Five year Strategic Plan for Walsall - 2014-2019

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Foreword

Welcome to Walsall Clinical Commissioning Group’s five year strategic plan for 2014-19. We are proud to have worked with our patients, our public and our partner organisations in developing this plan. All have contributed to our refreshed priorities, and with our health, mental and social care partners we will improve outcomes for the people we serve and address health inequalities across the Borough.

The challenges are immense. Walsall has areas of significant deprivation, coupled with changing demographics and high level of long term illness, which is going to continue into the future and grow. This will put huge pressures on the resources. We must make best use of the budget we have. All of this means we need to change and fully prepare for the future.

We recognise we can make a difference, but only by working collaboratively with our partners. This is why, as a member of the Health and Wellbeing board, we have committed to a shared vision "to improve the health and well being of the people of Walsall". This highlights our recognition that we are part of the wider system consisting of many different agencies working for the people of Walsall – covering areas such as education, housing and leisure – and emphasises our commitment to play our part in leading and supporting this work as appropriate.

This strategic plan describes how we will achieve our vision over the next five years. While everything we are planning will help in delivering our long term goals, we will be concentrating on a small number of priorities, some of which are nationally mandated and some locally determined. We have based this strategic plan on our current understanding of the needs of Walsall and will update and refresh our approach as needs change in the future.

We are planning to change the way services are organised and delivered so there is much greater emphasis on integrated care, care closer to home and support in the community; as part of this we will make best use of digital technology and improve the take up of personal health budgets. This will help to avoid unnecessary and avoidable admissions to hospital and support swifter discharge of patients. In addition, a number of our plans are aimed at improving life expectancy so we will be working to improve children’s services, promote take up and access to lifestyle services (prevention is always better than cure) and also the management and prevention of chronic conditions.

We will work to continually to transform health services locally. We will continually empower patients to take an active role in their own health, understanding effective ways of preventing illness and knowing when and how to access services, when the need arises. These improvements

This strategy is a plan for transformation and a plan for change, moving us from where we are now to a better state in the future. We will continue to engage with all our stakeholders as we develop the operational detail of delivery.

Dr Amrik Gill  
Chair
Walsall Clinical Commissioning Group CCG

Salma Ali  
Accountable Officer
Walsall Clinical Commissioning Group CCG
Executive Summary

Walsall Clinical Commissioning Group (CCG) serves a population of 274,000 and is coterminous with Walsall Metropolitan Borough Council. This five year strategic plan therefore covers health and social care needs for the Borough of Walsall.

Walsall currently faces many care challenges, including high levels of deprivation, a growing and ageing population, changing demographics with an increasing BME proportion, and a high level of unhealthy lifestyles. At the same time we have health and social services that are not well integrated, an over-reliance on A&E for out of hour’s treatment and some services of insufficiently high quality. These factors contribute to the below average health of our population, including high infant mortality, low male life expectation, inequality of health across the borough and a growing number of people with long term conditions. Our task is to address these challenges, whilst also needing to be more cost-effective.

Our vision is to rectify this situation for the people of Walsall, and this strategy will achieve this, by focusing on improving health outcomes and reducing inequalities; providing the right care in the right place at the right time; commissioning consistent, high quality and safe services across Walsall; and securing best value for the Walsall pound and delivering public value. These are our four strategic objectives, and these include specific priorities around integrated care and mental health.

For each strategic objective we have agreed local priorities, supported by a strong evidence base built on the Any Town Lite modelling tool, national Commissioning for Value data packs and programme budgeting analysis. This analysis has also enabled us to define measurable ambitions and an improvement trajectory to monitor our progress towards our overall goal. These goals include delivering c. £31m of QIPP projects and making good progress towards reducing the level of emergency admissions by 15% in real terms over the next five years.

Cross-referencing to ‘Everyone Counts’ - the national guidance for strategic health planning – confirms that our resulting strategy addresses the required characteristics, domains and ambitions for a robust and effective health economy.

Although a good strategic plan, this will only change the health and wellbeing of Walsall if we successfully implement it. We are committed to developing the capacity and capability needed to deliver the interventions in this plan and this is already underway.

In partnership with the wider system organisations, we are establishing strong governance processes to support and monitor delivery of these plans and will track performance against the improvement trajectories. We have also set out the enabling support strategies needed to enable delivery of these plans, including system leadership, finance, engagement, informatics, organisational development and estates.
Introduction

1 This document describes our strategy to improve the health and wellbeing of the people of Walsall over the coming five years

1.1 An introduction to Walsall

The role of Walsall Clinical Commissioning Group is to engage with the local community, including citizens, patients and carers and clinicians, to analyse, understand and address their concerns. It is also our role to ensure that services commissioned operate to the highest possible standards of clinical safety and quality. We need to strive for care which is personalised and genuinely meets the needs of the individual.

The health issues faced by Walsall have their roots in a number of key historical events. The town grew rapidly through the industrial revolution which swept across the West Midlands, generating massive growth in industry and transportation systems to accompany its development, including the railway, canal and then road systems. The rapid increase in the working population and many of those who came to work in the West Midlands came from waves of immigration, initially from within Great Britain but, from the mid 20th century onwards, from further afield.

Much of the industrialisation of the West Midlands, during the Industrial Revolution, was based upon the working of iron and then steel and other ores and metals. The manufacturing processes associated with this industry left a remarkable heritage in its decline, including some of the most polluted land in Western Europe.

With the prevailing winds blowing from the east, the managers and factory owners built their homes on the eastern side of the town and the workers homes were built on the west. The social divide, which began at this time, has continued on into the present day. We now have a situation where the life expectancy gap within the Borough is 8.2 years between the most affluent areas of the Borough (which are mainly located in the east of Walsall) compared to the most deprived areas of the Borough (which are located in the West of Walsall).

With the passing of manufacturing, the emphasis of much of the economy is now managing and dealing with information. This has posed enormous challenges for the population of Walsall, where educational attainments levels are below national averages. Income levels are low (although unemployment is consistent with the level across the West Midlands) and there is a lack of new industry and enterprise being drawn to the area.

Walsall also has a growing BME population and attracts asylum seekers and workers from Eastern Europe. As well as being harder to reach, these groups bring specific health and social care issues, which change the current disease prevalence of the area.

These population health characteristics add to the very particular challenges confronting us.

1.2 Our vision for Walsall

It is within this context that we present our ambitious vision for Walsall. We would like the people of Walsall to be proud of their local health and social care services: services which are the safest and most effective feasible, within the resources available.
We want patients to be treated with compassion, dignity and respect at all times, with the ability to take control and responsibility for their own health and social care, and their family’s health and care, as far as possible. We are working to deliver seamless services that are sensitive to the whole person, including mental health and social needs, as well as physical. Services must be accessible to all and based on individual needs.

The strategy is a plan for transformation over the next five years that will enable us to achieve this aspiration.

1.3 The purpose of the strategic plan

This strategic plan has been written to clarify, at a high level, where we are now, where we want to get to and how we plan to get there.

It will be a key reference document over the coming five years as it will underpin much that we do. A significant part our resource will be invested in delivering the strategic objectives and priorities set within it. Whilst Walsall has a number of issues in common with other areas, there are a number of specific matters that we need to address. For example, infant mortality and male life expectancy are worse in Walsall and we need to ensure that we prioritise these areas.

The strategy is about improving outcomes, quality, safety and the performance of services commissioned for our population at a time when current and future resource allocations for Health and Social care are challenging. We must focus the finite resources that we have to ensure we get the best value from every pound spent.

The strategy sits above our two year operating plan, which provides detail of our immediate agenda. Both the longer and shorter term plans are fully aligned to the vision and strategic objectives set out within this document.

1.4 The basis of the strategic plan

The strategy reflects the local priorities determined by the Walsall Health and Well Being Board, which have been informed by Joint Strategic Needs Assessment (JSNA). It also responds to the requirement to improve the NHS outcomes indicators for the CCG (set by NHS England) and the continued delivery of the pledges and rights under the NHS constitution. In addition, it covers the improvements needed and the priorities for action included in the Quality Premium, agreed with the local Health and Well Being Board. This Quality Premium is a scheme which is intended to reward CCGs for improvements in the quality of the services that it commissions, and for associated improvements in health outcomes and reducing inequalities.

The strategy has also been informed by local engagement with patients, service users, CCG member practices, staff and the public. In response to Call for Action there has been an on-going programme of public and stakeholder engagement branded as ‘Your Voice’, helping to set planning priorities for the future. This engagement is explained further in section 1.5.

The strategy is particularly important in view of the recent reconfiguration of the commissioning landscape and consequent realignment of commissioning budgets. Commissioning for health and well-being is now shared with NHS England (which is responsible for primary care commissioning, specialised commissioning, offender health and services for military personnel) and Local Authorities (which are responsible for Public Health, as part of lifestyle services). The CCG is responsible for commissioning hospital, community and locally commissioned services, and works in partnership
with the local authority through joint commissioning arrangements for mental health, older people, children, continuing care and learning disabilities. This strategic plan represents a shared picture of where all the organisations purchasing and providing care are aiming to get to.

1.5 Our system, our strategy and engagement

Our strategy has been developed in partnership with the Walsall health and social care system, which is made up of the following organisations:

- Walsall Clinical Commissioning Group CCG
- Walsall Metropolitan Borough Council
- Walsall Healthcare NHS Trust (Community and Acute Care)
- Dudley and Walsall Mental Health Partnership Trust.

We recognise that we are working as part of a wider health and social care system and specifically with NHS England Area Team for Birmingham, Solihull and Black Country. We will continue to work together with our Area Team and other local CCGs. We have also been working very closely with partners on the local Health and Well-Being Board to improve well-being in our community and positively impact on health outcomes.

Throughout the development of our strategy we have been working hard to involve, engage and inform our patients, stakeholders and members of the public and staff in a manner that has been creative, inclusive and accessible. Since being authorised in April 2013, we have held four patient and public involvement events (Your Voice), one Young Voice specifically for younger people, two GP Consultative Assemblies, three staff events, consultations with HealthWatch and a ‘Pop up Shop’ in Walsall Town Centre for two days during November that was visited by over 500 people. In addition the Chair and Lay member for Public and Patient Involvement have attended and presented at three Walsall Pensioners Conventions.

All of the events have had a ‘Call to Action’ theme where we have asked questions, held debates and had discussions on topics such as; prioritisation commissioning intentions, the CCG Constitution and the future of Primary Care services.

The events were well received and have evaluated positively All participants were actively involved and produced some interesting debates and comments. We have responded to various questions and concerns raised at these events through a ‘You said we did’ format . All of the responses have been shared in newsletters, at events and on our website and we are using the weightings from the prioritisation events to reflect these views in the consideration of commissioning decisions. These outputs are detailed in Appendix 1.

Walsall CCG is also a member of the Walsall Patient Representation Groups (PRG) network and we attend the 6-weekly meetings to ensure two way communication, information sharing and engagement with these patient groups.

We will continue to involve and engage with patients and the public in a range of commissioning aspects, and ensure we obtain the views of our population on a regular basis.

A wide range of provider and clinical views has also been sought during the writing of this strategic plan. This has been through a number of mechanisms including presentations to the Integration Board and the CCG Operational Group, individual meetings with the acute, community, mental health and social care providers and focused discussions with both clinical leads and local GPs.
In light of the system financial pressures and current political intent, there may be future organisational changes to the Walsall provider landscape. We are committed to working with our partners to explore such system-wide changes to ensure the best overall result is achieved for the delivery of sustainable, high quality care.

1.6 Delivering the strategy

Whilst the strategy has been developed in partnership with the system, and is the outcome of extensive discussions with many organisations, much of the detail within this document refers to our role in delivering change. It describes our contribution to improving the health and wellbeing of the people of Walsall.

The delivery of the strategy will be dependent upon close working between all partners. We will continue to engage with cross system work streams already established to review areas such as urgent and planned acute care, the management of long term conditions (LTCs), vascular services, trauma care, maternity, stroke and TIA services, adult mental health, pathology, services for offenders and services for military veterans.

1.7 What you will find within this strategic plan

The document has been set out in a way that tells our story.

Section two presents the background. There is a detailed profile of Walsall describing the population and the particular needs that services must be targeted to meet - Where are we now?

Section three outlines the overarching vision for the system - Where do we want to be in five years time?

Section four articulates the gap between where we are now and where we want to get to - what is the scale of the challenge before us? It details the particular barriers and challenges that need to be overcome, within a context of reducing financial resources and the need for even better value for money.

Section five describes in more detail our four strategic objectives and priorities and provides the specific measures that we will use to track and evidence our success. This section also describes how these interventions will be delivered.

Section six summarises the key features of a number of enabling strategies that sit under the strategy but which are essential to making it happen. For example, our commissioning, finance, ICT, estates and organisational development plans. Without the proper alignment of these plans, we will not be able to create the right context to ensure that the vision is realised.

Section seven sets out the governance and implementation structure that will assure the intervention arrangements. It includes a clear decision making framework, performance and risk management arrangements and, significantly, the role that patients, clinicians and other stakeholders will play in the delivery of this strategic plan over the coming years.
The current position

2 Walsall has some excellent healthcare services and is delivering some great outcomes. However, there is more to do.

This section provides a profile of the current services, an overview of our achievements in 2013/14 and a description of the population we serve.

2.1 Our services

Walsall CCG includes 62 GP practices that look after the health care needs of about 269,500 living in Walsall MBC area (figure 1).

Figure 1: Walsall CCG - The Spread of GP practices

The area is also served by a number of healthcare providers. Walsall Healthcare NHS Trust (WHNT) provides a full range of acute hospital services including A&E, outpatients, diagnostics, elective and non-elective admissions and community services. We also have a substantial contract with Wolverhampton Hospitals NHS Trust for a similar range of services, although the levels of activity are lower than that at Walsall Hospitals NHS Trust.
Specialised acute services (for example, cancer, renal, heart and lung treatment) are commissioned directly by NHS England and locally this is undertaken through the Birmingham, Solihull and Black Country Area Team for the West Midlands. These services are provided in relatively few hospitals to a catchment population of more than one million people. The number of patients accessing these rarer services is small and a critical mass of patients is needed in each centre in order to deliver the best outcomes. In addition a concentration of skills and expertise by the clinical team undertaking the treatment also benefits the standard of care delivered. For the population of Walsall these services are provided in acute hospitals situated mainly with Birmingham and the Black Country.

Dudley and Walsall Mental Healthcare Trust provide a full range of mental health services under contract with the CCG. This includes services for Adults, Older people, and Child and Adolescent Mental Health services.

We also commission Learning Disability services from Dudley and Walsall Learning Disabilities Partnership Trust. Services are both community and hospital based.

2.2 Our achievements

The diagram overpage provides an overview of our achievements over the past year.
Figure 2: Achievements during 2013/14

- CCG fully authorised
- GP Consultative Assembly working to achieve goals
- Lay members appointed
- Investments outlined in Budget adopted by CCG:
  - £4m in Acute Services
  - £1m in Continuing Health Care
  - £1m in Community Services
  - £700k in NHS 111
  - £800k in Mental Health
  - £1.4m in NICE recommendations / new drugs
- Supported by annual GIPP programme of £4.8m

April 2013
- NHS

May
- Patient Prospectus released

June
- Constitution updated

July
- Winter plan preparations commenced

August
- Staff event: working with the CSU to understand roles and activities

September
- Patient engagement events: Walsall & Aldridge
- GP consultative assembly event: prioritisation, primary care strategy, call to action
- Review of Local Enhanced Services

October
- First pop-up shop: over 600 visitors over two days
- Staff Council commences
- Nursing Times finalists
- Extended winter GP opening hours

November
- Staff event: delivering the vision
- HSJ finalists
- Healthwatch public launch
- First 'Young Voice' event
- Primary Care Quality Improvement Sub Committee established

December
- Defibrillators distributed to the Walsall community
- Connecting Communities Programme commenced

January 2014
- Urgent Care Review commenced

February
- Forecast additional investment of £4m in Acute Services including Urgent Care System
- Productive General Practice Programme

March
- Contracting & Procurement Team Highly Commended in National Government Opportunities Procurement Innovation or Initiative of the year award
- GIPP target delivered
- Patient Access Scheme Programme

- NHS Improving Quality: Primary Care Development Programme
- Procurement of Local Commissioned Services
- First Connecting Communities Engagement event
2.3 Our population

Walsall’s overall resident population is predicted to increase over the next 10 years by 4.5% from 269,500 in 2011 to 281,700 in 2021. In addition to this, Walsall’s older population, aged 65 and above, is also predicted to increase by 12.9%, with the number of people 85 year and older increasing from 5,467 in 2008 to 8,109 in 2021.

Figure 3: Walsall population projections, by age 2011-2021 (source: ONS)

Walsall also has a culturally-mixed population. People of Indian, Pakistani and Bangladeshi background form the largest minority ethnic groups in Walsall. The number of Non-UK Born residents in Walsall has increased by 3.7% (or 9,859 people) between the 2001 and 2011 censuses.

Figure 4: Minority ethnic group trends in Walsall 2001-2011 (Source: ONS)
2.4 Deprivation

In 2010, Walsall was ranked as the 30th most deprived of the 326 Local Authorities in England. This position has worsened since the last data release in 2007, where Walsall ranked 45th out of 354. The borough fares particularly badly in terms of education, income and employment deprivation. Central and western parts of the borough are typically more deprived than the east. However, while some parts of the borough such as Blakenall are among the most deprived in the borough, others rank within the very least deprived (see Figure below).

Figure 5: Walsall LSOA deprivation using Local Quintiles (Source: Department for Communities and Local Government)

114,800 (44.6%) of Walsall’s total population (2010 mid-year estimates) live within the most deprived quintiles compared to 30,400 (11.8%) living in the least. Looking specifically by age, 28,100 (52.3%) of 0 to 15 year olds live within the most deprived quintiles in Walsall and 16,100 (35.5%) of over 65’s. This compares to 5,000 (9.2%) of 0 to 15 year olds living within the least deprived quintiles in Walsall and 7,000 (15.6%) of over 65’s.

2.5 Infant mortality

Infant mortality has declined across England as a whole but the rates in Walsall remain higher than regional and national rates and are a significant cause for concern. The trend is starting to reverse, but the speed of improvement is slow.
Infant mortality rates in Walsall are highest when compared to statistical neighbours (by quite a margin). The other LAs are below regional rates with only 1 below national levels.
2.6 Life expectancy

Life expectancy for both men and women has improved over the past decade by 4.6 years and 4.4 years respectively. People in Walsall are living for longer. Typically, life expectancy is higher in women than men. For women, Walsall is on a par with regional trends, although lower than national figures. However, this gap is reducing. In contrast, male life expectancy is considerably lower in Walsall than regional and national figure.

Figure 8: Life expectancy in Walsall 1991-2011 (Source: ONS)

![Life Expectancy Chart]

The diagram below shows the potential year’s life lost and how the gap between Walsall and the England average is projected to increase from 472 to 1,497 per 100,000 population.

Figure 9: Graph showing potential years life lost for males from 2009 - 2019 (Source: The Ambitions Atlas)

![Potential Years Life Lost Chart]
2.7 Disease prevalence

The figure below shows that, within Walsall, the prevalence of some long-term conditions is very high and much higher than the average for England. This is particularly the case for:

- Coronary Heart Disease (CHD) - 4.02% of the Walsall population are on CHD registers (this is towards the maximum in the ONS range, which has a maximum of 4.49%. The England maximum is 5.33%)
- Diabetes in people aged 17 and above- 8.06% of the Walsall population are on diabetes registers compared to a maximum for England of 8.3% (ONS maximum is 8.3%)
- Obesity- 14.83% are on disease registers in Walsall compared to 14.83% (ONS maximum) and 16.2% (England maximum).

Figure 10: Disease prevalence in Walsall compared to national trends (Source: ONS)

In 2014 Walsall’s prevalence for dementia is 3,413. 52.4% of those people are currently on GP dementia lists. The prevalence is projected to rise to 3,810 by 2019. Of all older people in acute
hospitals, 25% are likely to have dementia. However regionally published papers suggested up to 40% of those older people admitted to acute hospitals will have dementia; either poorly or undiagnosed dementia. The average length of stay for people with dementia in acute hospitals is longer than those people who do not have dementia.

2.8 Other demographic factors

The Walsall Lifestyle Survey 2012 helps estimate the proportion of adults whose health could be improved through lifestyle changes. For example, the vast majority of residents do some form of physical activity but only a minority do it frequently enough to achieve health benefits. Half of residents eat fresh fruit and vegetables on a daily basis, but just one in eight has the recommended five portions a day.

Smoking reduces life expectancy by an average of ten years and obesity by an average of nine years; in Walsall there are tens of thousands of residents whose health and quality of life could be transformed by stopping smoking or losing weight.

Walsall also has high rates of harm, both to health and as a result of crime, related to alcohol consumption and drug misuse. The levels of misuse mirror the areas of the borough with the highest levels of social and economic deprivation.

There are an estimated 2,107 opiate and/or crack users (OCU) in Walsall, representing 13.06 per 1,000 population compared to 8.67 per 1,000 nationally.

The proportion of successful completions in Walsall is higher than the national rate and there has been a 33% growth in successful completions since 2011-12. However, Walsall is achieving lower than average rates of abstinence from opiate, crack and cocaine amongst adults in treatment.

People in treatment for prescription-only medications or over the counter medicines make up a much smaller proportion of the treatment population in Walsall than they do nationally.

The number of adults in treatment using club drugs such as mephedrone or ketamine in Walsall is negligible compared to national figures.

Walsall has an estimated 34,058 hazardous drinkers, 33,550 binge drinkers and 10,174 harmful drinkers. The estimate (based on a population of 269,323) for the number of people who are alcohol dependent is 10,772.

Walsall has a higher rate of alcohol related hospital admissions (3103 for 2012/13) than the national and regional average. Walsall’s alcohol specific hospital admissions in 2012/13 at 1785 represent a 6% reduction on the previous year’s figure.
2.9 Current outcome performance

The table below provides an overview of performance against NHS Constitution performance targets. This shows that all targets were achieved, apart from achieving the 4 hour A&E wait and category A ambulance calls. These issues are being addressed within a number of strategic transformation and redesign projects, which are discussed in section 5.

Figure 11: Walsall CCG performance 2013/14

<table>
<thead>
<tr>
<th>Overarching Area</th>
<th>Performance Measure</th>
<th>Performance Measure</th>
<th>Actual Performance</th>
<th>Year-end Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 week Referral to Treatment waiting times for non-urgent consultant led treatment</td>
<td>Admitted patients to start treatment within a maximum of 18 weeks from referral</td>
<td>+95% within 18 weeks</td>
<td>2013/14 – 92.0% 14,338 out of 15,503 patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-admitted patients to start treatment within a maximum of 18 weeks from referral</td>
<td>+95% within 18 weeks</td>
<td>2013/14 – 98.9% 45,666 out of 44,150 patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patients on incomplete non-emergency pathways yet to start treatment should have been waiting no more than 18 weeks from referral</td>
<td>+95% within 18 weeks</td>
<td>2013/14 – 94.6% Average of 12,158 out of 12,831 patients at any time</td>
<td></td>
</tr>
<tr>
<td>Diagnostic test waiting times</td>
<td>Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral</td>
<td>+95% within 6 weeks</td>
<td>2013/14 – 99.8% 58,144 out of 58,203 patients</td>
<td></td>
</tr>
<tr>
<td>A&amp;E 4 hour wait</td>
<td>Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&amp;E department (Walsall Healthcare NHS Trust performance only)</td>
<td>+85% within 4 hours</td>
<td>2013/14 – 93.7% 97,274 out of 103,784 patients</td>
<td></td>
</tr>
<tr>
<td>Cancer waits – 2 week wait</td>
<td>Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP</td>
<td>+95% within 2 weeks</td>
<td>2013/14 – 95.6% 5,861 out of 6,131 patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)</td>
<td>+95% within 2 weeks</td>
<td>2013/14 – 95.6% 732 out of 768 patients</td>
<td></td>
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<tr>
<td></td>
<td>Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers</td>
<td>+96% within 31 days</td>
<td>2013/14 – 98.5% 1,240 out of 1,239 patients</td>
<td></td>
</tr>
<tr>
<td>Cancer waits – 31 days</td>
<td>Maximum 31-day wait for subsequent treatment where that treatment is surgery</td>
<td>+94% within 31 days</td>
<td>2013/14 – 96.8% 268 out of 277 patients</td>
<td></td>
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<tr>
<td></td>
<td>Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen</td>
<td>+98% within 31 days</td>
<td>2013/14 – 99.7% 375 out of 376 patients</td>
<td></td>
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<tr>
<td></td>
<td>Maximum 31-day wait for subsequent treatment where that treatment is a course of radiotherapy</td>
<td>+94% within 31 days</td>
<td>2013/14 – 97.1% 476 out of 490 patients</td>
<td></td>
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<tr>
<td></td>
<td>Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer</td>
<td>+95% within 62 days</td>
<td>2013/14 – 85.4% 646 out of 732 patients</td>
<td></td>
</tr>
<tr>
<td>Cancer waits – 62 days</td>
<td>Maximum 62-day wait from referral from an NHS emergency service to first definitive treatment for all cancers</td>
<td>+90% within 62 days (locally set)</td>
<td>2013/14 – 94.8% 91 out of 96 patients</td>
<td></td>
</tr>
<tr>
<td>Cancer waits – 62 days</td>
<td>Maximum 62-day wait for first definitive treatment following a consultant’s decision to upgrade the priority of the patient (all cancers)</td>
<td>+91% within 62 days (locally set)</td>
<td>2013/14 – 94.4% 375 out of 399 patients</td>
<td></td>
</tr>
<tr>
<td>Category A ambulance calls</td>
<td>Category A ‘Red 1’ calls resulting in an emergency response arriving within 8 minutes (West Midlands Ambulance Service region)</td>
<td>+70% within 8 minutes</td>
<td>2013/14 – 80.0% 6,143 out of 7,681 patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Category A ‘Red 2’ calls resulting in an emergency response arriving within 8 minutes (West Midlands Ambulance Service region)</td>
<td>+70% within 8 minutes</td>
<td>2013/14 – 73.6% 262,977 out of 357,397</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Category A calls resulting in an ambulance arriving at the scene within 19 minutes (West Midlands Ambulance Service region)</td>
<td>+95% within 19 minutes</td>
<td>2013/14 – 97.0% 354,252 out of 355,078</td>
<td></td>
</tr>
</tbody>
</table>

For further information please contact
Kam Mirai at the Walsall CCG Performance Team
T: 01922 639999 E: kam.mirai@walsall.nhs.uk

Improving Health and Wellbeing for Walsall

Five year Strategic Plan for Walsall – 2014-2019 Page 21
An analysis of data showing the CCG position in relation to national outcomes indicators is given in Figure 12 below. It can be seen from this analysis, that Walsall is performing relatively well on patient reported outcomes in relation to emergency admissions, readmissions and GP out of hours, but relatively poorly on potential years of life lost from causes amenable to health, under 75 mortality rate for people with cardio-vascular disease and cancer, unplanned admissions for ACS conditions and unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s.

The impact of these population health factors on achieving our vision is discussed more fully in section four, which sets out the case for change.
Our vision and values

3 This five year strategy describes our vision and values for Walsall

3.1 Our vision

It is within this context, and our understanding of the community we serve, that we present our vision - to improve the health and well being of the people of Walsall.

Figure 13: Our vision for Walsall health and social care in 2019

We will do this by working in partnership with the public, people who use our services, carers, clinicians, our staff and health and social care providers, to design services which:

- Improve health and quality of life outcomes (measured against national and local targets)
- Reduce health inequalities across Walsall
- Target areas where there is greatest need
- Support people to take greater responsibility for living well, staying healthy and living independently.

We will focus on achieving the best health outcomes, regardless of organizational form across the system. This means that we will be advocates ‘for the people’, working in partnership with our providers, but using market shaping and every contractual lever available to us to achieve sustainable and high quality services. The diagram that follows provides a summary of where we are now and where we want to be.
Figure 14: Where we are now and where we want to be

3.2 Our values

The vision is underpinned by the following values, which have been developed in consultation with our constituent members and key stakeholders.

Respect and value people – individuals are at the core of what we do

Listen to local people – We are committed to involving patients, clinicians and communities in the design and improvement of their services

Clinical leadership - We recognise and embrace the need for clinical leadership in service planning and redesign to ensure highest levels of quality, safety and efficiency

Clear accountability and transparency – We value feedback and a clear sense of personal accountability and responsibility

Innovation – We will make best use of all new technology, particularly striving to be at the forefront of innovation in exploitation of information technology

Prevention – We will prevent poor health starting early with families, children and young people

Partnership – We will work closely with our partners in health, local authority and voluntary sectors to ensure a holistic approach to promoting health and equality in the community

Public Value - through our commissioning and procurements arrangements we will promote the creation of public value as measured by the social, economic and environmental impact on the community
**Parity of esteem** - between physical and mental health. We will work to not only improve mental health services, but also to change how people think about mental health, so that mental health is truly ‘on a par’ with physical health.

The sections that follow will explain where we are now, in relation to our vision (section four) and the key areas that we think need to change in order to realise it (section five).
The need for change

4  The gap between the current situation and our vision means we need to change

Having looked at the community we serve and summarised our overall vision for Walsall, we now describe more fully the key drivers for change- national and local. In addition to what we know and understand about our local population and area (as described in section two), what are the national and local forces creating an imperative for system change?

4.1  National drivers for change

The NHS is facing a number of key challenges. These include:

- An increasing population – people living longer, with 2 or more long term conditions
- Rising lifestyle and obesity related conditions e.g. diabetes & heart disease
- Expectations of the public regarding access, safety and standards of care and outcomes
- Expectations that technological advances in medicine keeps people alive and active for longer, this comes at a cost for medicines, procedures and ongoing monitoring
- Financial pressures with a projected funding gap of £30bn in health and care costs in 2020/21. In addition Councils will see 30% less money transferred to them from Central Government.

In 2013 NHS England provided planning guidance ‘Everyone counts: Planning for Patients 2014-19’, to support the development of our strategic plans. This sets out a vision for the NHS i.e. ‘The NHS exists to ensure high quality care for all, now and for future generations. The vision wants everyone to have greater control over their health and wellbeing, supported to live longer, healthier lives by high quality health and care services that are compassionate, inclusive and constantly improving’.

The guidance emphasizes an outcomes based approach and describes five key outcomes (domains) together with a set of ambitions to deliver these outcomes. These are summarised in figure 15, along with the characteristics of a successful health system also set out in the document.
Finally, the guidance describes the arrangements for the use of the newly formed Better Care Fund to support the delivery of integrated health and social care. CCGs are required to develop system strategies, which support the delivery of above outcomes, ambitions and system characteristics and demonstrate how proposed Better Care Fund Initiatives align with these strategies.

4.2 Local drivers for change

4.2.1 The health needs of the local population

Section two describes the key issues impacting on the health of the local population. This information, together with our analysis of other data on the health of the population, needs to inform the development of our system strategy and ensure that investment is targeted towards areas of greatest need. The key issues that we must address are summarised below:

- **High levels of deprivation** when compared with Local Authorities in England. Evidence shows that the determinants of health are wide ranging, including factors such as education, housing and employment. It is therefore imperative that we work in partnership with other agencies to address this issue

- **High infant mortality** rates compared with national and regional figures. A child born in Dudley has 40% less chance of dying under the age of one than a child born in Walsall. Other parts of the Midlands have made significant improvements in this area and we need to match, or better, this rate over the coming five years

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**Figure 15: Describing the NHS domains, ambitions and system characteristics**

<table>
<thead>
<tr>
<th>Domains</th>
<th>Ambitions</th>
<th>System Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventing people from dying prematurely</td>
<td>Improving health. Securing additional years of life for treatable mental and physical health conditions. Reducing health inequalities</td>
<td>• Modern model of integrated care</td>
</tr>
<tr>
<td>Enhancing quality of life for people with LTCs</td>
<td>Improving health related QoL for people with LTCs incl. mental health.</td>
<td>• Wider primary care at scale</td>
</tr>
<tr>
<td>Helping people to recover from episodes of ill health or following injury</td>
<td>Reducing avoidable hospital admissions (more integrated care out of hospital).</td>
<td>• New approach to ensuring people are included in service design and change and fully empowered in own care.</td>
</tr>
<tr>
<td>Ensuring people have a positive experience of care</td>
<td>Increasing proportion of older people living at home after discharge.</td>
<td>• Access to highest quality urgent and emergency care.</td>
</tr>
<tr>
<td>Treating and caring for people in a safe environment and protecting them from avoidable harm</td>
<td>Eliminating avoidable deaths in hospital caused by problems in care.</td>
<td>• Specialised services concentrated in centres of excellence.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• A step-change in productivity of elective care.</td>
</tr>
</tbody>
</table>

---

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<td></td>
<td></td>
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</tr>
</tbody>
</table>
• **Inequalities in male life expectancy** across the east and west of the borough, as well as lower male life expectancy compared to national and regional figures. In order to increase life expectancy, a number of key areas need to be addressed including: reducing mortality rates from the major diseases, promotion of healthier lifestyles, improving access to services and working to improve social determinants of health such as housing

• **Increasing ageing population.** This suggests that the care needs of the frail elderly will increase over a period of time, when the main workforce and wage earning section of the population is shrinking. Walsall will share the impact of changes in the national economy, which has previously relied on today’s workers to pay the real costs for those who are retired. The number of Non-UK born residents is also increasing (approximately 19.5% in 2011). Access and the appropriate provision of services will depend upon a well-informed understanding of the specific needs of these different communities

• **A growing number of people who have one or more long term conditions**, with a higher prevalence of some long term conditions, compared to the average in England. Walsall has the 3rd highest diabetes prevalence in England. This suggests that the strategy needs to address quality in primary care working to commission more preventative approaches to ill health and thereby reduce the incidence of these diseases in the population

• **1 in 6 adults has a mental health problem** at any one time, a relatively high number compared to other areas, and many do not seek help because of stigma. National evidence also shows that many people with mental health problems will die prematurely, as their physical health needs are not met, which reinforces the need to achieve parity of esteem

• **Walsall has one of the lowest records for early diagnosis of dementia in the West Midlands.** Given the high numbers of people with dementia who are admitted as an acute emergency, it is imperative that progress is made to achieve the national early diagnosis target and to improve health outcomes

• **A substantial proportion of the population have unhealthy life styles.** Around 55,000 adults (26%) are obese and around 130,000 (62%) are overweight or obese. The estimated prevalence for smoking in Walsall is 22.9% (approx 45,000 adults). For pregnant women rates of smoking at the time of delivery are high (16.8%). The data on lifestyles indicates low levels of regular exercise and intake of fruit and vegetables, plus high rates of harm related to alcohol consumption and drug misuse. There is a need to develop services which focus on prevention and education and support people to adopt healthier lifestyles.

In summary the above factors lead to poor population health and an increasing and ongoing demand for health and social care services. It is clear that improving the health and well being of the population of Walsall cannot be achieved through the provision of health care services alone. Addressing the above issues will require greater partnership working across health and social care organizations, other agencies and the third sector, in order to deliver joined up services. Importantly it also requires us to work in partnership with patients, carers and the public to support them in making healthier lifestyle choices and taking greater responsibility for managing their own health.

4.2.2 **Emergency admissions are increasing**

During the last year emergency admissions rose by 15%. Nationally there is a requirement to reduce emergency health admissions by 15 % over the next five years. This is to be achieved by developing alternative services that avoid the need for people to be admitted to hospital.
Delivering this target will be a challenge for us as the trend locally has been for emergency admissions to increase. The graph below shows the required target to reduce emergency admissions and shows the projected demand, based on current activity (2012/13) and assuming no change in service delivery. This graph shows that if there is no change in the services delivered, demand (the number of episodes) will continue to grow significantly and no progress will be made towards delivering the national target to reduce emergency admissions. The local health economy does not have the resources to sustain this trend. It is therefore imperative that transformational change is achieved at pace to manage demand for emergency admissions.

Figure 16: **Showing composite of all avoidable emergency admissions (Source: Levels of Ambition Atlas)**

We are currently undertaking a review of the urgent care pathway. The drivers for this review include:

- Growth in A & E attendances and emergency admissions
- Difficulties in achieving the 95% 4 hour wait target
- The CCG overspend on emergency admissions
- Caring for people with mental health needs
- Patient confusion and understanding of the different access points for “urgent care”

Emerging findings have identified a need, in the longer term, to develop a new urgent and emergency care centre at WHNHST, which would provide a single entry point for all patients. The review has also identified the need for immediate changes in the walk in centre due to regeneration of the town centre.
4.2.3 Specialised services

It is important that our strategy is aligned to the direction of travel nationally for specialised services over the next five years. The focus on planning across the entire patient pathway is vital i.e. any changes to a patient’s pathway locally will impact on the whole pathway.

Historically, specialised services account for £12.2 billion per annum of the NHS allocation and the growth in cost exceeds other parts of healthcare by as much as 4% per annum. Planning to look at how we work together with NHS England to review and achieve better value for money and improved quality is a key priority. Specialised services will be developing a robust QIPP challenge of its own and we will need to work with the Area Team to understand the QIPP agenda on the local health economy.

The national strategy being developed for specialised services is in the early stages of its development but is clear the direction of travel is towards fewer centres concentrated in centres of excellence (around 15 to 30 centres). We will need to work closely with NHS England to understand the implications of the strategy and work together on how to implement the transformational change required.

There will be joint opportunities for maximising research and teaching opportunities to encourage innovation and change. We will need to ensure that our planning involves:

- Strong engagement in the development of the national strategy for specialised services through the Call to Action programme completing in July 2014.
- Active participation in the proposed West Midlands governance arrangements for the strategy development which was considered and discussed at the 5th February Call to Action event.
- Identification of opportunities for joint planning and development of care across the whole patient pathway within local plans. Supporting the need for change within an agreed case for change.
- Close contract management arrangements with specialised commissioners for providers.
- Supporting the development of the local service priorities and/or reconfigurations currently being considered by the Area Team plan which include CAMHS Tier 4, Cancer services, Cardiology, Paediatric Intensive Care and High Dependency services and neuro-rehabilitation services.

This strategy will need to consider how changes in the provision and configuration of services across the wider health economy, may affect local demand for services, specifically changes in provision of services in Mid Staffordshire and future changes in the configuration of specialist services e.g. stroke, cancer pathways including chemotherapy and tier 4 CAMHs.

4.2.4 The imbalance between health need and service provision

The above information on the population health and the increasing demand for acute services shows that there is a need to shift the balance of services. It is critical that our system strategy focuses on managing the demand for emergency care by improving access to primary (e.g. primary care access schemes including GP telephone triage) and community care services. There is also a need to target health prevention, promote healthy life styles and support people to take greater responsibility for their own care.
4.2.5 The need for greater integration across the services provided

Whilst progress has been made to improve integration across specific care pathways, more needs to be done to develop integrated care and improve joint working across health and social care provider services. The Better Care Fund provides the opportunity to develop these services. The system strategy for Integration is to:

“Maintain and where possible improve the independence, health and well being of the people in Walsall”

The priorities are to:
- Support swift return home following an episode of bedded care
- Reduce the prevalence of emergency admissions to hospital
- Reduce the number of older people receiving ongoing social care services
- Keep people at home as long as possible.

4.2.6 Quality, safety and patient experience issues

The QOF outcomes indicators in section 3 show rates higher than England average for unplanned admissions chronic ACS admissions, unplanned hospitalization for asthma, diabetes and epilepsy for under 19s and the incidence of healthcare-associated infections - C.difficile and MRSA.

The Primary Care Strategy raises concerns regarding a general deterioration in patient satisfaction in General Practice (as reported by the National Patient Survey and significant variation in the quality and access to primary care as measured by NHS England tools.

Feedback from the Call to Action events highlighted the need for:
- More information on services available and access points
- Easier access to GP appointments
- More joined up and integrated care
- More care in the community - care closer to home
- Health education to support self management
- Greater focus on prevention.

The QOF disease register also shows that the percentage of patients that feel supported is below the England average.

We need to ensure that we use this feedback to inform service development. We also need to strengthen our contracting arrangements to ensure that they drive the delivery of quality outcomes.

4.2.7 Financial pressures

We are facing a number of financial pressures, including rising costs, potential changes in funding allocation and increasing demand for services.

Rising costs

Although it is recognized that the settlement for the NHS has been relatively generous in comparison to other areas within the public sector, the NHS faces efficiency challenges to cope with demographic changes, the cost of new technology and the Health Service's traditionally higher level of inflation.
Potential changes in funded allocation

The forward financial plan allows for the impact of the Fundamental Allocations Review and the creation of the Better Care Fund. The Fundamental Review of Allocations Policy, commissioned by NHS England, has reduced the level of growth available to the CCG. Initial modelling suggests that Walsall CCG is currently funded at a level of £35.3m or 10.32% above the target allocation. A key consideration will be the "Pace of Change" which is the speed at which funding moves from actual to target.

The outcomes of the Keogh recommendations are also likely to have an impact on the resources available for the commissioning of services by the CCG.

Rising demand

We have undertaken an exercise to model the impact of underlying growth, due to factors such as population growth and changes in demographics on contracted activity and contract value over a five year period. We have assumed an 8% increase in elective activity and 10% in emergency activity. The table below shows the impact of these activity increases on contract value, i.e. 6% increase in contract value for elective and 8% increase for emergency services.

This modelling shows that doing nothing is not an option. We will need to develop Quality, Innovation, Productivity and Prevention (QIPP) schemes, which support us in managing future demand and reducing costs to enable us to achieve a balanced position.

Figure 17: Contract modelling gap analysis 2014/15 to 2108/19

Contract Modelling GAP Analysis 2014/15 – 2018/19

<table>
<thead>
<tr>
<th></th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
<th>Five Year Impacts</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>Activity</td>
<td>Activity</td>
<td>Activity</td>
<td>Activity</td>
<td>Activity</td>
<td>Value</td>
</tr>
<tr>
<td>Elective Spells Projection - underlying growth</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>WALSALL HEALTHCARE NHS TRUST</td>
<td>22,741</td>
<td>23,390</td>
<td>23,196</td>
<td>23,595</td>
<td>23,660</td>
<td>24,164</td>
</tr>
<tr>
<td>THE ROYAL WOLVERHAMPTON NHS TRUST</td>
<td>3,086</td>
<td>4,592</td>
<td>4,066</td>
<td>4,147</td>
<td>4,744</td>
<td>4,230</td>
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<tr>
<td>HEART OF ENGLAND NHS FOUNDATION TRUST</td>
<td>1,536</td>
<td>1,578</td>
<td>1,592</td>
<td>1,598</td>
<td>1,630</td>
<td>1,630</td>
</tr>
<tr>
<td>SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST</td>
<td>1,236</td>
<td>1,369</td>
<td>1,261</td>
<td>1,386</td>
<td>1,414</td>
<td>1,414</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td>29,499</td>
<td>30,929</td>
<td>30,089</td>
<td>31,201</td>
<td>30,691</td>
<td>31,305</td>
</tr>
</tbody>
</table>

| Emergency Spells Projection - underlying growth |          |          |          |          |          | |
| WALSALL HEALTHCARE NHS TRUST | 21,938   | 39,983   | 22,486   | 40,532   | 23,048   | 41,712 |
| THE ROYAL WOLVERHAMPTON NHS TRUST | 2,976    | 5,314    | 3,050    | 5,387    | 3,127    | 5,544 |
| HEART OF ENGLAND NHS FOUNDATION TRUST | 900      | 1,552    | 923      | 1,573    | 946      | 1,619 |
| SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST | 648      | 891      | 664      | 904      | 681      | 930 |
| **Totals**            | 26,462   | 47,741   | 27,123   | 48,396   | 27,801   | 49,805 |

Fifteen year Strategic Plan for Walsall – 2014-2019
4.2.8 Identifying QIPP opportunities and demonstrating value for money

In looking at priorities for 2014/15 onwards work has been undertaken at national, regional and local levels to identify where the greatest opportunities lie to improve both quality and value by doing things differently. This work has involved substantial analysis of what the evidence says about best practice and how health services across the country and beyond currently respond to health needs (the degree of variation in that) with what outcome. It has been conducted through substantial clinical discussions about where front line clinicians see the greatest potential to do things differently and better. This has then been compared with current local practice to identify potential opportunities. We have reviewed and consulted on the following in order to determine our local priorities.
Where possible the above data was forecasted up to 2021/22 highlighting the effect of population growth on these indicators. The priorities have been shared with the IOB, Programme Leads, GP localities and PRGs. It must be borne in mind that a lot of the above mentioned tools are from the same source data just presented and sliced in different ways.

For illustration purposes the results of the Programme Budgeting Spend and Outcome tool and the Anytown Lite analysis are shown below.

### 4.2.9 Programme Budgeting and Spend Outcome Tool (SPOT)

The aim in setting the priorities was to take the SPOT and identify the best performing CCGs located in the top left hand quadrant of the analysis for each outcome indicator against spend. The spend was then predicted up to 2021/22 based on demographic changes and known expenditure for Walsall CCG and an inflation figure of 2% per year for all other CCGs.

<table>
<thead>
<tr>
<th>Group</th>
<th>Tool / Document / Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documents and Groups</td>
<td>The West Midlands and National QIPP work streams</td>
</tr>
<tr>
<td></td>
<td>Walsall JSNA</td>
</tr>
<tr>
<td></td>
<td>Programme Boards (Clinical &amp; GP Led)</td>
</tr>
<tr>
<td></td>
<td>STaR Groups (new)</td>
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<tr>
<td></td>
<td>GP Localities</td>
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<td></td>
<td>NICE QIPP Evidence (new)</td>
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<td></td>
<td>NHS Benchmarking (new)</td>
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<td></td>
<td>Better Care, Better Value Indicators</td>
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<td></td>
<td>NHS Comparators</td>
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<td></td>
<td>Anytown Lite</td>
</tr>
<tr>
<td>Programme Budgets</td>
<td>Programme Budgeting (Spend and Outcome Tool) (SPOT)</td>
</tr>
<tr>
<td></td>
<td>Atlas of Variation (new)</td>
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<td></td>
<td>Commissioning for Value (new)</td>
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<tr>
<td>Similar Metrics</td>
<td>West Midlands Estimated Potential Savings</td>
</tr>
<tr>
<td></td>
<td>CSU Report - Identifying Potential QIPP Opportunities for 2014/15</td>
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<tr>
<td></td>
<td>CCG Outcome Indicators (new)</td>
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<td></td>
<td>Primary Care Web Tool (new)</td>
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</tbody>
</table>
This analysis highlights those programme budgets that need to be reviewed in terms of investment and outcomes. Whilst we have a lower level of expenditure projected and better forecast outcomes in respect of mortality following an accident (trauma and injuries) and aspects of dental care, the
data suggests we could improve maternity care and support for people with respiratory conditions. In these areas, a higher level of spend is forecast and worse outcomes than for other organisations.

4.2.10 Anytown Lite

This modelling tool can be used to identify what the quality and financial baseline may look like for a typical CCG, based on two interventions i.e. High Impact and Early Adopter interventions.

This analysis shows that Walsall CCG has the potential to achieve over £13m savings (with any overlaps removed); if the full range of High Impact innovations is implemented. The diagram below describes the scale of opportunity by innovation. This shows that three of these changes (i.e. reducing variability in primary care; case management and co-ordinated care and safe and appropriate use of medicines) would provide over 50% of these savings.

Figure 22: High impact interventions – net estimated savings

<table>
<thead>
<tr>
<th>High Impact Intervention</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early diagnosis</td>
<td>£856,382</td>
</tr>
<tr>
<td>Reducing variability within primary care</td>
<td>£5,709,670</td>
</tr>
<tr>
<td>Self-management: Patient-carer communities</td>
<td>£1,004,580</td>
</tr>
<tr>
<td>Telehealth/Telecare</td>
<td>£857,063</td>
</tr>
<tr>
<td>Case management and coordinated care</td>
<td>£3,364,136</td>
</tr>
<tr>
<td>Mental Health - Rapid Assessment Interface and Discharge</td>
<td>£1,190,408</td>
</tr>
<tr>
<td>Dementia pathway</td>
<td>£416,669</td>
</tr>
<tr>
<td>Palliative Care</td>
<td>£1,436,176</td>
</tr>
</tbody>
</table>

The estimated savings from implementing the Early Adopter innovations is over £12m (with any overlaps removed). Three innovations (i.e. safe and appropriate use of medicines, acute visiting service and GP tele-consultation) would provide over 50% of the savings.

Figure 23: Early adopter innovations – net estimated savings

<table>
<thead>
<tr>
<th>Early Adopter Interventions (1-12)</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer screening programmes</td>
<td>£0</td>
</tr>
<tr>
<td>GP tele-consultation</td>
<td>£1,903,657</td>
</tr>
<tr>
<td>Medicines optimisation</td>
<td>£854,655</td>
</tr>
<tr>
<td>Safe and appropriate use of medicines</td>
<td>£5,367,404</td>
</tr>
<tr>
<td>Acute visiting service</td>
<td>£2,070,570</td>
</tr>
<tr>
<td>Reducing urgent care demand</td>
<td>£798,531</td>
</tr>
<tr>
<td>24-hour asthma services for children and young people</td>
<td>£11,851</td>
</tr>
<tr>
<td>Service user network</td>
<td>£726,830</td>
</tr>
<tr>
<td>Reducing elective caesarean sections</td>
<td>£0</td>
</tr>
<tr>
<td>Acute stroke services</td>
<td>£0</td>
</tr>
<tr>
<td>Integration of health and social care for older people</td>
<td>£298,530</td>
</tr>
<tr>
<td>Electronic palliative care coordination systems</td>
<td>£1,185,350</td>
</tr>
</tbody>
</table>

The results of the above analysis have shown that there are a number of common areas where there are opportunities to improve both quality and value by doing things differently. This information has been used to inform the identification of the QIPP programme, which is described in sections five and six.
In conclusion, the key drivers for change are focused on the need to improve the health and quality of life of our local population, by shifting the balance of services, in order to provide safe high quality services that are integrated and demonstrate value for money.
Five year Strategic Plan for Walsall – 2014-2019

Four strategic objectives

5 We have chosen four strategic objectives to drive our change agenda over the coming five years.

5.1.1 Overview

Having outlined where we want to get to and summarised where we are now, this section introduces, characterises and details the main components of our four strategic objectives - the broadly defined aims that we must achieve to make our strategy succeed. These are:

1. Improve health outcomes and reduce health inequalities
2. Provide the right care, in the right place, at the right time
3. Commission consistent, high quality, safe services across Walsall
4. Secure best value for the Walsall pound and deliver public value

They sit under the vision and will frame our work for the coming five years. They are fully aligned to the objectives of the Health and Well-Being Board and to the Better Care Fund Plan (a summary is provided within Appendix 4). The Better Care Fund work streams are an integral feature of our priorities and the key elements are reflected within the measures and interventions that will deliver this strategy.

Figure 24: The four strategic objectives sit under the vision and will ensure its delivery

Our vision: To improve the health and well being of the people of Walsall

1. Improve health outcomes and reduce health inequalities
2. Provide the right care, in the right place, at the right time
3. Commission consistent, high quality, safe services across Walsall
4. Secure best value for the Walsall pound and deliver public value

5.1.2 Development of the local priorities and interventions

Under each strategic objective we have defined a number of priorities – according to the system needs evidenced earlier - that will determine our operational work programme and focus. Each priority will be achieved by the delivery of a number of interventions, specifically chosen to address the root causes of the particular priority.
These interventions have been identified through communications and engagement with our key stakeholders, specifically the public, service providers and public health. We have focused on interventions which have a strong evidence base in delivering better outcomes and value for money and best match the needs of our local population.

These priorities and interventions are described more in the following sub-sections, along with the intended measures and trajectories to indicate our success in each area.

The numbers provided indicate our stretch target that we believe will be achievable but, in all areas, our ambition is to go beyond this to provide nationally recognised high levels of care.

Whilst we have clearly defined our vision, objectives and priorities for the coming five years, we are mindful of the immediate tasks before us, if we are to effectively deliver this agenda. Time will be invested, in the coming weeks (by 1 September 2014), in:

- Clarifying, specifically, who will benefit from the interventions
- Undertaking a detailed impact assessment of the changes proposed- developing detailed models, where appropriate, to allow us to test the level of change we can expect and the inter-dependencies
- Updating the financial implications of the interventions- we need to know, in some detail, the extent of the investment required and which will provide the best return, where different options are open to us
- Understanding the enablers and barriers to change, in all areas.

At present the precise impact of each discrete intervention is being quantified, to ensure that the combined total will enable us to meet the defined ambition. This quantification will be built as appropriate on a collection of modeling, case study evidence and best practice indications, and this will form an early part of assurance by the delivery teams.

Having agreed our strategy, this is now our immediate agenda and will be addressed as we develop project initiation documents and move into the implementation and delivery phase of our work.

5.1.3 Alignment to national priorities and ambitions

By concentrating on these areas, we will respond to the requirements stipulated within national planning guidance, the outcome of the joint strategic needs assessment, priorities agreed in the Health and Well-Being Strategy and local intelligence from the Call to Action work(where patient and stakeholder views were gathered).

Within the table below, we list our local priorities under each of the strategic objective areas, and illustrate in particular how they align to:

- The six characteristics of high quality, sustainable health and care systems expected by NHS England in five years time
- The five domains of better outcomes mandated through the NHS Outcomes Framework
- The seven critical ambitions that these systems must deliver, within the five domains.
### Figure 25: Alignment of our strategic objectives and local priorities with national guidance

<table>
<thead>
<tr>
<th>Local Priorities</th>
<th>Alignment to the six characteristics</th>
<th>Alignment to the five domains</th>
<th>Alignment to critical ambitions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategic Objective: 1. Improve health outcomes and reduce health inequalities</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduce perinatal and infant mortality</td>
<td>New approach to ensuring people are included in service design and change and fully empowered in their care</td>
<td>Preventing people from dying prematurely</td>
<td>Securing additional years of life for treatable mental and physical health conditions</td>
</tr>
<tr>
<td>Reduce the health gap across Walsall</td>
<td></td>
<td>Enhancing quality of life for people with LTCs</td>
<td>Improving health</td>
</tr>
<tr>
<td>Reduce and better manage - Long Term Conditions, especially diabetes, CVD and COPD</td>
<td></td>
<td></td>
<td>Reducing health inequalities</td>
</tr>
<tr>
<td>Target obesity in children.</td>
<td></td>
<td></td>
<td>Improving health related quality of life for people with long term conditions, including mental health</td>
</tr>
<tr>
<td>Improve mental health and well-being and ensure parity of esteem with physical health</td>
<td></td>
<td></td>
<td>More people with mental and physical health have a positive experience of hospital</td>
</tr>
<tr>
<td><strong>Strategic Objective 2: Provide right care, in the right place at the right time</strong></td>
<td></td>
<td></td>
<td>Parity of Esteem</td>
</tr>
<tr>
<td>Improve integration of primary, community and social care</td>
<td>Modern model of integrated care</td>
<td>Enhancing quality of life for people with LTCs</td>
<td>Improving health related quality of life for people with long term conditions, incl mental health</td>
</tr>
<tr>
<td>Bring care closer to home</td>
<td>Wider primary care at scale.</td>
<td>Helping people to recover from episodes of ill health or following an injury</td>
<td>Reducing avoidable hospital admissions (more integrated care, out of hospital)</td>
</tr>
<tr>
<td>Reduce emergency admissions to hospital</td>
<td>New approach to ensuring people are included in service design and change and fully empowered in their care</td>
<td></td>
<td>Increasing proportion of older people living at home after discharge</td>
</tr>
<tr>
<td>Strengthen emotional health and well-being services for children and young people</td>
<td>Access to highest quality urgent and emergency care</td>
<td></td>
<td>More people have a positive experience of care, outside of hospital</td>
</tr>
<tr>
<td></td>
<td>Specialised services concentrated in centres of excellence</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Local Priorities | Alignment to the six characteristics | Alignment to the five domains | Alignment to critical ambitions
---|---|---
**Strategic Objective 3: Commission consistent, high quality, safe services across Walsall**
Enhance the patient and public experience of health and care services | New approach to ensuring people are included in service design and change and fully empowered in their care | Enhancing quality of life for people for people with LTCs Ensuring people have a positive experience of care Treating and caring for people in a safe environment and protecting them from avoidable harm | More people with mental and physical health have a positive experience of hospital As above but outside of hospital, in general practice Eliminating avoidable deaths in hospital
Eliminate the number of recurring significant incidents | n/a | n/a
Improve service quality and performance | n/a | n/a

**Strategic Objective 4: Secure best value for the Walsall pound and deliver public value**
Delivering cost efficiency programmes (including QIPP) | A step change in the productivity of elective care | n/a | n/a
Ensure delivery of provider Cost Improvement Plans | n/a | n/a
Ensure services are provided by the most capable providers | n/a | n/a
Ensure providers deliver social, economic and environmental benefits to the Walsall community | n/a | n/a

This shows, for example, that through our plans to improve health outcomes and reduce inequalities, we will ensure that:

- People are included in service design and empowered in their care
- Outcomes will be improved, with fewer people dying prematurely and those with LTCs enjoying a higher quality of life
- Health inequalities are reduced and people with mental and physical health issues have a positive experience of hospital.
5.2 Objective 1: Improve health outcomes and reduce health inequalities

This objective maps fully to the Health and Well-Being strategy of Walsall, which states the intention to reduce the burden of preventable disease, disability and death.

As noted in section two, Walsall has a number of significant issues to address in respect of health inequalities and to improve health outcomes. Infant mortality, male life expectancy, obesity, smoking rates and alcohol consumption are unacceptably high in Walsall.

Based on our understanding, our resources need to be invested primarily in four areas:

- Reduce perinatal and infant mortality
- Increase male life expectancy
- Reduce the incidence – and better manage - long term conditions
- Improve mental health and wellbeing and ensure parity of esteem with physical health

5.2.1 Reduce perinatal and infant mortality

The programme of work to specifically address the infant mortality priority is currently being developed, in partnership with Public Health, the local authority and key partners. A deep dive is being conducted of all cases of infant mortality over the last four years, in Walsall, to understand the specific challenges that must be addressed. This will build upon elements of the Obstetrics and Gynaecology Strategic Transformation and Redesign Group (STaR) group, which has looked at improvements to maternal health.

Our aim is to reduce the level of infant mortality to follow the improvement trajectory shown below. However, these changes take time and it will take more than five years to reach the national average. This is because Walsall currently has one of the highest rates nationally, due to the unique local factors. Our improvement initiatives are designed to produce the fastest possible change and if possible we will improve the situation more quickly than the trajectory shown, to reach and surpass the national average as soon as possible.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant mortality rate per 1000 live births</td>
<td>8.1</td>
<td>7.6</td>
<td>7.2</td>
<td>6.7</td>
<td>6.3</td>
<td>6</td>
</tr>
</tbody>
</table>

Where we want to be

- Better prevention and reduced unplanned pregnancies through education
- Better antenatal care through encouraging early booking for antenatal care, continuity of care through pregnancy and improved detection of intrauterine growth restriction (IUGR)
- Reduced levels of maternal obesity and smoking in pregnancy through projects such as Maternal and Early Years, Smoke-Free Homes, improving smoking cessation in pregnancy and working with ethnic communities to reduce the use of ethnic tobacco products
- An effective antenatal and new-born screening programme
- Reduced sudden unexpected death in infancy (SUDI) and improving breastfeeding initiation and continuation rates
- Targeted interventions at vulnerable groups through specialised programmes such as the Enhanced Community Genetics service and the Family Nurse Partnership.
**Reduce perinatal and infant mortality**

**Key interventions**

- Reducing teenage pregnancy
- Reducing levels of maternal obesity and smoking in pregnancy
- Improved antenatal and postnatal care
- Interventions targeted at the most vulnerable groups
- Transferring of Gynaecology Services from Secondary Care to Primary Care.

**Current delivery mechanism**

Infant Mortality STaR Group and partnership working.
Obstetrics and Gynaecology Strategic Transformation and Redesign Group (STaR).

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### 5.2.2 Increase male life expectancy

As noted in sections two and four, high levels of deprivation within parts of Walsall create a notable divide in health and well-being across the Borough. Our analysis shows that men within these areas are the group at highest risk of ill-health and premature mortality. We need to address this gap by investing resources in this area, in close partnership with Walsall MBC, through the work of the Health and Well-Being Committee.

By paying particular attention to the health of men, we will narrow the health gap and reduce inequality.

#### Increase male life expectancy

<table>
<thead>
<tr>
<th>Our ambition and improvement trajectory</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased male life expectancy (years)</td>
<td>77.9</td>
<td>78.16</td>
<td>78.42</td>
<td>78.68</td>
<td>78.94</td>
<td>79.9</td>
</tr>
<tr>
<td>Close the gap in Life Expectancy within the Borough between the most deprived and affluent areas of Walsall (years)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Male</td>
<td>10.8</td>
<td>10.54</td>
<td>10.36</td>
<td>10.15</td>
<td>9.93</td>
<td>9</td>
</tr>
<tr>
<td>2. Females</td>
<td>8</td>
<td>7.84</td>
<td>7.62</td>
<td>7.4</td>
<td>7.19</td>
<td>6.97</td>
</tr>
</tbody>
</table>

**Where we want to be**

- Lower levels of smoking, obesity and harmful drinking in the Borough
- A clearer understanding of the main causes of death in the borough with a focus on prevention and early detection
- A greater influence upon lifestyle choices through the Every Contact Counts initiative
- A higher participation rate in NHS Health Checks and national screening programmes
- Robust pathways of care across all health care providers
- Those living in the West of Walsall have the same life chances as those living in the East.

**Key interventions**

- Reduce smoking, obesity and harmful drinking
- Increase early detection (for example, health checks)
- Influence lifestyle choices through Every Contact Counts
Increase male life expectancy

- Encourage participation in screening programmes
- Improve care pathways
- Targeted education and service provision through Lifestyle Services.

Current delivery mechanism

Male Life Expectancy Project

5.2.3 Reduce and better manage Long Term Conditions

Currently, the number of patients with LTCs requiring unplanned support is high and indicates that patients are not able to access the support that they need within the community. In addition, the financial impact of a high level of emergency admissions is not affordable in the longer term. Our expenditure on diabetes, COPD and CVD is higher than for other organisations and our outcomes, in all areas, are not as good.

Linked to this, incidence of obesity is also high (close to the maximum for England) and an area that must be addressed to avoid the further escalation of conditions such as diabetes. Improving the management of diabetes will also be a significant challenge.

<table>
<thead>
<tr>
<th>Reduce and better manage Long Term Conditions</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve the management of diabetes. Last HB1AC is &lt;=8% in last 15 months</td>
<td>78.2%</td>
<td>78.2%</td>
<td>78.2%</td>
<td>78.2%</td>
<td>78.2%</td>
<td>78.2%</td>
</tr>
<tr>
<td>Under 75 mortality rate from respiratory disease</td>
<td>36.1</td>
<td>35.5</td>
<td>35</td>
<td>34.5</td>
<td>34.0</td>
<td>33.5</td>
</tr>
<tr>
<td>Under 75 mortality rate from cardiovascular disease</td>
<td>83</td>
<td>81</td>
<td>80</td>
<td>78.3</td>
<td>76.6</td>
<td>74.9</td>
</tr>
<tr>
<td>Incidence of obesity in children-the percentage of 4 and 5 year old children who are overweight</td>
<td>22.8%</td>
<td>22.8%</td>
<td>22.8%</td>
<td>22.8%</td>
<td>22.8%</td>
<td>22.8%</td>
</tr>
</tbody>
</table>

Where we want to be

- More care delivered within localities with primary and community support for patients and reduction in number of treatments carried out in acute care settings including virtual clinics etc.
- Patients are treated with dignity and respect
- GPs can access multi-disciplinary expertise with access to range of diagnostics and advice from specialists to avoid unnecessary appointments and admissions for patients
- Regular use of benchmarking
- Greater use of Patient Recorded Outcomes Measure (PROMS) and patient satisfaction
- Clinicians and patients reviewing and redesigning pathways
- Avoid unnecessary appointments and admissions
- Patients have links to lifestyle services
- A wider range of providers for clinical services
- Practices effectively identifying patients in early stages of Long Term Conditions.
- Wider use of digital technology
Reduce and better manage Long Term Conditions

**Key interventions**

**Diabetes:**
- Reduction in avoidable admissions through Hypo alert project (Birmingham and Black Country (BCC) & WMAS)
- Structured Education and improving uptake in patient education programmes
- Diabetes Level 2a service
- Improve early diagnosis of Diabetes
- Reducing obesity through lifestyle

**Respiratory Disease:**
- Redesign COPD care pathway including Bronchiectasis
- Redesign of Walsall COPD Team (Nurse Led with Specialists)
- Replacement of COPD Management SLA
- Spirometry LES
- Design Long Term Oxygen Therapy annual reviews service
- Determine contractual arrangements regarding the newly structured Home Oxygen service
- Improve uptake of pulmonary rehabilitation.

**CVD:**
- Redesign of Stroke Care Pathway - review of rehab element - opportunities for application of telehealth
- 24 blood pressure monitoring
- New pathways for ischaemic heart disease, arrhythmia
- Breathlessness Clinics (joint with Heart Failure).

**Obesity**
- Food Dudes Early Nursery
- Primary Care Brief Interventions advice
- Referrals to maternal and early years programme (Brief interventions via CQUINN)

**Current delivery mechanism**

StaR groups are in place to deliver improvements in each of the areas but will be overseen by an overarching LTC Transformation Board.

5.2.4 Improve mental health and wellbeing and parity of esteem

We know that the number of people with mental health issues in the Walsall area is significant and that access to services is not always timely. We are also aware that mental health matters are not always treated with the same regard as physical health matters and that we need to ensure that there is parity of esteem. We believe that we can make a significant difference to many people by targeting these issues.

In respect of promoting and improving mental health, we are prioritising:
- Parity of esteem and the patient experience, overall
- Dementia care.

As with LTCs, we spend more on mental health services than other CCGs and yet our key outcomes are not better.
**Improve mental health and wellbeing and parity of esteem**

<table>
<thead>
<tr>
<th>Our ambition and improvement trajectory</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient experience of community mental health services</td>
<td>87.6%</td>
<td>89.2%</td>
<td>89.4%</td>
<td>90%</td>
<td>91%</td>
<td>92%</td>
</tr>
<tr>
<td>People with mental illness invited for an annual physical check (including baseline tests and medication review).</td>
<td>To be agreed in collaboration with the Area Team and providers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dementia diagnosis rate</td>
<td>52.4%</td>
<td>67%</td>
<td>67%</td>
<td>69.6%</td>
<td>72.3%</td>
<td>75%</td>
</tr>
</tbody>
</table>

**Where we want to be**

*Improve mental health and well-being:*
- An integrated tiered approach to mental health across the whole healthcare system
- Far greater understanding in the community about how to maintain mental health and wellbeing and challenge the stigma attached to having mental health problems
- People with common mental health problems or signs of psychological distress – including those where these problems are secondary to a long term physical health condition – can access a range of talking therapies and support in Primary Care to prevent escalation into, and extended use of, health and social care services
- Providing high quality care and support for people who become acutely mentally ill and need specialist in-patient and community services (specialist or generic services)
- People with mental health problems remain in or as near to Walsall as they wish in a genuine home with support to remain in or get employment/meaningful occupation
- Parity of esteem
- Robust risk assessments and suicide prevention measures in place and evident in prevention of attempted suicide cases.

*Dementia:*
- National dementia strategy implemented.

**Key interventions**

*Improve mental health and well-being:*
- Increasing implementation of 5 ways to wellbeing
- Reprovision of all Walsall inpatient services
- Website Development IAPT
- Redesign of wellbeing and prevention services
- Create an Intensive Community Rehabilitation Service
- Develop Psychiatric Liaison Pathway
- Implement personalisation and individual budgets
- Memory assessment service.

*Dementia:*
- Dementia Friendly Communities
- GP incentive scheme
- GP EMIS case finding tool
- Dementia Directed Enhanced Service
- Dementia acute hospital CQUIN.
5.3 **Objective 2: Provide the right care, in the right place, at the right time**

This will be achieved by shifting the balance of care towards the development of primary and community services. Success will be characterised by the emergence of new models of care, operating seven days a week and through a wider choice of providers. This will have a noticeable impact on urgent care services (patients will choose to receive care by services other than A&E) and home treatment options will expand. This will be of particular value to patients with mental health conditions, who have learning disabilities, who are older or who have a long term condition.

To deliver this objective, over the coming five years, we have prioritised the following areas for development:

- Improve the integration of primary, community and social care
- Bring care closer to home
- Reduce emergency admissions to hospital
- Strengthen emotional health and well-being services for children and young people.

### 5.3.1 Improve integration of primary, community and social care

Under this priority, we will make sure that the right structures and management arrangements are in place, across all organisations involved in delivering patient care, so that the outcome, for patients, is seamless care.

Transformational change will take place as services are redesigned. GPs will play an even greater role in relieving the increasing pressures on emergency and out of hour’s services as well as supporting development of better integrated care for people with long-term conditions.

We will work to provide primary care at scale—offering care that can be accessed in the right place, at the right time by those best placed to provide it.

We will also work to implement seven day working within health and social care, to support patients being discharged and prevent unnecessary admissions at weekends. This is part of agreed local plans within Walsall Council, WHT, and DWMHPT. Currently, seven day services include social care reablement and social work services. Walsall Healthcare Trust is examining possible arrangements for seven day working for therapy services. Funding has been provided for the expansion of community health services.

### Improve integration of primary, community and social care

<table>
<thead>
<tr>
<th>Our ambition and improvement trajectory</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of older people still at home 91 days after discharge is at least 90%</td>
<td>80%</td>
<td>82%</td>
<td>84%</td>
<td>86%</td>
<td>88%</td>
<td>90%</td>
</tr>
</tbody>
</table>
Improve integration of primary, community and social care

Where we want to be

- Change in culture to support prevention and self-care (patients and the primary healthcare team) including use of information relating to health care
- New models of primary care provision to deliver high quality services - including access to a broader range of services in primary care and the community, with GPs co-ordinating and delivering comprehensive care in collaboration with community services and expert clinicians
- Practices working collaboratively, together, to improve access, share specialist skills and share back office functions
- Develop the right infrastructure for community nursing, ensuring highly responsive, skilled services
- Virtual wards – patients being managed safely in the community where they want to be with the right care and ability to ‘step up and down’ along a continuum of care delivery
- Through good health and social care programmes of care prevent long term admissions to residential or nursing care
- Ensuring robust arrangements for Nursing homes, ensuring appropriate medical support available when required and maximise opportunities to develop nursing home skills to ensure alignment with a revised community service
- Maximising use of digital technology.

Key interventions

- Promote and support primary care at scale
- Primary care strategy development
- Co-commission primary care with the area team
- Revise community nursing arrangements
- Expand seven day working
- Expand multi-disciplinary teams
- Improve the quality and range of primary care provision
- Co-locate primary, secondary and community teams.

Current delivery mechanism

Integrated Care and BCF programme

5.3.2 Bring care closer to home

Within this priority, we will address the change in practice that the above re-structuring will allow, as care is refocused around patients within the community.

We will develop services that are proactive in supporting vulnerable patients, allowing them to stay in their own homes, wherever possible, and reducing the time that they spend in hospital by ensuring that the transfer between acute and community services is seamless.

### Bring care closer to home

<table>
<thead>
<tr>
<th>Our ambition and improvement trajectory</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number of delayed discharges (DTOCs) is reduced by 25% (against the 2013/14 baseline).</td>
<td>We are currently working with the Council and the Trust to ensure that DTOCs are correctly captured and recorded so that our position is clear.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Permanent admissions to</td>
<td>226</td>
<td>417</td>
<td>381.6</td>
<td>355.4</td>
<td>329.2</td>
<td>303</td>
</tr>
</tbody>
</table>
Bring care closer to home

Where we want to be

- Primary care is able to provide a same day service for patients with a perceived urgent care need
- Patients who access urgent care services receive a consistent and seamless approach and as a result are not passed from one service to another
- Patients with an emergency ambulatory care condition receive same day access to diagnostics and treatment
- Patients who need to be admitted stay in hospital for no longer than is necessary
- People with a learning disability who enter hospital will have a clearly defined treatment plan and be supported to return to a community setting within an agreed timescale.
- A robust discharge process is in place, which ensures that an expected date of discharge is set upon admission and patients are discharged at the earliest opportunity, supported by a comprehensive package of care, where necessary
- A surge plan that can be implemented at any time with short notice that doesn’t involve opening wards in the acute sector
- Ability to identify those patients ‘at risk’ early on ensuring community preventative measures are in place and evidenced through robust risk stratification of patient groups. Patients identified through this process are provided with a care management plan.
- Ability to respond rapidly to changing clinical and social care situations through an integrated Intermediate care ‘step up’ model preventing admission to hospital or expediting discharge through an effective ‘Step down’ model
- All the community healthcare team to act as care co-ordinators navigating and tracking patients through the system and removing blocks.

Key interventions

- Single point of access, including co-location of primary, secondary and community teams
- Implementing a discharge planning process and care planning
- Recommission SWIFT in the community (discharge to assess ward)
- Case management
- Risk stratification tools
- Develop intermediary care.

Current delivery mechanism

Primary and Community Services Programme Board

5.3.3 Reduce emergency admissions to hospital

Managing the number of emergency admissions is a priority as it is an expensive way of providing unscheduled care, it is not always the most appropriate way of providing care and because it often represents a failure of other parts of the system. We know that many people will attend A&E, and be admitted, as they are not aware of alternatives, or because the alternatives are not as easily accessible or perceived to offer the same quality of care.

By making this a strategic objective, we will ensure:

- Arrangements are made to prepare for the implications of the urgent and emergency care network, in line with Keogh
- Urgent care pathways are reviewed and transformed, designed to produce better outcomes
• That the BCF drives the integration of commissioning and provision to reduce emergency admissions to hospital of people aged 65 years and over.

<table>
<thead>
<tr>
<th>Reduce emergency admissions to hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Our ambition and improvement trajectory</strong></td>
</tr>
<tr>
<td>Emergency admissions for acute conditions that should not usually require hospital admission - per unit of population</td>
</tr>
</tbody>
</table>

**Where we want to be**

- Primary care is able to provide a same day service for patients with a perceived urgent care need
- Patients who access urgent care services receive a consistent and seamless approach and as a result are not passed from one service to another
- Patients with an emergency ambulatory care condition receive same day access to diagnostics and treatment
- Patients who need to be admitted stay in hospital for no longer than is necessary
- A surge plan that can be implemented at any time with short notice that doesn’t involve opening wards in the acute sector.

**Key interventions**

- Review Emergency & Urgent Care Centre and Walk in Centre
- Develop consultation documentation and options for Urgent Care Pathway.
- More effective and seamless use of step-up and step-down beds and rapid response care

<table>
<thead>
<tr>
<th>Current delivery mechanism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unscheduled Care Programme Board</td>
</tr>
</tbody>
</table>

**5.3.4 Strengthen emotional health and well-being services for children and young people**

One in ten children and young people between 5 and 16 has a mental health problem which significantly impacts on their health, education and social outcomes, with half of those with lifetime mental health problems experiencing symptoms by the age of 14. Currently, the services for children and young people with mental health problems are fragmented and insufficient to meet demand. Many are forced to receive treatment within adult or general paediatric services or travel out of the area.

<table>
<thead>
<tr>
<th>Strengthen emotional health and well-being services for children and young people</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Our ambition and improvement trajectory</strong></td>
</tr>
<tr>
<td>Total average difficulties score for all looked after children aged between 4 and 16 (inclusive) at the date of their latest assessment, who have been in care for at least 12 months on 31\textsuperscript{st} March.</td>
</tr>
<tr>
<td>The baseline and target for this measure is being discussed with partners and will be in place by September 2014.</td>
</tr>
</tbody>
</table>

**Where we want to be**

- Children and Young people with mental health problems or signs of psychological distress can access a
Strengthen emotional health and well-being services for children and young people

range of talking therapies and support in Primary Care to prevent escalation into, and extended use of, health and social care services

- In partnership with NHSE, providing high quality care and support for children and young people who become acutely mentally ill and need specialist in-patient services (specialist or generic services)
- Development of a community based service for those children and young people requiring access to Tier 3 plus arrangements
- Children and young people with mental health problems remain in or as near to Walsall as they wish in a genuine safe placement with support to access education and relevant social activities
- Robust arrangements for U18 admissions to acute wards are prevented through appropriate provision of specialist placements and relevant pathways e.g.: Deliberate Self Harm pathway.

Key interventions

- Implement a service specification for specialist CAMHS and Older People’s Mental Health Services
- Model Tier 3 + treatment at home services and out of hours provision across the Black Country
- Commission online psychological service for young people
- Develop a Children & Young People Emotional Wellbeing & Mental Health strategy.

Current delivery mechanism

Mental Health Programme Board and STaR groups considering Children and Young People’s Emotional Health and Well-Being Service

5.4 Objective 3: Commission consistent, high quality, safe services across Walsall

As noted in section four, feedback from patients and indicators of quality within the system have identified a number of issues that need to be addressed. As a commissioning organisation, we must ensure that we purchase high quality care that reflects all recent national learning, including from the Francis, Berwick, Winterbourne and Keogh reports. Appendix 2 summarises the five key areas of our Quality Strategy.

The quality strategy is reflected within this system strategic plan through the following local priorities:

- Enhance the patient and public experience of health and care services
- Eliminate the number of recurring avoidable significant incidents
- Improve service quality and performance.

5.4.1 Enhance the patient and public experience of health and care services

Feedbacks from patients and survey results have identified scope to improve both inpatient care and care received within general practice.

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</thead>
<tbody>
<tr>
<td>Inpatient survey score 84.5%</td>
<td>74</td>
<td>76</td>
<td>78</td>
<td>80</td>
<td>82</td>
<td>84.5</td>
</tr>
<tr>
<td>GP patient survey 97%</td>
<td>84.4</td>
<td>86.9</td>
<td>89.4</td>
<td>91.92</td>
<td>94.4</td>
<td>97</td>
</tr>
</tbody>
</table>

Where we want to be

- For patients and service users to be individually taking more control of their own care, and becoming more involved in the decisions taken with their clinicians about the services they receive, when and
Enhance the patient and public experience of health and care services

where

- For patients to feel empowered to share their experiences and for the CCG to act upon their feedback to ensure improvement
- For the CCG to be regarded as a transparent and open organisation
- For the public to have confidence and trust in their local NHS.
- For the lessons from the Winterbourne report to be implemented, with strengthened governance arrangements and regular testing of services through visits to units and services.

Key interventions

- Customer care service
- Patient experience project
- Greater access to information
- Education
- Self management support.
- Visits to Learning Disability units and services reported to Safety, Quality and Performance Committee
- CQUIN for Learning Disability forensic psychiatry services
- Complex Needs Board established

Current delivery mechanism

Contract Quality Review Meetings

5.4.2 Eliminate the number of recurring avoidable significant incidents

Ensuring the safety of patients is paramount to the CCG, within this priority we will address the recurring significant incident to ensure that lessons are learnt and embedded into the provider organizations to present recurrence of the common causes related to these incidents

Eliminate the number of recurring avoidable significant incidents

<table>
<thead>
<tr>
<th>Our ambition and improvement trajectory</th>
<th>2013/14</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>No avoidable significant incidents</td>
<td>45</td>
<td>35</td>
<td>25</td>
<td>15</td>
<td>5</td>
<td>0</td>
</tr>
</tbody>
</table>

Where we want to be

- Establish a CCG wide early warning system to determine when standards of care have fallen which will be sensitive and responsive enough to detect minor variances enabling action to be taken before the standards reach a harmful and or unacceptable level.
- To work with regulators (CQC), NHS Trust Development Authority (NTDA) and the local surveillance group (LSG) in a proactive and reactive manner tackling concerns in a co-ordinated manner.

Key interventions

- Implementation of early warning system
- Introduction of significant incident action plans.

Current delivery mechanism

Contract Quality Review Meetings
5.4.3 Improve service quality and performance

We expect a high standard of performance from our providers and we will agree a set of performance metrics for each contract which will be monitored as part of our contract management process. Where performance is not met, appropriate contract sanctions and levers, including financial penalties will be applied. Compliance will be measured over time and we expect the number of sanctions and value of penalties to reduce and the proportion of trajectories and thresholds that achieve their target to increase so as to reflect improved quality of care to patients. It is recognised that the traditional methods of contracting used in the NHS do not always meet modern day requirements including the need for the integration of services. Therefore, we will increasingly award contracts which focus on outcomes and we will adopt new contract methodologies which promote integration and joined up working between different providers along a pathway.

<table>
<thead>
<tr>
<th>Improve service quality and performance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Our ambition</strong></td>
</tr>
<tr>
<td><strong>2013/14</strong></td>
</tr>
<tr>
<td>The value of contract sanctions as a proportion of contract value with Walsall Healthcare NHS Trust (our largest provider) is reduced.</td>
</tr>
<tr>
<td>0.3%</td>
</tr>
<tr>
<td><strong>2014/15</strong></td>
</tr>
<tr>
<td>0.28%</td>
</tr>
<tr>
<td><strong>2015/16</strong></td>
</tr>
<tr>
<td>0.25%</td>
</tr>
<tr>
<td><strong>2016/17</strong></td>
</tr>
<tr>
<td>0.18%</td>
</tr>
<tr>
<td><strong>2017/18</strong></td>
</tr>
<tr>
<td>0.15%</td>
</tr>
<tr>
<td><strong>2018/19</strong></td>
</tr>
<tr>
<td>0.1%</td>
</tr>
</tbody>
</table>

*Note – KPIs and measures not achieved include those for which data has not been made available*

Where we want to be

- System wide procedure enables the CCG to respond in a rapid coordinated and collaborative manner to failings in quality whilst safeguarding patients and service users
- All providers have proven high level of performance and minimal levels of non-compliance.
- Contractual payments are directly linked to achievement of improved health outcomes.
- Contracts promote and embed integrated care.

Key interventions

- Robust contract management
- Improved provider performance
- Outcome based contracting
- New methods of contracting
Improve service quality and performance

Current delivery mechanism

Contract Quality Review Meetings and Contract Review Meetings

5.5 Objective 4: Secure best value for the Walsall pound and deliver public value

We will measure our success in this area by focusing on four priorities:

- Deliver cost efficiency programmes (including QIPP)
- Ensure delivery of provider cost improvement plans
- Ensure services are provided by the most capable providers
- Ensure providers deliver social, economic and environmental benefits to the Walsall community

5.5.1 Deliver cost efficiency programmes (including QIPP)

In order to deliver the efficiencies needed over the period, we have a range of schemes within our QIPP (Quality, Innovation, Productivity and Prevention) programme. These are based on our understanding of where changes need to be made in the system, informed by the work of the system and comparative information showing how Walsall compares to other areas. Each scheme is designed to improve services and deliver savings - therefore improving value for money.

QIPP schemes for 2014/15 - 2018/19 are linked to the commissioning intentions sent to our main providers and detailed separately in the Financial Plan. These are ambitious proposals which if delivered would bring about major transformation and potentially considerable cost savings over the strategic period.

### Cost efficiency programmes

|--------------------------------------------------------|---------|---------|---------|---------|---------|---------|
| £31.1m of QIPP savings and improvements are delivered  | 6.0     | 11.1    | 18.5    | 25.3    | 31.1    

### Where we want to be

**Improving the efficiency, range and providers of services. For example**

- Investing in community services funded through savings in emergency admissions (3% reduction in emergency admissions per annum to invest in community services)
- Expanding the use of Any Qualified Provider (AQP) – for example, for termination of pregnancy, ophthalmology and ultrasound.
- Making savings in first to follow up ratios for some specialties
- Funding complimentary therapy within the Palliative Care Pathway

### Key interventions

We have formulated a detailed QIPP for the first two years of the 5 year strategy with key themes as follows:

- Undertake and implement the outcome of an Urgent Care Review to save £1.9m
- Reduce emergency admissions to save £2.2m, to include **saving £1.1m by improving the assessment of the frail elderly**
- **Saving £2.6m by improving primary care prescribing**
- **Saving £0.9m by improving the new to follow up ratio for outpatients**
- Extending the number of AQP providers and the reprocurement of redesign services to save £1.3m
Cost efficiency programmes

- Repatriating patients with learning disabilities to save £0.7m.

Years 3-5 of the Strategy will focus on the continued movement of towards the best in England target.

Current delivery mechanism

QIPP Delivery Programme

5.5.2 Ensuring delivery of provider cost improvement plans

All providers to the NHS are expected to introduce efficiency improvements on an ongoing basis by introducing more efficient ways of working. We will continue to require and monitor such improvements by working in partnership with providers to explore efficiencies that provide improved care to patients whilst at the same time delivering better value. We will monitor NHS providers implementation of the NHS procurement strategy, “Better Procurement, Better Value, Better Care” to drive best practice procurement as this is a key contributor to improved efficiency and increased value for money.

Provider cost improvement plans

<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Key providers deliver 4% savings year on year</td>
<td>£12.0m</td>
<td>£23.0m</td>
<td>£36.0m</td>
<td>£48.0m</td>
<td>£61.0m</td>
<td></td>
</tr>
</tbody>
</table>

Where we want to be

- Providers maximize efficiency and cost improvements.
- More efficient and effective ways of working.
- Providers utilize best practice procurement to drive improved value for money.

Key interventions

- Providers to develop and implement savings programmes to meet national and locally agreed targets.

Current delivery mechanism

Contract monitoring mechanisms

5.5.3 Ensuring services are provided by the most capable providers

The required health outcomes can only be delivered by ensuring that services are delivered by those providers that are best placed to provide the required level of service. Selecting the optimum provider is, therefore, at the heart of our commissioning and in doing so we will conduct service reviews to assess the quality of current services and, where it is found that the highest level of service is not being provided we will, where applicable, market test services. This will include using the Any Qualified Provider mechanism to promote patient choice and to drive improvements in service quality. In doing so, we will stimulate the market resulting in the introduction of new providers of services.

Most capable providers

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>The proportion of CCG</td>
<td>91%</td>
<td>92%</td>
<td>93%</td>
<td>94%</td>
<td>95%</td>
<td></td>
</tr>
</tbody>
</table>
Most capable providers

<table>
<thead>
<tr>
<th>commissioning spend covered by formal contractual arrangements is increased.</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase the number of services subject to formal procurement exercises including AQP.</td>
<td>Annual increases: 10 12 10 8 8</td>
</tr>
<tr>
<td>The number of new providers of individual services to Walsall CCG is increased.</td>
<td>Annual increases: 25 20 15 10 5</td>
</tr>
</tbody>
</table>

Where we want to be

- Robust contractual arrangements drive service improvements.
- Patients have choice of provider where this is an appropriate tool to improve quality.
- Walsall CCG is the “commissioner of choice” for key providers of healthcare.

Key interventions

- Market management to stimulate increased competition and patient choice, where this can deliver improved service quality.

Current delivery mechanism

Market management and procurement mechanisms

5.5.4 Ensuring providers deliver social, economic and environmental benefits to the Walsall community

As well as the ambition to commission high quality services providing the best health outcomes for the people of Walsall at the best possible value, we are also committed to deliver broader public value for the people of Walsall by maximising the contribution that the CCG and our providers make to the local community through social, economic and environmental improvements. This approach embraces our obligations under the Public Services (Social Value) Act and is already reflected in our ethical commissioning framework, our prioritisation policy and our procurement strategy.

We will pilot the concept of Public Value accounts whereby, on an annual basis, our key providers set out the social, economic, and environmental benefits they have delivered to the Walsall community in providing the designated service. Such activity may include employing local labour, paying the living wage, introducing apprenticeships, and engaging the local community in the planning and delivery of services.

We recognise that this approach is consistent with the culture of third sector and SME organisations and is also likely to promote business with the Walsall economy. Accordingly, we expect the proportion of business with these sectors to grow, and we will take steps to measure and monitor this.

Public value

<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of spend with third sector, SMEs and Walsall based providers is increased</td>
<td>Appropriate measures and trajectories to be developed.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The number of providers</td>
<td>0</td>
<td>2</td>
<td>5</td>
<td>8</td>
<td>10</td>
<td>15</td>
</tr>
</tbody>
</table>
Public value

providing Public Value accounts (initially on a pilot basis) will increase.

Where we want to be

- The CCG is recognised as a key contributor, through its commissioning activities, to improved social, economic and environmental improvements to the Walsall community.

Key interventions

- Deliver and implement a new procurement strategy and social policy
- Introduce Public Value accounts so that providers record the social, economic and environmental benefits they deliver.

Current delivery mechanism

Procurement and contracting

5.6 Implementation routemaps

All of these interventions have been phased over the next five years to ensure feasibility of delivery, sustainability of operation and achievement of the desired performance levels by 2019. This phasing is indicated on the next pages, with one routemap for each strategic objective.
Figure 26: **Strategic objective 1 – Improve health outcomes and reduce health inequalities**

<table>
<thead>
<tr>
<th>Strategic objective 1 – Improve health outcomes and reduce health inequalities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2014/15</strong></td>
</tr>
<tr>
<td><strong>Q1</strong></td>
</tr>
<tr>
<td>Reduce perinatal and infant mortality</td>
</tr>
<tr>
<td>Reduce the health gap</td>
</tr>
<tr>
<td>Reduce health gap across Walsall</td>
</tr>
<tr>
<td>Reduce the incidence and better manage LTCs</td>
</tr>
<tr>
<td>Improve mental health and parity of esteem</td>
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</table>

Five year Strategic Plan for Walsall – 2014-2019 Page 58
Figure 27: **Strategic objective 2 – Provide right care, in the right place, at the right time**

<table>
<thead>
<tr>
<th></th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
<th>2017/18</th>
<th>18/19</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Q1</strong></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Q2</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Q3</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Q4</strong></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

- **Improve integration of Prim, Sec, Comm and Social care**
  - Revise community nursing
  - Expand Multi-Disciplinary team
  - Expand 7 day services
  - Co-locate Prim, Sec, Comm teams
  - Primary care at scale
  - Co-commission Primary care with Area Team
  - Improve quality and range of primary care provision

- **Bring care closer to home**
  - Introduce risk stratification
  - Develop intermediate care teams
  - Introduce Case Management
  - Re-commission SWIFT in the community
  - Introduce Single Point of Access

- **Reduce emergency admissions to hospital**
  - Agree new urgent care strategy for system
  - Implement new system
  - Introduce rapid response care
  - Improve use of step up/down

- **Strengthen mental health and well-being services for children and young people**
  - Re-specify specialist CAMHS
  - Implement Tier 3+ treatment at home
  - Out of hours provision

- **Key performance indicators**
  - >90% older people still at home 91 days after discharge
  - DTOG: 25% lower than 13/14
Figure 28: **Strategic objective 3 – Commission consistent, high quality, safe services across Walsall**

### Strategic objective 3 – Commission consistent, high quality, safe services across Walsall

<table>
<thead>
<tr>
<th></th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
<th>2017/18</th>
<th>18/19</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Q1</td>
<td>Q2</td>
<td>Q3</td>
<td>Q4</td>
<td>Q1</td>
</tr>
<tr>
<td><strong>Enhance the patient and public experience</strong></td>
<td></td>
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<tr>
<td>Provide customer care service</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Increase education</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Eliminate recurring significant events</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implement Early Warning system</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Introduce significant incident action plans</td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Improve service quality and performance</strong></td>
<td></td>
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</tr>
<tr>
<td>Provider performance management</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Strengthen outcome-based contracting</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Personalised commissioning budgets</td>
<td></td>
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</tr>
</tbody>
</table>

- Inpatient survey scores > 84.5%
- Recurring significant events = 0
### Figure 29: Strategic objective 4 – Secure best value for the Walsall pound and deliver public value

**Strategic objective 4 – Secure best value for the Walsall pound and deliver public value**

<table>
<thead>
<tr>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
<th>2017/18</th>
<th>18/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 Q2 Q3 Q4</td>
<td>Q1 Q2 Q3 Q4</td>
<td>Q1 Q2 Q3 Q4</td>
<td>Q1 Q2 Q3 Q4</td>
<td>Q1-4</td>
</tr>
</tbody>
</table>

#### Deliver cost efficiency programmes
- Deliver annual QIPP
- Deliver annual QIPP
- Deliver annual QIPP
- Deliver annual QIPP

#### Ensure delivery of Provider CIPs
- Provider contract management
- Apply NHS procurement strategy

#### Ensure services provided by most capable provider
- Engage primary care providers
- Market management to stimulate increased competition

#### Ensure providers deliver benefits to the Walsall community
- Develop and implement a new Procurement Strategy and Social Value Policy
- Introduce Public Value Accounts
5.7 Walsall’s ‘Plan on a Page’

Within this section, we have introduced our four strategic objectives which will allow us to deliver our vision, and illustrated how they align to national ambitions, domains and characteristics. We have then introduced the priorities that sit below each and summarised the agenda in place to deliver the changes needed. The high level measures that we will use to test our progress over the five year period and to illustrate our success have also been described. These will form the core of our performance management framework.

On the following page, we set out our ‘plan on a page’. This brings together, at a high level, all core components of our strategy explained so far.
## Five year Strategic Plan for Walsall – 2014–2019 – Our Plan on a Page

### Walsall CCG System Strategy - 2014-2019

#### Our Vision: To improve the health and wellbeing of the people of Walsall

<table>
<thead>
<tr>
<th>Why do we need change?</th>
<th>High levels of deprivation puts additional pressure on services and leads to poor health</th>
<th>Infant mortality is significantly higher than the England average</th>
<th>Male life span is low and varies from east to west Walsall</th>
<th>Our population is ageing. There is an increasing IMR proportion</th>
<th>A growing number of our people have Long Term Conditions</th>
<th>Unhealthy lifestyles cause a high rate of poor health</th>
<th>There is an over reliance on A&amp;E for out of hours and urgent care</th>
<th>Health and social care is not fully integrated</th>
<th>Some services are not of sufficiently high quality</th>
<th>Future funding will not support current levels of spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>We will address these challenges by focusing on four objectives ...</td>
<td>Specific priorities define our work in each of these areas. Those are to ...</td>
<td>The key interventions to achieve these outcomes are ...</td>
<td>We will know we are successful when, in five years time ...</td>
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</tr>
<tr>
<td>1. Improving health outcomes and reduce health inequalities</td>
<td>Reduce perinatal and infant mortality</td>
<td>Reduce smoking; obesity and harmful drinking; increase early detection; Influence lifestyle choices through Every Contact Count; Encourage screening participation; Improve care pathways</td>
<td>Male life expectancy is increased by two years. The gap in life expectancy within the Borough between the most deprived and affluent areas of Walsall is narrowed.</td>
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<tr>
<td>Improve mental health and well-being and ensure parity of esteem with physical health</td>
<td>Promote awareness of mental wellbeing; Improve take-up of the Five Programme; Improve access to mental health services; Improve diagnosis and management of mental health; Increase rates of physical health checks</td>
<td>Diagnosis of dementia increases to 75% and services are provided to meet the resulting needs. Proportion of take-up of physical health checks is increased. Patient experience of mental health is at least 92%.</td>
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</tr>
<tr>
<td>Improve the integration of primary, community and social care</td>
<td>Promote and support primary care at scale; co-commission primary care with Area Team; Revise community nursing arrangements; Expand 7 day working; Expand Multi-disciplinary teams; Improve quality and range of primary care provision</td>
<td>The number of older people still at home 91 days after discharge is at least 90%.</td>
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<tr>
<td>Bring care closer to home</td>
<td>Provide Single Point of Access and case management; Introduce risk stratification tools; Co-locate primary, secondary and community teams; Develop intermediate care teams;</td>
<td>The number of delayed discharges (DTOC) is reduced by 25%. Permanent admissions to residential and nursing homes is reduced.</td>
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<tr>
<td>Reduce emergency admissions to hospital</td>
<td>New urgent care strategy; More effective and seamless use of ‘step up and step down’ beds and rapid response care</td>
<td>Significant progress has been made towards achieving emergency admissions 15% lower in real terms.</td>
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</tr>
<tr>
<td>Strengthen emotional health and well-being services for children and young people</td>
<td>New service specification for specialist CAMHS; Model tier 3 treatment at home and out of hours provision, commission on live psychological services for young people;</td>
<td>The total average difficulties score for all looked after children aged between 4 and 16 (inclusive) at the date of their latest assessment, who have been in care for at least 12 months on 31st March improves.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2. Providing the right care, in the right place, at the right time</td>
<td>Customer Service Centre; The Patient Experience Project; Greater access to information; education; Self management support; Learning Disability Service audits; CQUIN for Learning Disability; Forensic Psychiatry Services; Complex Needs Board established</td>
<td>Inpatient survey scores are 84.3% and the GP patient survey is 97%.</td>
<td></td>
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</tr>
<tr>
<td>Enhance the patient and public experience of health and care services</td>
<td>Implementation of early warning system and significant incident action plans;</td>
<td>Avoidable significant incidents are reduced by 10% annually.</td>
<td></td>
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</tr>
<tr>
<td>Eliminate the number of recurring avoidable significant incidents</td>
<td>Urgent care redesign; Deliver annual QIPP</td>
<td>The number and value of contract sanction is reduced to 0.1%; Proportion of contract KPIs meeting the agreed threshold is increased (100% for Constitution Measures; 90% contract)</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Improve service quality and performance</td>
<td>Robust contract management; Improved provider performance; Outcome based contracting; New methods of contracting</td>
<td>Key providers deliver 4% savings year on year</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Commissioning consistent, high quality, safe services across Walsall</td>
<td>New service specification for specialist CAMHS; Model tier 3 treatment at home and out of hours provision, commission on live psychological services for young people;</td>
<td>New providers are introduced.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improve service quality and performance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deliver cost efficiency programmes</td>
<td></td>
<td></td>
<td>£311m of savings and improvements are delivered.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure the delivery of provider cost improvement plans</td>
<td>Providers maximise efficiency and cost improvements, introduce more effective ways of working, and utilise best practice procurement.</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure that services are provided by the most capable providers</td>
<td>Market management is used to stimulate increased competition and patient choice.</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure that providers deliver benefits to the Walsall community</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clear decision making mechanisms are through the Governing Body and its subcommittees. The Improving Outcomes Board will hold the planning structures to account and implementation will be managed via a PMO approach which will provide updates, key risks and details of mitigation. Mechanisms are in place for patient, public and clinical engagement.</td>
<td></td>
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</tr>
</tbody>
</table>

---

**Values**

- Respect and value people | Listen | Clinical Leadership | Clear accountability and transparency | Innovation | Prevention | Partnership | Public Value

---

**Governance**

- Clear decision making mechanisms are through the Governing Body and its subcommittees. The Improving Outcomes Board will hold the planning structures to account and implementation will be managed via a PMO approach which will provide updates, key risks and details of mitigation. Mechanisms are in place for patient, public and clinical engagement.

---

**Our Core Priorities**

- Public engagement and involvement | Partnership | Integration | Continuous improvement | Clinical Leadership | Clear accountability and transparency | Innovation | Prevention | Public Value | Values | Governance
Key enablers

6 Delivering our vision will be dependent upon key enabling strategies being aligned to this overarching strategy

The required enabling strategies – upon which the successful delivery of this strategic plan is dependent – are:

- System Leadership
- Finance
- Commissioning
- Organizational development
- Workforce
- Communications and engagement
- Informatics
- Estates and facilities
- Innovation

These are described in more detail in this section.

Our strategy will be achieved through partnership and integrated working and also through the CCGs commissioning, contracting, procurement and operating planning processes. We expect that everything we do will strengthen the ability of the CCG to meet its vision, as well as contributing to the aims of the overarching Health and Well Being strategy for the borough.

Within this section, we summarise the key elements of our commissioning, finance, workforce, estates, OD and informatics strategies, to illustrate the interface with this strategy. We show how the golden thread of our vision and four strategic objectives is woven into every area of the CCGs activity.
6.1 System Leadership

Full and successful delivery of the benefits of this strategic plan will depend on gaining momentum for these priorities and interventions across all parts of the health and social care system. This will require the agreement of the plan by all relevant leaders, and then championing of its delivery. For speed and efficiency it is vital that this work harnesses the existing structures, including the Joint Clinical Forum, GP body and Integration Board.

The engagement to date has ensured broad agreement of this plan and the required governance and structure for effective and efficient delivery. Whilst still in development this is detailed further in section 7.

6.2 Finance

The CCG has formulated a financial plan based upon three scenarios (base, best and worst case) to determine the level of QIPP (Quality, Innovation, Productivity and Prevention) and resultant service transformation required in each of the financial years. The size of the QIPP challenge is summarised in the table below.

<table>
<thead>
<tr>
<th>Scenario</th>
<th>2014/15 £m</th>
<th>2015/16 £m</th>
<th>2016/17 £m</th>
<th>2017/18 £m</th>
<th>2018/19 £m</th>
<th>Total £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base Case</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resources</td>
<td>363.9</td>
<td>369.3</td>
<td>374.6</td>
<td>379.7</td>
<td>384.8</td>
<td></td>
</tr>
<tr>
<td>Expenditure</td>
<td>366.2</td>
<td>370.7</td>
<td>378.2</td>
<td>382.7</td>
<td>386.8</td>
<td></td>
</tr>
<tr>
<td><strong>QIPP</strong></td>
<td><strong>-6</strong></td>
<td><strong>-5.1</strong></td>
<td><strong>-7.4</strong></td>
<td><strong>-6.8</strong></td>
<td><strong>-5.8</strong></td>
<td><strong>-31.1</strong></td>
</tr>
<tr>
<td>Planned Surplus</td>
<td>3.7</td>
<td>3.7</td>
<td>3.8</td>
<td>3.8</td>
<td>3.8</td>
<td></td>
</tr>
<tr>
<td>Best Case</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resources</td>
<td>363.9</td>
<td>369.3</td>
<td>375.3</td>
<td>381.1</td>
<td>387.1</td>
<td></td>
</tr>
<tr>
<td>Expenditure</td>
<td>366.2</td>
<td>370.7</td>
<td>378.9</td>
<td>383.2</td>
<td>388.1</td>
<td></td>
</tr>
<tr>
<td><strong>QIPP</strong></td>
<td><strong>-6</strong></td>
<td><strong>-5.1</strong></td>
<td><strong>-7.4</strong></td>
<td><strong>-5.9</strong></td>
<td><strong>-4.9</strong></td>
<td><strong>-29.3</strong></td>
</tr>
<tr>
<td>Planned Surplus</td>
<td>3.7</td>
<td>3.7</td>
<td>3.8</td>
<td>3.8</td>
<td>3.9</td>
<td></td>
</tr>
<tr>
<td>Worst Case</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resources</td>
<td>363.9</td>
<td>369.3</td>
<td>373.9</td>
<td>378.0</td>
<td>382.2</td>
<td></td>
</tr>
<tr>
<td>Expenditure</td>
<td>366.7</td>
<td>371.8</td>
<td>379.0</td>
<td>383.1</td>
<td>386.8</td>
<td></td>
</tr>
<tr>
<td><strong>QIPP</strong></td>
<td><strong>-6.5</strong></td>
<td><strong>-6.2</strong></td>
<td><strong>-8.9</strong></td>
<td><strong>-8.9</strong></td>
<td><strong>-8.5</strong></td>
<td><strong>-39</strong></td>
</tr>
<tr>
<td>Planned Surplus</td>
<td>3.7</td>
<td>3.7</td>
<td>3.8</td>
<td>3.8</td>
<td>3.9</td>
<td></td>
</tr>
</tbody>
</table>

This model shows that the financial challenge is between £29m and £39m over the five year planning period.

The CCG is planning to meet the target surplus figure at 1% of the allocation in each year of the financial plan. The size of the financial challenge facing the CCG is embodied in the QIPP Programme.

In addition the CCG will oversee the adoption of a Cost Improvement Programme with its healthcare providers which is planned to deliver savings of £61m over the five year period equivalent to 4% per annum.
Local schemes have encompassed the principles of:

- Exploring the ways in which services can be provided more effectively through the adoption of best practice
- Building on relationships with partners to ensure the opportunities for developing the interface between health and social care is maximised
- Facilitating increased supported care at home through the use of new technologies
- A recognition that some procedures are of limited clinical value

6.2.1 QIPP potential

The process for identifying QIPP programmes is based on the use of a number of information sources, including providing a comparative analysis of current performance against the 'Best in Class' target. The sources of information are detailed in section 4.2.8

The table below identifies the QIPP potential based on two factors, distance from base case target and moving to best in England (based on the Spend Outcome Tool (SPOT)).

**Figure 32 : QIPP schemes 2014 to 2016 and potential QIPP areas for 2016 to 2019**

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Mental Health &amp; Learning Difficulties</td>
<td>369</td>
<td>369</td>
<td>362</td>
<td>333</td>
<td>284</td>
</tr>
<tr>
<td>Planned Care</td>
<td>1,998</td>
<td>1168</td>
<td>1,553</td>
<td>1,427</td>
<td>1,217</td>
</tr>
<tr>
<td>Unscheduled Care</td>
<td>1,804</td>
<td>2827</td>
<td>2,271</td>
<td>2,087</td>
<td>1,780</td>
</tr>
<tr>
<td>Primary &amp; Community Care</td>
<td>2,413</td>
<td>2227</td>
<td>2,275</td>
<td>2,091</td>
<td>1,783</td>
</tr>
<tr>
<td>Other</td>
<td>1,600</td>
<td>315</td>
<td>939</td>
<td>863</td>
<td>736</td>
</tr>
<tr>
<td></td>
<td>8,184</td>
<td>6,906</td>
<td>7,400</td>
<td>6,800</td>
<td>5,800</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
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<tbody>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Mental Health &amp; Learning Difficulties</td>
<td>3,043</td>
<td>6,086</td>
<td>9,129</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Planned Care</td>
<td>1,251</td>
<td>2,502</td>
<td>3,753</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unscheduled Care</td>
<td>1,409</td>
<td>2,818</td>
<td>4,226</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary &amp; Community Care</td>
<td>204</td>
<td>407</td>
<td>611</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>1,273</td>
<td>2,546</td>
<td>3,820</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>7,180</td>
<td>14,359</td>
<td>21,539</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The table shows that the QIPP potential, based on distance from base case alone, would deliver savings above all scenarios in years 1 and 2 and within both the best and base case scenarios for years 3 to 5. If we were to achieve potential savings based on distance from base and on moving to best in England, we would exceed the levels suggested for all scenarios.
We have used this analysis to support us in the development of detailed QIPP schemes for the next two years and to model the impact of the adoption of the QIPP schemes on key providers.

### 6.2.2 QIPP schemes for 2014 to 2016

The table below describes the QIPP schemes for the next two years.

**Figure 33: QIPP schemes 2014 to 2016**

<table>
<thead>
<tr>
<th>Programme</th>
<th>STaR Group</th>
<th>2014/15 £'000</th>
<th>2015/16 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health &amp; Learning Difficulties</td>
<td>Repatriation of Out of Area placements</td>
<td>369</td>
<td>369</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Planned Care</td>
<td>Obstetrics &amp; Gynaecology</td>
<td>197</td>
<td>197</td>
</tr>
<tr>
<td></td>
<td>Procedures of Limited Clinical Value</td>
<td>568</td>
<td>44</td>
</tr>
<tr>
<td></td>
<td>Outpatient Redesign</td>
<td>853</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Re-procurement of redesigned services to include Any Qualified Provider (AQP)</td>
<td>380</td>
<td>927</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1,998</td>
<td>1,168</td>
</tr>
<tr>
<td>Unscheduled Care</td>
<td>Long Term Conditions</td>
<td>524</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Urgent Care Review / Emergency Admissions</td>
<td>1,280</td>
<td>2,827</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1,804</td>
<td>2,827</td>
</tr>
<tr>
<td>Primary &amp; Community Care</td>
<td>Medicines Management</td>
<td>1,300</td>
<td>1,300</td>
</tr>
<tr>
<td></td>
<td>Community &amp; Nursing strategy</td>
<td>1,113</td>
<td>927</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2,413</td>
<td>2,227</td>
</tr>
<tr>
<td>Other</td>
<td>Estates Review</td>
<td>500</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Management Cost Reduction</td>
<td>300</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>800</td>
<td>315</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1,600</td>
<td>315</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>8,184</strong></td>
<td><strong>6,906</strong></td>
</tr>
</tbody>
</table>

### 6.2.3 Contract modelling

The tables below show the impact of QIPP schemes over the next five years on projected contract values for elective and emergency services.
This modelling shows that the impact of adopting QIPP schemes would be a 5% increase in elective activity and a 3% increase in contract value and a 1% reduction in emergency activity and a 3% reduction in contract value.

QIPP opportunities for years 3 to 5 of the plan reflect the high level assumptions at this stage and will require further work to translate these opportunities into operational plans.

### 6.2.4 Delivering QIPP schemes

The successful delivery of the QIPP programme is crucial in providing us with the financial flexibility to develop the Community and Primary Care infrastructure to enable a significant shift in activity and resource from the hospital sector to the community. Assurance of QIPP delivery will operate via a centrally co-ordinated Programme Management Office with oversight by the Finance Contracting and QIPP committee.

The financial plan has focused on the creation of the infrastructure in primary, community and mental health services to contribute towards a planned reduction in the level of admissions to secondary care. Additional investment in social care of circa £2.8m through the Better Care Fund will support this process and offers a significant opportunity to the CCG and Local Authority to integrate health and social services across Walsall.

### 6.2.5 Key areas for investment

The key areas for investment over the planning period are summarised in the table below:

<table>
<thead>
<tr>
<th>Changes in Investment including the impact of inflation and efficiency changes</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
<th>Total</th>
<th>QIPP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>1.7</td>
<td>3.1</td>
<td>5.7</td>
<td>3.2</td>
<td>2.7</td>
<td>16.3</td>
<td>-16.8</td>
</tr>
<tr>
<td>Mental Health and Learning Difficulties</td>
<td>1.1</td>
<td>1.5</td>
<td>2.4</td>
<td>2.1</td>
<td>2.2</td>
<td>9.4</td>
<td>-3.9</td>
</tr>
<tr>
<td>Community and Reablement Services</td>
<td>0.7</td>
<td>4.1</td>
<td>2.1</td>
<td>1.7</td>
<td>1.7</td>
<td>10.2</td>
<td>-1.0</td>
</tr>
</tbody>
</table>
Continuing Care | 1.1  | 1.4  | 1.5  | 1.6  | 1.7  | 7.2  | -1.9
Primary Care   | 1.6  | 0.0  | 0.1  | 0.0  | 0.0  | 1.8  | 0.0
GP Prescribing | 1.6  | 2.7  | 2.8  | 2.8  | 2.8  | 12.7 | -6.5
Other Programme | 3.1  | -2.3 | -1.8 | 0.4  | -0.2 | -0.8 | -1.0
including non-recurrent expenditure | | | | | | | 
Total          | 11.0 | 10.4 | 12.6 | 11.9 | 10.9 | 56.8 | -31.1

The impact of this on the commissioning landscape is shown in the charts below, outlining the proportionate reduction in investment in acute services supported by increased investment in Primary, Community and Mental Health services to support this transformation.

Figure 34: Our spending being aligned to our changing priorities

---

**% of Total Programme Expenditure**

### 2013/14

- Acute: 52.7%
- Mental Health: 2.9%
- Community: 4.8%
- Continuing Care: 13.2%
- Primary Care: 10.6%
- Prescribing: 12.7%
- Other Programme: 3.1%

### 2018/19

- Acute: 49.3%
- Mental Health: 3.1%
- Community: 5.8%
- Continuing Care: 14.1%
- Primary Care: 12.2%
- Prescribing: 12.2%
- Other Programme: 2.5%
6.3 Commissioning

We have set out our commissioning intentions for 2014/15 - 2015/16 to providers with whom we will contract for services. These reflect the priorities set out within this strategy. Their implementation will impact on the delivery of our objectives, our outcomes indicators and the delivery of the rights and pledges of the NHS constitution.

Our commissioning intentions will be actioned in the following ways:

- **Maintaining ongoing dialogue** with patients and public
- **Delivery of transformational projects** detailed in Section 5. It is recognized that some of the projects are complex and will require careful planning, specification and in some cases formal public consultation
- **Through negotiation into the NHS standard contracts** agreed with providers for 2014/15. This will include agreed QIPP programmes and CQUINs for 2014/15.

Our commissioning intentions, which are the means for enabling the strategy, will be reviewed and issued on an annual basis and we expect that these will inform the basis of our operating plans with delivery through the planning structures and monitoring through the PMO and assurance structures.

We will continue to meet the rights and pledges of the NHS constitution and will use the contracts agreed with providers to maintain these. Contracts will apply financial penalties to providers where treatment waiting time standard are not met.

Walsall Council and Walsall Clinical Commissioning Group established a Joint Commissioning Unit (JCU) during 2009 (using Section 75 of the Health Act 2006) to combine the commissioning of adult social care & inclusion (SC&I) services in the Council, with associated services from Walsall Primary Care Trust (PCT) i.e. mental health, learning disability, and older people services (unscheduled care, continuing health care and intermediate care).

This has led to improved outcomes for people using services and greater cost effectiveness. We will continue the same partnership arrangement with Walsall Council.

6.4 Organisational development

Our Organisational Development (OD) plan has been produced in line with the Framework of Excellence in Clinical Commissioning for CCGs (NHS England, November 2013). The plan will support us in developing the key organisational characteristics needed to deliver this strategic plan.

This plan will require change amongst clinicians, supporting staff and from the Governing Body. Implementing the initiatives described in the Plan on a Page below will assist in creating an organisation, that not only commissions high quality services, helps to enhance life style choices and improves the life expectancy of the people of Walsall, but it will also offer excellent employment opportunities and development for our staff and the local community.

The diagram below provides an overview of the OD Plan, describing the links between our strategic objectives and values. The plan will evolve as we develop as an organisation.

The OD plan identifies seven key objectives:

- Clinical leadership
- A strong clinical & multi-professional focus with significant member engagement
• Staff engagement
• Meaningful involvement of patients, carers and the public
• Clear and credible plans
• Robust governance arrangements
• Collaborative commissioning.

Figure 35: An overview of the organisation development plan

Walsall CCG Organisational Development Plan 2014

<table>
<thead>
<tr>
<th>Strategic Goals 2014/2019</th>
<th>Core values</th>
<th>Excellence in Clinical Commissioning</th>
<th>OD Goals</th>
<th>Prioritised initiatives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve health outcomes &amp; reduce health inequalities.</td>
<td>Respect and Value People</td>
<td>A strong Clinical &amp; Multi-professional focus with significant member engagement.</td>
<td>Ensure Meaningful engagement with all staff groups within member practices and the third sector</td>
<td>The Staff Survey will show a 5% improvement across all domains.</td>
</tr>
<tr>
<td>Provide right care, in the right place, at the right time.</td>
<td>Prevention</td>
<td>Meaningful involvement of patients, carers and the public.</td>
<td>Services are commissioned in a way that promotes shared decision making, personalised care planning &amp; self-management</td>
<td>The 360 degree stakeholder survey will see an improved response rate by member practices to 70% &amp; the score for member participation &amp; decision making will improve to 85%.</td>
</tr>
<tr>
<td>Commission consistent, high quality safe services across Walsall.</td>
<td>Listen to local people</td>
<td>Clear and Credible Plans</td>
<td>The CCG contracts for outcomes</td>
<td>The National GP survey will see overall satisfaction improved 86.7%. A minimum of 3 staff events, 4 GP assemblies and 4 your voice events will be held.</td>
</tr>
<tr>
<td></td>
<td>Clear accountability and transparency</td>
<td>Robust Governance arrangements</td>
<td>Maintain &amp; improve rights &amp; pledges under the NHS Constitution</td>
<td>All contracts with our providers will contain measurable KPIs. CQUINs will be included in all provider contracts. All NHS Constitution measures will be achieved.</td>
</tr>
<tr>
<td></td>
<td>Innovation</td>
<td>Collaborative Commissioning</td>
<td>Seek out opportunities for greater integration, joint commissioning, integrated provision &amp; pooling of health &amp; local government resources.</td>
<td>Our strategy will align to the Health &amp; Well being Strategy.</td>
</tr>
<tr>
<td></td>
<td>Partnerships</td>
<td>Clinical Leadership and staff development</td>
<td>Invest time &amp; resources into developing leadership skills at all levels. Proactively identify and nurture future leaders.</td>
<td>Our Primary Care Strategy will be aligned to the Area Team Primary Care Strategy.</td>
</tr>
<tr>
<td></td>
<td>Clinical Leadership</td>
<td></td>
<td></td>
<td>The CCG will work closely with the Area Team on co-commissioning Primary Care.</td>
</tr>
<tr>
<td></td>
<td>Public Value</td>
<td></td>
<td></td>
<td>All staff including Governing Body members will have an annual appraisal and development plan.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>All senior staff including Governing Body members will undertake a 360 degree feedback survey.</td>
</tr>
</tbody>
</table>

The Organisational Development committee, lead by the Clinical Chair, will monitor the delivery of the Organisational Plan to ensure our organisational development objectives and associated work stream action plans are met. Each of the work streams has a clinical and management lead and will report via the PMO office.

6.5 Workforce planning

Our workforce structure is designed so that we work at the appropriate population scale for the task in hand. We directly employ a number of staff, some members have joint appointments with our Local Authority, and some are employed by the CSU and are embedded in the CCG. We also buy in functions from the CSU.

Due to the small size of the CCG and the specialist nature of some of the tasks involved in delivery of this plan, we will consider using interim subject matter experts where required, working in such a
way as to ensure skills transfer and development of our permanent staff. The results of recent staff survey and training needs analysis have highlighted a number of development areas for the CCG; these too have been incorporated into our OD plan as we recognise the importance of developing our own staff.

We will call upon the expertise of local clinicians on a substantive basis. We may join with other CCGs to commission services and will with the National Commissioning Board to ensure that our development remains on track.

Health and care is a person centred service industry relying heavily on the competence, behaviour and capability of the people working in all roles across the whole system. The current workforce has a range of strengths and weaknesses which once fully understood will need a degree of reshaping for successful delivery of the scale of service transformation planned.

To guide the work at this time a draft set of principles, objectives and risks are suggested. This will evolve during the development of this strategy.

**Draft Principles**

- Integrated care and working will be critical to the future successful service delivery.
- Use co-design with the workforce as they are closest to operational reality – this will help define more accurately new roles and ways of working.
- Be innovative with proposing new functions and expanding roles such as Primary Care utilising non-medical advanced practitioners and physicians assistants.

**Draft Objectives**

- Identify the future workforce requirements – clinicians, professionals, support staff, voluntary sector functions and roles
- Outline the skills and redesign requirements for Integrated Care and changes to the settings of care from Acute to Community
- Workforce planning is submitted by providers - CCGs need to sign off with sufficient insight into the requirements.
- Agree joint HR policies (Recruitment & Retention, employment contracts, management of change including disestablishment of posts, redeployment and redundancy).

**Draft Risks**

- Retirement of GPs and difficulty recruiting to posts in certain areas
- Recruitment of staff with the right skills and competencies
- Programmes and lead time for training of staff to deliver different functions and skill sets

6.6 Communications and engagement

We have developed a communications and engagement strategy, which sets out our plan to improve how we speak, listen and work with patients and the public, our staff, GP practices and partners.

We have evolved and grown over the past year and are proud of the new links we have formed with the people of Walsall. Examples of these links include:

- The use of Pop Up Shops, where we take over an empty shop in the shopping centre for a couple of days. We have been able to inform and listen to over 800 people using this new method
• Young Voice – meeting patients of tomorrow. We have been working with the Streetly Academy to engage with teenagers to influence how we plan, buy and monitor services.

Our strategy identifies our core values, describes the links with our organization development (OD) goals and sets out key objectives for each of our key stakeholder groups i.e. patients and public, staff, GP members and professional partners.

We have identified five key methods of engagement that will be used in order to reach, inform and hear from people. Engagement will take place on a range of different levels, which will change, depending on the level of interest or impact a stakeholder has in the work of the CCG. The diagram below describes our different methods of engagement.

Figure 36 : Methods of engagement

For each engagement method we have identified interventions and measures to be used assess their impact.

The diagram below shows our objectives for each stakeholder group and the planned method of engagement.
We have undertaken a mapping exercise to identify in more detail the local stakeholders within the four broad stakeholder categories above (see Appendix 3). This information will be used to develop the detail of an engagement delivery plan. Emphasis will be placed on building on our existing relationships with Healthwatch, voluntary groups, Young Voice, Youth of Walsall and patient representative groups as well as continuing to use patient surveys and the Friends and Family test to provide valuable feedback on the services we commission.

It is important that the feedback we receive is connected to our decision making process. The Communication, Involvement and Engagement Committee has the responsibility of overseeing all of the communications and engagement work within the CCG. This group ensures that all communications and engagement work is delivered in line with the communications and engagement strategy. This Committee also has links with the following partners:

- Walsall Health and Wellbeing Board
- Walsall Safeguarding Board
- Public Health
- Local NHS providers
- Other CCGs
- NHS England and the Area Team.
During delivery of this strategy, each programme will liaise with the communications and engagement team to ensure correct levels of interaction with each of the stakeholder groups.

We will continue to engage with work streams established to review on a cross CCG basis and in some cases led by NHS England, including Urgent Care, LTCs, Planned Care, Vascular Services, Trauma Care, Maternity, Stroke and Transient Ischemic Atrophy (TIA) services, Adult Mental Health, Pathology, Right Care Right Here, services for offenders and services for military veterans.

### 6.7 Informatics

The Informatics strategy for Walsall CCG will be developed in line with the National Strategy including empowering patients through access to their own records and the ‘power of information’.

Work will commence on:

- Improved use of aggregated information through Business Intelligence systems.
- Start pilot of patient access to GP Records, depending upon technological readiness.
- Improving access to patient information from all care settings

#### 6.7.1 Data Sharing

“The Power of Information” sets a ten-year framework for transforming information for health and care and how harnessing this information through appropriately secured applications and technology, efficiency can be driven through the health system and greatly improves health outcomes for patients. The benefits for all aspects of healthcare of having accurate, timely and relevant information available are well documented throughout this publication, the secret of realising the potential will be through a combination of local innovation and drawing down on experiences elsewhere. This will ensure the systems; applications; information and technology available across Walsall are world class.

Walsall Council and Walsall CCG with provider trusts have commissioned the Central Midlands Commissioning Support Unit to conduct work on data sharing based on the use of the NHS number embedded in all records across the system. An information sharing agreement has been signed off by Walsall Council, Walsall CCG and NHS Trusts. The above project aims to implement use of the NHS number in all social care records during 2014/15 starting from 1st April.

We are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards).

We are committed to ensuring that the appropriate Information Governance (IG) controls will be in place. These will cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and requirements set out in Caldicott 2.

The informatics requirements of this strategic plan will be determined once the interventions are fully defined (expected in July/Aug). These requirements will then be drawn into a cohesive strategy and costed, for approval in the autumn of 2014. Depending on the intervention, this may require clinical and patient group engagement to ensure the best solution is found.

Areas likely to require informatics change and/or investment include:

- Shared data systems and patient records
- Network support to new community bases
- New sign-on systems for cross-organisational teams
- Mobile working support.

6.7.2 Access to patient information across care settings

Data and information will only be recorded once and shared securely between systems and clinicians.

The NHS Number will be the primary identifier across all organisations and will be the common link as integration of systems across the health sector increases. It will also be embedded into any communication between the NHS and the patient.

The diagram below provides a high level view of the strategy.

The Walsall Patient Index is at the heart of the electronic record and the data contained within the patient index can then be used to support:

- Sharing of health information across health sectors and multiple providers;
- Patient and carer access to medical records enabling the “Power of Information” from the citizens perspective;
- Order Communications of diagnostic facilities across health care sectors and providers;
- Improved use of clinical decision support tools through better information;
- Development of provider independent disease registers to support public health screening initiatives and disease management;
- Development of, and access to safeguarding and at risk registers;
- Providing a robust information source to inform commissioning decision debates and monitor health outcomes at a service of individual level;
- Contribute to the Knowledge Management and Business Intelligence arena;
- Provide routine contracting and financial information;
- Utilise demand / management technology to reduce utilisation of health services;
- Development of tools to support care pathway compliance and monitoring;

6.7.3 Moving forward

This strategy is not just about deploying new and exciting systems, but also about making improved use of what is currently available. Taking both aspects, the current state of play and the proposed development, for Walsall it could mean ...

<table>
<thead>
<tr>
<th>Domain</th>
<th>What</th>
<th>How</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
<td>Improved provision of care</td>
<td>Accurate and timely data enabling more informed public health initiatives and commissioning intentions</td>
</tr>
<tr>
<td></td>
<td>Improved provision of care within the GP practice as a provider</td>
<td>Access to information for Primary Care clinicians</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Seamless transfer of care between Primary and Secondary Care supported by Information inter-change</td>
</tr>
<tr>
<td></td>
<td></td>
<td>More efficient GP business processes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Implementation of national directives to support primary care.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Improved provision of care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Informed Public Patient Involvements and disease centric discussion forums</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Access to personal medical records</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Access to GP clinical record</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ability to book appointments on line at all practices</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Order repeat prescriptions on line</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Access to disease specific information enabling advice and guidance to be generated automatically dependent on condition</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Safe &amp; Secure) Online communications within disease centric discussion groups which will enable patients to “own” their conditions</td>
</tr>
<tr>
<td>Staff</td>
<td>Improved access to electronic patient records and decision support tools</td>
<td>Access to information at the point of care</td>
</tr>
<tr>
<td></td>
<td>Improved staff IT literacy</td>
<td>Ability to share/view information with other NHS providers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reduced time chasing test results – information available instantly at the point of care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Staff will be required to reach basic levels of IT competency to maximise use of systems.</td>
</tr>
<tr>
<td>Improved administrative processes to support delivery of care, e.g. electronic document processing, automated clinic management will lead to more clinical time for staff</td>
<td>Primary Care document management solutions</td>
<td></td>
</tr>
<tr>
<td>Improved clinical time and patient interaction</td>
<td>Reduction in GP DNA’s</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Less time spent chasing information</td>
<td></td>
</tr>
</tbody>
</table>

**Organisation**

| Support for the Commissioning and Public Health agenda | Systems that capture outcomes data |
| Support the achievement of the corporate objectives | Systems that can pro-actively manage care reducing longer term cost |
| Improved Service Planning | Specific projects to support Diabetes, the newly commissioned Alcohol Hub and access to Information within Urgent Care setting |
| Support for QIPP | Improved information to enable and proactively impact on service re-design. |
| | Risk stratification and Telemedicine tools. |
| | Deployment of Integrated Care records for Health and Social Care. |
| | Enablement of QIPP schemes and achievement of goals through innovative use of IT. |
| | Assistive technology i.e. Telehealth, Telecare administered through the Better Care Fund. |
| | Supporting the long term conditions strategy. |
| | Supporting effective Medicines Management and Prescribing. |

### 6.8 Estates and facilities

We have recently established an Estates Group, which includes NHS England, to agree an estates strategy that will support the delivery of our vision and strategic objectives. Walsall MBC are a key partner and are also engaged.

Through this group, we will fully assess the impact of all planned interventions on our estates and work with clinical and patient groups to understand changes in requirements and consider how these can best be delivered.

Our estates strategy will be available by September 2014.
6.9 Innovation

As a CCG we have a duty to innovate and promote research and we recognise the importance of research and innovation in developing healthcare services fit for the future. In particular the quality improvement of primary care is a fundamental role of the CCG. We want to be recognised as a forward thinking, research active organisation.

Our quality strategy provides the detail of how we will plan to put this into practice by:

- Encouraging and supporting GPs, staff and patient and public to be involved in research.
- Requiring our providers to deliver services that are evidence based and up to date.
- Using the information available from patient experience, quality concerns, complaints etc. to influence the areas for quality improvement.
- Driving through transformation and improvement of primary care through relevant commissioning arrangements.

The CCG’s work in relation to medicines management and partnership with Local Government has been recognised nationally. These areas have successfully reduced future health care costs through medicines optimisation and proactively supporting private nursing homes.

Close relationships have been developed with academic institutions and we are currently participating in research projects relating to contracting in the NHS being conducted by Birmingham Business School, University of Birmingham and the Department of Public Health and Policy, London School of Hygiene and Tropical Medicine. These activities will continue and support the development of in-house skills and competences.
Delivering this plan

7  We will ensure that these initiatives are successfully delivered by using robust governance and implementation structures

Within this section, we explain the arrangements that we have established to make sure that the CCG, supported by the wider system, is able to focus on the delivery of the vision presented. Leadership structures, performance and risk management and mechanisms for stakeholder engagement have been aligned to the four strategic objectives, which will form our agenda for the period of the strategy.

7.1  Delivery structure for the strategic plan

Figure 38 below shows how the work connected with each priority will be overseen by a project team. They will be responsible for the design, tracking and delivery of the project, with accountability and escalation routes shown to the Board committees. The figure shows the structures currently in place, but the project control bodies have recently been reviewed and changes to standardise and improve the approach will be made in the third quarter of 2014.

The approach described in the illustration is designed to ensure maximum clinical engagement and leadership from the bottom upwards and accountability downwards, while maintaining an active and meaningful engagement with local people and other stakeholders in developing, consulting and delivering the Strategic Plan.

The Improving Outcomes Programme Board, a subcommittee of our Governing Body, will determine the overall commissioning strategy that the Governing Body will approve. It will set the priorities for the Service Transformation and Redesign (STaR) Groups. The STaR project teams will be focussed on the delivery of specific initiatives designed to address the strategic objectives and the priorities contained within them.

Once priorities, programmes and specific projects have been agreed and delivered commissioning specifications, they will be implemented through contracts with providers. We will monitor the implementation of agreed outcomes as part of our performance management arrangements, as covered in section 7.3.
Figure 38: The strategic plan delivery structure

Our Vision

- Improve health outcomes and reduce health inequalities
- Provide the right care, in the right place, at the right time
- Commission consistent, high quality, safe services across Walsall
- Secure best value for the Walsall pound and deliver public value

Our Strategic Objectives

- Reduce perinatal and infant mortality
- Increase male life expectancy
- Reduce the incidence of, and better manage LTGs
- Improve mental health and well-being and ensure parity of esteem
- Strengthen emotional health and well-being services for children and young people
- Reduce emergency admissions to hospital
- Bring care closer to home
- Improve integration of primary, community and social care
- Enhance the patient and public experience
- Eliminate recurring significant incidents
- Improve services quality and performance
- Deliver cost efficiency programmes (inc QIPP)
- Ensure the delivery of provider cost improvement plans
- Ensure that services are provided by most capable providers
- Providers deliver benefits to the Walsall community

Our Priorities

- Infant mortality programme
- Male Life Expectancy Project
- LTC Transformation Project
- Mental Health STaR group
- Unscheduled Care STaR group
- Integrated care and BOP programme
- Primary Care at Scale Programme Board
- Monthly Performance and Quality Review mechanisms reporting to
- STaR group
- Contract Review Meetings

Our delivery Mechanisms

Lines of Accountability

- IOB
- Safety, Quality and Performance Committee
- Finance, Contracting and QIPP Committee
- Governing Body
It is also important that this structure interfaces effectively with the wider system, and suitable communication and referral linkages are being implemented to maintain alignment with the various bodies, including those shown in figure 39. This will enable the integration of health and social care initiatives with the wider public service agenda.

Figure 39: Links being developed with the wider system

7.2 Roles and responsibilities in delivering the strategy

The Governing Board ensures the CCG is meeting its objectives and for ensuring that appropriate governance arrangements are in place.

The Improving Outcomes Board (IOB) will have responsibility for the delivery of the vision and the delivery of QIPP plans.

The Programme Management Office (PMO) provides the support, the definition and delivery of a portfolio of change across the organisation. It also provides the structure, governance, functions and services required for defining a balanced portfolio of change and ensuring consistent delivery of programmes and projects. The PMO ensures that project methodology is being appropriately applied throughout Walsall CCG and that all projects are proceeding to time and budget. As the PMO develops it will establish and maintain a Programme Management Office library and develop the Programme Management Office as a centre of excellence to provide information, support and development and to hold accurate records and files on all commissioning projects. The PMO will support implementation of the Better Care Fund and the Integration Plan by working with the JCU PMO.

The Strategic Transformation and Redesign Groups (STaRs) are the main delivery arm. These groups meet on a regular basis and are responsible for driving forward agreed commissioning priorities on a task and finish basis.
7.3  Performance management

Currently, we have a performance management framework that allows us to monitor progress against our core targets. This framework is currently being updated to ensure that the metrics within this strategy are routinely and regularly reviewed and monitored.

These measures will form a basket of high level indicators that will enable the Executive Team and Board to track our overall direction of travel.

The Improving Outcomes Board, Safety, Quality and Performance Committee and Finance, Contracting and QIPP Committees will be accountable for delivery (refer to figure 38) and report to the Governing Body. They will also review the detailed, supporting metrics (for example, the number of mothers breastfeeding, which will sit under the priority, to reduce infant mortality) and be responsible for instigating action when performance is not on track.

Through these groups, we will also track our performance against NHS Constitution Measures and other key contracting outcomes.

Better Care Fund measures will be monitored in collaboration with the Council, as well as within the CCG. Mechanisms for doing this are currently being established. The measures within both this strategy and the BCF programme include:

- Permanent admissions of older people to residential and nursing care homes
- The proportion of older people still at home 91 days after discharge from hospital
- Delayed transfers of care
- The dementia diagnosis rate

7.4  Risk management

We have assessed the key risks to the delivery of this strategy as:

<table>
<thead>
<tr>
<th>Strategic Objective</th>
<th>Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve health outcomes and reduce health inequalities</td>
<td>Failure to reduce the burden of preventable disease, disability &amp; death</td>
</tr>
<tr>
<td></td>
<td>Failure to improve health &amp; wellbeing through healthy lifestyles</td>
</tr>
<tr>
<td></td>
<td>Failure to enable healthy ageing &amp; independent living</td>
</tr>
<tr>
<td>Provide care in the right place, at the right time</td>
<td>Failure to enable an integrated approach to care provision &amp; commissioning.</td>
</tr>
<tr>
<td></td>
<td>Failure to redesign our urgent care pathway to reduce levels of unplanned admissions.</td>
</tr>
<tr>
<td></td>
<td>Failure to design community services to bring care out of hospital &amp; closer to home.</td>
</tr>
<tr>
<td></td>
<td>Failure to support the delivery of comprehensive range of primary health care services.</td>
</tr>
<tr>
<td>Commission consistent, high quality, safe services</td>
<td>Failure to improve access to mental health services</td>
</tr>
<tr>
<td></td>
<td>Failure to empower patients through better engagement in the planning and delivery of health &amp; social care services.</td>
</tr>
<tr>
<td></td>
<td>Failure to ensure all commissioned services are of high quality and maintain patient safety.</td>
</tr>
<tr>
<td></td>
<td>Failure to enable an integrated approach to health &amp; social care commissioning &amp; provision.</td>
</tr>
<tr>
<td>--------------------------</td>
<td>------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Secure best value for the Walsall pound and deliver public value</td>
<td>Failure to secure best quality &amp; value for every pound spent in Walsall</td>
</tr>
</tbody>
</table>

We are currently developing a detailed risk management plan which will ensure that these risks are developed and understood more fully, that mitigating arrangements are put in place and that accountability is clear.

They are all documented within the CCGs corporate risk register, which is reviewed and updated regularly. The Safety and Quality Committee and the Audit Committee oversee the corporate risk register and the delivery of the risk management plan.

In respect of the BCF, we are currently agreeing the process for identifying and managing risks jointly with the Council. As a common framework is established, we will ensure that ownership of risks is clear and that risk sharing arrangements are agreed.
Appendices

Appendix 1 - Communications and Engagement - Call to Action outputs
Appendix 2 – A summary of our Quality strategy
Appendix 3 – Our stakeholder map
Appendix 4 – Better Care Fund position statement
Appendix 1 - Communications and Engagement - Call to Action outputs

Figure 40: Outputs from the engagement events

<table>
<thead>
<tr>
<th>Theme</th>
<th>You said</th>
<th>We Did</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-management</td>
<td>Education</td>
<td>We have reviewed the structured education programme for Diabetes</td>
</tr>
<tr>
<td></td>
<td>More on prevention</td>
<td>We have increased access to lifestyle services and</td>
</tr>
<tr>
<td></td>
<td>Self-management</td>
<td></td>
</tr>
<tr>
<td>Information Technology</td>
<td>Better IT systems</td>
<td>We have invested in digital technology to empower more patients</td>
</tr>
<tr>
<td>Communications</td>
<td>Simple terminology</td>
<td>Will be using the Plain English Guide</td>
</tr>
<tr>
<td></td>
<td>More awareness of services</td>
<td>Developing a directory of services</td>
</tr>
<tr>
<td></td>
<td>Mental Health services (Young People) Urgent Care – what does</td>
<td>We have commissioned KOOTH</td>
</tr>
<tr>
<td></td>
<td>this mean?</td>
<td>Urgent Care Review leaflets and consultation</td>
</tr>
<tr>
<td>Acute services</td>
<td>More nurses</td>
<td>Invested £1.5 million in community care</td>
</tr>
<tr>
<td></td>
<td>Penalties on patients abusing the system</td>
<td>Our PRGs have undertaken a review of Missed appointments and provided</td>
</tr>
<tr>
<td></td>
<td>(missed appointments)</td>
<td>us with recommendations</td>
</tr>
<tr>
<td></td>
<td>Appropriate discharge from hospital</td>
<td>We are working with our hospital to improve discharge processes</td>
</tr>
<tr>
<td></td>
<td>Stop Health Tourism</td>
<td></td>
</tr>
<tr>
<td>Primary care</td>
<td>Penalties on patients abusing the system</td>
<td>Our PRGs have reviewed access to GP Appointments and provide</td>
</tr>
<tr>
<td></td>
<td>(missed appointments)</td>
<td>recommendations</td>
</tr>
<tr>
<td></td>
<td>Access to GP appointments</td>
<td>We are piloting a GP access scheme with 5 of our practices</td>
</tr>
<tr>
<td>System wide</td>
<td>Joined up care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Care in the community – closer to home</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Don’t privatise</td>
<td></td>
</tr>
</tbody>
</table>

This information has been used to inform the strategic priorities for the CCG over the period of the plan.
## Appendix 2- A summary of our Quality strategy

**Figure 41 : The five aims within our quality strategy:**

<table>
<thead>
<tr>
<th>Keogh/Berwick/Francis</th>
<th>Walsall CCG Quality Strategy Aims</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Experience</strong></td>
<td>Patient Experience</td>
</tr>
<tr>
<td></td>
<td>Walsall CCG will promise to use patient experience intelligence to deliver its commissioning responsibilities in terms of service improvement, innovation and service redesign. This involves setting out the central role that patients and service users must play in the oversight and scrutiny, design and measurement of high quality services.</td>
</tr>
<tr>
<td><strong>Safety</strong></td>
<td></td>
</tr>
<tr>
<td><em>Preventing problems</em></td>
<td></td>
</tr>
<tr>
<td><em>Detecting Problems quickly</em></td>
<td></td>
</tr>
<tr>
<td><em>Taking action promptly</em></td>
<td>To establish and maintain an early warning system that is sensitive, timely and responsive to small variances in quality of services. This includes setting out a system wide procedure to enable the CCG to respond in a rapid coordinated and collaborative manner to failings in quality whilst safeguarding patients and service users.</td>
</tr>
<tr>
<td><strong>Workforce</strong></td>
<td></td>
</tr>
<tr>
<td><em>Ensuring staff are trained and motivated</em></td>
<td>Contract management</td>
</tr>
<tr>
<td></td>
<td>It is through the contract management that WCCG can assure themselves of the quality of care being provided.</td>
</tr>
<tr>
<td><strong>Clinical and operational effectiveness</strong></td>
<td>Contract management</td>
</tr>
<tr>
<td></td>
<td>The management of the national contract is key to enabling commissioners to performance manage the provider, describe the quality metrics and standards required, drive continuous quality improvements and hold the providers to account.</td>
</tr>
<tr>
<td><strong>Leadership and governance</strong></td>
<td>Values</td>
</tr>
<tr>
<td><em>Ensuring robust accountability</em></td>
<td>To create an environment that supports and encourages a culture where the values and behaviours enable robust systems and processes to monitor, manage performance and regulate quality of care in a transparent and open manner.</td>
</tr>
<tr>
<td></td>
<td>Partnership working</td>
</tr>
<tr>
<td></td>
<td>This brings opportunities to strengthen and create new working relationships with local partners including the public to combine resources and tackle quality issues with a holistic approach.</td>
</tr>
</tbody>
</table>
Appendix 3 – Our stakeholder map
Appendix 4- Better Care Fund: Position in April 2014

The report below summarises a paper submitted to the CCG Board on April 24 2014

The final submission date for the Better Care Fund was 4 April 2014. An assurance process is currently underway and the outcome of this assessment is awaited. Notwithstanding this assessment, a work programme is required that details the next steps and sets out the work in a clearly defined and structured manner. This report therefore describes the areas of work we need to take forward in the coming months.

INTEGRATION OF HEALTH AND SOCIAL CARE SERVICES: FOUR MAIN WORKSTREAMS

Work is underway under the governance of the Health and Social Care Integration Board in four main service areas:

i) Integration of Community Services: this is described in the BCF submission as follows:

“To keep people at home as long as possible we will create integrated local teams comprising the competences of primary care, acute, mental health, secondary and social care to combine with a range of other skills from other partners. These teams will utilise tools such as the single point of access to intermediate care, and risk stratifying patients using a range of health and social care data sets to understand the individual needs of people most at risk of hospital or care home admissions and target the services which best enable them to stay at home.

To deliver this first objective, there are three components of our new model of service:

- a Single Point of Access for health and social care in the community
- multi-disciplinary locality teams with rapid response capability
- pragmatic use of risk stratification for people with long term, complex or multiple conditions and frail elderly people to target proactive early intervention for those most at risk of hospital or care home admissions.”

This work is being led by Dr S Abdalla and Sally Roberts CCG Lead Nurse with engagement and support of the CCG Community Service Transformation and Redesign (STAR) Group

ii) Integration of Intermediate Care Services: this is described in the BCF submission as follows:

“The second objective of the new model of service, that of swiftly and safely transferring people back to their own homes following an acute episode of care, requires a coherent and efficient joint intermediate care service which will be made up of the current separate health and social care services. This service will have the skills of hospital discharge and social care reablement, linking with the wider multi-disciplinary locality teams, to agree with people the packages of care they most need at home. Through the Single Point of Access, there will be a menu of packages of services ranging from at the most intense, hospital based intermediate care beds through to at the least intense,
“reablement ‘ which is available within 24 hours of request and provided for a specified duration of
days/weeks depending upon the recovery time needed.”

This work is being led by Deputy Chief Executive WHNHST and Head of Community Care, Social Care
& Inclusion -Walsall MBC.

iii) Recommissioning SWIFT Unit in to two community based units of circa 20 beds. One of the units
is for clinical interventions that prevent an avoidable emergency admission to hospital (step up) with
flow management being the responsibility of the multi-disciplinary community services, and the
other is a discharge to assess unit (step down) with flow management the responsibility of the ASC&I
Assessment and Care Management Team working as part of the hospital discharge process.

This work is being led by Head of Joint Commissioning - Walsall CCG & Walsall MBC

IV) Quality of Care in Nursing Homes: closer working with nursing homes via local community
services to reduce the transfers between nursing homes and hospital, particularly for end-of-life
services.

This work is being led by Sally Roberts CCG Lead Nurse working closely with WHNHST Community
Health Services senior clinicians and managers.

GOVERNANCE

The CCG and Walsall MBC will work together to ensure that appropriate governance mechanisms are
in place to oversee the work on the BCF. This will include clarifying the respective roles of Vulnerable
Adults Executive Board and the Health and Social Care Integration Board.

This work will be led by the CCG Accountable Officer and the Director of Adults, Social Care and
Inclusion with support from the Head of Joint Commissioning

FINANCIAL PLANNING

Some parts of the funding that has been set out in the BCF submission requires further definition,
e.g. the allocation for the Dudley and Walsall Mental Health Partnership Trust.

The guidance specifies that a pooled fund for the BCF is required to be in place in time for April 2015
under Section 75 of the Health Act 2006. There is an opportunity to expand the amount of funding
that forms part of the BCF in Walsall created by the joint commissioning arrangements that pre-date
the creation of the BCF.

There are two formalised S75 pooled budgets, one for the Community Equipment Service and one
for Learning Disability Services. All of the funding for the Community Equipment Service allocated by
the Council and the CCG has been placed in the BCF and so this pooled fund can be superseded by
the pooled fund for the BCF.

Consideration is to be made on the potential of merging the current pooled fund for learning
disability services (circa £33 million) with the BCF to make a single pooled fund.
IMPACT OF CARE BILL
The main elements of the Care Bill that require attention are the impact it will have on assessment, eligibility and care planning; commissioning and market shaping;

- information and advice; universal duties for wellbeing and prevention; workforce
- Planning and Informatics.

Walsall MBC Directorate of Adults, Social care and inclusion SC&I have established a Care Bill Board to define the impact within these main areas. A sum of funding is included in the BCF allocations to address additional financial pressures on adult social care as a result of the Care Bill. This has been referenced in the BCF submission.

Lead: Head of Joint Commissioning

JOINT PERFORMANCE MONITORING
The metrics are a major component of the BCF assurance process and partners need to establish routine and regular monitoring of Key Performance Indicators and routinely report on these to the appropriate committees. The metrics to be used are included in the BCF template submitted on 4th April to NHS England and when signed off will populate the performance template used locally to monitor and assure progress. Performance leads for the Council and CCG will develop the reporting routines and ensure regular reporting as required.

Lead: Head of Joint Commissioning

JOINT WORKFORCE DEVELOPMENT PLAN
The BCF requires the development of a joint workforce development plan. The West Midlands Local Education and Training Board (LETB) has approved the development of seven work programmes to achieve transformation of the health and social care workforce. These are themed from the top two priorities from each Local Education Training Committee (LETC) and include approval of the Older Adults Workforce Integration Programme (OAWIP), originally the Frail Elderly Workforce Programme, which is being led by Birmingham LETC.

A local joint workforce development plan for Walsall is to be developed. An action is for the workforce development leads for the Council and local NHS organisations to meet with representatives of the Health Education West Midlands Team who are responsible for the programme described above. Regular reports will be made to the local Health and Social Care Integration Board.

Lead: Head of Joint Commissioning
STAKEHOLDER AND PUBLIC ENGAGEMENT
The BCF requires the development of a joint stakeholder and public engagement plan. Public engagement leads in the Council and the CCG will develop a local plan, for agreement by the Health and Social Care Integration Board.

Lead: Head of Joint Commissioning

JOINT RISK REGISTER
Work is underway to identify those elements of existing risk registers in the Council and the CCG that are relevant to the BCF. Risk register leads will be brought together and asked to consider the most effective means of setting out a joint risk register. Options are to combine relevant elements from each in to a separate joint register, or for each agency to adopt in to its own risk register the elements of the others risk register that are relevant to the BCF.

Lead: Head of Joint Commissioning

PROJECT PLANNING
A project plan setting out key deliverables and milestones will be developed and progress assured through the agreed Governance arrangements and the Programme Management Office in the CCG.

Lead: Head of Joint Commissioning

CONCLUSION
The scope of work required under the BCF arrangements is wide ranging and complex. A more clearly defined work programme for the BCF is needed in order to ensure there is a planned, co-ordinated and cohesive approach to the work. The report identifies the steps need to be taken in the coming months.