
- Ageing well, including dementia
- Alcohol and tobacco
- Continuing healthcare
- Long-term conditions

**Enablers**

- Collaborative leadership
- Clinical and public engagement
- Outcome focus: NHS Framework

**Workforce**

- Infrastructure
- Service need reduction
- Service development
- Productive care
- Prioritisation
- Contracting efficiency
Principles – the Concordat

In strengthening and developing work across the health economy, organisations across the Cluster have signed up to a concordat of agreed principles:

- Decision-making will be clinically-led
- Maximise benefit for public expenditure
- Patient focus, not organisational boundaries
- Reduce the patient ‘footprint’ with services with the same or better outcome
- Keep services safe for patients
- Health economy responsibility and risk sharing

All commissioners and providers are working to improve patient experience and service quality through models of care based on choice and shared decision making.

“Making savings will be most effective if clinical teams across organisational boundaries look at different ways of working, fewer steps in care, disinvestment in care delivery that provides limited value, less duplication and improved communication”

Dr Peter Thebridge

Key owners of the Cluster System Plan

- **4 Birmingham and Solihull NHS PCTs** (NHS Birmingham East and North, Heart of Birmingham Teaching Primary Care Trust, NHS South Birmingham, Solihull Primary Care Trust)
- **Birmingham City Council**
- **Solihull Metropolitan Borough Council**
- **6 foundation trusts** (University Hospital Birmingham NHS Foundation Trust, Heart of England NHS Foundation Trust, Birmingham Women’s NHS Foundation Trust, Royal Orthopaedic Hospital NHS Foundation Trust, Birmingham and Solihull Mental Health NHS Foundation Trust, Birmingham Children’s Hospital NHS Foundation Trust)
- **3 NHS trusts** (Sandwell and West Birmingham Hospitals NHS Trust, Birmingham Community Healthcare NHS Trust, West Midlands Ambulance Service NHS Trust)
- **Emerging CCGs across Birmingham and Solihull:** Solihull Health, Forward Health Consortium, Birmingham Inner City Consortium, Equity Healthcare Consortium, Intelligent Commissioning Federation (IcoF), HealthWorks, Smartcare, MJM Sparkfield, Pioneers 4 Health, United Birmingham Consortia, Integrated Care Commissioning, South Birmingham Independent Commissioners. Clinical commissioners are beginning to federate around the three major acute providers.

Development of the system plan

The plan sets out direction of travel around how the different parts of the NHS will work together to deliver health and healthcare over the next five years.

The plan will continue to evolve in dialogue with clinicians, patients and wider stakeholders, and as future health policy and structures at a national level continue to be clarified.

We will need to balance the evolving partnership approach within the cluster with the need to use levers for change where appropriate. They may include:

- New services/pathways/locations/technologies
- New providers (such as NHS, voluntary, independent)
- New services from existing providers
- Multi providers delivering integrated services
- Decommissioning services where there is limited benefit

The strategic services and clinically lead review will begin this dialogue. We expect major changes in delivery to impact in 2012/13 onwards.
The overall approach to plan delivery

The local health system is based on different histories, cultures and goals that will have to be integrated and accommodated if effective action is to be taken. We have not yet reached the point of complete alignment of plans, but a series of actions have taken place to date that have led to the development of this plan:

- Agreement of Concordat principles
- Commissioning of whole system acute capacity review
- Aligning programmes of work
- Developing a shared QIPP programme across the cluster
- Sharing plans between commissioners and providers
- Developing a set of commissioning intentions for 2011/12 across the cluster

The biggest challenge will be to act, as a system, in the knowledge of what needs to be done and then make it happen.

A successful QIPP plan requires commissioners and referring clinicians to achieve reductions in the level and intensity of demand. It requires providers to be able to redesign services to deliver higher quality at lower cost, releasing a proportion of these savings back to the local system and, in many cases, reducing capacity to avoid “supply-induced demand”. Integration of services for patients and carers will only happen through concerted local action.

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Pyramid of care

The plan supports the ‘pyramid of care’. This model represents not only a tally of different kinds of healthcare events, but also stages in a patient’s journey e.g. a chronic condition dealt with largely by the patient with a minimal level of monitoring and supervision may flare up and require first of all primary care intervention, and then perhaps admission to hospital. In this sense the implied patient journey is a journey of escalation.

A key aim of the future care system is to minimise, as far as possible, the patient from progressing along this kind of journey - to prevent the escalation of the focus of care towards hospital. This is the aim of the various systems of chronic care management being developed around the cluster that help to keep people in their homes, maintaining independence and quality of life.

The model will ensure effective joint working between all those involved in delivering care - including patients, carers, primary, community and secondary care, ambulance trusts, social care and voluntary and community organisations - so patients experience a seamless journey through the health and social care systems.
Managing demand

The impact of successfully moving to this new model can be demonstrated by looking at the future modelled patterns of spend and activity, in particular the impact on the key acute areas:

- non-elective
- elective
- out-patient

The following activity charts represent the total activity projections for the four PCTs within the cluster from 2009-2014/15. On each chart the blue line shows activity with no QIPP schemes in place, the red line shows activity levels with QIPP schemes reflected in the contracts, which in general leads to a reduction in secondary care activity.

£235m
Total five year commissioner QIPP productivity target

Same demand for less (service change) Reduce demand (make people healthier)

£235m
Total five year commissioner QIPP productivity target

Assumed reduction in elective hospital care

Planned reduction in first outpatient appointments

Assumed reduction in non-elective hospital care

Planned reduction in number of follow-up outpatient appointments

Key:  
Without schemes  
With QIPP schemes

Leading to 6% reduction on expected in 2014/15

Leading to 11% reduction on expected in 2014/15

Leading to 6.9% reduction on expected in 2014/15

Leading to 18% reduction on expected in 2014/15
The charts below represent the changes expected in hospital and out of hospital activity at a cluster level over the period to 2014/15. Key points to note are:

- The increases in community and primary care provision as a result of reducing acute hospital based activities, in line with our transformational changes of providing the right care, at the right time, in the right place.
- The growth in community bed days represents increases in part of the cluster in 2011/12 to improve intermediate care provision. It is anticipated that total bed day usage will reduce but further modelling is needed as services are redesigned.
- The decrease in mental health activity reflects a significant shift from an acute/bed based service to a much greater emphasis on early intervention/primary care and prevention based service in line with user and carer preferences as well as greater efficiencies from the current service in line with best practice.
- The movement towards managing patients in primary care has the effect of increased prescribing and GP consultations.

These changes are planned within the QIPP strategic initiatives. This will be refined to reflect new service models as discussions with providers progress.
Changes in the provider landscape

Achievement of our goals is dependent on providers making changes which continue to improve patient experience, safety and efficiency of care in a very difficult financial climate. The challenge is immediate and the solutions will need to be owned across the health economy which will require collaborative leadership, across providers and commissioners, and support for major change to release major benefits.

The solutions lie in reducing hospital attendances and admissions and caring for people more appropriately outside of hospital.

Detailed modelling has been undertaken to ascertain the level of beds Birmingham and Solihull would need. This modelling is based on demographic changes and historical activity trends. It is based on a calculation of the level of beds commissioned, based on activity and assumed occupancy rates. It is not a physical bed count of capacity within providers.

However when hospital care is needed, the aim is to minimise length of stay in hospital whilst not undermining patient safety or quality of care. A focus on changes to systems and processes should help front line staff to spend more time on patient care thereby improve safety and efficiency enabling patient’s to recover more quickly and be safely discharged.

Healthcare is a complex process and the size of the challenge requires whole system change not individual service areas. Improvement programmes like ‘Productive Ward’, do have the potential to have a significant impact on cost and quality however they need to be implemented on a large scale and as quickly as possible. Partnership working is clearly required to release the maximum benefit from these work programmes, for example reducing the length of stay releases capacity in the system but also requires proactive planning of the whole process of care, as well as active discharge planning. This involves having a clear integrated pathway of care through acute, community and primary care settings for particular conditions which reflect patient needs.

System workforce: Healthcare providers employ staff with the skill mix appropriate to deliver a high quality service to patients in every circumstance. The challenges ahead require a workforce that is responsive to meet patient needs and the changing service models, with a blend of skills which repeatedly change to satisfy the evolving healthcare needs of local communities. Workforce planning needs to ensure there is a security of supply, having people with the right skills in the right place at the right time.

The talents and contribution of all members of staff needs to be recognised as the potential benefits will only be secured if there is purposeful leadership across organisations at all levels with a focus on continuous improvement.
If ‘best practice’ was applied, the following results could be delivered across the cluster over five years:

- Outpatient attendances could be reduced by more than 300,000 (17%) by 2014/15
- Nearly 11,000 emergency admissions could be avoided
- Up to 10,000 procedures are of limited clinical benefit
- Equivalent of 429 hospital beds could be provided by alternative, community based services

Provider organisations across the cluster have been working on change programmes via:

**Workforce redesign**: Skill mix reviews, management cost savings and reductions in sickness rates

**Reduced length of stay in hospital**: Reducing variation in patterns of patient discharge and controlling the discharge process.

**Care pathway redesign**: Including cardiology, diabetes care and infectious diseases

**Review of support services and estates**: Reviews of clinical support services, back office efficiencies and more effective use of e-procurement

**Productive wards**: Including theatre utilisation, productive ward programmes and management of bank and agency staff for managing staffing peaks
4. The System Plan: our shared goals

The System Plan involves a wide range of change initiatives on commissioner and provider sides, most of which interact. This section of the plan summarises those initiatives and their intended consequences.

In devising our strategic initiatives we have developed projects which have high impact, both in the short and long term. We have chosen QIPP projects where we know there are big opportunities to improve outcomes, quality and patient experience while reducing cost. We know that large scale changes to delivery are required. We will begin this dialogue through the Strategic Service Review.

Over 40% of savings assumed in the QIPP plan are attributable to service redesign, 30% to rationing and prioritisation and the remaining 30% split across service need reduction and running cost reduction. This recognises that we will only achieve delivery through doing things differently, by using evidence of clinical effectiveness to drive commissioning decisions, and not by relying solely on price efficiency and cost reduction programmes.
## Planned care
- Redesigning hospital care; outpatient, day care and in-patient services. For example;
  - referral and access
  - nurse-led clinics
  - direct access diagnostics
  - procedures of lower clinical value
  - telephone and online support

## Medicines management
- Improving cost, quality and management of medicines for patients. For example;
  - medicine safety advice
  - medicines waste schemes
  - standardising prescribing
  - procurement efficiencies

## Business efficiencies
- Reducing our day to day running and management costs. For example;
  - prioritising and decommissioning
  - rationalising the estate
  - streamlining business systems
  - strengthening clinical leadership

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- Improving cost, quality and management of medicines for patients. For example;
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## Business efficiencies
- Reducing our day to day running and management costs. For example;
  - prioritising and decommissioning
  - rationalising the estate
  - streamlining business systems
  - strengthening clinical leadership

## Maternity and children
- Delivering easier access to high quality maternity services, choice and personalised care;
- Planning and monitoring capacity and access increasing access to community midwifery
- Support children and young people to be safe, healthy and adopt positive lifestyles;
- Early prevention and escalation of difficulties
- Reducing waiting times for access to childrens mental health support

## Mental health
- Integrating services for people with mental health needs across NHS and social care.
  For example;
  - partnership agreements across frontline and specialist providers
  - more community psychological support

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## Urgent care
- Ensuring A and E is for emergencies only and people receive urgent treatment in a choice of locations.
  For example;
  - prompt and appropriate referrals for urgent care
  - promoting access to local services for minor ailments
  - pricing efficiency

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- Ensuring A and E is for emergencies only and people receive urgent treatment in a choice of locations.
  For example;
  - prompt and appropriate referrals for urgent care
  - promoting access to local services for minor ailments
  - pricing efficiency

## Alcohol and tobacco
- Reduce smoking and impact on the rates of alcohol specific and alcohol related hospital admissions.
  For example;
  - increasing brief interventions in secondary care
  - increasing service efficiency
  - primary care identification and management

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  For example;
  - increasing brief interventions in secondary care
  - increasing service efficiency
  - primary care identification and management

## Continuing healthcare
- Improving quality and resource allocation for support packages to people meeting continuing health care criteria.
  For example;
  - whole system approach to assessment and access
  - procurement efficiencies
  - regular review of care packages

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  For example;
  - whole system approach to assessment and access
  - procurement efficiencies
  - regular review of care packages

## Long-term conditions
- Adopting systematic and personalised care pathways to maintain health and independence.
  For example;
  - virtual clinics and wards
  - integrated community teams
  - lifestyle and telecare services
  - pathways for key conditions

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### Strategic initiatives

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<th>Initiative</th>
<th>Goal</th>
<th>Funding</th>
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<tr>
<td>Planned care</td>
<td>Redesigning hospital care; outpatient, day care and in-patient services. For example; referral and access, nurse-led clinics, direct access diagnostics, procedures of lower clinical value, telephone and online support</td>
<td>£37m</td>
</tr>
<tr>
<td>Medicines management</td>
<td>Improving cost, quality and management of medicines for patients. For example; medicine safety advice, medicines waste schemes, standardising prescribing, procurement efficiencies</td>
<td>£14m</td>
</tr>
<tr>
<td>Business efficiencies</td>
<td>Reducing our day to day running and management costs. For example; prioritising and decommissioning, rationalising the estate, streamlining business systems, strengthening clinical leadership</td>
<td>£82m</td>
</tr>
<tr>
<td>Maternity and children</td>
<td>Delivering easier access to high quality maternity services, choice and personalised care; Planning and monitoring capacity and access increasing access to community midwifery Support children and young people to be safe, healthy and adopt positive lifestyles; Early prevention and escalation of difficulties Reducing waiting times for access to childrens mental health support</td>
<td>£3m</td>
</tr>
<tr>
<td>Mental health</td>
<td>Integrating services for people with mental health needs across NHS and social care. For example; partnership agreements across frontline and specialist providers more community psychological support</td>
<td>£17m</td>
</tr>
<tr>
<td>Urgent care</td>
<td>Ensuring A and E is for emergencies only and people receive urgent treatment in a choice of locations. For example; prompt and appropriate referrals for urgent care promoting access to local services for minor ailments pricing efficiency</td>
<td>£34m</td>
</tr>
<tr>
<td>End of life care</td>
<td>Improving end of life services and support to enable at least 80% of people to die in their place of choice. For example; people supported to die at home access to support services reducing unnecessary hospital admissions in the last year of life</td>
<td>£3m</td>
</tr>
<tr>
<td>Alcohol and tobacco</td>
<td>Reduce smoking and impact on the rates of alcohol specific and alcohol related hospital admissions. For example; increasing brief interventions in secondary care increasing service efficiency primary care identification and management</td>
<td>£8m</td>
</tr>
<tr>
<td>Continuing healthcare</td>
<td>Improving quality and resource allocation for support packages to people meeting continuing health care criteria. For example; whole system approach to assessment and access procurement efficiencies regular review of care packages</td>
<td>£21m</td>
</tr>
<tr>
<td>Long-term conditions</td>
<td>Adopting systematic and personalised care pathways to maintain health and independence. For example; virtual clinics and wards integrated community teams lifestyle and telecare services pathways for key conditions</td>
<td>£14m</td>
</tr>
</tbody>
</table>
Revised Commissioning QIPP targets
£’000s

<table>
<thead>
<tr>
<th>Strategic initiative</th>
<th>2010/11</th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/15</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned care</td>
<td>3,893</td>
<td>13,566</td>
<td>9,868</td>
<td>9,773</td>
<td>-</td>
<td>37,100</td>
</tr>
<tr>
<td>Medicines management</td>
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<td>2,103</td>
<td>3,864</td>
<td>3,631</td>
<td>2,051</td>
<td>14,215</td>
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<td>Business efficiencies</td>
<td>18,119</td>
<td>37,167</td>
<td>13,281</td>
<td>10,029</td>
<td>2,922</td>
<td>81,518</td>
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<td>Maternity and children</td>
<td>0</td>
<td>0</td>
<td>1,003</td>
<td>996</td>
<td>1,001</td>
<td>3,000</td>
</tr>
<tr>
<td>Mental health</td>
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<td>4,379</td>
<td>5,020</td>
<td>5,040</td>
<td>1,003</td>
<td>17,442</td>
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<td>Urgent care and end of life</td>
<td>3,052</td>
<td>4,669</td>
<td>16,311</td>
<td>10,103</td>
<td>-</td>
<td>34,135</td>
</tr>
<tr>
<td>Ageing well</td>
<td>0</td>
<td>0</td>
<td>2,997</td>
<td>2,003</td>
<td>-</td>
<td>5,000</td>
</tr>
<tr>
<td>Alcohol and tobacco</td>
<td>628</td>
<td>989</td>
<td>1,924</td>
<td>1,924</td>
<td>2,000</td>
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<tr>
<td>Continuing healthcare</td>
<td>572</td>
<td>4,061</td>
<td>6,497</td>
<td>5,168</td>
<td>5,072</td>
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<tr>
<td>Long term conditions</td>
<td>3,707</td>
<td>2,191</td>
<td>5,153</td>
<td>2,339</td>
<td>754</td>
<td>14,144</td>
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<tr>
<td>Total</td>
<td>34,537</td>
<td>69,125</td>
<td>65,918</td>
<td>51,007</td>
<td>14,802</td>
<td>235,389</td>
</tr>
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</table>

**QIPP within the overall Cluster budget position**

- £2.3bn per annum

**Percentage breakdown of Commissioning QIPP themes**

<table>
<thead>
<tr>
<th>Key</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Cluster budget</td>
<td>£2.3bn</td>
</tr>
<tr>
<td>Commissioner QIPP productivity target over 5 years</td>
<td>£235m</td>
</tr>
<tr>
<td>Planned care</td>
<td>15.8%</td>
</tr>
<tr>
<td>Medicines management</td>
<td>6.0%</td>
</tr>
<tr>
<td>Business efficiencies *</td>
<td>34.6%</td>
</tr>
<tr>
<td>(* running costs, disinvestments and other)</td>
<td></td>
</tr>
<tr>
<td>Maternity and children</td>
<td>1.3%</td>
</tr>
<tr>
<td>Urgent care and end of life</td>
<td>14.5%</td>
</tr>
<tr>
<td>Mental health *</td>
<td>7.4%</td>
</tr>
<tr>
<td>(* Dementia financially aligns to mental health)</td>
<td></td>
</tr>
<tr>
<td>Ageing well</td>
<td>2.1%</td>
</tr>
<tr>
<td>Alcohol and tobacco</td>
<td>3.2%</td>
</tr>
<tr>
<td>Continuing healthcare</td>
<td>9.1%</td>
</tr>
<tr>
<td>Long term conditions</td>
<td>6.0%</td>
</tr>
</tbody>
</table>

**Commissioner QIPP productivity target over 5 years £235m**

**Key**

- Planned care 15.8%
- Medicines management 6.0%
- Business efficiencies * 34.6%
- (* running costs, disinvestments and other)
- Maternity and children 1.3%
- Urgent care and end of life 14.5%
- Mental health * 7.4%
- (* Dementia financially aligns to mental health)
- Ageing well 2.1%
- Alcohol and tobacco 3.2%
- Continuing healthcare 9.1%
- Long term conditions 6.0%
We need to prioritise our resources for innovation and service improvement. This includes stopping services that are not effective.
5. Assuring safety and quality through change

This is a period of unprecedented change therefore risks around quality, safety and transition need to be managed effectively at a number of different levels. Efficient systems and process, values and behaviours are required to ensure early detection and prevention of serious failures.

Our local system will ensure:

- The whole system – from individual clinician to whole organisations – fosters a culture of openness, transparency and co-operation which embraces learning
- Close listening to patient and public concerns to help organisations identify potential risks before they become serious failures
- Regulation and performance management of healthcare organisations including the NHS Performance Framework, Monitor’s Compliance Framework for the NHS Foundation Trusts and the contract management function
- Staff are supported during this time of significant change

We will ensure quality is monitored as an integrated system which requires co-operation and understanding from both commissioners and providers.

Programme management is a vital component of delivering change. A cluster Programme Management Office (PMO) has been established alongside the adoption of an effective programme approach. The strategic themes and portfolio of planned changes described with the system plan will be delivered by the contribution of programmes and projects for which the PMO will monitor and assure delivery.

It will be important to strike a balance between the need for system management against the independence of individual organisations. Commissioners, providers and regulators will work together to ensure that the initiatives and actions of one organisation do not have unintended adverse consequences on another.
6. Clinical leadership

Clinical Leadership and Engagement

Clinical expertise is a key component of a trusted healthcare system. GPs and other professionals are working together to form Clinical Commissioning Groups (CCGs) by 2013.

Since the announcement of the NHS changes in summer 2010, groups of GPs across the country have been in discussions with clinical colleagues about the formation of CCGs. In summer 2011, the Department of Health announced the process for authorising CCGs. Termed the Authorisation Framework, this process supports CCGs to develop sufficiently so that they can take on their commissioning and statutory duties.

Phase 1 of the framework risk assessed CCGs by their form and footprint assuring that they have a defined and appropriate geographic coverage, are a credible size to effectively operate and have a fully signed up practice membership. The number of CCGs has reduced from 12 to five as part of this discussion and assessment process in differing ways. The new formation includes federated models as well as mergers to form new organisations that will be in development as new boards are formed.

There is an established Clinical Network across Birmingham and Solihull to ensure strong clinical leadership in the transfer of commissioning responsibilities. The focus of this group is on supporting delivery of the plans to support high level system challenges such as urgent care. It is critical that the cluster clinical network continues to be driven and owned by clinicians.

There needs to be clinical involvement and leadership at a number of levels. Locally through emerging CCGs, and system wide both in terms of provision and population.

Success through clinical commissioners

Dr Andrew Coward: “Our priority is to eliminate waste and promote cost effectiveness in our practices, in order to redirect resources.”

Dr Peter Patel: “The challenges can only be delivered by GPs and their CCGs through active engagement of all GP practices and good leadership which includes clinical and management leaders working together with high quality of resources.”

Dr Nick Harding “Excited about the challenge ahead. We have a unique opportunity to get best healthcare for our population. We want to work with our communities to give them the best health possible with the current resources available.”
7. Engaging providers, partners and the public

Together we have involved the public, clinicians, staff, partners and stakeholders in developing the local Strategic Plans as well as in building the System Plan. Continued engagement at all levels is crucial to creating ownership of the challenges ahead and making the changes in the right way.

This is above all about making best use of public resources to improve health and wellbeing and to ensure good care when and where it is needed.

To achieve common understanding about why there is a need for change and to mobilise improvements there is a process of listening, informing and involving that is actively managed and debated by those designing, developing, delivering and receiving NHS services.

There are dynamic tensions around the best solutions but there is a clear agreement that we need to change and make efficiencies whilst ensuring quality and good outcomes are at the heart of the changes we make.

Making this plan work requires a new level of open and clear communication as well as comprehensive plans to inform and consult all those affected by change. We will be open and transparent about what needs to change and engage all stakeholders.

Engaging our local communities

Engaging communities is key. People and patients want to know about the plans for local health services and how it affects them. Public services have a duty to involve and consult and have a commitment to “nothing about me without me”.

It goes further than that as we need to engage people to use services in the best way without waste - including non attendance for appointments as well as avoiding A&E for minor attendances. We also need to encourage and promote a healthy lifestyle.

We are accountable to the public and elected members through the shadow Health and Wellbeing Board and the emergent Healthwatch. As structures emerge we will ensure there is regular update and dialogue on plans.

Local people and communities can be involved at every level and we are in dialogue to look at the best ways to achieve this across the Birmingham and Solihull area, building on the experience of our providers, partners and from the PCTs. We are also looking to innovate through emerging clinical commissioners who understand the value and importance of good engagement with their communities.

There are many public and community groups taking an active interest in the NHS locally and they are getting involved in the debate. Individuals and groups
have already expressed more interest in getting involved in the prioritisation process, in planning and re-designing services and in checking quality of provision. Information and support for public engagement is key for clinical commissioners.

An ongoing communications and engagement plan ensures regular dialogue as well as special meetings to focus on key areas of system challenges. We have traditionally met with community groups, arranged special meetings, conducted regular surveys and used traditional media. We need to do more through social media to listen and to engage openly and transparently.

Engaging our Providers and Partners

NHS and partner organisations need to work together as one around the system changes in order to ensure they work for patients. We need to collaborate at every level. There is a great opportunity for working together around specific health and social care needs.

It is vital the intentions and plans are understood. Not just in terms of what needs to change but also why it needs to change. We need to focus on the end goal for improving health for people in Birmingham and Solihull to ensure changes are made in the right way.

At a strategic level we will engage providers through a System Wide QIPP Chief Executive Forum as well as at a local level through the Clinical Contracting Groups. The Cluster Board will operate to engage stakeholders with regular updates on progress and a call to action around the specific work programmes.

We are meeting regularly with the Voluntary Sector groups and the Health and Well Being Board will play a key role in ensuring effective engagement of Local Authorities and NHS organisations around the health priorities.

Health and other professionals need to have an understanding of the changes. Through emerging Clinical Commissioners there are plans to strengthen engagement of primary care. Hospitals are working with us to build engagement around these plans in a way that is meaningful for them. More campaign style approaches using social marketing techniques to encourage behaviour change to promote quality and efficiency are key. We will trial this approach in specific areas such as urgent care.

Call to action

Improving patient care lies at the heart of all these changes. Successful implementation of the System Plan will help to:

- Improve patient experience with more evidence based, seamless and integrated care across different services
- Increase quality and safety in home care, community clinics and in hospitals
- Develop the workforce to ensure we have appropriately trained and skilled clinical staff
- Bring care closer to home with fewer visits to hospital
- Improve efficiency and generate less waste by ensuring healthcare services are sustainable and provide value for money
“There are some big changes coming up, nothing ever stays the same in the NHS! I do have some worries about how the cluster will work across such a wider area and with such a large, diverse population... will some cluster areas be more dominant than others, will some be the ‘poorer relation’? People still have a lot of questions around the transition between clusters and GP groups.’

“There’s opportunity to make some really positive changes and staff will be a key part of helping this to happen. There’s an opportunity to strengthen patient and public involvement, however I think it’s important that patients and local people recognise that we can’t change everything... there are some boundaries and limitations. It will be interesting to see how things develop with HealthWatch, but this will all be dependent on what funding each local authority gives.”

Patient representative.
8. Making it happen: case studies

If greater efficiencies are realised local NHS resources could be used to develop and deliver a wider range of innovative healthcare
Planned Care

Our challenge

Planned care relates to a full range of healthcare which can be planned in advance such as outpatient and elective care, regardless of where it is provided. Ensuring that the NHS has best outcomes and best value from planned care is a key priority for the NHS. There are improvements that can be made such as redesigning care pathways, developing new services and systems and negotiating contracts to guarantee the sustainability of this critical provision.

Many care pathways have not been developed around patient needs but instead around historic provider service models. This currently leads to a situation where patients are having their treatment within a hospital setting, when a high proportion could safely have their care in a setting closer to home. There are many examples of where this is starting to change at a local level but this needs to be replicated on a larger scale across Birmingham and Solihull.

Locally early evidence suggests high levels of patient satisfaction where care has been delivered in a local and convenient community setting, examples of this is that patients arrive on time and clinics run on time. Clinicians also see this model of care as a positive experience for similar reasons.

What needs to be done

This initiative is about ensuring that people’s care is planned appropriately - for example when they go to hospital it is for the right reasons. It’s about redesigning services to improve quality of care and the appropriateness of where people are treated.

*High quality care can be provided outside of hospitals. Depending on the patient’s condition, treatment can be provided by highly trained clinicians out in community settings.*

It’s about changing the way care should be delivered to enable skills and competencies in both primary and secondary care clinicians so that care can delivered more efficiently ensuring patients get the right treatment, in the right place, at the right time.

We need to work with local people and patients so that they understand these changes and manage any concerns and expectations.
Success

People will have a greater range of choice and location of provider regardless of where they live. If greater efficiencies are realised local NHS resources could be used to develop and deliver a wider range of innovative healthcare. Maximising the use of technology offers new opportunities. It offers information on hand in real time and can help provide alternatives to face to face appointments. Developments around digital technology will mean that patients can have access to things like x-rays at their local health centre, not just in hospital.

More choice around anti-coagulation care

We want to ensure that patients receiving anti-coagulation services are offered the best possible standard of care and choice. A one stop service has been developed in offering patients a choice of where they wish to receive their treatment; it has seen a 40% increase in patients monitored in community clinics. The service ensures safe discharges from hospital and patient satisfaction levels rated it and its greater choice as ‘excellent’.

Procedures of lower clinical value

The cluster continues to look at non-urgent treatments and procedures called Procedures of Lower Clinical Value (PLCV). The PLCV work stream focuses on equity and patient safety, considering the perceived benefits of some clinical procedures versus the potential risk of undergoing that procedure. The cluster has developed an initial set of 19 PLCV commissioning policies. The policies set out specific clinical criteria that must be met before any of these procedures can be undertaken and are consistent with national guidance including NICE. Developing these policies has involved open and challenging clinical dialogue between commissioners, primary care clinicians and secondary care clinicians. Over time, equity of the service provided is improving and since October 2010 activity changes have indicated potential cost savings of approximately £1m.

Community dermatology

A community based dermatology service has been established providing high quality, cost effective care closer to home. Outpatient activity has been transfer from secondary care to a community setting empowering patients and carers to manage their own skin conditions and promote disease prevention. A Nurse Practitioner will be offering ongoing education and assistance with procedures in a general practice that would otherwise have been referred to secondary care. A 30% reduction in the cost of new referrals, review attendances and minor procedures will achieve a potential saving of £290K.

What can you do? Your call to action

- **Primary care:** As future commissioners, you need to be involved in this key area particularly to identify priority areas that can be shared across Birmingham and Solihull. Work with secondary care to relocate specialities where appropriate to community and primary care services.

- **Secondary care:** Work collaboratively with commissioners, facilitate the provision of skills and expertise to community settings and help adapt the way they deliver care.

- **Staff:** Understand the change of flexible and different working patterns and locations.

- **Patients and public:** Understand that the way in which healthcare is provided is likely to change where it is clinically safe to do so. Be assured that services will be far more patient focused.
Medicines Management

Our challenge

Medicines management is about supporting patients and healthcare professionals make the best use of medicines.

With the right support, advice and empowerment, patients can manage their medicines to improve their health, maintain well being, minimise risk of harm and optimise best value for the NHS.

There are over 22 million prescription items (drugs and appliances) prescribed in primary care (mainly by GP practices) per year across the Birmingham and Solihull NHS Cluster. These relate to an NHS spend of around £212m in 2011/12.

National published evidence suggests that around half of medicines are not taken as intended, which means that the full benefit may not be achieved for individual patients and medicines may be wasted so there is opportunity to improve care for patients.

Medicines Management focuses on supporting prescribers with advice about updated clinical evidence, improving patient safety, optimising best value for the NHS and providing support services for patients to get help with their medicines. Management of medicines care between hospitals and GPs or other organisations requires a focus on the quality of information shared and delivery of a seamless journey for patients as care is passed from one clinician to another.

What needs to be done

Some of the areas being targeted to improve the quality of medicines management in the cluster include:

- Delivery of clinical pharmacist medication reviews with GPs for some of the most vulnerable patients, for example elderly patients in Care Homes.
- Implementing local formularies to ensure use of the most recent clinical evidence and cost effective approaches across both primary and hospital care.
- Clinical audit of areas where the quality of prescribing can be improved.
- Implementing national community pharmacy services to support patients’ get help with their medicines.

Success

to help them get the best from their medicines. Patients should feel supported with information and partnership in relation to medicines related decisions that are made.
The development of services such as advice from Community Pharmacies for patients prescribed new medicines will support these aims. In this service patients prescribed specific new medicines will receive advice from specially trained pharmacists to ensure that safety is optimised, that the patient has all the information they require and are able to take their medicines to get the most benefit.

The Medicines Management Team have implemented a cluster wide service to support urgent access to medicines to facilitate end of life care for people who choose to die in their own home. This service is available across Birmingham and Solihull through accredited Community Pharmacies and advertised to Community Palliative Care Teams, GPs and Community Nurses who may all be involved in palliative care.

The Medicines Management Team will support GPs with clinical medication reviews for over 700 patients in the next year. The reviews will deliver improved quality of care for these patients and minimise drug wastage. This service also supports care home staff with audit and advice to improve the quality of medicines related care.

Medication review in care homes

Elderly patients in care homes are often prescribed several medications for various medical conditions. Disease and age related changes in the body mean that older people are more vulnerable to medicines related side effects and harm from interactions between different medicines. As patients become more elderly, the use of medicines becomes more complicated and more frequent clinical reviews are required, drawing on a greater knowledge of different drugs available.

The Medicines Management Team provides services for GPs and Care Homes to support better medicines care for these most vulnerable patients. This involves joint working with care home staff, residents and families, GPs and other health professionals. Clinical pharmacists carry out medication review with the Homes and the prescribers and make recommendations for improvement. Over 90% of recommendations are implemented by GPs who value the advice of these specially trained pharmacists.

As an example, medication review of 811 residents implemented £188k NHS cost improvement with evidence that there was better evidence based care for individual patients and less drug wastage. In 2011/12, 700 clinical medication reviews will be undertaken across Birmingham and Solihull.

What can you do? Your call to action

- **Primary care:** Focus on your systems for medicines management, work together with patients to achieve better understanding around medicines management
- **Community pharmacies:** Deliver initiatives like Medicines Use Reviews effectively and efficiently. Provide advice and guidance to patients
- **Social care:** Support dietitians and care homes to improve dietary needs in care homes
- **Secondary care:** Align internal plans to complement wider cluster plans and objectives, aim to achieve better implementation
- **Patients and public:** Feel confident to ask questions and seek information and guidance and become active participants in your own use of medicines.
Business efficiencies

Our challenge

The NHS system reform means that the responsibility for commissioning of most NHS-funded services will go to new Clinical Commissioning Groups (CCGs). Although clinical (GP) commissioning has existed in various forms, it has never achieved universal coverage. CCGs will require support services to help them build the skills they need in commissioning.

Alongside the system changes, these are also uncertain economic times and NHS organisations are challenged with meeting demand but at the same time realising efficiency savings and delivering high quality care.

The challenge is delivering the commissioning support within a reduced amount of funding, whilst ensuring good value for tax payers money.

What needs to be done?

Business Efficiency is not just about making financial cuts. It is also about doing things smarter and looking at new ways of working and delivering services. In many cases efficiency and quality can be realised by taking an alternative approach driven by innovative ways of working.

Potential costs saving areas are around reducing waste and duplication, using Information Technology effectively, reducing the amount of administration, exploring flexible patterns of working. A motivated and enthusiastic workforce is key to delivery.

There will be areas of disinvestment. This will be based around maximising the use of public money to invest in areas of greatest value for money which deliver the biggest impact. This requires redistributing resources to the areas of greatest benefit.

Success

Success will be demonstrated by a streamlined and efficient business which delivers the most efficient use of funding providing the best value for money.

This will require staff understanding the vision for the future and being supported effectively in the transition to new working arrangement. Strong leadership is required to deliver the business efficiencies in an open and transparent manner.
What can you do? Your call to action

- **Primary care and clinical commissioning groups:** Partnership working is required to develop a shared understanding of what CCGs want, what they would like to provide themselves and what they may want from a Commissioning Support Unit.

- **Local Authority:** To engage in the smooth transition of Public Health functions

- **Staff:** To be supported and to be an active partner in helping to deliver business efficiencies, suggesting areas of improvement.

- **Patients and public:** For local people and patient groups to continue to be involved in the disinvestment decision making process.

These are uncertain economic times and NHS organisations are challenged with meeting demand but at the same time realising efficiency savings and delivering high quality care.
Our challenge

A healthy start in life is at the heart of a happy childhood and the ability of every young person to achieve their potential and grow up well prepared for the challenges of adolescence and adulthood.

Most children and young people are healthier than ever before but this is not the case for everyone. Infant mortality rates (children dying before one year old) in Birmingham are amongst the highest in England and are significantly above the national average.

Giving birth is an emotional and life-changing event, which a woman and her family will remember for life. Not all women have a positive experience of childbirth and some feel they are not able to exercise their right to choose the maternity service they want.

Some children do not have the same opportunities of others because of where they live, that the health and social care services they access are not always tailored to their needs. The journey from childhood to adulthood has many significant transition points. For young people with any form of disability, chronic disease or mental health problem, this is made more difficult. Young people can often fall through the gaps in service provision which has significant impact on their future outcomes.

What needs to be done

The health of the mother significantly impacts on the health of the child. It is vital that women have the support and care they need, both physically and mentally; this includes support and information on a range of lifestyle choices including giving up smoking, losing weight and making sure they have the vitamins they need.

Improving women’s experience of maternity services is important and requires providing high quality, safe and accessible services that are both women focused and family-centered. Community midwifery care has a vital role as it is provided for the majority of women during the antenatal and the postnatal periods. Early contact during antenatal period helps ensure more time for informed choices in planning care and ensures women can take advantage of all support and tests which can help reduce the risk of infant mortality. Increasing access to community midwifery and reviewing the size and the complexity of their caseloads will enable community midwifery to provide an equitable and effective service.

To improve outcomes it is important to join up children’s services and healthcare into an integrated service that is welcoming to all families, irrespective of their situation in life. Prevention and early intervention is a key component of the integrated services.
One of the most important developments for vulnerable families has been the piloting of the Family Nurse Partnership (FNP) programme. This is an evidence-based home-visiting programme conducted by specially trained nurses and targeted at some of the most vulnerable teenage mothers and their families. Increasing the numbers of FNP will be essential.

Services need to be redesigned with young people in mind to ensure a safe and effective transition for young people to appropriate adult provision services.

**Success**

Mothers and their families, including those from more disadvantaged backgrounds, will feel supported during pregnancy and childbirth by providing easy, equitable access to a choice of high quality, maternity services.

Children and young people will see improvements including more convenient health support and advice tailored to the needs and expectations of children, young people and parents, rather than those of service providers.

The importance of prevention, early intervention and health education will be reinforced, focusing on the needs of all young people and especially the most vulnerable, assessing health needs to ensure best use is made of skills and resource. Ensuring care pathways are right from the start is fundamental with a particular areas of focus will be Child and Adolescent Mental Health Services, services for young people with chronic illness such as expanding Hospital at Home services and developing work with primary and community care. New technologies will also be used for effective triage and capacity management systems.

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**New Birth Centre**

A midwife-led birth centre at Solihull Hospital has meant that women in the borough and surrounding areas have a greater choice in the kind of delivery they want.

It opened in 2010 and, following public consultation with women, their partners, families and stakeholders, is to be a permanent feature of maternity provision. Solihull Primary Care Trust and NHS Birmingham East and North worked together to engage with local people, clinicians and others to produce a maternity strategy that starts with pre-conception care right through to support for mothers and families when the baby is born.

The unit is on course for the projected first year delivery target of 300 births and early feedback suggests that women are happy with the service.

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**What can you do? Your call to action**

- **Primary care:** First port of call for most children and their families therefore providing effective holistic advice and guidance is essential. Collaboration is required to provide universal access to the essential package of interventions, addressing the needs of the vulnerable and marginalized.

- **Secondary care:** Provide the highest-quality care, grounded in evidence based medicine, share best practice, test new approaches, use the best tools possible and audit clinical practice.

- **Staff:** Identify areas where services could be improved and innovations made. Ensure that women and children are treated with respect and sensitivity when they receive health care. Act as a public health workforce providing key messages such as smoking in pregnancy making sure every contact counts.

- **Local authority:** Develop partnership working based on trust to integrate services where appropriate to improve outcomes and ensure resources are used effectively.
Mental health

Our challenge

There’s no health without mental health. Positive mental health and resilience is important in terms of physical health, relationships, education to name but a few aspects. One in four people in the UK will have a mental health problem at some point in their life and mental health problems can affect anyone. The Centre for Mental Health, estimated that the economic and social costs of mental health problems in England in the financial year 2009/10 was £105 billion. Improving the mental health and well-being of the population should be a key priority for the cluster.

However, mental health services can sometimes be complicated and confusing to navigate which can lead to people unnecessarily being admitted to hospital. Long stays in hospitals can make people less independent and reduce their quality of life. It is important that appropriate services are available to support and care for people and reduce the often debilitating impact of poor mental ill health.

What needs to be done

Talking to people who have accessed mental health services in the past, the clear message is that people do not want to stay in hospital, and if people do need to go into hospital, then they should be discharged safely as soon as possible. Avoiding hospital admissions requires effective joined-up community care and ensuring that hospital inpatient care itself is effective and that unnecessarily long stays are avoided. This requires resources to be refocused on services that promote positive mental health for all, reduce the negative impact of mental illness and focus on early identification and effective intervention.

There have not always been alternatives to hospitals and residential care, but now there are options with more services offering care and support out in communities. A change in the way current services are delivered is further required. Work still needs to be done around ensuring early access to services in a quick and timely manner, as well as having a wide range of choice of services offered. It is also important that patients and their families are actively involved in all aspects of care. Partnership working between health, social care and voluntary services is therefore essential. This will mean the continued development of a whole system approach to care at different levels to be effective, achieve efficiencies and avoid unnecessary duplication.
Success

Success will be demonstrated by effective and efficient services which both promote better mental health for all, and intervene quickly when people have poor mental ill health.

There will be a focus on limiting long-term mental health problems, which often manifest in childhood and adolescence, so services need to be available that are acceptable, accessible and appropriate for young people to enable them to receive support sooner rather than later.

Service users and carers need to be involved in the planning of services to ensure they best meet their needs.

Joint working with Local Authority partners demonstrates good use of resources; for example the economies of scale anticipated via a pooled budget for mental health services in Birmingham is expected to save around £1.2 million over the forthcoming two years.

“*The clear message is that people do not want to stay in hospital, and if people do need to go into hospital, then they should be discharged safely as soon as possible.*”

New look services

A new look for services for people with mental health support needs aims to move the emphasis of care away from hospital into provision which helps them remain independent by being treated and supported in their community.

At the heart of the proposed strategy is the person, his or her needs and those of carers. It’s a way forward that is supported by mental health user groups and individuals.

In Solihull, investment in improved access to psychological therapies created the Solihull Healthy Minds programme to support people with depression and anxiety.

Between October and December 2010 of the 824 referrals to Healthy Minds, only 12 had needed secondary care. HYPE (Helping Young People Early) which is designing mental health services for young people won the Transforming Community Services award from the Department of Health. The uniqueness of this project is the very strong voices of young people in service re-design.

What can you do? Your call to action

- **Primary care:** Primary care via, GP’s assessment, assess to secondary care has a key role in ensuring availability of recovery treatments. Therefore collaborative working with secondary care, local authority and voluntary agencies to develop appropriate care pathways which achieve good outcomes and use resources and expertise effectively.

- **Secondary care:** Redesign to increase capacity and capability of the model of care to be based around recovery and rehabilitation. We need high quality treatment options both in hospital and with a quicker turn to the community.

- **Local Authority:** Achieving best outcomes and quality of life for people with mental health problems requires a multidisciplinary and multi-agency approach, involving not just health care but also services such as social care, housing and leisure.

- **Voluntary sector:** Ensuring that the experience and concerns of service providers and users are effectively communicated. Have a key role in supporting service user and carers providing recover focused mental health services.

- **Patients and public:** Having a stronger voice for users of mental health services and their carers including those who have difficulty getting their voice heard. Involvement in creating holistic outcome measure which reflect a person’s whole life and individual goals.
Urgent care

Our challenge

If a person needs to receive urgent care, they should get it at the most appropriate place – wherever that’s at home, from their local pharmacy, from their GP surgery, from an Urgent Care Centre or at Accident and Emergency (A&E).

However we know there is confusion about what urgent care services exist and how to access them. Presently we have unsustainable year on year growth in A&E attendances. There is variation in the out of hours primary care services and management of demand/capacity for community services. People are not making the best use of the different services available to them resulting in them experiencing multiple conversations, tests and referrals before arriving at the most appropriate response to their need.

Too many patients with long term physical or mental health conditions are not being properly supported to manage their conditions leading to repeat acute episodes that require emergency admission to hospital. All of this means a lack of efficient use of NHS resources to best meet patients’ needs.

What needs to be done

The system needs to be as simple and streamlined as possible making it less confusing and complicated for people accessing them. This requires integration and effective links between urgent and emergency care services and primary and social care. This is particularly important for those people who need these services the most, such as older people and people living with long-term health problems or disabilities.

Integrated services are easier for patients to understand and navigate, they are also more likely to make the most of resources (for example, avoiding unnecessary journeys to hospital), and are better placed to meet the needs of people with long-term conditions or disabilities, and whose pathways through care are likely to involve more services (and therefore more opportunities for issues to arise). Hospital admissions should be based on clinical judgement because the patient requires this admission not because the system cannot meet their needs effectively.

To support the delivery of integrated services, information and data is required to ensure effective continuity of care, for example from secondary care to primary care. This can be a challenge as different providers have different IT systems in place.
Clear information, support, advice and guidance is required to enable people to be able to choose the right NHS service to get the best possible care and treatment.

Success

Successful delivery of this initiative will result in a dynamic integrated system that responds to people and their individual needs in an urgent care situation. The urgent care system will be fair and equitable, ensuring that services are not used inappropriately so that they can be there when people really need it.

This includes delivering the right care, given by the right person, at the right place and the right time by:

- More effective communication between primary care out-of-hours and emergency department teams
- Comprehensive directory of services for urgent care to know what services are available where and when and can refer patients to the right help, first time
- Excellent support for people to manage their long term or mental health condition, as well as their end of life care needs
- Increasing the seniority of decision-making at critical points in the urgent care pathway
- Reducing the length of hospital stays

Rapid Response...a better service

The Rapid Response Service offers patients access to individually tailored care delivered by the most appropriate professional in the most appropriate place which, in many cases, is the patient’s home.

The service is available to patients over 17 years registered with a South Birmingham GP and provides initial assessment within two-hours. In most cases, referral will follow a worsening of a long-term condition or as an alternative to hospital admission when the patient might more appropriately be treated in the community.

Rapid Response has reduced frequent admissions to hospital and the length of stay of necessary hospital admissions. This patient-centred approach has also improved the management of chronic disease within the community and helped people manage their condition better.

What can you do? Your call to action

- **Secondary care:** Ensure the right-skilled and expert clinicians at the ‘front door’ to properly assess patients’ needs and decide on the best course of action so that patients are not admitted unnecessarily and not kept in hospital longer than necessary.
  Be efficient and effective in the processes which manage patients coming through your doors.

- **GPs/Primary care:** Work collaboratively with multi-disciplinary and multi-agency to work with and understand the needs of those who frequently attend our A&Es. Patient and public need support to help them choose the best and most appropriate services for their care.

- **All agencies:** Understand your role in the whole system approach – needing collaboration and good interface. Support efficient discharge of patients from hospital ensuring the right systems and relationships are in place with social care, primary care and community services to make sure this happens. Involve and consult with patients to tailor services around their needs.

- **Patients and public:** Find out more about the range of different urgent care services available so you can get high quality, convenient care.
End of life

Our challenge

National evidence suggests that 56% of people would prefer to die at home but less than 25% of people achieve it. Developing care services that enable people to die in the setting of their choice is a key priority but good end of life care goes beyond this.

It is about support of the individual and their loved ones in their last year of life to enable them to be more in control of the decisions that are made about their care and the services they receive. It includes the relief of distressing symptoms such as pain and breathing difficulties as well as opportunities to address emotional and spiritual needs. Help with the practical and emotional aspects of caring for people who are dying can enable carers to meet their loved ones wishes. We recognise it is important for the family and carers to have as positive an experience as possible in the circumstances for their own health and well-being.

The last year of life is the most expensive healthcare year in a person’s life with many potentially avoidable hospital admissions. Around 90% of all deaths are predictable and our challenge is to have a pathway in place that identifies individuals early and offers them opportunities and choices to plan for their end of life care. This will build on the developments of the last ten years of cancer care extending the availability of good support to people with other conditions. To achieve this, we need health, social care and voluntary sector services to work well together, communicate effectively and adapt their skills.

What needs to be done

We will develop support for health professionals to raise the issue early with people coming to the end of their life and help plan with them their care. We need to be open and honest about what can and cannot be done for people as they approach the end of their life. Systems and services will be developed to provide optimal care so that people and their carers can be confident to die with dignity in their place of choice. Staff across the Cluster will work to the Gold Standards Framework using supportive care pathways to enable individuals and their loved ones to express and meet their wishes. Supported care pathways will help to reduce the number of emergencies that require hospital admission.

Success

Supporting patients and their families in the last year of life, to enable them to be cared for in the place of their choice, and have their symptoms and concerns managed with respect and dignity must be at the forefront of all service improvement.
The Family Liaison Service

The Family Liaison Service (FLS) aims to make what can be a difficult time for patients and families, as secure and comfortable as possible.

Experienced Family Liaison Coordinators act as professional friends, supporting the patient and their carers in every way possible, from sitting and chatting, right up to organising treatment.

What the FLS does is invaluable – it can access services and care that patients may not have the means to get themselves.

At the end of life

Few people currently die at home which, research shows, is where most people would prefer to die if they could. While more than half of people want to die at home, most deaths occur in hospitals.

If health services discuss with patients their preference and plan their care accordingly, dying at home is more likely to happen.

Building on the excellent reputation and performance of the already established End of Life Service in Solihull, a new ‘Hospice at Home’ Service is emerging led by Heart of England NHS Foundation Trust in partnership with Macmillan and Marie Curie Charities. All the organisations involved are now using the same patient records system which will improve communications and the service is expanding to include more people with long term conditions. All general practices in Solihull meet regularly with the service to ensure patients and families that would benefit are referred.

National evidence suggests that 56% of people would prefer to die at home but less than 25% of people achieve it

What can you do? Your call to action

- **Primary care**: Identify and talk early, initiate pathway, avoid unnecessary interventions and admissions, know when comfort only measures apply and support family and individual

- **Secondary care**: Identify and talk early, initiate pathway, avoid unnecessary interventions and admissions, know when comfort only measures apply and support family and individual, feed into pathway, develop innovative pathways and financial models with partners

- **Community services**: Talk early, be confident to help people plan for the future, support and provide specialist services, feed into pathway and develop innovative pathways

- **Voluntary sector**: Talk early, be confident to help people plan for the future, support and provide specialist services, feed into pathway and develop innovative pathways

- **Local Authorities**: Be confident to help people plan for the future, feed into pathway, develop innovative pathways and financial models with partners

- **Patient and public**: Talk to your family and friends early on about some of your wishes at the end of your life
Ageing well

Our challenge

By 2025, the number of people in the UK aged over 85 will have increased by two thirds and this pattern is consistent across Birmingham and Solihull. This is significant as older people are the main users of health and social care services. Older people are three times more likely than younger people to be admitted to hospital following attendance at an emergency department. Once there older people are also more likely to stay and suffer infections, falls and confusion which make them less independent.

Generally, older patients often have multiple health problems taking a variety of medication and therefore often minor problems can result in significant consequences such as falls, confusion and inability to cope.

Our existing services were not designed with older people’s needs in mind including prevention and maintaining independence.

Older people’s mental health is important with dementia one of the most important issues we face as the population rises. There are estimated to be over 750,000 people in the UK with dementia - in Birmingham and Solihull this equates to 12,500 people. Numbers are expected to rise with numbers doubling over the next 30 years. Although dementia is primarily a condition associated with older people, there are also a significant number of people who develop dementia earlier in life.

What needs to be done

We aim to define a plan which covers all aspects of the support required by older people to age well. This includes individual support and guidance for older people to maintain a healthy and independent lifestyle within their community for as long as possible and also provide the services to ensure effective management of need as it emerges. Priority will be placed on keeping people at home as far as possible and promoting independence, only admitting people to hospital when it is the right option. Delivering this will need collaborative working between health, social care and voluntary sectors as equal partners.

This agenda is developing through a system wide approach between health, social care and voluntary sectors, commissioners and providers and therefore is not yet fully evolved, however current priorities are:

**Dementia** and **healthcare support to care homes**
Dementia: What needs to be done

Implement a local care pathway which covers all aspects of dementia; from preventing early changes in the brain, supporting early diagnosis and intervention and managing the impact of advanced disease and finally end of life care. This will include the prescription of appropriate medication and management of multiple medications.

Older people with dementia will have other physical needs and therefore all services need to adapt to be able to include working with people with dementia. This is particularly important in community based services which aim to prevent hospital admissions. We aim to ensure easy to access, high quality information and training is available to the general public, carers and professionals through a range of different channels linked to specialist expertise.

Success

People with dementia should be able to remain as independent for as long as possible. People and their carers should be able to delay onset of dementia symptoms, forward plan, manage symptoms and make informed decisions. GPs and other health professionals will be better informed and more responsive to requests for memory assessment and dementia diagnosis and giving earlier access to anti-dementia drugs. Dementia will not be a barrier to accessing other services that are needed.

Healthcare support to care homes: What needs to be done?

Care homes are a positive choice for some older people, however for others they have resulted due to lack of sufficient opportunities for recovery and reablement following a period of ill health however minor. Some of the most vulnerable older people in our society live in care homes and evidence suggests are more likely attend emergency and urgent care services and be admitted to hospital.

Partnership working with Local Authority partners and the Care Quality Commission (CQC) is essential in this area. We aim to support care homes to have the necessary skills, knowledge and competencies to meet the needs of their residents and in particular to be able to take preventative actions to promote health. Alongside this additional support services will be provided to care homes to enable people to stay at home during the period of ill health when appropriate to do so. It is important to achieve an appropriate balance between support and holding homes to account through their contracts.

Success

Assisting homes to meet and exceed minimum CQC home standards should result in improved experience and quality of care for care home residents, in both their day to day lives and when they have a health issue.

What can you do? Your call to action

- **Do what’s right:** work in real partnership committing to compromise (needs to work all ways) to achieve system outcomes
- **Commissioners:** improve engagement and partnership working
- **Primary care:** support other providers to keep people at home if hospital admission are not essential. Links to Care Homes are key
- **Care homes:** Commit to improving quality and experience by working proactively with partners and engaging CQC in increasing standards
- **Community services:** Support and enable staff to be proactive, innovative and manage risk. Develop new service across providers that seek to manage and support people at home and transfer skills into the community and to carers
- **Local authority:** Work in partnership to develop integrated outcomes and solutions around the needs of people and the whole system
- **Secondary care:** Assess to admit, not admit to assess. Develop new service and financial models and partnerships that incentivise ‘doing the right thing’
- **Mental health services:** Commit to community models of care and sharing skills
- **Voluntary sector:** Develop innovative models and partnerships to support both health and social care
Our challenge

Moderation is key around safe alcohol consumption; however nationally 33 per cent of men and 16 per cent of women (24 per cent of adults) are classified as hazardous drinkers (NHS Information Centre, 2007).

Alcohol related problems cross a range of boundaries including class, gender and ethnicity. Harmful drinking is a major avoidable risk factor for noncommunicable diseases, in particular cardiovascular diseases, cirrhosis of the liver and various cancers. It is also associated with road traffic accidents, violence and suicides as well as wider social costs including domestic violence and safe guarding issues.

- Birmingham: 15,000 alcohol specific hospital admissions and 30,000 alcohol related hospital admissions. Admissions increasing at rate of 6-8% per annum. Alcohol hospital admissions cost £25.5 million

The cost of alcohol misuse is substantial, both in terms of direct costs (e.g. costs to hospital services and the criminal justice service) and indirect costs (e.g. loss of productivity and the impact on family and social networks).

Both Birmingham and Solihull have invested in alcohol services, but there is still a lot of work to be done. The affordability and wider availability of alcohol has impacted on drinking habits. Tackling this requires alcohol control policies that are evidence-based and proven to reduce alcohol-related harm and enforce responsible retailing.

What needs to be done

We need to embed three key steps around alcohol across primary, secondary and community care:

- Screening
- Brief intervention
- Referral to treatment

There is good evidence that brief interventions work to reduce alcohol consumption. Therefore everyone has a responsibility to ask questions about alcohol use. Health professionals should feel confident that if they ask people about their alcohol habits, that there are now services in place to support those patients who need it. It is also about ensuring choice of a holistic, more family focused approach to services and interventions.

Screening should be systematic. Information and data can play a key role in helping to identify people at highest risk of alcohol problems and regular hospital admissions. These admissions can incur high health costs and these patients often
have the most to gain in terms of being able to offer them a better quality service.

**Success**

This is not about stopping those who enjoy consuming alcohol sensibly, it is about tackling alcohol misuse.

Alcohol is a mainstream issue therefore people should have access to integrated treatment and support covering the full range of services from brief interventions to community and residential care if required.

Effective, appropriate plans and services should result in fewer people having their lives cut short because of alcohol; fewer families suffering as a result of other people’s drinking and our communities and city centres free from alcohol-fuelled violence. Equally important is that there will be a reduction in the financial costs of alcohol abuse.

### Providing personalised support

**Case study 1**
- 42 year old man
- Drinking 240 units of alcohol
- 3 previous hospital admissions including for pancreatitis
- Alcohol audit score 28
- Referred by GP to Aquarius (support for dependent drinkers)/ Birmingham and Solihull Mental Health NHS Foundation Trust
- Received a community detox, as well as intensive ongoing treatment and relapse support for up to a year

**Case study 2**
- 34 year old women
- Drinking 70 units of alcohol a week
- Alcohol audit score 14
- Referred to the ‘A’ team (primary care based service for hazardous and harmful drinkers) by her GP
- Received six sessions of alcohol information and advice, delivered from the surgery

**Case study 3**
- 42 year old man
- Drinking pattern unclear
- Referred by his GP to the ‘A’ team
- Assessed - drinking 180 units of alcohol and physically dependent
- Referred for a community detox, as well as intensive ongoing treatment and relapse support for up to a year

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**What can you do? Your call to action**

- **Service providers:** For both smoking and tobacco it is for everyone regardless of whether they work in primary, community, secondary care to remember ‘every contact counts’ and to ask the question about alcohol/smoke use. This should lead to the provision of appropriate advice and support as required to enable people to make positive changes their behaviours.

- **Local Authority:** To work together to enforce and regulate the sale of alcohol and tobacco.

- **Patient and public:** To proactively, where possible, seek help and support to make positive lifestyle changes around alcohol and tobacco use.
Tobacco

Our challenge

Smoking kills half of all long-term users and is the biggest single cause of inequalities in death rates between rich and poor. There is also a financial cost to the NHS of £2.7 billion per year.

There have been significant improvements in the reduction of smoking as there are now 2.1 million fewer adult smokers in England than there were a decade ago. However the numbers are still high as 1 in 5 adults continue to smoke.

What needs to be done

All smokers who come into contact with the NHS should expect to receive appropriate advice and support, whenever and wherever they access the NHS.

In order to support this the whole NHS estate will be seen as smokefree and will promote smokefree living. The NHS should provide a good example and to make the NHS truly smoking free, NHS staff that smoke will be supported to stop smoking.

All staff should feel empowered to promote healthier living to others and stop smoking service providers will provide the most effective treatments and be more accessible to all.

Success

Ultimately the impact should be a reduction in:

- The number of people using tobacco across Birmingham and Solihull
- The number of people suffering from tobacco related conditions
- Associated healthcare and social costs

Every Contact Counts.... put someone on the first step to better health and wellbeing
Making every contact count: E-learning tool

Every Contact Counts is a web tool helping people who work with the public get the knowledge, skills and confidence to have that “chat for change” - that short conversation that may put someone on the first step to better health and wellbeing.

The generic e-learning tool has been developed by NHS West Midlands and the Department of Health West Midlands in line with their commitment to support commissioners to improve health and to reduce inequalities across their local communities.

Freely available on www.nhslocal.nhs.uk it aims to give frontline staff in the NHS and beyond the knowledge, skills and confidence to Ask, Advise and Assist on a range of health behaviours, namely alcohol, smoking, healthy eating, physical activity and mental health & wellbeing.

The tool aims to make people more aware of opportunities to promote change in their day-to-day work, give basic skills to introduce lifestyle behaviour change into the conversation and the knowledge to signpost support services in the right way.

What can you do? Your call to action

- **Service providers**: For both smoking and tobacco it is for everyone regardless of whether they work in primary, community, secondary care to remember ‘every contact counts’ and to ask the question about alcohol/smoke use. This should lead to the provision of appropriate advice and support as required to enable people to make positive changes their behaviours.

- **Local Authority**: To work together to enforce and regulate the sale of alcohol and tobacco.

- **Patient and public**: To proactively, where possible, seek help and support to make positive lifestyle changes around alcohol and tobacco use.
Continuing healthcare

Our challenge

NHS continuing healthcare is a package of care arranged and funded solely by the NHS to meet physical and/or mental health needs that have arisen because of disability, illness, accident or following hospital treatment. Care can be provided in any setting including, but not limited to a care home, a hospice or your own home.

With a growing and ageing population with more complex needs and co-morbidities, the NHS is facing unprecedented demand for continuing healthcare services and costs are rising.

We are challenged to meet growing demands within existing resources to deliver services which meet the needs of patients. There are differences in the quality of services provided and some services are not used as efficiently or effectively as possible. We need to meet these challenges.

What needs to be done

The aim is to develop a cluster wide approach, working with key partners to develop a high quality, sustainable service.

We need to ensure that the needs of the patients are met in the right place for them, that their experience is positive whether that’s having family to visit them at home or helping those with complex needs to stay out of hospital. Everyone should have opportunity to be assessed for continuing healthcare packages within in open and transparent process against clear criteria to ensure that care goes to those who most need it.

Supporting and maintaining packages of care is required to prevent any breakdown and provide a productive and supportive relationship between the family and service providers.

Carers are also able to have their needs assessed to ensure they access available support such as advocates and additional support services in what can be stressful times.

Recognising the demands placed by an ageing population and the constraints around budgets is vital. It is a difficult balance act between containing the financial costs packages of care whilst ensuring no impact on quality. Choices of the packages of care available will be offered within set financial parameters.
Success

Individual care packages, based on the individual patient and their specific needs will be provided.

These packages will be developed with the patient, their carers and their clinicians working together to get the best possible outcomes.

New technology is bringing new opportunities for more care to be provided in people’s homes.

Case study 1

When Mr S suffered a severe brain injury it completely changed his and his family’s life. Following an assessment under The National Framework for Continuing Healthcare his health care needs were identified so that he could receive a care package within his own home using skilled, cost effective nursing care.

With regular monitoring and reassessment he and his family can be assured that he will receive the most appropriate care in order to enhance his wellbeing, prevent readmission to hospital and receive the support needed for him to progress towards greater independence where his care need not be totally healthcare funded.

Case study 2

Mrs B’s father had a severe dementia condition and was becoming increasingly frail and unable to cope within his own home. Following assessment under the National Framework for NHS continuing Healthcare it was identified that his care should be funded at that point in time by the National Health Service.

By working closely with Mrs B healthcare professionals were able to identify an appropriate nursing home placement within NHS contracted homes where both his ongoing needs could be met safely, adjusted appropriately and where care could be monitored and assessed on a regular basis to ensure quality and cost effectiveness.

What can you do? Your call to action

- **GP/Primary Care/Community/Secondary Care:** Work collaboratively to develop clear care pathways for continuing care across Birmingham and Solihull. Integrate effectively to ensure seamless transitions from various services.

- **Local authority:** Develop a high level agreement which supports transition from one system to another, seamlessly.

- **Voluntary sector:** Champion patient/carers needs and act as their advocate.

- **Independent sector:** Work with commissioners to develop and provide capacity to meet the range of needs for the population.

- **Patients and public:** Work in partnership with commissioners and providers to achieve the best possible care package within the resources available.

*We are challenged to meet growing demands within existing resources to deliver services which meet the needs of patients.*
Long-term Conditions

Our challenge

Long-term conditions (LTC) are health conditions like heart disease, asthma and diabetes that cannot be cured, but that can be controlled and managed and is a major element of the NHS’s work.

There are 15.4 million people in England with at least one long-term condition, and it is thought many more are not yet diagnosed. Three out of every five people aged over 60 in England have a long-term condition, and as the population ages, this proportion is likely to rise. Patients with long-term conditions use a significant proportion of all appointments with GPs and outpatient clinics and of inpatient hospital bed days.

Living with a long-term condition brings challenges and it’s important that people have confidence, support and information they need to take control of their condition. As well as the impact on individuals and their families, the strain on the economy is huge.

The challenge is to reduce this burden through prevention and developing services that enable people to remain living independently in their own homes. Some people do not have these opportunities. Primary and community services can be confusing for patients with no clear pathway of care and support. Without a key worker, patients can be unclear who they can contact leaving them to navigate the system alone which can cause distress and anger, with some patients ending up in hospital or living at home with a lower standard of living. Moving away from this system is important as well as empowering patients, by giving them information about their condition and offer them choice about where and how they are treated.

What needs to be done

There are two clear visions for around long-term conditions:

- Early identification of people at high risk of developing a long-term condition
- Minimising the impact of long-term conditions to enable people to live independently for as long as possible

No one approach to the management of long-term conditions is necessarily superior to others. The key to success is the joint development of local solutions across all providers to meet local need, and thereafter the systematic application of what has been jointly agreed, with regular monitoring and evaluation built in. This approach provides opportunities for both health improvement and for prevention.
Alongside this patients and their carers must be involved so that they become the managers of their own chronic conditions acquiring skills and the confidence required to do this. Well-informed patients make for better services and a clearer co-ordination of care for people with LTC – it’s about getting it right, and getting it right the first time.

There needs to be a balance between clinical goals and patient’s individual personal goals, helping to personalise the service and outcomes. Services should help to offer choice and help to maintain independence and quality of life. Providing services locally is an important aspect of good care. Patients should only be expected to undertake long journeys for advice and treatment to hospitals or to specialist centres if there is no equivalent level of skill and expertise closer to home.

**Success**

Care should be clearly co-ordinated between primary care and community services offering the patient a clear, joined-up journey across different services.

There should be one named contact person co-ordinating this care helping to provide clear direction and support. We need to look at maximizing the systems we currently have in place, looking to make efficiencies like reducing repeat appointments. Technology provides opportunities with assisted technology initiatives providing more care and support in people’s homes.

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**Assistive technology**

The Assertive Case Management Service (ACM) cares for patients with long-term conditions, encompassing a self care model which optimises quality of life and educates patients regarding their condition.

The assistive technology project started in January 2008 and the ACM, heart failure and Chronic Obstructive Pulmonary Disease teams refer patients to be monitored remotely via a Honeywell Genesis machine, with readings sent through via the Lifestream software to the Birmingham OwnHealth call centre.

Parameters are set by ACMs/specialist nurses and key questions detect any deterioration in the patient’s condition, raising an alert when necessary for a face to face response by a clinician. Admissions fell from 175 to 24, with a cost saving of £277k since the implementation of this service.

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**What can you do? Your call to action**

- **GP/Primary Care/Community Services:** Identify patients most at risk of a hospital admission and then intervene to manage them in the community. Use telecare and telehealth to support people with long-term conditions at home.

- **Secondary care:** Develop appropriate joined up care pathways from diagnostics to living independently.

- **Voluntary sector:** Help to reach out to the most vulnerable.

- **Patients and public:** Work in partnership with clinicians to develop new models of service provision. Work to become the principal carer in managing your condition.
Appendix 1: Cluster Objectives - 2011/12

**Delivery**
1. Improve health outcomes and reduce inequalities for the population of Birmingham and Solihull.
2. Ensure quality and safety for healthcare.
3. Lead and facilitate the delivery of a system wide plan for Birmingham and Solihull health economy, in partnership with GP commissioning consortia, which will bring about increased performance, better quality and within the resources available.

**Transition**
4. Provide and develop flexible commissioning support (in house and external) to consortia enabling them to take on roles and functions by March 2012 and fully ready by March 2013.
5. Manage system risks and provide coordination, integration and resilience to ensure that quality is maintained and improved.
6. Develop and support joint commissioning infrastructure that is fit for the future.

**Transformation**
7. Lead and manage a strategic review of services and ensure public and stakeholder engagement in any major service change.
8. Support NHS provider organisations through the reforms including Foundation Trust applications (SWBH, BCHC, WMAS) and delivery of the system plan.
9. Support the development of GP commissioning consortia, both individually and collectively, as a community of cluster wide consortia, enabling them to play a transformational role in healthcare.

**Engagement and Leadership**
10. Champion health and wellbeing for Birmingham and Solihull – leading, influencing and shaping the agenda, locally and nationally.
11. Ensure robust management of change through effective HR and staff engagement processes, organisation development and professional leadership.
12. Manage and develop relationships with the local authorities, new organisations responsible for NHS and healthcare and other key stakeholders.
Appendix 2: Cluster Board and Committees Architecture