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Sandwell and West Birmingham Hospitals NHS Trust

Report Title	Acute/Provider Collaboration		
Sponsoring Executive	Richard Beeken, Chief Executive		
Report Author	Dave Baker, Director of Partnerships and Innovation		
Meeting	Trust Board (Public)	**Date**	7th October 2021

1. Suggested discussion points *[two or three issues you consider the Board should focus on]*

This paper provides a stock take of the system wide collaborative around acute/provider collaboration. It sets out the strategic context, the current scope, the clinical engagement levels to date and where we are against the original plan.

It highlights some strategic and operational considerations to bring clarity and focus in the long and short term and small number of recommendations to consider.

2. Alignment to our Vision *[indicate with an 'X' which Strategic Objective this paper supports]*

Our Patients		Our People		Our Population	
To be good or outstanding in everything that we do	X	To cultivate and sustain happy, productive and engaged staff		To work seamlessly with our partners to improve lives	

3. Previous consideration *[where has this paper been previously discussed?]*

The acute provider collaborative has been discussed in previous Trust Board meetings as part of the Chief Executive's monthly report.

4. Recommendation(s)

The Trust Board is asked to:

a.	**CONSIDER** the clarity of the role of the acute collaboration Board in the long-term operating model of the ICS
b.	**CONSIDER** the process for prioritisation so acute collaboration helps to deliver our strategic objectives and that we make best use of our resources.

5. Impact *[indicate with an 'X' which governance initiatives this matter relates to and where shown elaborate]*

Trust Risk Register							
Board Assurance Framework							
Equality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	
Quality Impact Assessment	Is this required?	Y		N	X	If 'Y' date completed	

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Report to the Private Board: 7th October 2021

Acute/Provider Collaboration

1. Strategic Context/Literature

1.1 On 26 November, NHS England and NHS Improvement published Integrating care: next steps to building strong and effective integrated care systems across England. One of the key areas set out was the development of provider collaboration at scale. It stated that providers would join up services across systems both vertically (place based partnerships) and horizontally (provider collaboratives).

1.1.1 Provider collaboratives would join up services across systems both vertically (placed based partnerships) and horizontally (provider collaboratives). Provider collaboratives provide scale where similar types of provider organisation share common goals such as **reducing unwarranted variation in clinical practice and outcomes, supporting higher quality and more sustainable services; transforming services, reducing health inequalities with fair and equal access across sites; better workforce planning; providing mutual aid through a formal provider collaborative arrangement and more effective use of resources, including clinical support and services**.

1.1.2 All NHS provider trusts are expected to be part of a provider collaborative. These would vary in scale and scope, but all providers were to take on responsibility for acting in the interests of **the population** served by their respective system(s) by entering into one or more formal collaboratives to work with their partners on specific functions.

1.1.3 Two weeks later (9/12/20) the Kings Fund released its paper on "The next steps towards integrated care". In its introduction it stated that "The future landscape for the NHS and its partners will be made up of four interlocking elements:

- **Place,** which for most areas (but not all) will usually be based on local authority boundaries but could be other locally relevant definitions
- **Provider Collaboratives,** bringing together NHS Trusts and Foundation Trusts to work more closely with each other
- **Integrated Care Systems (ICSs),** bringing together commissioners and providers of NHS services with local authorities and other partners to plan and manage services that benefit from being considered at greater scale than can be undertaken at place
- **the national and regional bodies,** including NHS England and NHS Improvement, the Care Quality Commission (CQC) and the Department of Health and Social Care".

2. The population(s) and the future operating model of the ICS

1.1 There are, perhaps, two ways of thinking about provider collaboratives:

The first is that they provide a forum for providers (acute or broader) to collaborate in order to advance the strategic objectives of each of the statutory organisations.

The second is that the provider collaborative is a vehicle/chain by which acute or potentially broader care is provided in the Black Country and potentially more broadly (regional services, networks or an ICS merger).

If we are gearing up for the long term the first question that we may wish to consider is - which of these two models will form part of the long-term operating model of the ICS?

1.2 Behind this consideration is perhaps another question. Do we consider the population of the Black Country to be one population or five populations (four post April 2022)?

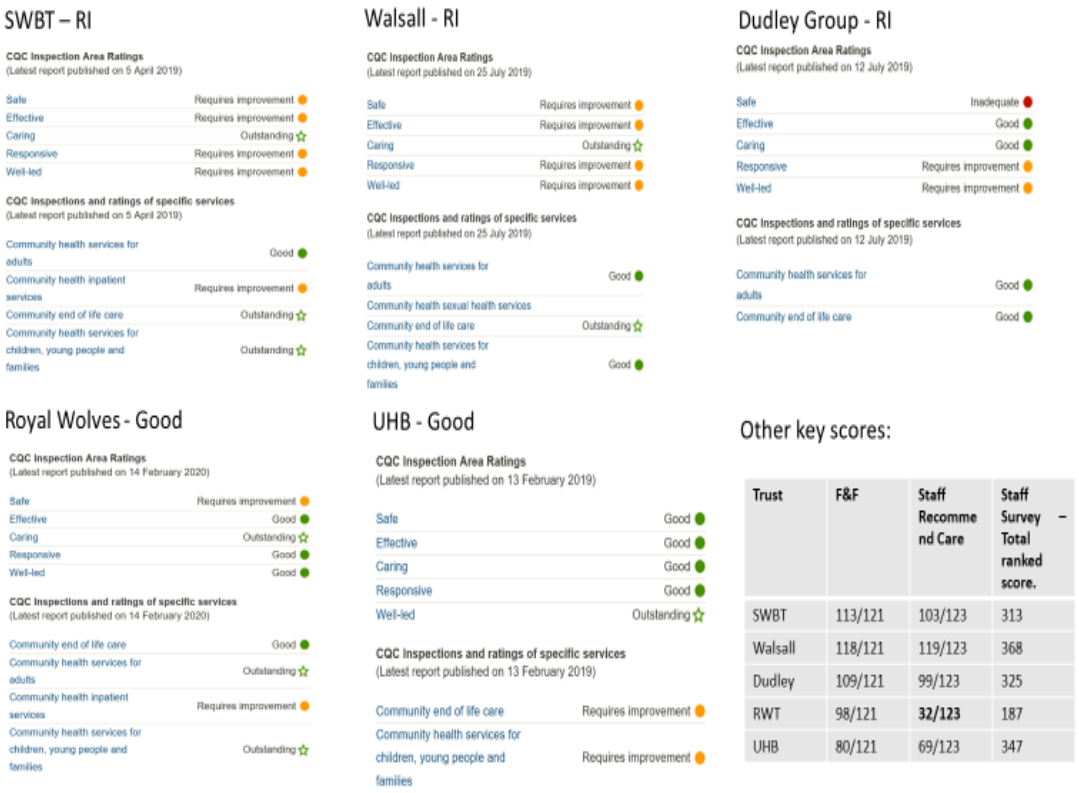
1.3 Perhaps the answers to both these questions sits within a detailed vision and governance infrastructure that underpins the core purpose of the ICS and its constituent organisations and it's stated vision "working together to improve the health and wellbeing of local people".

3. Provider Collaboration and SWBT

3.1 SWBT is beginning to focus itself around three new and emerging strategic objectives: People; Patients and Population. Our "population" objective is pretty much outside the scope of the acute/provider collaborative. This links more directly to our place-based partnership/ICP work and our direct work around being an anchor institution.

3.2 The acute provider collaborative plays most closely to the objective around patients and so the external assurances we must consider are the CQC ratings (including use of resources), elements of the system oversight framework and the staff survey. Our internal assurance is driven by our Board level metrics; our "We-assure" work and the Pulse Survey.

3.3 In this context it is probably worth us noting the latest CQC ratings for the large acute providers in the Black Country and Birmingham & Solihull systems along with some other key metrics:



3.4 The link to the people objective, perhaps, need further thought as to whether it forms part of acute collaboration or whether it sits with the ICS wide People Board and under the ICS strategic objective around our system being the best place to work. It is, perhaps, worth noting the other two ICS strategic objectives are: “healthier people” and “fit for the future”;

4. The Black Country and West Birmingham acute collaborative - current scope

4.1 The BCWB acute collaborative has been set up as a programme rather than a formal vehicle. It’s programme outline (see annex A) sets out four objectives:

- To optimise clinical outcomes for acute services across BC and WB;
- To secure sustainable services delivered by a robust workforce;
- To ensure maximum efficiency of delivery;
- To address inequalities in access and outcomes experienced within the local population.

and 5 outcomes

- Clinical outcomes -measurable improvement (to be defined for each project);
- Successful restoration and recovery of services in line with National targets;
- Financially sustainable system of acute care in place;
- Increase access to services for BAME and deprived communities (to be quantified)
- Reduced vacancy rate for staff

4.2 The acute provider collaborative in the Black Country and West Birmingham is one of three system wide collaboratives that sits alongside the 5 place-based partnerships. The remaining two system wide collaboratives are: mental health, learning disability and autism and NHS 111/999.

4.3 The acute collaboration Board receives updates from 7 workstreams covering:

Delivery workstreams

- Clinical Projects;
- Back Office efficiency and Financial modelling;

Enabling workstreams

- Workforce and OD;
- Intelligence, Insight and Outcomes;
- Communication and Engagement;
- Governance and Implementation;
- Digital, data and technology

4.4 There is, as yet, no visible dashboard/set of metrics that show progress against the objectives and the outcomes.

4.5 There is a "two-pager" for each of the 7 workstreams similar to that of the programme outline (see Annex A).

4.6 At the most recent meeting it also received papers on: the emerging commissioning architecture; the diagnostic programme update; quality and safety across the ICS.

4.7 The clinical projects workstream has had three clinical summits covering 16 specialties to look for improvements. Outcomes from the event are currently being considered to find those specialties that are ready, willing and able to progress and those that need to be progressed to mitigate risk.

4.8 In addition to the work around the 16 specialties, the acute collaboration board is also looking to carry out an external review around 'hot and cold' site options.

4.9 The Back-office efficiency and financial modelling workstream has received feedback from 11 suppliers around how to approach a procurement process. The result of this exercise is an evolution of scope to this workstream towards NHS facilitated workshops to;

- Gain an understanding of the current service provision by: sharing latest information from the Corporate Data Collection returns; explaining the assumptions used in compiling the returns – the Trusts will no doubt have used different assumptions; gaining an understanding of proposed developments not captured in the returns

- Exploring the potential for collaboration to drive quality improvement to back office services, for instance by: upskilling opportunities through jointly run training sessions; development of "centres of excellence" for complex areas which all Trusts could call on; the establishment of single virtual teams; sharing of enhancements to common systems and processes.

- The intent is to look at 8 different areas drawing on the leads from each Trust for each area. These areas are: Finance; HR; Data, Digital and Technology; Procurement; Governance and Risk; Legal; Payroll.

5. Supporting our Strategy

5.1 Should the provider/acute collaboration remain a programme (rather than a formal part of the ICS Governance), perhaps the most obvious route for value creation is two-fold: 1) to help us to retain or achieve good or outstanding CQC ratings; 2) to help us to improve the CQC domain related Board Level Metrics.

5.2 Recognising that we are part of the ICS we should also consider where our working with our partners will help them to achieve their strategic objectives.

6. Strategic Considerations

6.1 The first set of considerations pursue greater clarity around the long-term vision for acute/provider collaboration:

6.1.1 What is the long-term operating model for acute/provider collaboration? At present it is described as a programme but it could become a horizontal delivery vehicle (organisational form or joint leadership change) across the Black Country. It is recommended that the long-term intent of acute/provider collaboration is clearly stated and communicated by the ICS Board and agreed with the member Boards.

6.2 What is/are the interplay/interdependencies between the acute collaboration Board and other Boards such as the People Board (e.g what is the strategy for developing our workforce and what is the delivery vehicle?) This has been a key output from the clinical summits as has the digital connectivity and the "Efficiency" Board e.g. what is our strategy for delivering financial surpluses and what is the delivery vehicle for this?

6.3 How and when do we prioritise change initiatives? We could harness tools such as A3X to understanding the whole portfolio and its links to the strategic objectives and the departments that will be required to make the work a success and a PICK chart with which to measure payoff versus effort. Whatever is selected it is recommended that we try to influence the selection of priorities from across the programmes/workstreams rather than within them as 80% of the benefits may reside in a single programme, for example, the placed based partnerships. Ultimately, we are searching for "bang for buck" with limited resources.

7. Operational Considerations

7.1 Operational considerations include:

7.1.1 How we align around a mechanism for identifying those areas which, either: have the greatest need for direct quality improvement (mitigating risk registers e.g. fragile services); or are believed to present the greatest opportunity for indirect quality improvement (aiding clinical decision making or saving the time of the front line through the creation of a more responsive back office).

7.1.2 What the model is for specialised services which represents ~10% (£45m) of our current income, covering the high cost low volume areas such as: Neonatal; Gynae Oncology; Acute Oncology; Cancer drugs and Neurophysiology. These areas may lend themselves to a "strategic supplier model".

7.1.3 How to test that any team chosen to drive change are ready, willing and able to do so.

7.1.4 How we monitor how our resources are utilised as our staff are being asked and paid to become clinical leads in collaborative change. This is not necessarily a bad thing but we may wish to consider how we support their existing work, this additional work and their personal recovery.

7.1.5 How we consider the interplay between place-based partnerships/ICPs and acute collaboration so that we have considered the end to end process. This is consistent with our MMUH acute care model.

7.1.6 How we link prioritised specialties to the "area network" projects being driven by the GIRFT team to harness all potential expertise and avoid duplication of effort e.g Urology is both a GIRFT area network project and one of the 16 acute collaboration specialties.

7.1.7 Whether the purpose of the back office workstream is amended to "be more proactive and responsive to the front line". If this is the case we may wish to consider where waste exists to front line teams and how that could be resolved. There is available money for clinical roles without necessary the clinicians to fill them – could this be diverted to make the existing clinicians to operate more effectively?

7.1.8 The back office may also wish to consider how to align the performance agenda so that oversight meetings do not ask a different set of questions to the ones that the acute collaboration or place based partnership/ICPs are working to deliver. Initial work was carried out to align each Trust to the 3 new objectives that will drive our strategy. This was well received by the Strategy Directors and through them their organisations, but this has not yet been considered at ICS Board.

8. Final Summary and Recommendations

8.1 Phase 1 of the acute collaboration programme plan (annex A) was set to end on 30/9/21. It covered: Programme establishment; Intelligence and evidence gathering;

Clinical engagement; Agreement of priorities for change (clinical and non-clinical). We should consider what we have learned and the process that is used to select the priorities. We may also wish to answer some of the strategic considerations before proceeding so that there is real clarity.

8.2 Phase 2 of the acute collaboration programme is planned to run from Oct 21 – Mar 22 ad involves: Establish projects based on priorities; Confirm new service models; Financial modelling and Commencing implementation. This precedes Phase 3 which covers: Implementation of phase 1 priorities; Confirm priorities for phase 2; Review to ensure delivery against programme objectives and outcomes; Review governance and organisational arrangements

8.3 It is recommended that the Trust:

- Seek clarity around the end point for acute collaboration in the future ICS operating model;
- Influence the selection of the priorities in phase 2 so that further work is aligned to our strategic objectives and outcomes. This includes supporting any work that helps us to land the MMUH opening and may involve us choosing not to engage in certain projects which won't immediately deliver on our chosen priorities;
- Ensure that we commit to giving the right resources the right amount of time to help the project to deliver its objectives on time and that there is a process to ensure that other Trusts do the same.;
- Contribute our learning from phase 1 in order to create the best possible process for phase 2 and phase 3 of the acute collaboration work.

Dave Baker
Director of Partnerships and Innovation

25th September 2021

Annex 1: Original Programme Outline – note Richard Beeken formally stepped away as joint chair. Dave Baker joined the acute collaboration Board in August 2021.

Annex 1

ACUTE PROVIDER COLLABORATION PROGRAMME

PROGRAMME OUTLINE

PURPOSE

To deliver effective, accessible and sustainable acute care services for the Black Country and West Birmingham.

OBJECTIVES

1. To optimise clinical outcomes for acute services across the Black Country and West Birmingham.
2. To secure sustainable services delivered by a robust workforce.
3. To ensure maximum efficiency of delivery.
4. To address inequalities in access and outcomes experienced within the local population.

OUTCOMES

1. Clinical outcomes – measurable improvement (to be defined for each project)
2. Successful restoration and recovery of services in line with national targets.
3. Financially sustainable system of acute care in place
4. Increase access to services for BAME and deprived communities (to be quantified)
5. Increased proportion of care delivered to the BC and WB population from within the BC and WB.
6. Reduced vacancy rate for staff.

WORKSTREAMS

Delivery workstreams:-

1. Clinical change
2. Back office / infrastructure and efficiency

Enabling workstreams:-

1. Evidence and intelligence
2. Financial modelling
3. Comms and engagement
4. Digital
5. Workforce and OD
6. Governance and implementation

GOVERNANCE

A Programme Board has been established comprising the Chairs, CEOs and a number of Lead Directors from each of the four Trusts.

The Programme Board reports into each Trust Board making recommendations regarding key decisions. Each Trust Board will then consider decisions affecting the organisation. However, it should be highlighted that all NHS organisations will have to have regard for system sustainability as part of forthcoming ICS arrangements.

SROs

Richard Beeken, Chief Executive, Walsall Healthcare NHS Trust

Diane Wake, Chief Executive, Dudley Group NHS Foundation Trust

LEADS

Jonathan Odum	Medical Director rep, Lead for Clinical Projects
Ann-Marie Riley	Director of Nursing rep
Liam Kennedy	COO rep
Tom Jackson	Finance Director rep, Lead for Efficiency and Infrastructure / Financial Modelling
Alan Duffell	HR Director rep, Lead for HR, OD and Leadership
Sally Evans	Comms and engagement lead
Dinah McLannahan	Lead Exec for Sandwell and West Birmingham
Glenda Augustine	Lead Exec for Walsall, Lead for Intelligence and Evidence
Simon Evans	Lead Exec for Royal Wolverhampton
Katherine Sheerin	Lead Exec for DGFT, Lead for governance and implementation

PROGRAMME PHASES

PHASE 1: April – Sep 21

Programme establishment

Intelligence and evidence gathering

Clinical engagement

Agreement of priorities for change (clinical and non-clinical)

PHASE 2: Oct 21 – Mar 22

Establish projects based on priorities

Confirm new service models

Financial modelling

Commence implementation

PHASE 3: Apr 22 – Sep 22

Implementation of phase 1 priorities

Confirm priorities for phase 2

Review to ensure delivery against programme objectives and outcomes

Review governance and organisational arrangements