WALSALL HEALTHCARE NHS TRUST

BECOMING YOUR PARTNERS FOR FIRST CLASS INTEGRATED CARE

5 YEAR STRATEGIC PLAN
2016-17 – 2021-22

For Board Approval
Table of Contents

Introduction ........................................................................................................................................... 5

These documents provide further clarification on how we will work together to deliver our Vision and strategic objectives. .......................................................... 5

Executive Summary .......................................................................................................................... 5

1. Walsall Healthcare NHS Trust Profile ....................................................................................... 8
   1.1 Health Challenges for Walsall ............................................................................................... 8

2. The Population We Serve ............................................................................................................. 9
   2.1 Key Priorities for Public Health in Walsall ........................................................................... 10
   2.2 Impact on the Walsall Health and Social Care System ......................................................... 11
   2.3 Care Quality Commission (CQC) Inspection ....................................................................... 12

3. Partners and Competitors ............................................................................................................ 13
   3.1 Our approach to Partnerships ............................................................................................... 13
      3.1.1 Partnerships ............................................................................................................... 13
      3.1.2 Accountable Care Organisation (ACO) .................................................................... 13
      3.1.3 The Black Country Alliance ...................................................................................... 14
      3.1.4 Walsall Together Partnership .................................................................................... 15
      3.1.5 GP Federations ........................................................................................................... 16
         3.1.5.1 Palmaris Healthcare .......................................................................................... 16
         3.1.5.2 Modality Partnership ......................................................................................... 16
         3.1.5.3 Walsall Alliance ............................................................................................... 16
      3.1.6 Walsall Metropolitan Borough Council ....................................................................... 16
      3.1.7 Sandwell and West Birmingham Hospitals NHS Trust (SWBH) .................................... 17
         3.1.7.1 New Midland Metropolitan Hospital .................................................................. 17
      3.1.8 The Dudley Group NHS Foundation Trust (DGFT) ....................................................... 18
      3.1.9 Spire Healthcare ......................................................................................................... 18
      3.1.10 The Royal Wolverhampton NHS Trust ..................................................................... 18
      3.1.11 Heart of England NHS Foundation Trust .................................................................. 19
      3.1.12 Birmingham Community Healthcare NHS Foundation Trust ............................... 19
      3.1.13 Dudley and Walsall Mental Health Partnership NHS Trust (DWMHPT) ................... 19
      3.1.14 Others ..................................................................................................................... 20
      3.1.15 Competitor Monitoring ............................................................................................ 20
<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.2</td>
<td>Historic and Projected Expenditure Analysis</td>
<td>54</td>
</tr>
<tr>
<td>14.3</td>
<td>Finance Summary (LTFM)</td>
<td>55</td>
</tr>
<tr>
<td>14.4</td>
<td>Financial Recovery Plan (CIP)</td>
<td>55</td>
</tr>
<tr>
<td>14.5</td>
<td>Draft Capital Programme</td>
<td>56</td>
</tr>
<tr>
<td>15.</td>
<td>Supporting Strategies</td>
<td>57</td>
</tr>
<tr>
<td>15.1</td>
<td>People Strategy</td>
<td>57</td>
</tr>
<tr>
<td>15.2</td>
<td>IM&amp;T Strategy</td>
<td>57</td>
</tr>
<tr>
<td>15.3</td>
<td>Estates Strategy</td>
<td>58</td>
</tr>
<tr>
<td>15.4</td>
<td>Clinical Services Strategy</td>
<td>58</td>
</tr>
<tr>
<td>15.5</td>
<td>Improvement Strategy</td>
<td>58</td>
</tr>
<tr>
<td>15.6</td>
<td>Commercial Strategy</td>
<td>58</td>
</tr>
<tr>
<td>15.7</td>
<td>Quality Strategy</td>
<td>59</td>
</tr>
<tr>
<td>15.8</td>
<td>Patient Experience Strategy</td>
<td>59</td>
</tr>
<tr>
<td>15.9</td>
<td>Equality and Diversity</td>
<td>60</td>
</tr>
<tr>
<td>15.10</td>
<td>Social Value</td>
<td>60</td>
</tr>
<tr>
<td>16.</td>
<td>Risk Management and Assurance</td>
<td>60</td>
</tr>
<tr>
<td>17.</td>
<td>Conclusion</td>
<td>61</td>
</tr>
</tbody>
</table>
Introduction

This Strategy has been developed over a year with extensive engagement and input from the Board and operational care groups.

Our people have also reviewed the organisational values and elected to retain the Promises that were developed for them and for patients following the establishment of the organisation.

To achieve success it is vital that every one in the organisation understands what the strategy means for them, and what they are expected to do to ensure we achieve our goals. And so, moving forward, as well as extensive communication of the Strategy, the Listening into Action events will be linked to strategic planning and service improvement.

Section 15 outlines the key supporting strategies of this overarching document and include:

- Service Improvement Strategy
- Long Term Financial model aligned to STP
- People Strategy
- Clinical Service Strategies
- IMT Strategy
- Stake Holder Strategy
- Commercial Strategy
- Estates Strategy
- Patient Experience Strategy

These documents provide further clarification on how we will work together to deliver our Vision and strategic objectives.

Although our strategic direction and long-term vision will remain unchanged, some elements contained within this document are written in the context of our current market and may change in response to developments. Therefore, this Strategy and the plans therein will be reviewed annually as part of the Trust’s annual planning process.

Executive Summary

This Strategic Plan for Walsall Healthcare NHS Trust is the route map for the journey the organisation is currently navigating and sets out the longer term direction of travel towards sustainability.

It outlines the context in which the Trust delivers care, including the demographics of its population, our comparative market position with our peers, the increasingly onerous task of striking a balance between reducing funds and increasing expectations and demand. These challenges are not only recognised by the Trust and this document sets out to explain how...
we will be addressing them through partnership work within the local health and social care economy and also more widely across the Black Country footprint.

The Trust starts from a challenging position. Our recent CQC inspection crystallised the impact of a series of difficult years on our services, our patients and our colleagues. Our teams have responded well to the challenge to make sure we offer safer, high quality care in the short-term especially in ED and maternity services. On its own however we know that this is not sufficient and we have a duty to ensure that our services are sustainable in the longer-term as well as being safe.

In setting out to meet this challenge, we recognise that we serve a population that faces significant health and care challenges and that we are likely to face rising demand for hospital care as a result if we do not make changes. At the same time we face changes on our borders especially in Staffordshire and Sandwell and must face all of this against an increasingly challenging national context for the National Health Service.

We do, however, have reason for optimism. We are an integrated provider of hospital and community health services with the opportunity to exploit integrated pathways of care; we have strong links with our local GPs, CCG, mental health services and social care services; and we are partners in the Black Country Alliance – a partnership with SWBH and Dudley Group.

We have therefore set out a Vision that seeks to build on these opportunities and meet our challenges: Becoming Your Partners for First Class care. This Vision is underpinned by five strategic objectives that will be at the heart of our future success:

1. Provide safe high quality care across all our services
2. Care for patients at home wherever we can
3. Work closely with partners in Walsall and surrounding areas
4. Value our colleagues so they recommend us as a place to work
5. Use resources well to ensure we are sustainable.

To deliver the Vision and Strategic Principles we identified seven high level strategic themes and demonstrate how working in these areas will start to address the challenges that the Trust faces and how the route map will enable us to reach our destination.

The delivery of this Vision will mean significant change in the way we provide care to the population we serve in future. This will include:

- working with GPs to help them identify and support patients at most risk of needing acute care
- integrated locality health and care teams working to support as many patients as possible at home
- an “assess to admit” approach to patients presenting for emergency care and a “discharge to assess” approach once patients acute care is completed
- improving elective care pathways to reduce unnecessary hospital activity and to work with partners to share smaller specialist services
ensuring our hospital estate is fit for purpose with major developments in ITU, maternity, neonatal services, ED and acute ward capacity.

With all journeys there is a starting point and a destination, sometimes the exact route varies but we set out the supporting strategic documents which are in place to ensure that the destination we reach is the one we are setting out for.
1. Walsall Healthcare NHS Trust Profile

Walsall Healthcare NHS Trust provides integrated health services for the people of Walsall and increasingly parts of South Staffordshire and the Black Country. We work closely with our partners in primary care, mental health services and social care to deliver our 2022 Vision to become "your partners for first class integrated care".

Our Hospital has 512 beds and provides a full range of local acute hospital services including an Emergency Department, medical and surgical emergency services, critical care, obstetrics, paediatrics and a Level 2 Neo-natal Unit as well as the full range of outpatients, diagnostics and elective care. We are part of wider tertiary networks for trauma, cancer and neo-natal services. We also operate Walsall’s Palliative Care Centre (excluding inpatients which is run by St. Giles)

We deliver community services from over 20 principal locations across the borough. Our community teams provide care for adults who are house bound; the frail and elderly who need their complex care needs to be met in their own home or within our intermediate care beds. We provide case management for patients in private nursing and residential homes to ensure that their care needs are being met. We deliver specialist nursing care in the areas of stroke, continence, tissue viability, cardiac nursing and palliative care.

We have public health nurses providing care for children including health visitors and school health nurses. We provide care for looked after children and ensure that transition from children’s services to adult services are managed effectively. We also focus on prevention, including sexual health, smoking cessation and we deliver specialist equipment where identified.

We employ some 3,800 whole-time equivalent (wte) colleagues (4,410 headcount) and have a turnover of around £243.5m a year (2015/16 outturn).

1.1 Health Challenges for Walsall

There are five specific challenges that we face in our service delivery: growth in activity\(^1\) (spells for emergency care, inpatients and outpatients); the deprivation levels of the population; the diversity of the population; the increasing healthcare needs of our population and the inequality of life expectancy across the area. The specific challenges and metrics are set out below.

- **Growth in Activity:** 5% growth 2011 – 2021; fastest growth in older groups (13% in over 65 year olds)

---

\(^{1}\) Health Evaluation Data 2015/16 against 2014/15 and Q1 2016/17 year on year
**Deprivation Levels:** 33rd out of 326 local authorities ranked for deprivation. 27% of children live in poverty

**Diversity of the Communities:** 23% from Black & Minority Ethnic groups

**Health Needs of the Population:** Long term care challenge, high infant mortality, high rates of obesity, smoking, diabetes, coronary heart disease and alcohol related hospital admissions

**Inequality in Life Expectancy:** 10 year difference in male and 7.5 in female life expectancy.

The map below highlights the levels of deprivation across the borough. Some of the more rural areas of the borough are less deprived, with the highest levels being found in more urban expanses.

![Deprivation Heat Map](image)

The above challenges and delivery of our Vision and strategic objectives need to be set against the context of our main Commissioner, Walsall CCG, being placed in special measures. This will have an impact on the ability of the CCG to commission services within a very tight financial envelope. In addition the situation is further exacerbated given that Walsall Local Authority is under increasing financial pressures. This means that resources to deliver key services which depend on social care will become even more challenging and we have seen trends in tighter tendering conditions and increased competition for the provision of key community-based services.

### 2. The Population We Serve

Shown below is a summary of the diversity and health needs of Walsall’s population which impact on the Trust.
2.1 Key Priorities for Public Health in Walsall

The latest Joint Strategic Needs Assessment, (JSNA), which was coordinated by Public Health for Walsall, highlights the population’s health and social care needs. We have reviewed our strategic priorities to ensure that the wider public health needs are considered and aligned with our planning response over the next five years.

➢ The high prevalence of a range of preventable conditions presents a real challenge and requires a concerted effort from communities and public bodies working together

➢ Cancer is the leading cause of death in the under-75s in Walsall; coronary heart disease is extremely common across Walsall, and diabetes prevalence is higher than nationally

➢ Substance misuse is higher than national averages with high alcohol-related harm across a number of health and wellbeing indicators, and a significantly higher rate of problematic drug users than nationally

➢ The estimated prevalence for smoking 22.7% (c.45,000 adults), and smoking related deaths are significantly higher than national averages

➢ The healthy life expectancy in Walsall is about 60.3 years old this is 2.3 years lower than West Midlands and 3.4 years lower than England averages

➢ A range of measures demonstrate that older people in Walsall are high users of institutional care, an approach that neither promotes efficient use of limited resources, nor meets the individually identified needs of older people and their carers
The number of Walsall residents with Dementia is a growing issue, likely to increase by 22.5% over the next eight years, putting extra pressure on all health services.

The loss of independence is a concern where there has been an increased number of falls in older people in Walsall; particularly those in institutional settings.

Walsall has a higher proportion of excess deaths amongst older people than the region as a whole, especially amongst women and those with underlying health problems yet many of these deaths are preventable.

An increasing proportion of Walsall’s population care for someone with a long term illness; 10.6% in 2001 increased to 11.6% in 2011 - the national rate stayed the same.

Walsall is committed to reduce harm to vulnerable children with a particular focus on reducing the impact and costs of looked after children including through meeting the children’s needs in the right way and as early as possible.

Appendix 1 contains a cross check of the above key priorities and how we are addressing them within our Strategy.

2.2 Impact on the Walsall Health and Social Care System

Together with our partners we have to be responsive to the specific care needs of the population. The implications are detailed below:

- Tackling specific health inequality issues for men both in terms of mortality rates in our infants through our STP work and alcohol specific problems for the 40-59 year age band. This is contributing to the widening gap of life expectancy
- Aligning our services to the unique requirements of different segments of the community, for example:
  - caring for the aging population through our Frail and Elderly Service model
  - the ethnicity of the population, cultural tendencies to access services (greater incidence of diabetes); and, in recent years,
  - the increased rates of drug and alcohol misuse
- Providing tailored interventions at neighbourhood level to respond to health inequalities
- Primary and secondary interventions in relation to cancer, COPD, Diabetes, stroke, liver disease and frailty are required
- The systematic management of patients with long term conditions in primary care and community health services contributes to better healthcare outcomes
- Improve monitoring and earlier intervention to prevent unnecessary admissions and to create the conditions to enable people to retain their independence in their communities
- Continuing focus on mental health and physical health
Our community services have made significant progress with the frail and elderly service, and building on this, the assess to admit model will be developed further to continue to avoid admissions and treat patients in the most appropriate setting for their clinical need.

2.3 Care Quality Commission (CQC) Inspection

The Trust was inspected by the Care Quality Commission (CQC) in September 2015. We were open about the challenges we faced in recovering from a difficult period. Their Report concluded an overall Inadequate rating, and the Trust being placed into Special Measures in January 2016 following a quality summit.

However, a number of our community and children’s services were highlighted as being Good across all of the CQC domains. We took prompt action to improve the quality of care for our patients and to ensure that we are meeting the required CQC standards for each of our services. Table 1 summarises our response.

<table>
<thead>
<tr>
<th>CQC Domain</th>
<th>Our response</th>
<th>Impacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe</td>
<td>Quality Strategy • Independent reviews by West Midlands Quality Review Service • Effective Manager Programme and mandatory training • Recruited greater number of nurses to meet the demands and ensure our services are operating at a safe staffing level</td>
<td>Establishes a Trust-wide approach to achieving a quality system • Reinforces and confirms whether safe clinical care is being delivered for our patients • Staff kept updated with latest standards</td>
</tr>
<tr>
<td>Effective</td>
<td>Patient care improvement plans developed and input into a new electronic software – PM3 • Independent, 6 month programme of peer group visits • NHSI observers have been invited and participated in peer reviews • Recruited/appointed three new quality governance advisor roles</td>
<td>Provides assurance that our services are operating at their most effective • Establishes a monitoring mechanism for tracking progress • Dedicated resource to drive and influence lasting patient care improvements</td>
</tr>
<tr>
<td>Caring</td>
<td>Maintain the standards for providing care, which was rated as “Good” in our community healthcare services and predominantly “Good” in most of our core acute services.</td>
<td>Reputation of the organisation. • Patients will recommend the Trust to Family and Friends • Patient Experience</td>
</tr>
<tr>
<td>Responsive</td>
<td>Launched Listening into Action for staff • Team Briefing opened up for all grades of staff and our external stakeholders (e.g. CCG, Local Authority) • Celebration of the contribution of the BME communities to Walsall Healthcare as part of October’s Black History Month</td>
<td>Engagement with staff to help identify Trust-wide and clinical improvements by an empowered workforce • Staff satisfaction rates • Equality and Diversity for all staff, including the minority ethnic communities • Operational performance for A&amp;E and 18 weeks.</td>
</tr>
</tbody>
</table>
Our response

- Trust Five Year Strategy 2016-17 to 2021-22
- Strategic Plan
- Improvement Strategy
- A new clinically-led delivery model
- Board Development
- People Strategy
- Commercial Strategy

Impacts

- Sets the blueprint for future strategic clinical improvement and a sustainable model to deliver care for our patients
- Robust governance
- Highly qualified and attuned Board members
- Resource management optimised

<table>
<thead>
<tr>
<th>CQC Domain</th>
<th>Our response</th>
<th>Impacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well led</td>
<td>• Trust Five Year Strategy 2016-17 to 2021-22</td>
<td>• Sets the blueprint for future strategic clinical improvement and a sustainable model to deliver care for our patients</td>
</tr>
<tr>
<td></td>
<td>• Strategic Plan</td>
<td>• Robust governance</td>
</tr>
<tr>
<td></td>
<td>• Improvement Strategy</td>
<td>• Highly qualified and attuned Board members</td>
</tr>
<tr>
<td></td>
<td>• A new clinically-led delivery model</td>
<td>• Resource management optimised</td>
</tr>
<tr>
<td></td>
<td>• Board Development</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• People Strategy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Commercial Strategy</td>
<td></td>
</tr>
</tbody>
</table>

Table 1: CQC Response

Our overriding aim is to make sustainable improvements to our services ensuring that patients receive safe, high quality care that is responsive to their needs. In addition, that the contribution our people make to patient care is regularly recognised and celebrated.

A number of the enabling schemes, people and tools that were developed, recruited and implemented in the first six months following the rating, will start to demonstrate their value in the current financial year. Progress is monitored using programme management software, which underpin SMART objectives.

3. Partners and Competitors

3.1 Our approach to Partnerships

The Trust is working in partnership with organisations that provide care co-terminously within Walsall and across the Black Country footprint. The care provision landscape has become complex with services that are being commissioned crossing traditional boundaries.

3.1.1 Partnerships

Partnership working is the only sustainable model for the Trust and the health and social care economy. The form of these partnerships is developing. The overarching model towards which we are working is the Accountable Care Organisation model. We are, therefore, constantly reviewing developments and emerging trends in relation to competitors but also exploring opportunities to form collaborative partnerships where appropriate. This will ensure that care for our patients is delivered in the most effective manner and in line with one of our guiding principles of only providing care if we can do so safely; if not then we will work with partners to do so.

3.1.2 Accountable Care Organisation (ACO)

This is the preferred option for partnership working for the Trust. Going forward, the model will be focussed on a Walsall wide footprint, including the council, GP Federations, CCG and the Trust. This organisational form will need to be established and the governance will need to be developed. In essence the ACO model enables all the providers to work together in a collaborative delivery of the statutory and mandatory services that need to be provided and the supporting services that make these sustainable.
The ACO would hold the overall funding and the partner organisations that form the ACO work together to ensure that there is no duplication and no gaps in service provision. The Trust needs to build strong relationships between the leaders of participating organisations and the clinicians who deliver care. This will include developing a culture of collaboration and teamwork to overcome organisational and professional silos to and deliver truly coordinated care.

Building strong relationships and cultures of collaboration takes time. Confirming the organisational form, constitution and governance will also take time. The work being undertaken through Walsall Together is an example of how the collaborative approach can work across the borough.

3.1.3 The Black Country Alliance

The Black Country Alliance (BCA) is a new model of acute care collaboration between three NHS Trusts which manage medium sized District General Hospitals that

- serve over a million patients in the Black Country
- use over £1 billion of tax payers money and
- employ more than 15,000 colleagues.

The BCA has at its heart three aims:

- **Improve Health Outcomes**
- **Improve the Experience of Health Care**
- **Make better use of our collective resources.**

These aims are expanded upon in some high level objectives and outcomes associated with each piece of work.

The BCA provides an opportunity for us and our colleagues to think big about the future plans for services, and how working in alliance with the other Trusts may enable us to solve a problem or realise an opportunity or ambition. Working together we have the opportunity to deliver a scale of efficiency that is beyond the reach of our individual organisations. The horizontal integration of support services which each organisation needs to provide and reducing the duplication that currently exists, is a key efficiency plan. There are further horizontal integrations that will be developed over the life of this Strategy which are being developed within the Sustainability and Transformation Plan (STP).
We have delivered some great examples of collaboration through some of the early work we have done together;

- **closing the gap on 7 day service requirements**: we launched a pilot to deliver 7 day non-vascular interventional radiology services

- **acting together to stabilise a service**: we stabilised a rheumatology service that was at risk of failure due to inability to attract and retain consultant rheumatologists

- **sharing expertise**: with the creation of a specialty and sub-speciality Urology map covering the patch, which allows more informed discussions about building on strengths, improving areas of weakness and removing unwarranted variation

- **doing something together that might not have been possible separately**: we have secured the Mobile Health Research Bus to help bring access to research to areas previously not accessing research

### 3.1.4 Walsall Together Partnership

This is the partnership of the principal health and social care organisations in Walsall that are undertaking collaborative strategic planning to deliver a programme of transformation and improvement projects. It will lead to a more effective and well-led framework for delivery of patient care.

The following key organisations are collaborating to develop services in Walsall:

- Walsall Clinical Commissioning Group (CCG)
- Walsall Healthcare NHS Trust
- Walsall Local Authority
- Dudley & Walsall Mental Health NHS Trust
- Walsall GP’s through GP Federations
- Walsall Public Health
- Walsall Voluntary Action
- West Midlands Ambulance Service

The partners are working together to reduce barriers and duplication and to improve the flow of patients to deliver better care closer to people’s homes.

The goal of the programme is to ensure, through effective collaboration, that health and care services in Walsall achieve the triple aims of:

- Improving health and wellbeing outcomes for the Walsall population
- Improving care and quality standards in the provision of care
- Meeting the statutory financial duties of all partner organisations
The partnership approach will enable a high degree of synergy between the collective strengths of each organisation that will deliver an integrated service for our patients’ needs across a wide range of clinical pathways. Service improvement will be at the heart of our approach backed up with targeted project workstreams and cross cutting enablers which include digital IT, Estates and effective workforce planning and development.

3.1.5 GP Federations
This is an evolving process and we will ensure that we engage with them as they grow and develop including any new federations that may emerge in the future.

At the time of writing, there are a number of GP federations that have been formed in Walsall as detailed below. These organisations are potential competitors for the Trust but also partners especially in areas of community and planned care services

3.1.5.1 Palmaris Healthcare

This organisation is a small federation of less than a dozen practices in Walsall. They won a contract in 2015 to provide GP bank holiday cover. As at November 2015 the company had in excess of 100,000 patients.

3.1.5.2 Modality Partnership

The Modality Partnership operates mainly in Sandwell in Birmingham and has recruited a number of GP federations including Smethwick Medical Centre which serves approximately 10,000 patients.

3.1.5.3 Walsall Alliance

This is the largest of the federations and has 31 independent GP practices covering 125,000 patients across Walsall. The GP practices are dispersed widely across the borough serving a diverse population. This is a federation structured as a limited company with four directors elected by a Board of Directors.

We recognise the mutual benefits of working in partnership with our GP federations.

Key components of our Strategy include shared pathways that would begin in primary care with GPs and would include initial diagnostic decisions for planned care activity. This would speed up the patient journey and reduce the burden on the Hospital. The patient experience will be far more positive and will lead to quicker clinical outcomes. GPs will be instrumental in initiating early intervention and diagnosis of conditions than previously.

We envisage that some of the pathways will be delivered within our Community-based healthcare services through:

- Telemedicine linking GP’s to Specialist Consultants
- Chronic care management in the community setting
- Planned care pathways that start with GP intervention and diagnostics
- Specialist advice from consultants supporting primary care on preventative medicine
Further proposals include the Trust potentially offering primary care IM&T, HR and payroll support.

The above engagement work will continue to help shape and crystallise our collaborative working with all the GP Federations listed above and those that may emerge in the future.

3.1.6 Walsall Metropolitan Borough Council

We have a long standing working relationship with our key local authority Walsall Metropolitan Borough Council. They are an important member of the Walsall Together partnership and play an active part in the future development of services within Walsall. In recent years, they too have come under increased financial pressure within the social care and public health agenda. They are also key commissioners for public health contracts such as sexual health and healthy child programme. In recent times it has been noticeable that tender opportunities have become even more demanding and competitive and will continue to be so given the financial context.

Social care and integration will remain a key focus of our discussion to maximise our strategic aim of collaborative working with our partners within our five year strategy.

3.1.7 Sandwell and West Birmingham Hospitals NHS Trust (SWBH)

An integrated Trust and Teaching organisation, employing around 7,500 people and a budget of circa £430m largely drawn from the local Clinical Commissioning Group. It serves a population of 530,000 from across North-West Birmingham and all the towns within Sandwell. Community inpatient facilities are provided from its community hospital at Rowley Regis and Leasowes Intermediate Care Centre. It also runs the Midlands Eye Centre.

Being on our border, we see regular movements of patients depending on the specialities and waiting lists within our respective organisations. Our relationship is predominantly one of partnership and co-operation given that both organisations are part of the BCA. Regular meetings are held to discuss current and future opportunities and challenges for delivery. This will be kept under review.

3.1.7.1 New Midland Metropolitan Hospital

Geographical changes to our boundaries continue to take place, and in 2018 our emergency services will see patients from north Sandwell migrating towards our Hospital when SWBH opens its Midlands Metropolitan hospital on the Sandwell/Birmingham border in 2018. The impact on our population footprint is anticipated to be an increase of 50,000 bringing a 7,000 per year increase in ED attendances. This boundary shift is an opportunity for our Trust to increase market share but we have learnt from our experience of changes in Staffordshire
that we will suffer the consequences if we do not plan properly for this change and ensure that we have sufficient capacity to accommodate the additional activity.

3.1.8 The Dudley Group NHS Foundation Trust (DGFT)

DGFT provides hospital and adult community services in Dudley, some areas of Sandwell and to small areas of South Staffordshire and Wyre Forrest. It serves a population of 450,000.

It has three hospital sites – Russell’s Hall Hospital is the largest with 770 beds and a range of planned and emergency, surgical, medical and supporting clinical specialities. It is the regional provider of emergency vascular operation and for planned surgery for abdominal aortic aneurysms as part of the Black Country Vascular Centre. It has the Guest Outpatient Centre in Dudley and Corbett Outpatient Centre in Stourbridge. These centres provide a range of outpatients and day case services. It operates from circa 40 community sites across the Dudley borough and in patients’ homes.

While our relationship with Dudley is predominantly that of partnership working, there are occasions when our two organisations compete, especially for the provision of community services and public health contracts. We also compete with SWBH and The Royal Wolverhampton NHS Trust (RWHT).

3.1.9 Spire Healthcare

Spire Healthcare is a provider of planned care and has seen an increase in its market share across the Walsall borough. Over the last two years that activity has been from work diverted from our Trust because of waiting list pressures. We recognise that we will need to ensure that our patients needs are fully aligned to our capacity to provide an effective service.

3.1.10 The Royal Wolverhampton NHS Trust

Geographically, the RWHT is the closest Trust to our own. It is not part of the BCA although there are some established pathways and shared resources. We have worked closely with Wolverhampton to divert some maternity activity to their service as part of our plan in response to the CQC report.

It provides some specialist services such as cancer and vascular, and it runs the Heart and Lung Centre, and Cannock Hospitals.

Wolverhampton provides acute and specialist services, and is pursuing a “vertical integration” Strategy within the city bringing together the trust with local general practices into a single organisation.
3.1.11 Heart of England NHS Foundation Trust

Heart of England Teaching Foundation Trust’s (HEFT’s) operation includes Good Hope Hospital, which is on our southern border. As with Sandwell, patients will move between Good Hope and Walsall services as their need dictates. We do some joint work with HEFT on stroke pathways.

As well as Heartlands Hospital, the Trust operates a community district general service in Solihull.

It has recently been announced that HEFT and University Hospitals Birmingham (UHB) intend to become a single entity in the near future possibly through a merger, though more likely through acquisition by UHB of HEFT.

UHB / HEFT’s declared intention is not to reduce the range of services provided from Good Hope Hospital but we need to be mindful of any migration of services from Good Hope Hospital to the UHB site, which would impact our catchment area on the Walsall / north Birmingham border.

3.1.12 Birmingham Community Healthcare NHS Foundation Trust

BCHC recently achieved FT status, one of the first community trusts in the country to do so.

It has declared and is pursuing a strategy to be the main provider of children and families services in the West Midlands.

The Trust has a well-resourced commercial team and regularly reviews opportunities to bid for the provision of adult and children services across the Black Country, including those in Walsall and further afield.

They have been successful in bidding for school health nursing services in Sandwell and South Staffordshire, and for the region-wide provision of the Child Health Information Service. They are also looking at opportunities to bid for health visiting services around the region. They have recently been awarded the contract for the West Midlands Paediatric Sexual Assault Services which they are delivering in conjunction with three other NHS Trusts, a consortium of voluntary counselling services and private sector partners.

Recently the CEO of BCHC was also appointed CEO of Birmingham and Black Country Partnership NHS Foundation Trust, potentially facilitating the integration of mental health into mainstream healthcare services. The organisation is also working collaboratively with Dudley and Walsall Mental Health Trust. Sandwell and West Birmingham Hospitals Trust have expressed interest in working with them on the Birmingham STP.

3.1.13 Dudley and Walsall Mental Health Partnership NHS Trust (DWMHPT)

DWMHPT serves a combined catchment area in Dudley and Walsall of 586,000 and operates from the following acute mental health hospitals: Dorothy Pattison, Bloxwich Hospitals in Walsall and Bushey Fields in Dudley. In addition, it also operates from 23 sites
across the geographical area. Services are also provided to neighbouring Trusts in Worcestershire, Staffordshire, Birmingham and Warwickshire for Community recovery, older adults, early intervention and acute mental health care.

DWMHPT was chosen as a preferred partner with Birmingham Community Healthcare NHS Trust in creating sustainability for Black Country Partnership NHS Foundation Trust. They are a key partner of the Walsall Together Partnership and is an active partner organisation for helping to develop a collaborative approach for our patients in the Walsall borough.

3.1.14 Others

There are a number of organisations who deliver small scale contracts and services across the local area. The most significant of which is Primecare who operates the Urgent Care Centres in Walsall and is actively growing their capacity and capability across the Black Country. Other smaller organisations will be looking to increase their market share of the activity within the borough and as such the Trust will be developing good working relationships with those who hold specialist skills.

Where large organisations have a foot hold in small scale contracts in Walsall the Trust will be seeking to secure contracts and repatriate activity in collaboration with partners.

3.1.15 Competitor Monitoring

Our approach to competitor analysis and monitoring is outlined in table 2. As competitors are identified we will monitor their prospective intent and impact on service provision across the Walsall area. A model of competitiveness verses competitive interest will be used that determines the type and frequency of monitoring that is needed.

Table 2: Competitor Matrix
3.1.16 Provider Landscape

The Trust performed well in the areas of infection control, staff engagement with our peer groups and notably scored the highest in three out of the 4 metrics for the Family and Friends Test (with maternity being joint second highest).

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Staff Engagement</td>
<td>3.65 (3.59)</td>
<td>3.77 (3.72)</td>
<td>3.91 (3.70)</td>
<td>3.86 (3.85)</td>
<td>3.63 (3.53)</td>
</tr>
<tr>
<td>2</td>
<td>Family and Friends Test for Inpatient's</td>
<td>97%</td>
<td>86%</td>
<td>92%</td>
<td>95%</td>
<td>93%</td>
</tr>
<tr>
<td>2</td>
<td>Family and Friends Test for A&amp;E</td>
<td>93%</td>
<td>84%</td>
<td>81%</td>
<td>92%</td>
<td>81%</td>
</tr>
<tr>
<td>2</td>
<td>Family and Friends Test for Maternity services</td>
<td>96%</td>
<td>-</td>
<td>98%</td>
<td>96%</td>
<td>91%</td>
</tr>
<tr>
<td>2</td>
<td>Family and Friends Test for Outpatients</td>
<td>97%</td>
<td>86%</td>
<td>93%</td>
<td>92%</td>
<td>91%</td>
</tr>
<tr>
<td>3</td>
<td>Current Overall CQC rating</td>
<td>Inadequate (Special Measures)</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
<td>Requires Improvement</td>
</tr>
<tr>
<td>4</td>
<td>MRSA incidence (July 2015-July 2016)</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>2</td>
<td>C. Difficile incidence (rate per 100k bed days, pts. 2yrs +) (2012/13)</td>
<td>1</td>
<td>3</td>
<td>7</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2</td>
<td>HSMR rates Target 1.0</td>
<td>1.08</td>
<td>0.94</td>
<td>0.99</td>
<td>1.02</td>
<td>0.97</td>
</tr>
<tr>
<td>3</td>
<td>Dignity and Nutrition (100 hospitals inspected) (2011)</td>
<td>Fully Compliant with Minor Concerns</td>
<td>Non-compliant</td>
<td>Fully compliant</td>
<td>Not inspected</td>
<td>Fully compliant</td>
</tr>
<tr>
<td>2</td>
<td>18 weeks RTT (Target 90%)</td>
<td>76.50%</td>
<td>81.48%</td>
<td>74.58%</td>
<td>94.15%</td>
<td>76.27%</td>
</tr>
<tr>
<td>2</td>
<td>Cancer 2 weeks (Target 93%)</td>
<td>96.45%</td>
<td>95.66%</td>
<td>92.92%</td>
<td>95.09%</td>
<td>93.27%</td>
</tr>
<tr>
<td>2</td>
<td>A&amp;E waits (Target 95%)</td>
<td>85.76%</td>
<td>88.70%</td>
<td>88.63%</td>
<td>96.21%</td>
<td>89.42%</td>
</tr>
</tbody>
</table>

The comparative position of our key partners and competitors is shown in table 3. Areas that we need to improve on are our CCQ rating, HSMR, 18 weeks RTT and achieving the 4 hour standard for A&E. It has been independently noted that while patients have some frustrations with the processes and length of time in being admitted to the Hospital for treatment, once they are admitted, patients have indicated that the care that they receive has been of a good quality.

3.1.17 Our Market Share

The market share of the Trust has changed significantly over the past few years due to the challenges experiences with reconfiguration in South Staffordshire, and internally with our own performance and capacity issues. Market share in 2015/16 has increased for emergency in emergency activity (against the previous year) and reduced in elective care. There is an opportunity to recover some of the lost elective market share with a stable and efficient operational performance.

An analysis of where our activity comes from by CCG is shown below in percentage terms across three main points of delivery. The market analysis given in these graphs looks at the data from a number of different perspectives:
Graph 1 highlights the Trust’s total activity by CCG with regards to elective referrals.

Graph 2 highlights the Trust’s total emergency spells by CCG.

Graph 3 below shows the origins of the outpatient activity seen within the Trust.
Graphs 1, 2, and 3 above represent the measurement of the activity seen within our Trust from different CCGs. The following graphs (4, 5 and 6) show by percentage where the activity, relevant to Walsall CCG, is seen across the local NHS Providers, giving the relative market share that we hold and the potential opportunity open to us through repatriation of activity.

Graph 4 shows that 48.67% of Walsall CCG’s activity is provided by other organisations; much of this is activity we will be seeking to repatriate.
Graph 5 shows that only 23.49% of the emergency activity relating to Walsall CCG is seen by other providers. Emergency activity is an area that is less easy to repatriate depending on the reason for presentation.

Graph 6 demonstrates that we provide 67.39% of new outpatient appointments for Walsall CCG. The Royal Wolverhampton NHS Trust remains the next biggest recipient.

The Trust has set up a market share group, the purpose of which is to:

- identify opportunities and threats in neighbouring areas
• consider and evaluate market share trends within the local health economy and to ensure that market intelligence is shared with the Trust’s annual planning process
• monitor future opportunities for increasing market share and also threats to the Trust’s delivery of key objectives
• share with divisional and senior clinical leads marketing analysis outputs to inform business decisions.

3.1.18 Repatriation of Services

Following detailed engagement with our clinical teams several have indicated an ambition to repatriate services from other providers. Our first priority though would be to reduce our backlog and ensure we are operating within national standards. This should come after we have completed the service line demand and capacity work to ensure that we have effective and responsive plans to meet our challenges. We will use our professional relationship with our commissioners to ensure that repatriation opportunities are fully considered and actioned where appropriate.

4. Integration

The Trust’s future, critically, relies on our ability to work in strategic partnerships with local providers and commissioners to reduce demand for our hospital based services through vertical integration. Conversely, when services are required, they need to be provided to a high quality; be responsive and sustainable. This is where our partnership with other Trusts becomes critical through horizontal integration.

In all our planning assumptions the need to ensure that we are meeting the CQC domains is paramount in ensuring that we deliver safe, responsive and caring services that are built on solid foundations of being well-led and effective. To achieve this we will be mirroring the strengths that the CQC identified within our community services.

4.1 The Black Country Sustainability and Transformation Plan (STP)

The Trust is participating in the Black Country STP. This plan brings together 10 healthcare providers, numerous Local Authorities and four CCGs to create an ambitious local blueprint for accelerating the implementation of The NHS Forward View, for the period October 2016 to March 2021.

The STP’s vision is to transform health and care in the Black Country and West Birmingham ensuring that we bridge three critical gaps:
1. Our populations suffer significant deprivation, resulting in poor health and wellbeing;
2. The quality of the care we offer varies unnecessarily from place to place, so not everyone has the best experience of care or the best possible outcome; and
3. We risk not being able to afford all the services our populations need unless we take early action to avoid future costs, creating a sustainable health and care system that helps Black Country and West Birmingham lives to thrive.

It is clear to us that the current way of operating is unsustainable. Under our plan, individual organisations and partnerships will continue to make the improvements and efficiencies that are directly within their own control but the overall scale of opportunity will be transformed by our working together as a single system with a common interest.

Partners have agreed to recognise work that was already planned or underway on a cross partner or Black Country basis, and not seek to disrupt or duplicate it through the STP process.

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

I. Implement a pattern of **vertical integration** on a place-based basis building on Primary and Acute Care Systems (PACS) and Multi-speciality Community Provider (MCP) approaches to deliver an Accountable Care Organisation model appropriate to each of our localities

II. Create, through **horizontal integration**, single systems to operate across the Black Country to improve quality and to deliver efficiencies on a scale not accessible to individual organisations, building on the Black Country Alliance and the Transforming Care Together Partnership for Mental Health and Learning Disability Services. This includes a reduction from 5 to 4 acute sites through the Midland Metropolitan Hospital development

III. Take coordinated action to address the particular challenges faced by our population in terms of **Maternal and Infant Health**, and we will create a single Black Country maternity plan that inter-relates with Birmingham and Solihull where necessary

IV. Work together on key enablers that will facilitate the achievement of significant workforce efficiencies, to rationalise public sector estate utilisation, and to streamline commissioning functions

V. Act together, and in partnership with the West Midlands Combined Authority, to address the **wider determinants of health**.
4.2 Identified External Challenges on Key Service Lines

As part of the evaluation of the strategic direction the Trust considered some of the main risks to the key service lines. These are summarised in the table below.

<table>
<thead>
<tr>
<th>Service Line</th>
<th>Risks</th>
<th>Mitigation</th>
</tr>
</thead>
</table>
| Planned      | • Other provider competitors  
               • Loss of key market share due to historical performance issues  
               • Competitive recruitment by other Trusts | • Achieving RTT to make attractive for choice  
               • Creating capacity to repatriate activity  
               People strategy focuses on retention of our staff and succession planning |
| Emergency    | • Activity growth higher than capacity available  
               • Diversion via Urgent Care Centre  
               • Changes in Commissioner Pathway  
               • Unfavourable tariff | • Walsall Together partnership to coordinate demand reduction initiatives  
               Reviewed staffing model  
               • Demand and capacity modelling  
               • Capital plans to expand department  
               • Contract negotiations with the CCG |
| Diagnostics  | • AQP  
               • Capacity to meet access targets/demand | • One stop diagnostics shop  
               • Demand and capacity analysis to drive strategic decisions  
               • Additional MRI capacity to be added |
| Community    | • MCP model of care deployed without the Trust being a key partner  
               • Private providers such as Virgin care becoming stronger in the market | • Accountable care provider proposal linking partners together  
               • Walsall Together partnership establishing specialist pathways in the community |
| Specialised  | • Specialised Commissioning priorities  
               • Recognition of services | • Adopting Dalton provider models  
               • Black Country Alliance |

Table 4: Key external service line challenges
5. Strengths, Weaknesses, Opportunities and Threats, (SWOT) Analysis

As part of the review of the local and national picture the Trust has undertaken a SWOT assessment which is summarised below. This is preceded with our key responses to each of the SWOT domains. A PESTLE analysis is included in Appendix 2 for reference.

We will **build** our strengths to ensure that we are fully exploiting our market position within the local health economy. Key strands include our locality teams to fully embed and deliver pathways that contribute to increasing care in the community and reducing hospital re-admissions. We already have existing collaborative forums that will help to shape future partnership working.

Our aim is to **close** our weaknesses by focusing on the areas that directly impact on our patients and future sustainability. Major areas of focus include the provision of robust financial planning to deliver our targeted savings in year and in future years. We recognise that robust data quality is required to ensure that demand capacity decision making is made on accurate baselines to inform cogent planning. The Listening into Action initiative is well established to empower staff to deliver change. This will also be an important part of our objective to raise staff engagement and satisfaction levels.

Opportunities will be **exploited** to deliver lasting positive change for the populations that we serve. Key drivers will be the need to consider shifting geographical boundaries and the greater potential catchment areas and shared clinical pathway options that the Black Country Alliance offers. Service improvement will be led by a new PMO that will enhance transparency with governance for the delivery of projects through the software system, PM3. The use of technology will be maximised to ensure we are making the best use of our resources in an agile environment.

We will **mitigate** the threats that are real and becoming even more challenging than in earlier years. Through our existing collaborative forums we will enter into discussions at a much earlier stage to influence change especially with changes to services and future system-wide architectural reconfigurations. We will work with our partners and competitors if commercially viable.
The Trust’s high level SWOT analysis is shown below.

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>• We remain the only integrated acute and community healthcare provider in Walsall</td>
<td></td>
</tr>
<tr>
<td>• Successful integrated locality teams and FEP service reducing impact on front door</td>
<td></td>
</tr>
<tr>
<td>• Some strong specialist areas, e.g. community services, bariatrics</td>
<td></td>
</tr>
<tr>
<td>• We are operating co-terminously with partners to deliver integrated care</td>
<td></td>
</tr>
<tr>
<td>• Largest provider of healthcare services in the borough</td>
<td></td>
</tr>
<tr>
<td>• Well regarded L&amp;D Centre</td>
<td></td>
</tr>
<tr>
<td>• Notable apprenticeship scheme.</td>
<td></td>
</tr>
<tr>
<td>• Performance and financial challenges- £70m efficiency savings over five years; and capacity and capability to respond to pressures on the system</td>
<td></td>
</tr>
<tr>
<td>• Technological enablement/facilitation – some of our IT systems and processes are outmoded</td>
<td></td>
</tr>
<tr>
<td>• Our staff surveys and external reviews reveal a lack of engagement with staff and issues with the culture of the organisation including poor leadership and a lack of accountability in some areas</td>
<td></td>
</tr>
<tr>
<td>• The organisation has a history of being reactive rather than proactive -</td>
<td></td>
</tr>
<tr>
<td>• Lack of resources when system is under pressure</td>
<td></td>
</tr>
<tr>
<td>• There has been a significant management change, and issues with retention of some key staff roles. Some of our Board and senior leaders are relatively new to post with limited experience in their roles</td>
<td></td>
</tr>
<tr>
<td>• The lack of accurate data and resources to model our demand and capacity frustrates our ability to effectively meet our access targets</td>
<td></td>
</tr>
<tr>
<td>• Some of our most experienced staff are due to retire within the life of this Strategy which may lead to a loss of &quot;corporate memory&quot;</td>
<td></td>
</tr>
<tr>
<td>• Our relationship with the CCG has been strained due to performance issues and financial pressures.</td>
<td></td>
</tr>
</tbody>
</table>
Opportunities

- Turnaround – scope for improvement following CQC inspection and our responses to their recommendations, overseen by the service improvement team and supported by the Director of Strategy and Transformation to give focus to our longer-term ambitions
- Horizontal Integration – with the Black Country Alliance facilitating a sharing of resources across the Region
- Changes in our geographical boundaries presents opportunities to expand our service offers
- Public procurement opportunities may facilitate an expansion of services beyond our natural boundary of Walsall
- Re-engagement and upskilling of staff – led by Director of HR and OD
- Technological enablers, particularly virtual technology used in an agile environment and supporting estates rationalisation
- Development of services, e.g. HASU site, tertiary centre for Bariatrics
- SLR reporting, and other data tools to inform services. Our BCA will offer our workforce opportunities across a much wider network.

Threats

- CCG future survival giving funding challenges and the potential for CCGs to be operating in a new form
- Competitive recruitment – some Trusts are offering higher banding to attract clinicians working in roles where there are national shortages
- The expected increase in patients attending the hospital needs to be appropriately funded and resourced
- Public procurement and cuts in Local Authority spending puts some of our services under threat of competition and may potentially destabilise some of our pathways and/or impact on patient quality
- Cuts to social care services increasing length of stay in hospital
- National shortage of trained nurses and some specialists.

Table 5: SWOT Analysis
6. Our Strategic Vision

Our Strategic Vision articulates the areas that we need to focus on going forward. We have delivered the immediate requirements to improve the safety and equality of the services that we deliver. Going forwards our Strategy focuses on the steps that need to be taken to ensure that the organisation is sustainable for the long term, as well as safe.

Our Strategic Vision is  

becoming your partners for first class care

and is achieved through aligning our Vision to 5 strategic objectives as shown below in Figure 5. This aligns to the CQC’s five domains of safe, effective, caring, responsive to patient needs and well-led (see Table 6).

Figure 5: Strategic Vision and Objectives
We have developed our strategic plan to ensure that our five year business plans are driven by the above five strategic objectives for the interests of our patients, the collective and mutual interest of all our partners who are instrumental in delivering care, and for our colleagues to ensure that services delivered are of the highest quality and safe.

7. Our Values and Promises

Our promises, designed by our staff, establish the sets of behaviour we expect from our people. They make a commitment to our patients that we will make them feel welcomed, cared for, in safe hands and, likewise for our own staff who should feel part of one team, supported to meet our high standards and to feel appreciated.

Figure 6: Promise and Values
8. Vision Mapped to CQC

The Vision that has been developed will enable the Trust to address the CQC concerns across the organisation. The Strategic Objectives have been mapped to the CQC domains and table 5 below sets out the areas covered by each strategic objective, the CQC domains they address, and the NHS Improvement Single Oversight Framework areas.

<table>
<thead>
<tr>
<th>Trust Vision/Strategy</th>
<th>CQC Domains</th>
<th>NHSI Single Oversight Framework</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic Objective</td>
<td>Indicators Covered</td>
<td></td>
</tr>
<tr>
<td>Safety and quality of care indicators</td>
<td>Safety and quality of care indicators</td>
<td>Quality of Care</td>
</tr>
<tr>
<td>Patient experience indicators</td>
<td>Patient experience indicators</td>
<td>Operational Performance</td>
</tr>
<tr>
<td>Access standards performance</td>
<td>Access standards performance</td>
<td></td>
</tr>
<tr>
<td>Shift of care to community</td>
<td>Safe</td>
<td>Strategic Change</td>
</tr>
<tr>
<td>Readmissions, frequent flyers and alternatives to admission.</td>
<td>Responsive</td>
<td></td>
</tr>
<tr>
<td>Intermediate care indicators (e.g. clinically stable list)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not included in dashboard</td>
<td>Well Led</td>
<td>Strategic Change</td>
</tr>
<tr>
<td></td>
<td>Responsive</td>
<td></td>
</tr>
<tr>
<td>Operational HR indicators</td>
<td>Well Led</td>
<td></td>
</tr>
<tr>
<td>Staff satisfaction indicators</td>
<td>Patient Experience indicators</td>
<td></td>
</tr>
<tr>
<td>Temporary staff usage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recruitment and vacancies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial performance</td>
<td>Well Led</td>
<td></td>
</tr>
<tr>
<td>CIP delivery</td>
<td>Responsive</td>
<td></td>
</tr>
<tr>
<td>Operational productivity (outpatients, theatres etc.)</td>
<td>Effective</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Finance and use of Resources</td>
</tr>
</tbody>
</table>

Table 6: CQC Alignment
9 Our Strategic Objectives

The overall Vision of the Trust is to ‘Become Your Partners for First Class Integrated Care’. We will work proactively with our colleagues, patients and their families/carers to deliver integrated health and social care services that best meet the patients’ needs. This was adopted by the Trust Board in February 2016 where it was agreed our future sustainable care offering was in partnership with the wider health economy.

We will achieve these objectives as follows:

- **We will ensure that all of our services are safe and of the highest quality by constantly monitoring and improving the services that we provide using data, reporting and feedback from staff, patients and carers as the basis for all improvements. If we cannot provide a service safely and to an acceptable level of quality on our own, we will say so and work with partners to develop an alternative approach.**

- **We will provide the right care, in the right place by the right person at the right time – providing care for patients at home whenever we can. In order to deliver this we will focus on the care that can be delivered in the community. The clinical and social needs will always be forefront in the decision making process in order to achieve the best outcomes for all patients accessing our services. Supporting more patients to live longer at home and reducing reliance on hospital care will be a key measure of our success.**

- **We know we cannot deliver our Vision on our own. In order to deliver a first class service we will focus on working as part of a seamless service with our colleagues outside Walsall Healthcare NHS Trust. This will see us further developing our relationships with colleagues in primary care, mental health and social services to streamline services and ensure that our patients are following one clear pathway with minimal handovers. It will also mean collaboration with other providers through the Black Country Alliance to sustain and develop smaller acute services.**
Our Strategy has been developed in response to the national drivers such as the three gaps outlined in the Five Year Forward View, the need for integration of health and care services as outlined by the Kings Fund and Nuffield Trust. In addition, regional and local drivers as set out in the Sustainability and Transformation plans (STP) and our place based care as coordinated by the Walsall Together programme have also been factored in our Strategy.

Our approach to the new models of care being developed is underpinned by a set of principles, depicted below.

### 9.1 Principles for New Models of Care

The care we deliver in support of this Strategy will have two guiding principles:

1. We will deliver the **right care, in the right place, at the right time** as we would want it delivered for our families and friends
2. If we provide a service we will **provide it safely**. If we cannot do so on our own we will work with partners or seek a different provider.

To ensure we maintain these guiding principles, we have underpinned them with our key service principles.
1. Our services will help patients take responsibility for looking after their own health working with communities, other agencies and the voluntary sector

2. Our services will care for patients in their own homes whenever it is safe to do so

3. Our services will respond to crises by seeking to keep patients safe and well at home (e.g. rapid response interventions)

4. Our services will “assess to admit” – acute assessment, ambulatory whenever possible in advance of admission

5. Our services will support GPs to care for patients in primary care – diagnostic and outpatient pathways will share care

6. Our services will minimise hospital stay – minimally invasive techniques, a culture of “no delays” and discharge planning from day one

7. Our services will “discharge to assess” – “home first”; no decision about long-term care from acute hospital. We will provide intermediate care to support this.

9.2 Plan Development

9.2.1 Strategic Engagement

The Strategy was approved by the Board using the methodology prescribed in the Monitor Strategy Development Toolkit (Now NHSI). It has been agreed that the Strategy must be monitored through a series of key milestones that should be reviewed by the Board at regular periods.

There have been ‘deep dive’ sessions held with clinical and management teams of each specialty to understand how they might change over the coming years. The output from this work informed the strategic direction and intentions for the Trust. The detailed output of this work is built into the Clinical Services Strategy that will inform the Trust’s annual planning through a set of milestones. We recognise that there is more work to be done in further refining the five clinical services strategy.

It is clear that future service delivery and high quality sustainable services will only be achieved through significant partnership working and collaboration. Integrated services are seen as a significant contributor to the potential strategic solution for all partners.

The next phase focuses on the development of a wider service delivery vehicle as Walsall’s health and social care economy aligns with the Five Year Forward View. The Trust will play a significant role in this programme.

Partnership Boards for Walsall Together and the Black Country Alliance have been established, in order to develop a sustainable and deliverable plan and to provide the underpinning governance structure. This includes key partners from the third sector, the Local Authority, mental health trusts and primary care providers.

As the Partnership Board becomes established further work will be undertaken to assess and modify the alignment of current service strategies across Walsall providers and the CCG with a view to having a single Walsall activity model for the future.
10. Strategic Improvement for 2021/22 Services

The Trust’s Strategy is aligned to this principle of working in partnership to achieve system-wide transformation through our Vision of “Becoming your partners for first class integrated care”.

To deliver the transformation of services for 2021/22, our high level strategic plan focuses on transforming the care we provide through the following seven high level strategic themes:

1. Prevention and Self-management
2. Care at Home
3. Maternity and Children
4. Elective Care
5. Acute Care
6. Intermediate Care
7. End of Life Care

What does this mean?
We have a responsibility to deliver major changes in health service provision to benefit the communities we serve. Going forward a major focus will be in the transition of care from hospital to community services in line with the NHS Five Year Forward View; improving our processes for recording information; efficiency improvements to deliver value for the public purse and in developing our workforce. Fundamentally, we have to meet and satisfy the expectations of NHS Improvement as measured by the CQC (January 2016) for all of the domains to be rated as “good”. Appendix 3 details our plan on a page.

What are we doing?
We are taking a programme management approach to facilitate service improvement that will future proof our services, support sustainability and ensure that we learn from past mistakes. The Service Improvement team will engage with colleagues from across the system to demonstrate progress against agreed metrics. A robust Service Improvement Strategy sets the aspirations of the Trust; the approach that will be used; the tools to be deployed and the educational programme for embedding an improvement approach across the organisation.

The following sections set out the work to be undertaken to deliver the seven high level strategic themes. Driver diagrams set out the underpinning actions and intermediate steps that need to be taken to deliver these strategic themes. These diagrams can be found in the Improvement Strategy 2017-2019.

Our Two Year Operational plan 2017-2019, contains further details as to what we are proposing to deliver and how.
10.1 Prevention & Self-Management Services:

Our Vision for prevention and self-management is to enable the people of Walsall to have the best chances in life, living more independently and with a healthier lifestyle. To achieve this the Trust needs to engage in a prevention program linked to care at home ensuring that the prevalence of long term conditions is controlled, if not reduced, by specialised early intervention and education. A patient self-help program will be developed with partners to reduce demand on secondary care. We will utilise trained volunteers to help patients live with their long term conditions.

<table>
<thead>
<tr>
<th>Area</th>
<th>Impact</th>
</tr>
</thead>
</table>
| Expert Patient Programme           | • Increase number of patients who can manage their conditions more effectively  
                                | • Decrease the number of admissions from cohorts of patients           |
| Supporting healthy choices         | • Make maximum impact for patients by linking to community and hospital services |
| Prevention linked to mainstream care pathways | • Referrals into self-care courses increase and newly diagnosed patients have an improved management of their own care. |
| Healthy Lifestyles Programme for Trust employees | • Healthier staff  
                                | • Greater awareness of health promotion amongst wider workforce |

Table 7: Components of Prevention & self-management

The development of IT mobile working solutions will release some of the currently occupied estate and will realise the benefits of mobile teams. The workforce will have greater flexibility, though will require further education in health promotion to provide a high level of service to patients and Trust employees.

10.2 Care at Home

The Vision for Care at Home services is to move to a true single point of access including co-location of the various team members from mental health, social care and Walsall Healthcare to be able to coordinate patient care in a more holistic way. The teams will be able to focus more on increasing independence and reducing the reliance on care through health promotion and early identification and intervention. This will be supported by the Resilient Communities Project.

An increase in wraparound care and a structured approach to nursing home support will further reduce admissions and readmissions to the acute environment. Actively working on pulling patients from the acute service will also reduce our length of stay. The ultimate aim is to reduce acute bed stock by 20%. The shift from acute care to more community based care
is a significant step for the patients as well who will need to be engaged in how service models will change.

<table>
<thead>
<tr>
<th>Area</th>
<th>Impact</th>
</tr>
</thead>
</table>
| • Integrated Community locality teams, based on a population of 50,000 per locality | • Reduced barriers to effective working  
• Reduced estate pressures  
• More IT supported mobile working |
| • Shared approach to identification of vulnerable patients | • More vulnerable patients identified and supported earlier  
• Agreed approach to management of patients |
| • Rapid Response Team linked to social care re-ablement | • Capacity to respond to increased levels of demand |
| • Case management model for vulnerable patients | • Agreed approach to out of area patients  
• Alignment of workforce to demand and development of shared roles with primary care and social care |

Table 8: Care at home key areas and impacts

Collaborative working with partners will need to be supported by an integrated IT solution and redeployment of some staff. Development of capacity and demand will ensure the workforce is appropriately and efficiently aligned. Work is required to create a common approach to patients from out of Walsall e.g. Staffordshire and Sandwell.

10.3 Maternity and Children

The redeveloped Maternity Unit and Midwifery Led Unit planned for 2018 will have capacity to deal with up to 5,000 births per year, with a Neonatal Unit capable of dealing with the associated needs. Earlier intervention from maternity pathways will support high risk women, improving outcomes reducing in perinatal mortality.

With greater integration between community children’s services, social care and education services, more children can be cared for at home, and sufficient CAMHS support can be made available for those in need.

<table>
<thead>
<tr>
<th>Area</th>
<th>Impact</th>
</tr>
</thead>
</table>
| • Maternity service estate and staff – anticipate 5,000 births per year | • Increased activity and demand on services  
• Sufficient maternity and NNU workforce for level of activity |
| • Neo-Natal Unit – 20 cots for 5,000 births | • Support available for increased demand and retention of activity within Walsall |
| • Maternity pathways – improving outcomes | • Better patient experience  
• Ensuring pathway accommodates geographical boundary shift |
| • Paediatrics – integrated emergency model and community based pathways | • Workforce recruitment improves  
• Delivery of service retained  
• Quick access to CAMHS may be required |

Table 9: Maternity key factors

Becoming your partners for first class integrated care
Maternity service model redesign is needed and requires integration to work effectively, linking with the ‘front door’ of the Trust more easily. To accommodate the expected increase in births to 5000, sufficient staffing to safe levels is being factored into the workforce plan.

10.4 Elective Care

We intend that all specialties will be operating shared care pathways with primary care and one-stop models that are well organised and efficient with quick access to diagnostics.

Pathways will be redesigned so that provision can be provided in community rather than hospital settings where appropriate. This will be linked with diagnostics in the right sequence before the first clinic.

Where possible, day case and minimally invasive surgery will be adopted as standard, with early supported discharges. The consistent delivery of NHS Constitutional Standards for cancer and elective care will ensure high quality care for patients.

<table>
<thead>
<tr>
<th>Area</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Shared care and one-stop care pathways</td>
<td>• Change to service models to deliver shared care and one stop pathways</td>
</tr>
<tr>
<td>2. Diagnostic capacity – second MRI / gamma camera</td>
<td>• Estates impact – capacity for new equipment in existing estate to be determined • Case for expansion to meet demand</td>
</tr>
<tr>
<td>3. Effectively organised specialist clinics</td>
<td>• Better patient flow • Reduction in waiting times and backlog</td>
</tr>
<tr>
<td>4. Day case, minimally invasive and early supported discharge for electives</td>
<td>• Configuration – future sustainability of colorectal cancer surgery</td>
</tr>
</tbody>
</table>

Table 10: Elective care factors

With the changing of patient pathways and service redesigns, there may be an impact to the number, type and complexity of patients being referred through the elective care route, so a wider understanding of the change would be beneficial. The current number of referrals is reducing, but if they increase again capacity may become problematic, in addition to the challenges of having the appropriate workforce to manage the different complexities of the patients.

10.5 Acute Care

An integrated emergency and urgent care ‘front door’ run by the Trust is the key aim to ensuring we provide consistent, effective and efficient services for patients. Having the assessment and ambulatory care elements co-located will also benefit the patient pathway.
We need to flex the current medical staffing model to utilise more advanced practitioners with senior clinical decision-making support and a short stay acute care and assessment unit to assist in reducing length of stay.

This will be combined with more 7-day service provision, increased use of the assess to admit protocol, and integrated community pathways to support more patients to be treated effectively in the community. An integrated IT solution will bind and strengthen all of the work areas and pathways.

<table>
<thead>
<tr>
<th>Area</th>
<th>Impact</th>
</tr>
</thead>
</table>
| 1. Emergency Care Centre – Integrated “front door” | • Patients streamed to primary care or community care urgent care or ED  
• Reduce pressure on ED from cases which can be dealt with elsewhere |
| 2. Assess to Admit and short stay acute model | • Use community alternatives more effectively  
• Short-stay acute care – ambulatory care  
• Significant change to Service models |
| 3. 7 day national standards for acute care (section 10.11 refers) | • Services meet National 7 day standards in Medicine, surgery and trauma  
• Workforce impacts to deliver 7 day services |
| 4. Specialist networks for trauma, cancer, cardiac and stroke | • Strong links to networks  
• Development of pathways |
| 5. Fit for purpose integrated critical care unit (HDU and ITU) | • New unit under construction |
| 6. Improved LOS model | • Full deployment of SAFER bundle  
• Integrated pathways linked to high volume conditions |

Table 11: Elective Care Key factors

The construction of the new ITU planned for opening in 2018 is a big step forward, but planning for the Urgent and Emergency Care centre (front door) requires considerable focus to ensure it is fit for purpose and future proof. Changes in working practices and staffing models will take time to adjust to, but will benefit patients throughout. The impact of the Midland Met Hospital in 2018 is expected to increase ED attendances by up to 7000 pa with the associated need for an additional 2 medical wards (see activity modelling in section 11).

10.6 Intermediate Care

The future model will be an integrated health and social care, adult physical and mental health intermediate care model. The Multi-Disciplinary Team will develop processes where discharge home to assess and home-based admission avoidance is the default approach, focussed on setting patient-centred goals and measuring achievement against these.

The ultimate aim is to reduce the fragmentation and complexity in the current intermediate care pathways. There is also a requirement for workforce and capacity modelling to be aligned, to deliver the most effective and efficient match between demand and capacity
Area                                Impact                                                   
1. Integrated intermediate care –  
   health, social care and older  
   adult mental health            • Better patient flow through the system with less  
                                   handovers                                                   
                                   • Patients experience along care pathway seamless  
2. Discharge to assess care path-  
   way                           • Improved patient flow and experience                        
                                   • Reduce length of stay                                        
3. Elderly Care Centre – fit for  
   purpose step-down facilities   • Patients in a care environment suitable to their care needs  
4. Frail Elderly Service / rapid  
   Response Team – maximising    • Frail Elderly service running but not yet up to                       
   their impact              capacity                                                   
                                   • Run service to capacity enabling better care and  
                                   patient flow                                              

Table 12: Intermediate Care key factors

A wider understanding of the impact on the acute environment, bed capacity and availability will need to be modelled. There are also significant changes to the various service models, e.g. discharge to assess, which require engagement and collaboration to ensure they are effective and robust in their approach. Detailed estate plans will also be needed to enable this to work effectively.

10.7 End of Life Care

The specialist palliative care team work across hospital and community services, with teams supporting end of life patients to remain comfortable at home as much as possible rather than in hospital. The recently launched Individualised End of Life Care Plan is being implemented to further enhance the care for patients and work has commenced on the Amber Care Bundle in hospital and primary care.

Being the prime provider of all palliative and End of Life care across the borough is a key aim for the team, working with primary care to increase the uptake of the Amber Care Bundle and improve planning for end of life care. Early identification of patients at the end of life and a closer alignment of social care, mental health and use of specialist care beds for respite etc. will result in patients experiencing a more integrated approach to their care.
1. Specialist palliative care team using end of life care plan
   - Meeting patients preferred choice and place of care

2. Awareness of end of life care across all pathways
   - Access to the right services for patients and carers
   - Improved patient dignity along the pathway

3. Increased range of non-hospital end of life care services
   - Patient choice of place of death respected and alternatives available (i.e. hospice or home)

<table>
<thead>
<tr>
<th>Area</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Specialist palliative care team using end of life care plan</td>
</tr>
<tr>
<td>2.</td>
<td>Awareness of end of life care across all pathways</td>
</tr>
<tr>
<td>3.</td>
<td>Increased range of non-hospital end of life care services</td>
</tr>
</tbody>
</table>

Table 13: End of Life key factors

For more patients to be treated in the community, further estate options would need to be considered. However with the changes to the national guidelines for palliative care, the tariff changes and NICE guideline amendments there is a need to plan appropriately to accommodate all of these changes into any future service redesign work. Training in end of life care for all clinical staff across the Trust will ensure the early identification of end of life patients is achieved and that their needs are met.

10.8 Seven Day working

Underpinning the above is the requirement for services to be offered 7 days a week.

Achieving equity across health services is a fundamental requirement within the NHS Constitution, and the Five Year Forward View for the NHS is clear about the need to have diagnostics and other key services available seven days a week.

There are three key milestones for achievement of 7 day working:

By March 2017:- 25% of the population will have access to the same quality of service on every day of the week

By March 2018:- 50% of the population will have access to the same quality of service on every day of the week

By March 2020:- 100% of the population will have access to the same quality of service on every day of the week

The primary areas of focus for development of 7 day services within the Trust are detailed in the table below.
<table>
<thead>
<tr>
<th>Standard</th>
<th>Brief Description of Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard 2</td>
<td>All emergency admissions have a thorough clinical assessment by suitable consultant within 14 hours</td>
</tr>
</tbody>
</table>
| Standard 5 | Inpatients must have seven-day, scheduled access to diagnostics:-  
1. within 1 hour for critical patients  
2. within 12 hours for urgent patients  
3. Within 24 hours for non-urgent patients |
| Standard 6 | Inpatients must have must have timely 24-hour access, seven days a week, to consultant-directed interventions that meet the relevant specialty guidelines |
| Standard 8 | All patients on the AMU, SAU, ICU and other high dependency areas must be reviewed by a consultant twice daily, including all acutely ill patients directly transferred, or others who deteriorate. To maximise continuity of care consultants should be working multiple day blocks. |

Table 14: Seven day standards

10.9 Strategic Milestones

This document sets out our Strategic Plan for the Trust for the next 5 years to 2021/22 and has articulated the wider context, the need for partnership working and collaborative approaches to delivering new models of care.

Initial milestones and dependencies for each of the seven high level strategic themes have been developed and set out into short term, medium term and long term delivery. Our plans will develop further with details and these milestones will be updated. The initial milestones are given in the table overleaf.
<table>
<thead>
<tr>
<th>Strategic Theme</th>
<th>Milestones</th>
<th>Medium Term Years 3-4</th>
<th>Long-term Year 5</th>
<th>Dependencies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prevention and Self-management</strong></td>
<td>Increased number of self-care programmes</td>
<td>Reduction in average number of patient attendances</td>
<td>Reduced diagnosis of targeted conditions</td>
<td>Quality and efficacy of the programmes</td>
</tr>
<tr>
<td></td>
<td>Healthier staff</td>
<td></td>
<td>Continued and expanded self-care programmes</td>
<td>Public Health initiatives</td>
</tr>
<tr>
<td><strong>Care at Home</strong></td>
<td>Integrated place based teams</td>
<td>Up-skilled staff improving multi-professional working</td>
<td>Shared approach to management of vulnerable patients</td>
<td>Partnership working with other care organisations</td>
</tr>
<tr>
<td></td>
<td>Clarity of care pathways</td>
<td></td>
<td>Improved health and care services in the community setting , services built around patients</td>
<td>Mobile technology implementation</td>
</tr>
<tr>
<td></td>
<td>Increased training for staff</td>
<td></td>
<td></td>
<td>HEWM training programmes</td>
</tr>
<tr>
<td><strong>Maternity and Children</strong></td>
<td>Test model for future demand to determine if model is sustainable.</td>
<td>Embed the service, recruiting staff with the right skills to maintain a safe and quality service</td>
<td>Review the birth rate and confirm model for demand</td>
<td>HEWM training programmes</td>
</tr>
<tr>
<td></td>
<td>Estates redevelopment required</td>
<td></td>
<td></td>
<td>Recruitment of appropriate staff within timeframe</td>
</tr>
<tr>
<td></td>
<td>Succession planning and staffing skills</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Elective Care</strong></td>
<td>Meet standards for 7 day working (section 10.8 refers)</td>
<td>Recruitment and retention of appropriately skilled workforce</td>
<td>Consistently hitting the NHS constitution Standards for cancer and elective care</td>
<td>Commissioning intensions</td>
</tr>
<tr>
<td></td>
<td>Appropriately skilled work force</td>
<td>Increase in day case activity for certain procedures</td>
<td></td>
<td>Role of GPs</td>
</tr>
<tr>
<td></td>
<td>Reduce DNA rates for OPD operating in core capacity</td>
<td></td>
<td></td>
<td>Development of new organisational forms (i.e. ACO)</td>
</tr>
<tr>
<td><strong>Acute Care</strong></td>
<td>Improve GP links</td>
<td>Specialist services will be aligned</td>
<td>Integrated front door for emergency care</td>
<td>Repatriation of activity from other providers</td>
</tr>
<tr>
<td></td>
<td>Timely completion of</td>
<td>Improved discharge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strategic Theme</td>
<td>Milestones</td>
<td>Dependencies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------</td>
<td>------------</td>
<td>--------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>EDS</strong>&lt;br&gt;Ambulatory care pathway&lt;br&gt;Meet the national A&amp;E targets</td>
<td>processes embedded&lt;br&gt;Effective assess to admit pathways</td>
<td>Prevent inappropriate admissions&lt;br&gt;Improved patient flow</td>
<td>Quality of diagnosis for conditions.&lt;br&gt;HEWM programmes</td>
<td></td>
</tr>
<tr>
<td><strong>Intermediate Care</strong>&lt;br&gt;Develop home to assess pathway&lt;br&gt;Expand rapid response team&lt;br&gt;Develop post-acute stroke rehab</td>
<td>Fit for purpose step-up and step-down facility&lt;br&gt;Home based admission avoidance is first consideration&lt;br&gt;Reduction in readmissions</td>
<td>Elderly Care Centre&lt;br&gt;Reduced reliance on bed based services&lt;br&gt;Reduced duplication</td>
<td>Estate reconfiguration&lt;br&gt;Case for post-acute rehab</td>
<td></td>
</tr>
<tr>
<td><strong>End of Life Care</strong>&lt;br&gt;Individualised end of life care plans&lt;br&gt;Patients able to die in their chosen location&lt;br&gt;Specialised end of life care team in place&lt;br&gt;Improved communications between staff, patients and families&lt;br&gt;Training for all staff regarding end of life care</td>
<td>Improved planning for end of life care&lt;br&gt;Early identification of patients at the end of life</td>
<td>Specialist training for end of life care&lt;br&gt;Engagement with patients and carers</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 15: Strategic Milestones
11. Improvement Approach

We have assessed our improvement objectives and evaluated the impacts both from a strategic financial and operational perspective. The results are detailed below and provide a clear focus for our Trust imperatives.

<table>
<thead>
<tr>
<th>Area</th>
<th>Improvement Activity</th>
<th>Financial Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Care at Home</td>
<td>• Maximise impact of integrated health and care locality teams (+7) in keeping highest risk people well at home.</td>
<td>• Reduction in overall bed days (OBDs) equivalent to one ward (10,000 in total; 1,400 per locality team per annum).</td>
</tr>
<tr>
<td>Potential priorities</td>
<td>• Continue to redesign frail elderly pathway - double impact of frail elderly team and rapid response team.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Redesign respiratory care pathway to prevent admissions.</td>
<td></td>
</tr>
<tr>
<td>2. Patient Flow / Length of Stay</td>
<td>• Discharge to assess – new model of care for medically fit patients using care at home and step down beds (modular block option, off site step down options).</td>
<td>• Reduction of OBDs equivalent to one ward (10,000) – reduce hospital bed capacity.</td>
</tr>
<tr>
<td>Potential priorities</td>
<td>• Establish an integrated health and social care intermediate care service.</td>
<td>• Sustainable reduction in medically fit list to &lt;50 pts.</td>
</tr>
<tr>
<td></td>
<td>• Consistent rigorous application of SAFER bundle approach supported by use of red to green days including establishment of effective discharge lounge.</td>
<td>• SAFER standards – at least 30% discharges by noon.</td>
</tr>
<tr>
<td>3. Outpatients</td>
<td>• Redesign of outpatient booking and clinic operation to halve DNAs and significantly reduce cancellations.</td>
<td>• Eliminate use of outpatient WLIs.</td>
</tr>
<tr>
<td>Potential priorities</td>
<td>• Standardise referral pathways, launch Advice &amp; Guidance and maximise use of triage to reduce unnecessary steps – start with orthopaedics and chronic pain services.</td>
<td>• Significant reduction in outpatient cancellations.</td>
</tr>
<tr>
<td></td>
<td>• Redesign pathways to reduce need for outpatient follow-up – start with urology, gastroenterology and orthopaedics.</td>
<td>• Clear outpatient follow-up backlog.</td>
</tr>
<tr>
<td>4. Theatres</td>
<td>• Improved theatre productivity – better in-session utilisation and earlier start times.</td>
<td>• Eliminate elective WLI spend.</td>
</tr>
<tr>
<td>Potential priorities</td>
<td>• Redesign pathways to make maximum use of minimally invasive and day case approaches to surgery.</td>
<td>• Reduce pre and post operational LOS.</td>
</tr>
<tr>
<td></td>
<td>• Improved theatre start times</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Improved in-session utilisation</td>
<td></td>
</tr>
<tr>
<td>5. IM&amp;T</td>
<td>• Community mobile technology – full remote access and case load management for the community teams.</td>
<td>• circa 10 – 20% increase in community team productivity.</td>
</tr>
<tr>
<td>Potential priorities</td>
<td>• E-prescribing – launch e-prescribing module (from Lorenzo subject to assessment) to complete elements necessary for EPR.</td>
<td>• Improved med management and support to reduced LOS.</td>
</tr>
<tr>
<td></td>
<td>• Tele-tracking – IT to support patient flow and bed management (New Cross Hospital model).</td>
<td></td>
</tr>
<tr>
<td>6. Workforce</td>
<td>• Continue to reduce sickness absence.</td>
<td>• Reduce agency spend – progress towards NHSI ceiling (TBC – NB this requires halving our agency spend)</td>
</tr>
<tr>
<td>Potential priorities</td>
<td>• Recruitment – effective plan for recruitment to keep clinical vacancies to a minimum.</td>
<td>• Agreed new roles in use and fewer vacancies.</td>
</tr>
<tr>
<td></td>
<td>• Redesign – full redesign of workforce model in specialities with biggest challenges to adopt sustainable models including use of new roles. To include – nursing roles (band 4, CSWs etc.) emergency medicine and paediatrics as first phase.</td>
<td></td>
</tr>
<tr>
<td>Area</td>
<td>Improvement Activity</td>
<td>Financial Impact</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| 7. Clinical Support Services              | • Deliver a shared pathology service for the three Black Country Alliance Trusts and Royal Wolverhampton  
  • Deliver our agreed Pharmacy improvement actions to respond to Carter recommendations.  
  • Assess extent to which other clinical support services need similar approach.                                                                                                                                | • Pathology delivers at least 5% pa savings.  
  • Pharmacy delivers their contribution to CIP – aiming for at least 5% pa.                                                                                                                                          |
| Possible priorities                        |                                                                                                                                                                                                                       |                                                                                                                                                                                                                |
|                                           | • Deliver BCA pathology model  
  • Pharmacy activity                                                                                                                                                                                                     |                                                                                                                                                                                                                |
| 8. Non-Clinical Support Services          | • Act on the outcome of the Black Country Alliance and Royal Wolverhampton “back office” review.  
  • Work with all our existing non-clinical support services to increase “self-serve” approach and increase standardisation and digitisation.                                                                   | • Non-clinical back office delivers savings of at least 5% pa – expect this this will be through sharing services across the patch.                                                                              |
| Possible priorities                        |                                                                                                                                                                                                                       |                                                                                                                                                                                                                |
|                                           | • Programme of back office change                                                                                                                                                                                      |                                                                                                                                                                                                                |
| 9. Procurement / Non-Pay Spend            | • Newly appointed Black Country Alliance procurement director to lead Alliance-wide programme to deliver procurement savings.  
  • Deliver a review of the Walsall Hospital PFI agreement to ensure trust is getting full value for money from the contract and unitary payment.                                                  | • Procurement savings in line with Carter recommendations – value to be finalised across BCA.  
  • Potential for improved VFM from PFI identified.                                                                                                                                                                |
| Potential priorities                      |                                                                                                                                                                                                                       |                                                                                                                                                                                                                |
|                                           | • BCA procurement activity  
  • PFI contract review                                                                                                                                                                                                     |                                                                                                                                                                                                                |
| Plus Sustainability Review                | • Assessment of sustainability of key services in light of trust strategy, workforce models, clinical quality and financial position.                                                                                  | • Process to be agreed in light of Q4 priorities.                                                                                                                                                                |
| [Trust Board]                             |                                                                                                                                                                                                                       |                                                                                                                                                                                                                |

Table 16: Improvement Programme

### 11.1 Stakeholder Engagement

The Strategy will be communicated to our people and external stakeholders using a variety of communications methods and approaches to ensure full engagement and understanding. Executive summaries will be produced for easy access and onward distribution.

Internal processes will include presentations at senior team, divisional and operational meetings and inclusion in the Trust’s social media channels. Targeted communications to operational staff and those without regular access to PCs will include posters, notice board information and face to face briefing sessions.

As part of developing effective partnerships the Trust is identifying and mapping its stakeholders. We will be utilising the NHS Improvement’s model to identify types of stakeholder and to understand how we can best meet their, and our, needs for communication, involvement and wider engagement.

The grid given at figure 7 shows the NHS Improvement’s model for prioritising stakeholders.
To supplement the above grid we have plotted our key stakeholders to contextualise their relative position and influence. In addition, in applying the NHSI Stakeholder model the Trust has identified stakeholders which fall within the 9 categories and how best to engage with them as shown below.

12. Activity Model

We estimate that 20% of our hospital activity will need to move into the community settings over the next five years in order to manage future predicted demand and to remain sustainable. Further, that our out-patient activity will rise between 1% and 3% for each of our specialties year on year with some exceptions.

We continue to engage with our clinical leads, care groups and partners to agree the assumptions on activity to 2021. These will be refined as more intelligence is received and as our modelling activity refers.

The current activity levels and assumptions for the next two years are shown in the tables below.
Table 17: Activity projections

<table>
<thead>
<tr>
<th>Activity Line (POD)</th>
<th>Trust 15/16 Outturn</th>
<th>Forecast outturn 16/17</th>
<th>17/18 Plan</th>
<th>18/19 Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Referrals (GP and Other)</td>
<td>93,591</td>
<td>99,518</td>
<td>103,352</td>
<td>107,073</td>
</tr>
<tr>
<td>Consultant led Total 1st Outpatient attendances</td>
<td>87,029</td>
<td>88,330</td>
<td>91,422</td>
<td>94,713</td>
</tr>
<tr>
<td>Consultant led Follow up outpatient attendances</td>
<td>156,818</td>
<td>131,181</td>
<td>135,722</td>
<td>140,660</td>
</tr>
<tr>
<td>Total Elective admissions (spells)</td>
<td>25,667</td>
<td>23,523</td>
<td>23,946</td>
<td>24,377</td>
</tr>
<tr>
<td>Total Non-elective admissions (spells)</td>
<td>37,440</td>
<td>33,867</td>
<td>34,544</td>
<td>35,339</td>
</tr>
<tr>
<td>Total A&amp;E attendances</td>
<td>77,231</td>
<td>70,323</td>
<td>74,076</td>
<td>75,706</td>
</tr>
<tr>
<td>Community Activity</td>
<td>365,729</td>
<td>362,889</td>
<td>371,236</td>
<td>379,774</td>
</tr>
</tbody>
</table>

Alongside our strategic modelling is the Trust’s operational demand and capacity modelling. This is owned by each care group and then built up into a Trust level plan. This ensures that data is present and utilised for key decision making within the divisions. Our future resources will include a dedicated demand and capacity manager who will be responsible for developing and maintaining a strategic activity model.

13. Risks

Our key risks are tabulated below:

<table>
<thead>
<tr>
<th>Financial gap – Local Health Economy (LHE)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk:</strong> Overall Strategy does not deliver required changes resulting in services not affordable to LHE.</td>
</tr>
<tr>
<td><strong>Conclusion:</strong> The work across Walsall is enshrined in Walsall Together, which will develop and deliver an approach across commissioners and providers that is affordable. This work will cover the development of integrated care approach across the system and delivery of the most effective elective care pathways. In both cases, improving the patients’ journey by reducing duplication, variation and waste and improving communication.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Financial gap – Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk:</strong> That the Trust overspends compared to its agreed deficit plan in 2016-17 and is unable to return to balance in 2017-18</td>
</tr>
<tr>
<td><strong>Conclusion:</strong> The Trust has set an ambitious financial recovery plan in 2016-17 and 2017-18. Staff are working on 2017-18 schemes and also 2018-19.</td>
</tr>
</tbody>
</table>
Financial gap – Local Health Economy (LHE) targets. There is a plan which is being worked to.

Impact if a LHE wider Strategy of integration is not delivered

**Risk:** Making the required changes to patient's pathway and flow, particularly in urgent care is not possible if not all partners fully collaborate.

**Conclusion:** The Trust will look to influence the LHE Strategy to consider a wider model of integration beyond health.

Current performance with regard to delayed transfers of care significantly impacts on the experience and outcomes for patients who are unable to receive care in the most appropriate location. Evidence and policy suggests that greater degrees of integration across health and social care can minimise these through improved use of resources, shared and single points of assessment and decision making.

Growing range of providers in the market

**Risk:** New entrants into the market will succeed in attracting services resulting in income loss

**Conclusion:** The Trust needs to ensure that it take opportunities to work collaboratively with partners and be able to demonstrate safe, high quality services as well as the added benefits of placing activity with the Trust.

Over recent months competitors have secured tendered services in and around the Trusts footprint. The recent tender of community services in Dudley to deliver services under an MCP form of contract will bring more competitors into the local area. The CAO from Dudley CCG is now covering the CAO post within Walsall. That spotlight may remain and generate more interest in other services due to go out to the market soon. In any tender process we need to be able to demonstrate the added benefits of the Trust.

Organisational Culture

**Risk:** The Trust's culture is focused on meeting today's challenge and not looking forward

**Conclusion:** Robust plans have been put in place to address the reporting and monitoring of plans and alongside the Transformation Strategy to embed an improvement approach across the Trust

Plans are developed in isolation and not shared and objectives are often produced and then not monitored or refined.

Five year plans are being developed by each care group working from the bottom up in a system alignment approach. A strategic planning group has been established to develop and support clinical strategies. Annual planning process is being embedded with quarterly reviews

Improved performance management systems are being introduced to ensure that problems are identified at the earliest point and mitigation developed to maintain delivery.

Ability to deliver scale of CIP during the period

**Risk:** The service improvement and cost efficiency programme does not deliver the financial impact planned resulting in non-delivery of financial plan.

**Conclusion:** Delivery of robust governance and reporting system will enable the Board to identify how plans for cost efficiency are progressing and when additional measures are required.

The Trust's long term financial plans assume that a significant saving will be required each year during the period.

Schemes are in place for 16/17, with an element of 17/18 in planning. A robust programme approach has been developed which has clear senior executive governance of schemes. Over time, the Trust Strategy should deliver efficiencies.
**Impact of the Vanguard & Multi-specialty Community Providers (MCP) is unknown**

**Risk:** The progress of these provider structures does not support the Trust’s business strategy.

CCGs within the Black Country have placed significant elements of care into the market under the MCP initiative. The delivery of these service types within Walsall is key to the sustainability of the Trust. As an existing provider locally, we would be well placed to retain our role, if our local CCG follows the same process. Providing that we remain flexible to change requirements based on service improvement and continue to improve our delivery of services.

**Conclusion:** The Trust will work effectively in collaboration with partners to develop the model delivering the best outcomes and ensure that it has a flexible approach to proposed changes.

---

**Table 18: Risk and mitigations**

---

**14. Finance**

**14.1 Historic and Projected Income Analysis**

The financial impact of the price and volume (growth) by source and year is shown in the below table. The 2014/15 and 2015/16 figures represent actual outturn income agreed with the commissioners. The 2016/17 position reflects agreed contract levels (FOT). Future years 2017/18 to 2018/19 are based on agreed/estimated contract values within the December 2016 contracting rounds and Financial Plan submissions.

<table>
<thead>
<tr>
<th>Income</th>
<th>2014/15 Outturn £000’s</th>
<th>2015/16 Outturn £000’s</th>
<th>2016/17 FOT £000’s</th>
<th>2017/18 Forecast £000’s</th>
<th>2018/19 Forecast £000’s</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCG</td>
<td>185,127</td>
<td>187,682</td>
<td>189,216</td>
<td>191,853</td>
<td>196,304</td>
</tr>
<tr>
<td>NHSE</td>
<td>23,917</td>
<td>21,015</td>
<td>20,320</td>
<td>20,229</td>
<td>20,757</td>
</tr>
<tr>
<td>Other Internal (HEE, S7, LA, BCF)</td>
<td>30,354</td>
<td>34,672</td>
<td>32,113</td>
<td>27,416</td>
<td>27,437</td>
</tr>
<tr>
<td>Other External</td>
<td>93</td>
<td>156</td>
<td>207</td>
<td>108</td>
<td>108</td>
</tr>
<tr>
<td>Total Income</td>
<td>239,491</td>
<td>243,525</td>
<td>241,856</td>
<td>239,606</td>
<td>244,606</td>
</tr>
</tbody>
</table>

**Table 19: Income Projections**

The above table does not include activity movements from demand Midland Metropolitan Hospital are excluded from the above scenarios subject to agreement with Sandwell and West Birmingham Hospitals NHS Trust.
14.2 Historic and Projected Expenditure Analysis

The table below demonstrates the impact of the price and volume (growth) assumptions by forecast as per assumptions in the Black Country STP submission, local commissioning agreements and nationally recognised cost pressures prior to CIP delivery for 2017/18 and 2018/19.

<table>
<thead>
<tr>
<th>Expenditure</th>
<th>2014/15 Outturn £000’s</th>
<th>2015/16 Outturn £000’s</th>
<th>2016/17 FOT £000’s</th>
<th>2017/18 Forecast £000’s</th>
<th>2018/19 Forecast £000’s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workforce - Substantive and Bank</td>
<td>153,970</td>
<td>155,782</td>
<td>160,355</td>
<td>164,253</td>
<td>161,939</td>
</tr>
<tr>
<td>Workforce - Agency</td>
<td>8,296</td>
<td>9,180</td>
<td>11,175</td>
<td>9,180</td>
<td>7,800</td>
</tr>
<tr>
<td>Drugs</td>
<td>16,227</td>
<td>17,553</td>
<td>17,780</td>
<td>18,516</td>
<td>19,186</td>
</tr>
<tr>
<td>Procurement</td>
<td>32,261</td>
<td>28,377</td>
<td>26,381</td>
<td>29,096</td>
<td>29,806</td>
</tr>
<tr>
<td>PFI</td>
<td>7,073</td>
<td>5,186</td>
<td>7,587</td>
<td>7,775</td>
<td>7,972</td>
</tr>
<tr>
<td>Capital Charges</td>
<td>6,850</td>
<td>6,900</td>
<td>7,149</td>
<td>7,508</td>
<td>7,748</td>
</tr>
<tr>
<td>Litigation</td>
<td>6,926</td>
<td>10,735</td>
<td>11,808</td>
<td>13,760</td>
<td>16,080</td>
</tr>
<tr>
<td>Provider Other</td>
<td>23,322</td>
<td>20,514</td>
<td>21,433</td>
<td>21,018</td>
<td>20,286</td>
</tr>
<tr>
<td><strong>Total Expenditure</strong></td>
<td><strong>254,925</strong></td>
<td><strong>254,227</strong></td>
<td><strong>263,668</strong></td>
<td><strong>271,106</strong></td>
<td><strong>270,817</strong></td>
</tr>
</tbody>
</table>

Table 20: Expenditure Projections

Assumptions for growth assumptions for the Midland Metropolitan are excluded for consistency with income forecasts.
14.3 Finance Summary (LTFM)
The table below demonstrates the overall income and expenditure impact based on the growth and inflation assumptions as indicated above and prior to CIP delivery (2017/18 onwards).

<table>
<thead>
<tr>
<th>Summary</th>
<th>2014/15 Outturn £000’s</th>
<th>2015/16 Outturn £000’s</th>
<th>2016/17 FOT £000’s</th>
<th>2017/18 Forecast £000’s</th>
<th>2018/19 Forecast £000’s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care Income</td>
<td>209,044</td>
<td>208,697</td>
<td>209,536</td>
<td>212,082</td>
<td>217,061</td>
</tr>
<tr>
<td>Other Income</td>
<td>30,447</td>
<td>34,828</td>
<td>32,320</td>
<td>27,524</td>
<td>27,545</td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td>239,491</td>
<td>243,525</td>
<td>241,856</td>
<td>239,606</td>
<td>244,606</td>
</tr>
<tr>
<td>Pay Expenditure</td>
<td>162,266</td>
<td>164,962</td>
<td>171,530</td>
<td>173,433</td>
<td>169,739</td>
</tr>
<tr>
<td>Non Pay Expenditure</td>
<td>78,736</td>
<td>77,179</td>
<td>77,402</td>
<td>82,390</td>
<td>85,358</td>
</tr>
<tr>
<td>PFI</td>
<td>7,073</td>
<td>5,186</td>
<td>7,587</td>
<td>7,775</td>
<td>7,972</td>
</tr>
<tr>
<td>Capital Charges</td>
<td>6,850</td>
<td>6,900</td>
<td>7,149</td>
<td>7,508</td>
<td>7,748</td>
</tr>
<tr>
<td><strong>Total Expenditure</strong></td>
<td>254,925</td>
<td>254,227</td>
<td>263,668</td>
<td>271,106</td>
<td>270,817</td>
</tr>
<tr>
<td>Surplus/(Deficit)</td>
<td>(15,434)</td>
<td>(10,702)</td>
<td>(21,812)</td>
<td>(31,500)</td>
<td>(26,211)</td>
</tr>
</tbody>
</table>

Table 21: LTFM

A key assumption is that we will deliver the 2016/17 financial forecast outturn of a £22m deficit.

The above summary shows a recurrent deficit increasing to £26.2m by 2018/19. This is prior to any cost improvement plan (CIP) delivery beyond 2016/17. The CIP challenge remains fairly consistent at an income and expenditure shortfall of circa £10.5 - £11m per annum.

The financial modelling includes the impact of any QIPP schemes to be implemented by the commissioner.

14.4 Financial Recovery Plan (CIP)

The table below demonstrates the percentage level of CIP planned for 2017/18 and 2018/19 and cumulatively based on the I&E table shown above.

At these projected percentages we would be above the national average of 2.5%.

The projections include the Trust’s targeted outturns for 2016/17 to 2018/19.
A key assumption above is that the targeted CIP is delivered recurrently in each year.

A key assumption above is that the targeted CIP is delivered recurrently in each year.

### 14.5 Draft Capital Programme

The Trust's capital planning assumptions are tabulated below. Key programmes include the A&E development and Integrated Critical Care Unit. An additional ward for A&E has also been factored. The additional ward and A&E department both require business case approval to secure funding.
Table 23: Draft Capital Programme

<table>
<thead>
<tr>
<th>Project</th>
<th>Initial</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other</td>
<td>712</td>
<td>232</td>
<td>144</td>
<td>200</td>
<td>200</td>
</tr>
<tr>
<td>West Wing Improvements</td>
<td>4,000</td>
<td>0</td>
<td>0</td>
<td>1,300</td>
<td></td>
</tr>
<tr>
<td>Donated Assets</td>
<td></td>
<td>352</td>
<td>100</td>
<td>100</td>
<td>552</td>
</tr>
<tr>
<td>Maternity expansion</td>
<td></td>
<td>370</td>
<td>5,230</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A&amp;E Development</td>
<td>461</td>
<td></td>
<td>2,000</td>
<td>10,500</td>
<td></td>
</tr>
<tr>
<td>Additional emergency ward</td>
<td></td>
<td></td>
<td></td>
<td>5,000</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>11,016</td>
<td>2,582</td>
<td>4,844</td>
<td>17,850</td>
<td>21,478</td>
</tr>
</tbody>
</table>

15. Supporting Strategies

15.1 People Strategy

Our People Strategy sets out the future Vision for the people within the Trust. It has a Vision where our colleagues are recruited, developed, and valued in order for the Trust to become a supportive employer, delivering excellence in patient care. At the heart of this Strategy is how the workforce is positively encouraged to perform at its best and will become a prime requirement for every leader and manager.

Progressive Human Resources (HR) practices with a strong emphasis on organisational development and engagement are essential to realising the Trust’s Vision and delivering our strategic objectives within the context of the wider NHS reforms. We have clear commitment to creating a learning organisation to support the on-going development and sustainability of the Trust. This will entail a more strategic focus; addressing the underlying causes of disengagement rather than fire-fighting the symptoms of the problem, such as managing grievances, sickness absence and personal conflict.

Listening into Action (LIA) is the core of our approach to improving services through engaging colleagues. LiA is about re-engaging with colleagues, unlocking their potential and empowering action in order to contribute to the Vision for 2020.

15.2 IM&T Strategy

As part of the Digital Road Map, the Trust plans to secure investment to implement mobile working infrastructure and logistics management systems to reduce inherent inefficiencies associated with care in the community, setting the foundations for the shift of activity from acute to community over the next three to five years.
15.3 Estates Strategy

Our Estates Strategy reflects our ambition of delivering care closer to home, and enabling our community teams with technology to support mobile working, and a shift of care from the hospital to community settings. The introduction of technological enablers will facilitate a rationalisation of our community estate. We are looking at a number of measures to reduce energy consumption and cost.

15.4. Clinical Services Strategy

All care group managers have engaged with the Strategy directorate over the last 12 months. This has resulted in the formulation of rolling five year plans, which will help to inform key clinical service priorities in line with the Trust’s overriding objectives. More recently the newly formed PMO will help to facilitate and deliver clinical service improvements on an on-going basis.

It is recognised that the service Strategy will also be aligned to the annual planning and NHSI imperatives.

15.5. Improvement Strategy

The Improvement Strategy sets out the aims of the Trust Board to provide a framework to support the implementation of service transformation and improvement across the Trust and to support a culture of continuous improvement going forward. It outlines the roles and responsibilities of all staff in transformation and the way in which the Trust will operate to get the best outcomes for staff, patients and carers.

The Strategy sets out the tools and approaches that will be used, and the programme of education that will be undertaken to ensure that staff are supported to deliver improvements in services.

15.6 Commercial Strategy

The Commercial Strategy has been developed based on the Trust’s five year strategy with consideration of our work with the Black Country Alliance (BCA), and the system-wide Sustainability and Transformation Plan (STP). It has also had input from care groups during the business planning rounds.

The document outlines the processes and tools that the Trust will apply with a view to developing a more commercial approach to the way we manage, develop and compete with our services. Our responses to opportunities outside of our existing service provision and geographical boundaries will depend on the Board’s appetite for risk and partnership working, and of course our capacity and capability to credibly deliver services.
15.7 Quality Strategy

The updated Quality Strategy, which will be called **Quality Commitment**, has an overarching objective to improve quality and safety of care for our patients. Broad principles that have been established are to provide effective care through improving patient outcomes; to improve safety by reducing harm and to improve the patient experience through continuing to deliver a caring and compassionate service.

The Trust has highlighted the following as key priorities:

- National and Compliance priorities
- CQUINS
- Local priorities
- Sign up to Safety Priorities

It is recognised that whilst most of the priority areas have existing good governance, it is intended to add further rigour by including outcome measures and milestones to ensure that the primary focus of the Trust Quality Executive and its sub-committees is aligned more effectively.

15.8 Patient Experience Strategy

The Patient Experience Strategy sets out our **four key ambitions** for improving the experience of patients who use our services. These are detailed below:

**Ambition 1:** We want to improve the experience of our patients and carers from their first contact with the Trust, through to their safe discharge from our care

**Ambition 2:** We want to improve the information we provide to enhance communication between our staff, patients and carers

**Ambition 3:** We want to meet our patients’ physical, emotional, cultural and spiritual needs while they are using our services, recognising that every patient is unique. Within this we want to recognise the cultural diversity of our patient population and other protected characteristics

**Ambition 4:** We want to demonstrate that there has been real learning and change in practice where necessary from what patients have told us about the care we have delivered as a Trust.
15.9 Equality and Diversity

The Board recognises the tremendous power of valuing individuals from different cultures, perspectives and experiences. We are committed to recruiting, developing and retaining the most talented people, regardless of their background. The Trust firmly believes that by being a diverse and inclusive employer it helps us to fulfil our responsibility to deliver the best level of care for our patients from a diverse and multi-cultural population.

The Trust uses its Equality Analysis Policy to ensure that we are compliant with legislation, especially in the areas of procurement, recruitment, human resources, governance and scrutiny.

15.10 Social Value

Public sector organisations are obligated to contract services that also deliver wider social economic and environmental health benefits (Social Value Act, 2013). This is true of our commissioners and our own contract procurements. The Trust is increasingly asked to provide evidence of social value, and although we do much that contributes to the economic and environmental health of our local economy we do not necessarily record it as such. The Trust will develop a Corporate Social Responsibility Plan to formalise our approach and collation of supporting evidence.

16. Risk Management and Assurance

The Trust has a risk assurance framework in place that is monitored regularly at Board. The framework identifies the risks from an operational and corporate perspective that may impact on achieving the annual business plans. This is an integral process of the “well-led” domain.

- Risk registers are maintained at a divisional operational level, and are discussed and scrutinised as part of each division’s own governance arrangements
- Executive management review the key operational risks in order to assess if they should be escalated to the Trust’s corporate risk register, and also consider those corporate risks that have been mitigated to an acceptable level for transfer to the relevant operational risk register
- This scrutiny and challenge is provided through the Executive Risk and Assurance Committee
- The Trust Board utilises the established Board Assurance Framework that maps the assurances over the key controls mitigating the principle risks (from the corporate risk register) that threaten the achievement of the Trust’s stated objectives.

The Framwork will be utilised to manage the risks facing the Trust over the life of this Strategy and beyond. The stated risks that could impact on the viability of the Trust will be
weaved within those business as usual risks, along with the key short term projects such as the delivery of a new Trust wide electronic health record system.

17. Conclusion

Our five year strategic journey will be driven by our Vision for our patients by, “Becoming Your Partners for First Class Integrated Care” through the formation and development of close collaborative working with local health economy organisations. We recognise that in order to provide the best possible care for our patients and to be sustainable, forging effective working relationship with organisations will be a key component of our approach and will require in some cases bold decisions for changing models of care and critical reviewing our current offer. Our strategy acknowledges that for a truly effective integrated care pathways will need to be seamless between the social care, mental health and other Trusts such as the BCA to help us to deliver the required shift of more care in the community from the acute hospital setting where we can do so safely.

Our five strategic objectives will act as over-arching guiding beacons for our staff, colleagues and the driver for our engagement with partner organisations. All our colleagues and staff will ensure that these dominate, motivate our day to day dealing with our patients underpinned by our promises and values for each other and our patients.

The Trust Board recognises that staff needs to feel valued and will continue to ensure that Colleague engagement and opportunities for staff development and training are kept high on our list of priorities for the organisation and the people that we serve.

The Trust has experienced unprecedented pressures on our services coupled with tightening financial pressures. We are determined to ensure that our focus remains on delivering high quality care. Our strategy will also explore and maximise opportunities to ensure that we are sustainable now and in the future.

Finally, we commend our five year strategic plan to our partners, patients and staff as a blueprint that will deliver the best for our patients by becoming an organisation that seeks to establish powerful and effective collaborative working that will deliver “…First class integrated care.”
## Appendix 1 Public Health Priorities in Walsall

<table>
<thead>
<tr>
<th>Identified Need - JSNA</th>
<th>Our response</th>
<th>Reference in document</th>
</tr>
</thead>
<tbody>
<tr>
<td>The high prevalence of a range of preventable conditions presents a real challenge and requires a concerted effort from communities and public bodies working together.</td>
<td>Community Care – Prevention services – Stop Smoking, Sexual health services, Cardiac Nursing, Respiratory team</td>
<td>Objectives 1, 2, 3 High level Levers Section 1.1</td>
</tr>
<tr>
<td>Cancer is the leading cause of death in the under-75s in Walsall, coronary heart disease is extremely common across Walsall and diabetes prevalence is higher than nationally.</td>
<td>Cardiac Nursing, Palliative Care Team, Integrated Care teams, Diabetes Care</td>
<td>Objectives 1 High Level Levers 4 Section 1.1</td>
</tr>
<tr>
<td>Substance misuse is higher than national averages with high alcohol related harm across a number of health and wellbeing indicators, and a significantly higher rate of problematic drug users than nationally.</td>
<td>We are actively pursuing these health priorities through the Walsall Together partnership approach. This includes Local Authority, Public Health and GPs. Expert Patient Programme</td>
<td>Section/s 2.1 and 3</td>
</tr>
<tr>
<td>The estimated prevalence for smoking 22.7%, (c.45,000 adults) and smoking related deaths are significantly higher than national average.</td>
<td>Smoking cessation, Patient Self-management Supporting healthy choices</td>
<td>Objectives High Level Levers Section 10.1</td>
</tr>
<tr>
<td>The Healthy Life Expectancy in Walsall is about 60.3 years old this is 2.3 years lower than West Midlands and 3.4 years lower than England averages.</td>
<td>Patient Self-Management Supporting healthy choices</td>
<td>Objectives High Level Levers Section 10.1 Strategy</td>
</tr>
<tr>
<td>A range of measures demonstrate that older people in Walsall are high users of institutional care, an approach that neither promotes efficient use of limited resources, nor meets the individually identified needs of older people and their carers.</td>
<td>Care Closer to Home, Integrated Care Teams Forge closer collaborative partnerships with GPs federation through the Walsall Alliance to improve clinical outcomes. This will also mean planned care pathways can begin with earlier GP interventions/diagnostics. Greater use of telemedicine.</td>
<td>Objectives High Level Levers Section/s 3.1.5; 10.2</td>
</tr>
<tr>
<td>Identified Need - JSNA</td>
<td>Our response</td>
<td>Reference in document</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>The number of Walsall residents with Dementia is a growing issue, likely to increase by 22.5% over the next eight years and this will put extra pressure on all health services.</td>
<td>Integrated care teams; skill mix to be aligned to service need.</td>
<td>Objectives High Level Levers 1, Section/s 3.1; 3.1.4</td>
</tr>
<tr>
<td>The loss of independence is a concern where there has been an increased number of falls in older people in Walsall; particularly those in institutional settings.</td>
<td>Integrated care teams.</td>
<td>Objectives High Level Levers 1, 2, 5, 6</td>
</tr>
<tr>
<td>Walsall has a higher proportion of excess deaths amongst older people than the region as a whole, especially amongst women and those with underlying health problems yet many of these deaths are preventable.</td>
<td>End of life care</td>
<td>Objectives 1, 2, 3, 5 High Level Levers: 1, 3, 5, 6, 7 Sections 10.1; 10.7</td>
</tr>
<tr>
<td>An increasing proportion of Walsall’s population care for someone with a long term illness; 10.6% in 2001 increased to 11.6% in 2011, whilst the national rate stayed the same.</td>
<td>Expert patient programme</td>
<td>Objectives 2 High Level Levers 1, 2, 6, Section 11</td>
</tr>
<tr>
<td>Walsall is committed to reduce harm to vulnerable children with a particular focus on reducing the impact and costs of Looked after Children including through meeting the right children’s needs in the right way and as early as possible.</td>
<td>Looked After Children Health Visitors 0-5</td>
<td>Objectives 1, 3 High Level Levers Section 1.1</td>
</tr>
</tbody>
</table>
### Appendix 2: PESTLE Analysis

<table>
<thead>
<tr>
<th>Political</th>
<th>Economic</th>
<th>Social</th>
</tr>
</thead>
<tbody>
<tr>
<td>FYFV and STP new models of integrated care</td>
<td>Financial challenges</td>
<td>Increasing Demand</td>
</tr>
<tr>
<td>Uncertainty regarding the future of CCGs</td>
<td>Taxation levels</td>
<td>Ageing population impact</td>
</tr>
<tr>
<td>Immigration controls and ability to recruit nurses and doctors post Brexit.</td>
<td>£ value depreciation vs Euro and US$</td>
<td>Co-morbidities</td>
</tr>
<tr>
<td>Regulation and guidance—Duty of Candour/ NHSI NICE / JAG / etc.</td>
<td>Potential future inflation increases</td>
<td>Patient expectations/24/7 social media</td>
</tr>
<tr>
<td>Carter Recommendations</td>
<td>New hospital in Black Country</td>
<td>Shortage of trained nurses and specialists</td>
</tr>
<tr>
<td>7 Day Working Standards</td>
<td>Push to charge for overseas patients/visitors</td>
<td>More litigious society</td>
</tr>
<tr>
<td>General election during timeline of Strategy</td>
<td>Competitive recruitment of nurses and specialists</td>
<td>Increasing use of drugs and alcohol</td>
</tr>
<tr>
<td>Partners with different views on solutions</td>
<td>Commissioners’ propensity for market testing</td>
<td>Obesity/Diabetes increases</td>
</tr>
<tr>
<td>Minimum/living wage</td>
<td></td>
<td>Increasing levels of immigration</td>
</tr>
<tr>
<td>Duty of Candour</td>
<td></td>
<td>Increasing levels of deprivation</td>
</tr>
<tr>
<td>Public Procurement Regs</td>
<td></td>
<td>Housing shortages</td>
</tr>
<tr>
<td>Technological</td>
<td><strong>Legislative</strong></td>
<td><strong>Environmental</strong></td>
</tr>
<tr>
<td>Telehealth, telemedicine, teletracking, etc.</td>
<td>Health &amp; Social Care Act 2012.</td>
<td>NHS Estate suitability for new models of care and future demand</td>
</tr>
<tr>
<td>E-health and e-prescriptions and other “e” solutions</td>
<td>Care Act 2014</td>
<td>Taxation on utilities</td>
</tr>
<tr>
<td>Remote/agile working</td>
<td>Equality Act 2010</td>
<td>Recycling costs and issues</td>
</tr>
<tr>
<td>Virtual technology enablers</td>
<td>Social Value Act 2014</td>
<td>Disposal of Hazardous Materials requirements</td>
</tr>
<tr>
<td></td>
<td>Health and Safety At Work Act 1974</td>
<td>Digital road map—paperless NHS by 2020</td>
</tr>
</tbody>
</table>
Appendix 3: Strategic Plan on a Page

**Vision**

- Provide safe, high quality care across all our services
- Ensure services are safe
- Providing a patient-focused approach
- Care for patients at home the reference we can
- Provide care in the right place at the right time
- Clinical and social needs will be at the forefront

**5 Year Strategic Objectives**

- Prevention and Self-Management
  - Support Patient Programmes
  - Supporting Healthy Choices
  - Prevention linked to mainstream care pathways
- Care at Home
  - Integrated Community Healthy teams
  - Shared approach for vulnerable patients
  - Registered Nurse
- Maternity & Children
  - Delivers a `normality` based approach to childbirth
  - Develop services to accommodate increase in births
  - Integrated emergency and community model
- Elective Care
  - Shared care and one-stop care pathways
  - Increase Diagnostic capacity
  - Day care, and early supported discharge
- Acute Care
  - Integrated Pathways for Emergency Care Centre
  - Access to support ambulatory emergency care service
  - 7 day national standards
  - Reducing readmission rate
- Intermediate Care
  - Integrated Intermediate Care
  - Discharge to assess
  - Palliative Care Service
  - District Care Centre
- End of Life Care
  - Specialist Palliative Care Team at home of
  - Life Care Plan
  - Increase range of non-hospital end of life care

**2017/18 & 2018/19 Trust Objectives**

-Embed the quality, performance and patient experience improvements that we have begun in 2016/17.
-Embed an engaged, empowered and clinically led organisational culture
-Tackle our financial position so that our deficit reduces.
-With local partners change models of care to keep hospital activity at no more than 2016/17
-Embed continual service improvement as we do things linked to our Improvement Plan
-Ensure our hospital estate is future proof and fit for purpose.
-Deliver a sustainability review of all our services to set plans for next 5 years.

**2017/18 & 2018/19 Improvement**

- Care at Home
  - Integrated teams, reduce re-admissions
  - Redesign pathways, improve FEH pathways
- Patient Flow – Length of Stay
  - Consistent use of SAFER bundles, Assess to admit, discharge to assess
- Outpatients
  - Effective booking and scheduling, reduce DNA, cancellations, follow ups
- Theatres
  - Start on time, in session, utilization, improve booking process
- IM&T
  - Community mobile working, presenting, fully electronic patient record
- Workforce
  - Increase pre-sessional, reduce agency spend, new roles, long term workforce plan
- Clinical Support Services
  - Deliver BCA pathways, Pharmacy efficiency, Review other CSE and work through options
- Non-Clinical Support
  - Agreed approach to reducing costs, baseline office efficiencies, Review local estate utilization
- Procurement / Non-pay spend
  - BCA Procurement, PI contract review

Becoming your partners for first class integrated care

- Safe, High Quality Care
- Care at home
- Partners
- Value Management
- Resources
Appendix 4: Black Country STP

BLACK COUNTRY STP

### Our Triple Gap

| Better Health | Significant challenges - obesity, alcohol & smoking related illness. 46% live in most deprived areas. |
| Better Care | Unwarranted variation - maternity services & infant mortality; emergency admissions (ACSC/UCSC). |
| Sustainability | £809m ‘Do nothing’ gap 2020/21 (includes full WMAS impact). |

### Demand Reduction Through Vertical Integration - £108M

- Each local system will implement a place-based care model to maximise impact on:
  - Eliminating unwarranted variation and improving access to primary care through standardised outcomes and model of delivery.
  - Achieving integrated continuity of care for the 1/3 of the population with Long Term Conditions - improving management and reducing admissions for chronic conditions.
  - Delivering better co-ordinated care to reduce unscheduled admissions.
  - We will also adopt a developmental evaluation framework to enable accelerated implementation and to contribute to national learning.

### Efficiency at Scale Through Horizontal Integration - £418M

In addition to individual provider CIPs, we will build on existing innovations to maximise impact through:

- Increased secondary care collaboration (‘single services’ for planned care, paediatric collaboration, 2x2 model for acute general surgery, shared service plan for Orthopaedics and Maternity)
  - Consolidation of clinical (pathology, IT) & non-clinical support services
  - Midland Mest development - reducing from 3 to 4 acute sites
  - Developing JV model with housing associations to improve post-acute intermediate care and significantly reduce DTOC
  - Reduce workforce spend & increase efficient use of estates
  - Streamlining commissioning functions in health and social care.

### Addressing the Wider Determinants - £186M

We will build on existing partnerships with individual Local Authorities and the West Midlands Combined Authority to:

- Support the delivery of appropriate Local Authority efficiencies (also assumes application of Pragmat & net BCF increase)
- Take effective action together on prevention & the wider determinants
- Implement the recommendations of the Mental Health Commission, with the strategy unit and its partners we see
- Undertake a ground-breaking study of the economic impact of healthcare spending
- Exploring the identification of opportunities to reduce the impact of Mental Health on demand for physical health services (avoidable admissions, diagnostics & bad day use).

### National Support - £37M plus 5% of 1%

In order to develop our plans to the next level of detail and then to accelerate delivery at pace and scale we will need:

- The indicative STT allocation of £37m p.a. to help meet increasing demand.
  - Annual release of 5% of 5% non-recurrent CGG reserves (£51m) to enable implementation of critical decisions. The Black Country does not have the established whole-system infrastructure which underpins other transformation areas, and it needs to develop this urgently.
  - Also vital to our success will be support from regulators to ensure that system drivers, incentives and controls reinforce the alignment of organisational plans and behaviours with STP priorities (including through the 2017/18 contracting round).

Becoming your partners for first class integrated care