Annexe C

Model A – Commission services in ten local authority areas	
Advantages	**Disadvantages**
<u>Medium importance</u> Minimisation of disruption (for example in respect of IT, HR processes etc.) and stability of services; Current providers are familiar with local issues, needs and history and can tailor services appropriately to ensure access to patients; Retention of 'organisational memory' and existing relationships with local authorities, GPs etc. if current providers remain in place; Sensitivity to the needs of individual local authorities, for example to the requirements of multiple safeguarding boards. <u>Low importance</u> Continuity of care for patients and continuity for staff; Greater scope for Integration with current secondary care providers (particularly where the Trust provides both services); Workforce more likely to live locally. Reduced impact of travel time. More able to attend local meetings.	<u>High importance</u> Current premises are a mixture of historically decided premises. Some are understood to be not fit for purpose; If existing providers are retained it may be more difficult to re-design services (and so achieve a more standardised approach across the Local Office); More difficult to address existing inequity of resources and services provided; Perpetuates current boundary issues and inconsistencies (i.e. services not being provided to out of area patients); Misses the opportunity of economies of scale; Does not address issues regarding the commercial viability of the smaller services; Resilience of staffing (for example including recruitment issues and current skill/staff shortages) and impact on clinical leadership; Misses the opportunity to make better use of the skills mix available across a wider geography (and to secure greater access to specialist support); Lack of link to future configuration of Sustainability and Transformation Partnership (STP) and Integrated Care System (ICS) areas; Lack of consistency of the records maintained (for example to support safeguarding arrangements). <u>Medium importance</u> Inconsistent governance and approach to patients; May be difficult to address the current inconsistency of data collected and reported;

	Replication of posts between services. <u>Low importance</u> Does not address localised issues where there is a mismatch between existing CCG areas and coverage of current services; Does not address current use of Commissioners' resources to service seven separate contracting relationships; Less peer support and lack of flexibility regarding workforce/career.
Model B – Commission services from a single provider for the entire West Midlands area	
Advantages	**Disadvantages**
<u>High importance</u> Offers greater opportunity to exploit economies of scale and mitigates the potential issues regarding the viability of smaller services; Facilitates the development of common policies, approach and governance (for example safeguarding, training, investigation of Serious Incidents, discharge, pathways, acceptance criteria etc.); Facilitates re-design and likely to lead to greater equity of resources and services provided; Maintenance of common records (would lead to, for example, improved safeguarding arrangements); Likely to lead to better use of skills mix (and to greater access to specialists) <u>Medium importance</u> Greater consistency of data collected and reported;	<u>High importance</u> Scale of impact if the service fails (all the eggs in one basket); Whether there is a provider big enough to be able to deliver and manage the service effectively across a large and diverse geography; Leads to centralisation and a 'one size fits all' ethos; Increased travel time for staff (and possibly for patients) – may impact on recruitment; Practical considerations with change on that scale (for example dealing with legacy IT systems, estates, communications etc.); Danger of destabilising services, particularly during the transition period; Need for significant change – including cultural change - with the associated resource cost etc.); Lack of link to future configuration of STP and ICS areas;

More robust clinical leadership (for example by enabling better succession planning) and, potentially, resilience of staffing more generally; May offer the opportunity to review the facilities offered by current premises and lead to improved standards; Would remove current boundary issues (which instead may move to external boundaries). <u>Low importance</u> Reduced administrative burden on provider and commissioners (for example a single contracting relationship to service); May promote peer support and offer greater flexibility regarding workforce/career.	Whether the timing is appropriate for such a big change given the scale of change in the health sector and the wider environment; Significant loss of 'organisational memory '. <u>Medium importance</u> Resource needed to liaise with multiple local authority areas and their diverse needs; Ability to cope with disparate geographies; Lack of local knowledge, local ownership and/or sensitivity to local needs; Administrative resource needed to monitor any consequent sub-contract arrangements (if applicable); <u>Low importance</u> Need to secure buy-in from key stakeholders and partners; May lead to reduced scope for working with current secondary care providers (although this may be mitigated if sub-contract arrangements are in place); Workforce may need to travel greater distances which (for example) could impact on their ability to attend local meetings; Potential for some short-term disruption to patients (for example in respect of continuity of care).
Model C – Commission services based on the four Sustainability and Transformation Partnership (STP) and Integrated Care System (ICS) areas within the West Midlands area	
Advantages	**Disadvantages**
<u>High importance</u> Alignment with STP (and existing CCG) areas. Would assist with the integration with wider services (direction of travel).	<u>High importance</u> Practical considerations with change on that scale (for example dealing with legacy IT systems, estates, communications etc.);

Greater prospect of common policies, approach and governance – at least within an STP/ICS area; Facilitates re-design and likely to lead to greater equity of resources and services provided- at least within services within the same STP. Maintenance of common records (would lead to, for example, improved safeguarding arrangements). Likely to lead to better use of skills mix (and to greater access to specialists) <u>Medium importance</u> Offers some opportunity to exploit economies of scale and may help mitigate the potential issues regarding the viability of smaller services; More robust clinical leadership (succession planning) and, potentially, resilience of staffing more generally; Liaison is likely to be through the STP/ICS board which mitigates the resource required to liaise with multiple local authorities; Greater consistency of data collected and reported.- at least within STP areas; May offer the opportunity to review the facilities offered by current premises and lead to improved standards; Would reduce current boundary issues. <u>Low importance</u> May promote peer support and offer greater flexibility regarding workforce/career; Reduced administrative burden on provider and commissioners (for example a	<u>Medium importance</u> Ability to cope with disparate geographies (although less of a risk than in the case of a single provider solution); Scale of impact if one or more services fail; Administrative resource needed to monitor any consequent sub-contract arrangements (if applicable); Danger of destabilising services, particularly during the transition period; Need for significant change – including cultural change - with the associated resource cost etc.); Some loss of organisational memory; Possibility of no willing providers for one or more areas. <u>Low importance</u> Need to secure buy-in from key stakeholders and partners; Some reduction in local knowledge, local ownership and/or sensitivity to local needs; Workforce may need to travel greater distances which (for example) could impact on their ability to attend local meetings; Potential for some short-term disruption to patients (for example in respect of continuity of care).

reduced number of contracting relationships to service).	
Model D – Commission services from a number of providers[1] who would offer services across more than one local authority area	
Advantages	**Disadvantages**
<u>High importance</u> Greater prospect of common policies, approach and governance – at least within local authorities served by the same provider; Facilitates re-design to some degree and lead to greater equity of resources and services provided – at least within local authorities served by the same provider; Maintenance of common records (would lead to, for example, improved safeguarding arrangements). Likely to lead to better use of skills mix (and to greater access to specialists) <u>Medium importance</u> Offers some opportunity to exploit economies of scale and may help mitigate the potential issues regarding the viability of smaller services; More robust clinical leadership (succession planning) and, potentially, resilience of staffing more generally; Greater consistency of data collected and reported - at least within STP areas. Would reduce current boundary issues. May offer the opportunity to review the facilities offered by current premises and lead to improved standards; <u>Low importance</u>	<u>High importance</u> Non-alignment with STP (and existing CCG) areas. Might prevent integration with wider services (direction of travel). That said, there has been limited recognition of dental services within the development of STP/ICS strategies to date; Potential for non-alignment with local authority areas; Whether the timing is appropriate for such a big change – particularly as it runs counter to the direction of travel of change in the health sector and the wider environment; Practical considerations with change on that scale (for example dealing with legacy IT systems, estates, communications etc.); Difficulty in co-ordinating OHP and epidemiology across different local authority areas. More generally, resource needed to liaise with multiple local authorities. <u>Medium importance</u> Ability to cope with disparate geographies (although less of a risk than in the case of a single provider solution); Danger of destabilising services, particularly during the transition period; Scale of impact if one or more services fail; Some loss of organisational memory; Need for significant change – including cultural change - with the associated resource cost etc.);

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May promote peer support and offer greater flexibility regarding workforce/career; Reduced administrative burden on provider and commissioners (for example a reduced number of contracting relationships to service).	Administrative resource needed to monitor any consequent sub-contract arrangements (if applicable); Possibility of no willing providers for one or more areas. <u>Low importance</u> Need to secure buy-in from key stakeholders and partners; Some reduction in local knowledge, local ownership and/or sensitivity to local needs; Workforce may need to travel greater distances which (for example) could impact on their ability to attend local meetings; Potential for some short-term disruption to patients (for example in respect of continuity of care).