The Dudley Group NHS Foundation Trust

Strategic Plan Document for 2014-19

The Dudley Group NHS Foundation Trust

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Strategic Plan

Strategic Plan for y/e 31 March 2015 to 2019

This document completed by (and Monitor queries to be directed to):

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Date	**26th June 2014**

The attached Strategic Plan is intended to reflect the Trust's business plan over the next five years. Information included herein should accurately reflect the strategic and operational plans agreed by the Trust Board.

In signing below, the Trust is confirming that:

- **The Strategic Plan is an accurate reflection of the current shared vision and strategy of the Trust Board having had regard to the views of the Council of Governors;**
- **The Strategic Plan has been subject to at least the same level of Trust Board scrutiny as any of the Trust's other internal business and strategy plans;**
- **The Strategic Plan is consistent with the Trust's internal operational plans and provides a comprehensive overview of all key factors relevant to the delivery of these plans;**
- **All plans discussed and any numbers quoted in the Strategic Plan directly relate to the Trust's financial template submission; and**
- **The 'declaration of sustainability' is true to the best of its knowledge.**

Approved on behalf of the Board of Directors by:

Name *(Chair)*	John Edwards

Signature

Approved on behalf of the Board of Directors by:

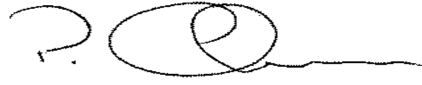
Name *(Chief Executive)*	Paula Clark

Signature

Approved on behalf of the Board of Directors by:

Name *(Finance Director)*	Paul Assinder

Signature



Declaration of sustainability

The board declares that, on the basis of the plans as set out in this document, the Trust will be financially, operationally and clinically sustainable according to current regulatory standards in one, three and five years time.	***Confirmed***

Following the assessment of the plans we can confirm that we can show sustainability for years 1 and 2.

For years 3, 4 and 5 the uncertainties in terms of the NHS and political/economic backdrop are too great to predict and plan with sufficient confidence to be truly meaningful. We recognise to guarantee future viability and clinical sustainability for the Trust there will have to be system changes across the Black Country and the Birmingham area in common with the whole NHS system. We are currently being proactive in this endeavour with local provider partners and welcome the opportunity to play a major part in re-engineering the landscape going forward.

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Local context

The Dudley Group NHS Foundation Trust, (DGFT), based in the Black Country within the West Midlands, is the main provider of hospital and adult community services to the populations of Dudley, significant parts of the Sandwell borough and smaller, but growing, communities in South Staffordshire and Wyre Forest.

Currently the Trust serves a population of around 450,000 people from three hospital sites at Russells Hall Hospital, Guest Outpatient Centre in Dudley and Corbett Outpatient Centre in Stourbridge. The Trust provides the full range of secondary care services and some specialist services for the wider populations of the Black Country and West Midlands region. The Trust also provides specialist adult community based care in patients' homes and in more than 40 centres in the Dudley Metropolitan Borough Council community.

To summarise the two year operational plan

- The Dudley health economy, like most English health economies, is struggling to manage the "pinch point" between increasing quality standards and decreasing financial headroom.
- Challenges which the Trust faces over the next planning cycle include required improvement to the Trust's urgent care performance; increasing and recruiting to, nursing establishments; planning for a lower level of admissions under the Better Care Fund (BCF) intentions; planning for the delivery of the 7/7 national standards; and recovery of a deteriorating financial position through turnaround and further service improvement
- Central to our operational and financial plan is the creation of significant inpatient capacity to improve our elective activity contract and Referral to Treatment, (RTT), performance. That plan adopts mitigations for three different scenarios around the anticipated levels of admission avoidance through the BCF developments. Key to those developments is our reconfiguration of locality, multi-agency teams focused on long term conditions and care of the older person
- To underpin both our response to quality and operational challenges, the Trust is adopting a radical new IT strategy and roll out of a new Electronic Health Record, (EHR), through "Programme Fusion". This programme will be overseen in tandem with our service improvement/financial efficiency plan through a new Board governance framework.
- Our quality strategy will remain applicable throughout the term of the 2 year plan, however this will be revised and re-launched by the end of 2014/15
- The greatest quality risks we face within the duration of this timeframe are poor patient flow (leading to poor ED 4 hour performance and poor patient experience) and our inpatient nursing establishment, which is not yet optimised in all areas.
- The financial plan we are pursuing will be a major challenge for the organisation and its staff. We have initiated a financial turnaround programme to enable the planned deficit budget of £6.7m to be delivered in 2014/15, with a return to financial stability in 2015/16
- Key planning risks reside in the joint assumptions of ourselves and local commissioners with respect to BCF activity assumptions, elective contract activity to return to a high performance on RTT and thirdly, the Urgent Care Centre activity and procurement processes.
- The Trust's deteriorating trading position has resulted in a deteriorating liquidity position. In 2015-16 the year ends with liquidity days of 0.2 and a cash balance of £12.0m. This will clearly have a detrimental impact on our ability to fund capex from surplus cash from now on. It therefore places even greater emphasis on our financial turnaround planning, in order to improve the Trust's trading position and enable reinvestment in Trust services as a result.

For long term sustainability the Trust subscribes to Monitor's latest planning guidance which offers 3

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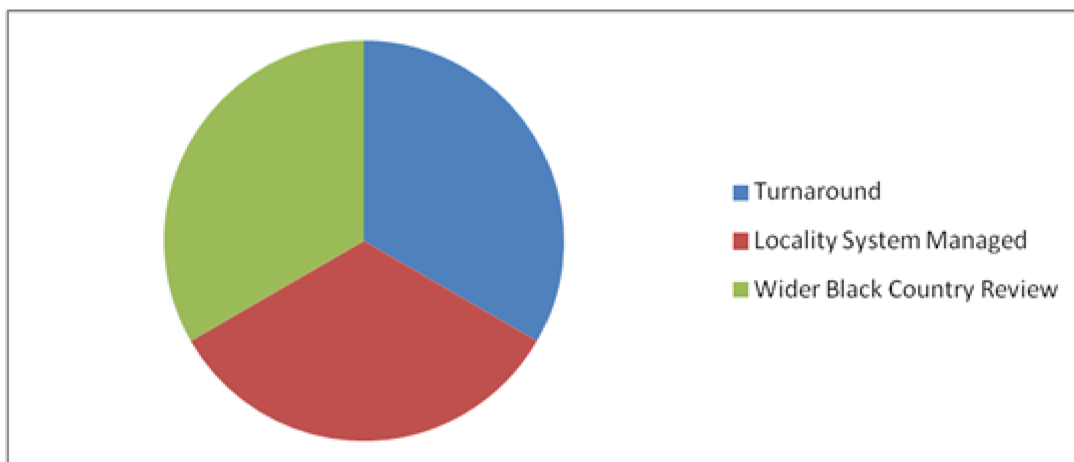
approaches to improved productivity and efficiency:-



In developing this plan, our guiding principles are:

- **One third of benefit can be delivered by local service improvement/turnaround effort within the Trust**
  Redesigning and improving patient services in individual providers to improve quality and efficiency, through, for example, shorter lengths of stay; assume 2% savings per annum.

- **One third can be delivered across the local health economy**
  Redesigning care pathways to transform how patient care is provided across the system and reduce unnecessary emergency admissions, improving quality and efficiency; assumes between 1 and 2%
  Further measures which commissioners and providers can undertake in their local areas to improve quality and efficiency, such as reducing inappropriate variations in how care is provided or reducing interventions which have little if any benefit to patients

- **One third requires wider system intervention**
  We propose that a Black Country review is considered, this has to be viewed in the context of the Dalton Review, which hopes to identify a range of ways to develop the FT model to enable providers to come closer together to ensure sustainability.

  The Trust takes due note of both the Dalton Review and the early pronouncements of Simon Stevens in shaping its future strategy:

  The Department of Health highlighted that the Dalton review would look at the barriers to development in the NHS of non-geographical “hospital chains”, of the kind that are common in European countries.

  The review team will seek to establish the scope for developing a range of organisational forms that are not currently widespread in the NHS, but which it thinks might help providers meet rising quality standards and deliver seven-day services in the midst of an escalating financial squeeze.
  The review is considering:

  - how to create a system – dubbed “credentialing” – for accrediting a list of excellent providers that would be the go-to candidates to take on ownership or management of failing trusts;
  - the scope for temporarily ringfencing the balance sheets and performance metrics of excellent providers, so they could take responsibility for struggling organisations without immediately damaging their own performance;
  - “redeploying” the money currently spent on management consultants, turnaround directors and

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bailouts for failing trusts to create financial incentives for high-performing providers to get involved in their management; and
- how to ensure competition rules – or perceptions about them – do not inhibit the development of new organisational forms
- These could range from the extension of the "buddying" arrangements that have been made for some troubled trusts, to management franchises, joint ventures to run single services, to chains.

The review panel is due to produce its final report in October 2014.

Simon Stevens, the NHS England Chief Executive, in May 2014 indicated a future 'different direction' for the NHS; "where the division between what consultants do in hospitals and what GPs do in community settings, is going to be changed".

Stevens notes the potential of US accountable care organisation models, in which one or a group of providers is given a single budget to serve a specified population, often adjusted for quality and efficiency delivered, with delegated financial risk and benefit. An area could create a unitary provider group that might take delegated financial risk and run combined hospital, primary care community services. The integrated structure within the Dudley Group, and the work with the commissioners on the provision of the Urgent Care Centre sets us in a good starting position to lead such change across the wider Black Country.

Simon Stevens is also exploring how multispecialty groups - out of hospital providers bringing together specialist and primary care doctors - could take shape. DGFT through the joint appointment with Dudley CCG of the Director of Support Operations will again be well placed to formulate a response to this challenge.

DGFT has stated in its current clinical strategy, 2013/18, that it positions itself as a "*District General Hospital Plus"* provider. Although the Trust is always seeking to innovate and develop best practice we are not planning to become a specialist hospital. However, we are already a successful tertiary level provider for key areas of our services and provide the Black Country hub for the vascular surgery network. Therefore, we will continue to provide these services and where there are clinical developments in these services we will expand.

Context of the Trust going though turnaround & restructuring/refocus

The challenges that the NHS in England faces, with respect to increasing public expectation, increasing regulation and the need for assurance on quality and safety combined with the unprecedented financial efficiency challenge of the next few years, are well rehearsed and have been discussed at Board meetings at length. Last year concerns were expressed at executive level about whether the way the organisation was structured, made its decisions and implemented its change, was fit for purpose in order to meet these significant challenges. A reorganisation was proposed which the Board supported that addressed those challenges. The timeline for implementation was set to June 14 to accommodate the CQC inspection in March allowing focus on that important milestone for the Trust. It also allowed the appropriate time to ensure the major organisational and recruitment critical paths could be met safely to minimise the risks associated with such a wide ranging organisational change.

Drivers for change

There were a number of drivers for the change to the organisational structure and decision making processes. The most significant of these be the following;

1. As of the 1st April 2011, the organisation became an acute and community healthcare provider. Thus far, with the exception of some changes to more specialised elements of our clinical service, (i.e. sexual health), there had been limited formal managerial or clinical integration

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of community services with acute trust services. The strategic intention of the CCG dictates that we must maximise our deployment of care in community settings as much as possible. The integration of community and acute clinical teams and management structures will facilitate this.

2. The organisation had a gap in terms of corporate capacity in its ability to plan effectively for the future strategically. The appointment of Director of Strategy & Transformation helped to focus the organisation on longer term aims and needs and this has been made a substantive post. The corporate and clinical management structure of the Trust then needed to be able to respond far better to the capacity planning, strategic planning and workforce planning agenda and meet the recommendations of the RSM Tenon internal audit review of our business planning function and capability.
3. The Keogh Mortality review process exposed some gaps in how we deployed quality governance, particularly at clinical directorate level. This has been addressed by the Deloitte Review and the new performance balanced scorecard.
4. The organisation was starting to struggle significantly on both financial and operational requirement and in a position of having to agree a deficit budget for the first time in its organisational history for the coming year. Similarly, performance against targets which hither to have been met exceptionally well (i.e. 4 hour waits, diagnostic waits, RTT) was starting to slip and action had to be taken to prevent that pattern deteriorating. The turnaround team and changes to operational management are addressing this.
5. There had been significant concerns raised by both the Director of Nursing and the Matrons group as a whole that the clinical professional role of matrons in patient advocacy and overseeing safety and quality in a visible and hands on manner were becoming increasingly challenged. The organisation agreed the management structure and resource which enabled the matrons to deliver this significant agenda and meet many of the needs of the Keogh review action plan.
6. There had been a concern about the Transformation Programme not proceeding quickly enough for the organisation's needs and failing to engage senior clinicians sufficiently in transformational change. Using the turnaround programme as the vehicle going forward there is a need to restructure and reprioritise the transformation and turnaround programme both internally but significantly, externally with the CCG and the local health economy as a whole.
7. Some corporate support services required augmentation or better alignment to clinical management team needs.
8. The Medical Director struggled to create the capacity to manage the increasing expectations and time commitment required of the Responsible Officer/Medical Director role. To compound this, the development of the CCG as a predominantly clinically led organisation has led to an increased expectation from them, that our Medical Director and other senior clinicians within the organisation devote more time to detailed discussions of service redesign with them.
9. The relationship with our local Commissioning Clinical Group and health economy as a whole, needed to be more sophisticated and more focused on clinical service redesign and transformation. The previous management structure did not always facilitate this easily.

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Local market analysis

Healthcare Needs Assessment

The latest Joint Service Needs Assessment, (JSNA), carried out by the Dudley Health & Wellbeing Board in 2012, describes the population's health and social care needs.

Health Status and Health Inequalities

Dudley is characterised by significant health outcome differences between the most and least deprived parts of the Borough and bears the legacy of post industrialisation. The JSNA sets out a number of key

messages:

- the gap in life expectancy for the least and most deprived areas of Dudley has widened, mostly due to coronary heart disease, chronic obstructive pulmonary disease and lung cancer in men;
- the mortality rate in 60-74 age band is significantly higher for males;
- nearly a quarter of deaths in the 40–59 age band are due to cardiovascular disease, smoking, obesity and lack of physical activity;
- mortality from respiratory disease is significantly higher than the national average. Lower respiratory tract infection is the major condition;
- the next two decades are forecast to see an additional 25,100 more people over the age of 65 and an extra 9,900 over 85;
- nearly one fifth of 40-59 year olds are living with a long term limiting illness;
- disease prevalence rates as determined by primary care disease registers are low compared to modelled prevalence;
- the rate of delayed hospital discharge attributable to social care is higher than the national rate;
- emergency admissions for gastroenteritis and lower respiratory disease are increasing for the 60 – 74 age band;
- emergency admissions for gastroenteritis in the 75+ age band are increasing;
- hospital admission rates for 40–59 year olds suffering from alcohol specific conditions are rising, particularly from the deprived quintiles of the population.
- 20% of single person households are in the 60+ age group;
- with the ageing population there is an increasing number of older people who are carers of older people, or who are carers of adult children with learning or physical disabilities.

For our child population:

- the infant mortality rate is 5.0 per 1,000 live births, compared to 4.3 for England & Wales;
- between age 1 and 4, 29% of deaths were related to congenital malformations, deformations and chromosomal abnormalities, 18% to respiratory diseases and 14% each for external causes and diseases of the nervous system;
- 30% of the 3732 emergency hospital admissions in 2011/12 for 0-5 age band were due to respiratory diseases, with 15.2% due to unspecified viral infection, 6.2% due to viral intestinal infection and 3.5% due to non-infective gastroenteritis;
- the proportion of 9 to 11 year olds with a high self-esteem score has remained relatively constant at 27% in 2012;
- 3.8% (4.5% of males and 2.9% of females) of the household population in the 0-9 years age band reported having a limiting long-term illness, health problem or disability that limits their daily activities;
- looked after children prevalence rate significantly higher in Dudley (93 per 10,000 aged under 18) than England (59 per 10,000 aged under 18);
- 3.9% of school age children in care in Dudley have special educational needs.

"Commissioning for Prevention" suggests that in Dudley premature death is worse than average for:-

- cancer
- heart disease
- stroke
- liver disease

In addition, the CCGs review of the health data assessment within the "Commissioning for Value Pack", the "CSU QIPP Opportunities Pack", "Commissioning for Prevention" and the CCG Outcome Indicators Framework, suggests that the conditions listed below present opportunities for health improvement, service and cost improvements:

- gastroenteritis
- cancer and tumours
- Cardiovascular disease
- mental health problems

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- musculoskeletal problems
- endocrine, nutritional and metabolic
- vaccine preventable conditions
- falls
- ambulatory care sensitive conditions
- frail elderly
- admissions via A&E with a primary mental health diagnosis

This means:

- We have specific health inequalities for the male population both in terms of mortality rates in the 60-74 year age band and alcohol specific problems for the 40-59 year age band. This is contributing to a widening of life expectancy gap between the most and least deprived parts of our population.
- We need to ensure our locality based service delivery model (see below) provides an appropriate, differential intervention at neighbourhood level to respond to local health inequalities.
- Interventions in relation to cancer, heart disease, stroke, liver disease and stroke are required. We must ensure that the GP practices perform well in delivering smoking cessation services.
- The systematic management of patients with long term conditions in primary care and community health services will be a major contributor to our success, including the management of diabetes.
- We have a growing frail elderly population, we need to improve the care pathway to prevent unnecessary admissions and create the conditions to enable people to be re-abled and retain their independence in their communities.
- We require a continued focus on mental health and the relationship between mental health, physical health and the management of long term conditions.
- We need to ensure that our approach to prescribing and the input of our practice based pharmacists continues to improve our performance in relation to the use of drugs to reduce cholesterol, reduce blood pressure and manage atrial fibrillation.
- We need to ensure that our work on the systematic management of children with long term conditions, redesigning urgent and planned care pathways and integrating services in our localities is sensitive to the needs of our child population.

This is reflected in the priorities of the Commissioners. To ensure congruency the Trust's strategic intentions should align with these if we are to foster their support for the future shape of the Trust. We used these principles to sense check the clinical specialties future intentions.

Dudley CCG Strategic Intent

Building on from the JSNA the CCGs stated strategic intent is based around four particular types of care which patients may require, each of which displays separate characteristics. These are:-

- **Planned care** – to deliver quick, reliable, value added interventions at a time and place of the patient's choice;
- **Urgent care** – to deliver value added interventions in a crisis, where the capacity available is appropriate to the presenting need and each part of the system has a clear, distinct and exclusive role;
- **Reablement care** – to deliver an integrated system, where people regain independence in the least restrictive setting possible;
- **Preventative care** – to empower people to take as much care of themselves as possible, in partnership with appropriate professionals, so that their level of clinical risk is reduced and their overall wellbeing enhanced.

DGFT is working with the CCG to influence the outcome. The Trust and the CCG have a Collaborative Leadership Team which agrees the actions that will provide outcomes that are mutually beneficial.

- **Planned**
  How to be responsive, driving down the waiting times which will guarantee referrals and repatriation

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from the private sector

- **Urgent Care**
  The development of the Urgent Care Centre, which will be located on the Russells Hall site is being driven by the Urgent Care Programme Board, which has whole health economy membership, including Social Care
- **Reablement**
  The Trust is in negotiation with the CCG to develop a non-hospital bed base for reablement and step down, as well as enhancing the use of the Dudley Rehabilitation Service, which is Therapy led, and located at the Corbett Hospital.
- **Preventative Care**
  This is a cornerstone of the Better Care fund. The Trust is working with the CCG to develop community based integrated locality teams.

The achievement and then sustainability of the **Better Care Fund** is a risk to both the financial stability and the capacity plans of the Trust. The 2 year Operational Plan assumes the 15% reduction in non-elective activity, with the related closure of 36 beds, and reduction in income of £6m is achieved during 2015/16. If this is not the case the planning assumptions will need to be re-run.

The Better Care Fund plan and appropriate governance has been approved by Dudley Health and Wellbeing Board. the aims and objectives of the plan are

Aims and objectives:-

- every Dudley person will have a high quality experience of health and social care throughout their life journey;
- the health and social care system will be geared towards supporting independence; prevention and wellbeing will be integrated and privileged.
- every unplanned admission will be treated as a system failure;
- risk stratification and other data tools will enable an intelligent approach to service intervention.

These will be measured through:-

- reduced clinical risk as measured by the risk stratification tool;
- reduced dependency;
- reduced A&E attendances and unplanned admissions;
- efficient management of patients with long term conditions;
- transferring investment from treatment to prevention.

The Dudley Better Care Fund and DGFT Service Development and Improvement Plan combine to focus efforts on 5 key areas

i) Urgent Care Centre – with the streaming of patients to more appropriate settings 30% of the less ill patients currently attending ED are likely to be better cared for by other services. The procurement of the non-ED element of the Urgent Care Centre is progressing jointly. The estate, financial and workforce consequences are being identified as part of the internal DG NHS FT options appraisal for delivery.

ii) Community Rapid Response Team – we now have nurses in the team and they are routinely receiving referrals from GPs for acutely ill patients in their own homes. The working model for the ambulance service referral route has been outlined and the joint commissioner/provider team are putting agreed clinical accountabilities in place.

iii) Integration of community health and social care teams – the creation of five locality teams of health and social care staff, providing a single point of access, greater service resilience and capacity and more care in the patient's home is proceeding. A communication plan is being delivered to discuss with the affected staff how the new teams will function, where they will be based and how they interact.

iv) Commissioning changes for services to be provided to increase capacity, bring care closer to

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home and deliver financial savings are being identified, and joint working groups set up to progress these service by service reviews.

v) 7 day service challenge – Dudley CCG is an early implementer and DG NHSFT is playing its part in responding to the challenge initially for the acutely ill, newly admitted patient.

The Dudley Urgent Care Working Group and its subgroups provide operational focus on the various actions in BCF and SDIP which relate to Urgent Care. Oversight of the progress of the BCF and SDIP work is via the Dudley Health and Social Care Leadership Group, and reports to each organisation separately. The Collaborative Leadership Team comprised of executive leads from both DGFT and Dudley CCG, oversees progress and provides strategic steer to the progress of each actions.

The impacts of the BCF/SDIP internal to DGFT have been assessed from a strategic perspective and the reduction in emergency capacity and expansion of elective capacity remains a key operational target for Q2/Q3 2014/15.

The future payment mechanism – PBR & beyond

In 2015/16 PbR tariffs will continue, but are likely to be remodelled using a more recent version of reference costs before the application of inflation and efficiency assumptions. This is currently out for consultation. Following the consultation period, the final outcome and tariff will be published in December. Opportunities remain to employ local modifications, and the Trust will need to consider providing demonstrable evidence to the CCG regarding loss making areas.

2016/17 and beyond may see more radical changes, with a move away from PbR to long term tariffs, but these discussions are very much in their infancy. For the purpose of our 5 year financial planning assumptions on PbR have been used.

Dudley Local Development Framework

The four Black Country Local Authorities, Dudley, Sandwell, Walsall & Wolverhampton, agreed to work together to produce a Black Country Core Strategy, which forms the basis of the Local Development Framework.

The Black Country Core Strategy anticipates that the number of households in Dudley will increase by approximately 16,127 up until 2026 which equates to approximately an additional 38,705 people based on an average household size of 2.4, taken from the 2011 Census data. Therefore the population in Dudley is expected to rise from approximately 312,900 in 2011 to approximately 351,605 in 2026, an increase of 12.4%. Inevitably, this will have an impact on the infrastructure requirements of the Dudley Group NHS Foundation Trust.

There is a current need for further capital investment to respond to the healthcare needs of the population as it grows. There are no funding streams in place to enable the necessary capital investment. The Community Infrastructure Levy (CIL) charging schedule represents the primary potential funding stream for healthcare infrastructure investment to ensure standards of the healthcare service are maintained for the population as it grows.

It is inevitable that development on the scale currently proposed in Dudley in the Black Country Core Strategy will place a significant financial burden on the Dudley Group NHS Foundation Trust to retain and maintain an acceptable level of health care infrastructure. Details of the scale of investment which will be required in response to the projected growth are set out above and it has been shown that there will be an estimated deficit in funds in the region of £35m.

The need for CIL funding has been demonstrated by the Dudley Group NHS Foundation Trust and has been broken down on the attached table. The Dudley Group NHS Foundation Trust requested that a proportion of the revenue raised from developers through CIL be allocated towards ensuring minimum healthcare standards can be maintained within the Dudley Group NHS Foundation Trust to meet the need arising from the growth proposed in the Black Country Core Strategy. The expression of interest has

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been accepted.

The table below details the schemes included in the bid:

Infrastructure item and location (RHH is Russells Hall Hospital)	**Reason for development**	**When is this infrastructure required - start of**	**Cost of the infrastructure and Capital Funding Gap**
Hybrid theatre at RHH: (surgical theatre equipped with advanced medical imaging e.g. fixed C-Arms, CT scanners or MRI scanners, to allow intra and post-operative on-table imaging and intervention)	To respond to the demands for minimally invasive surgery for a growing population with an elderly demographic	0 to 5 years	£1.5 to £2m
Additional bed base at RHH: 40 bed ward	To respond to the growth in population size that will require surgical and orthopaedic services both electively and emergency	5 to 10 years	£4m
Additional day case facilities at RHH	To respond to the growth in surgery and the range of services that can now be offered on a day case basis	0 to 5 years	£1m
Growth in Emergency Dept, RHH.	To respond to population increase	0 to 5 years	£2.5m
Aseptic Suite at RHH	To respond to population increase	0 to 5 years	£2m
Maternity at RHH: The current Paediatric Assessment Unit needs to be expanded within existing ward space – this could be provided in the Children's Day Assessment Unit in the Children's Out Patient Department through internal alteration to provide a 6 bed area, waiting area, 3 cubicles and triage area.	To meet the increased population.	0 to 5 years	£2m

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Additional CT & MRI scanning and facilities at RHH. CT in existing accommodation but there is no space for MRI so there would be a need for an alternative facility elsewhere.	To meet increased population and forecast housing development profile will require a minimum of a specialist CT and MRI suite.	0 to 5 years	Cost up to £1.5m, plus cost of the accommodation.
Outpatient expansion: additional space required which will require the relocation of services and expansion to Corbett Hospitals.	To meet increased population.	0 to 5 years	£2m+
Mortuary facilities at RHH: extension to existing facility or new build facility.	Principally to meet increased population and also rise in Bariatric demand.	0 to 5 years	£500,000 upwards.
X-Ray facilities at RHH: digital X-ray kit required.	To meet increased population and diagnostic need.	0 to 5 years	£500,000 per room including shielding.
Pharmacy at RHH: The Trust is currently developing a temporary building solution for the pharmacy retail facility adjacent to the main entrance. Options being considered for relocating pharmacy manufacturing as part of the potential changes to the emergency department and need for release of accommodation for expansion.	Enabling works to allow for Pharmacy expansion in core inpatient services.	0 to 3 years	£250,000

Commissioning contracts –

As indicated in the table below DGFT accounts for 84% of Dudley CCG acute commissioning budget.

(Extract from Dudley CCG Board Papers 03/04/2014
Financial Budget Summary: Service Improvement & Quality 2014/15)

Acute Provider	£000	%
Dudley Group Foundation Trust – acute services	162,555	84%
University Hospital of Birmingham Foundation Trust	6,767	3%
Royal Wolverhampton NHS Trust	6,409	3%
West Midlands Hospital (Ramsay Healthcare)	5,019	3%
Sandwell and West Birmingham Hospitals NHS Trust	4,628	2%
Royal Orthopaedic Foundation Trust	3,150	2%

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Birmingham Childrens Hospital Foundation Trust	1,304	1%
Birmingham Womens Foundation Trust	1,159	1%
Other Providers	2,376	1%
QIPP - SDIP	-1,015	-1%
NCAs	2,191	1%
Other	14	0%
Total Acute Commissioning	194,557	100%

In addition DGFT receives £22.095m from Dudley CCG for Community services

Dudley CCG accounts for 64.2% of DGFT income. The table below outlines the current total income stream for DGFT.

CCG / Commissioner	**£000**	**%**
Dudley (acute & community)	184,650	64.2%
Specialised Services	33,478	11.6%
Sandwell & West Bham	30,561	10.6%
SE Staffs & Seisdon	9,097	3.2%
Wolverhampton	5,196	1.8%
Wyre Forest	2,723	0.9%
Non Contracted Activity	1,961	0.7%
Walsall	1,918	0.7%
Birmingham Cross City	845	0.3%
Shropshire	650	0.2%
Birmingham South & Central	608	0.2%
Other CCG contracts	601	0.2%
Cannock Chase	374	0.1%
Redditch & Bromsgrove	365	0.1%
South Worcestershire	294	0.1%
Other	8,871	3.1%
NHS England - Dental	2,778	1.0%
LA - Public Health	1,626	0.6%
NHS England - PH Screen	1,230	0.4%
Total Clinical / Patient Income	287,828	100.0%

For each of the elective specialties, the directorate teams have reviewed the opportunity for them to grow their activity, by either repatriating Dudley CCG activity that is being commissioned elsewhere, in particular West Midlands Hospital, or by increasing the market share in other CCGs, for example Wyre Forest

The alignment of findings from local health economy partners, (LHE)

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Dudley CCG has produced their long term strategic plan outlining how health and wellbeing within the borough must improve. It outlines the vision for elective and emergency care, re-ablement and integration. DGFTs strategy is in line with their vision. Indeed the co-commissioning of the Urgent Care Centre ensures that the pathways will be in accordance.

DGFT reviewed Dudley and other local CCGs "Commissioners Intentions" as both part of the two year operational planning process and the contract negotiation. It has subsequently reviewed the CCGs Service and Delivery Improvement Plan submission to ensure that the planning assumptions are aligned.

The Trust and CCG have formed an executive Collaborative Leadership Team. This was established to oversee systematic and sustainable change across the Dudley healthcare eco-system.

The following principles have been adopted by the Collaborative Leadership Team:

1. Care will be provided in the right **place** and through the right setting.
2. Care will be provided in a **timely** manner – urgent when it is urgent and appropriate timing for elective procedures.
3. Patients will receive **minimum intervention for maximum impact**.
4. Care will be provided in a **good (compassionate)** manner.
5. Care will be provided in a **seamless** manner.
6. Best **value** in terms of cost and quality will be continually strived for.
7. **Patient engagement** at all stages of their care is paramount.

The Trust and the CCG have created a joint leadership role that enhances our new divisional structure and supports the CCG's aim for improved clinical engagement between our two organisations. It will lead on and facilitate the implementation of our joint Service and Delivery Improvement Plan, particularly enabling the right clinical connections to deliver our shared transformation plans; this will include working together with the CCG on developing the clinical leadership and extension of the community integration model.

DGFT does not have membership of the Health & Wellbeing Board, which may be a risk to influencing the development of the Better Care model, and so the operational assumptions as a consequence. All of the capacity plans have been risk adjusted to take into account any likely failure to deliver against the stated activity reductions. This possible impact was also factored into the contract negotiations.

The Chairs and Chief Executives of the Black Country Providers have met to have some initial thoughts on how they might work together going forward.

Monitor, at the meeting with the Trust on 6th June 2014, agreed to facilitate a round table discussion with the commissioners and Local Area Team, (LAT), to ensure that there are common goals and understanding within the LHE over the necessity to agree a long-term plan for sustainability. The Trust supported this proposal, the details will be worked up.

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Forecasted activity and revenue in a "do nothing" scenario

Application of assumptions for inflationary increases for pay, drugs, PFI, CNST, other non-pay coupled with an estimated net tariff reduction based on a national requirement to deliver efficiency savings result in an increasing predicted gap between income and expenditure.

This is further exacerbated in 14/15 by the requirement to fund legitimate cost pressures that are significantly in excess of national assumptions, i.e. additional nursing investment.

If no action was taken to turnaround and transform services, the deficit would rise from £16.9m in 2014/15 to £48.8m by 2018/19.

It is in this context that the turnaround project was launched by the Trust.

Capacity analysis to meet healthcare needs

The two year operational plan outlined a planned reduction in inpatient capacity of 68 beds (on a base of 712) through three initiatives; Better Care Fund admissions avoidance; Elective Medical Unit re-organisation of activity and other length of stay reductions (risk adjusted).

The physical capacity created through these initiatives will be used for additional admissions during the winter and patients requiring treatment within RTT targets. The development of the broader Better Care Fund initiative across the wider health and social care economy may elicit further reductions in patients stay in hospital (more admissions avoided, earlier discharges) in the later part of the planning period but it is difficult to quantify the impact of these. The assumption has been made that any growth in emergency or elective activity across years two to five is offset by an equal and opposite improvement in efficiency.

The detailed Outpatient capacity assessment undertaken for the two year operational plan identified potential spare capacity. The growth assumption for outpatients at approx 0.5% per annum could be accommodated in the spare capacity identified.

The plans for the Urgent Care Centre, to be functioning by 1st March 2015, encompass the redesign of pathways of the current Emergency Department and the Walk-In Centre patients into a facility that will have capacity to deal with the anticipated number of patients in each pathway.

The CCG have included in their plans an assumption of 1.54% for demographic growth, the ONS figures (issued in 2012) suggest that over the period the resident Dudley population will grow by 1.1% - the impact of these is contained within the planning assumptions for growth for elective and outpatients at 0.5% per annum, and for emergency admissions at 1% per annum.

It is difficult to quantify the impact of proposed schemes that are in their infancy. The details will be worked up as part of the project development, and incorporated into the active operational plan at that time.

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Market share assessment

We have undertaken an assessment to identify where opportunities may exist for The Dudley Group to repatriate elective activity that either has been regularly referred elsewhere, or has been lost over the last 1-2 years to competitors.

The initial focus was where DGFT has the expertise, but not necessarily current capacity, to perform the activity. It was based on referrals for the Dudley CCG registered population, where DGFT currently undertakes high volumes of that work.

Aspirational activities such as new medical day cases have not been considered at this stage.

Opportunity is considered to be where market share of Dudley CCG GPs is relatively low e.g. below 90% across the two year period reviewed, or where activity has been lost.

A market share already above 95% has been considered to give little opportunity for growth as the gap may be issues that the Dudley Group cannot influence, such as patients living on the borders of other providers, or specialist activity referred elsewhere.

Only specialties with a reasonably significant current elective workload were considered.

We have the breakdown of data by Healthcare Resources Group, (HRG), to enable clinical teams to carry

out more in depth planning

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Competitors

1	Royal Wolverhampton Hospital Trust	2	Dudley Group NHS Foundation Trust	3	Sandwell & West Birmingham NHS Trust
4	Walsall Healthcare NHS Trust	5	Birmingham Children's Hospital Foundation Trust	8	University Hospital of Birmingham Foundation Trust
9	Worcester Acute Hospital NHS Trust	1	West Midlands Hospital, Ramsay Healthcare UK		

From the geography and market assessment the Trust identifies four main competitors, none of which are Foundation Trusts, one is a Private Provider.

To the north, **Royal Wolverhampton Hospital NHS Trust, (RWHT).**
This is a teaching hospital with 800 beds, there is one acute hospital site, and a rehabilitation hospital. The Trust has an operating budget of £374m.

DGFT has some close clinical links with RWHT across cancer sites, oncology, vascular, cardiology and

head and neck.

RWHT has been identified as a preferred provider to take on the services at Cannock Hospital, as a result of the Mid Staffs review. Their expansion is currently focused in that direction.

To the south/east, **Sandwell and West Birmingham Hospital NHS Trust, (SWBH).**
SWBH is an integrated care organisation, caring for a population of about 530,000 across West Birmingham and Sandwell, with an operating budget of £430m. There are several regional services provided by the Trust, including the Midlands Eye Centre, of which some of the DGFT Ophthalmology consultants have joint contracts across both Trusts.

DGFT and SWBH Boards of Directors have committed to work together in service areas that would have mutual benefit..

SWBH is nine years into a significant project, The Right Care Right Here partnership, a large component of that is the re-provision of acute services into a single purpose built hospital, situated in Smethwick, within Birmingham. This could result in a shift in patients who currently choose Sandwell Hospital to DGFT. Whilst there is no modelling available, DGFT experienced an increase in 600 births when the maternity unit at Sandwell Hospital closed, and services were re-provided at City Hospital.

To the south west, **Worcestershire Acute Hospital NHS Trust, (WAHT).**
WAHT has three hospital sites based at Redditch, Kidderminster and the main site in Worcester. The population base is more than 550,000 with an operating budget of £349m.

Worcestershire has been subject to significant Joint Service Review, (JSR), to determine the future shape of acute health provision across the county. Question marks existed over the future tenure of the Alexandra Hospital in Redditch and the hospital at Kidderminster.

In 2013 the JSR concluded and the project was rebranded and it is currently referred to as the ‘Worcestershire reconfiguration of A&E, women's and children's services.

WAHT stated publicly that it wishes to continue to run all three sites, with the centralisation of inpatient paediatric service at the WRH site, overcoming medical workforce issues and securing safe, sustainable 24/7 services.

West Midlands Hospital, Ramsay Healthcare UK
This is a private facility. Dudley CCG commission elective and diagnostic activity here, so a proportion of patients using the facility are NHS patients, choosing this organisation via Choose & Book.

The CQC report for the hospital is good. The CCG notes that the facility is achieving its quality standards. As stated previously this is the second highest receiver of referrals from Dudley CCG for T&O and Gynae.

Supporting Corporate Strategies

Clinical Strategy:
The current Clinical Strategy document was ratified in 2013 and sets out what we want to achieve for our clinical services over the next five years until 2018. It is supported by a set of enabling strategies, such as the quality, estates, Information Technology and workforce strategies which will each add more detail.

The strategy is based on our agreed vision and values:
"Our vision is of a highly regarded healthcare provider for the Black Country and West Midlands, offering a range of closely integrated acute and community based services, driven by the philosophy that people matter"
This vision distils into a strong memorable strapline for the staff and patients of *"where people matter"* and drives the pursuit of our three core values of *Care, Respect and Responsibility* each and every day.

To deliver our vision to become a highly regarded healthcare provider for the Black Country and West Midlands we established our strategic goals in six key areas. Four of those relate to:

- Being well known for the safety, quality and transformation of our services
- Providing the best possible patient experience
- Strengthening and diversifying our services
- Strengthening and developing clinical partnerships to maintain and protect our key services

The remaining two recognise that none of this is achievable without committed and engaged staff and a sound infrastructure from which to operate.
The strategic goals therefore provide the platform for the necessary actions to deliver the clinical strategy.

We are committed to maintaining our current range of clinical services as set out in our strategic goals, but this is in the context of ensuring that our services continue to be financially and clinically viable and therefore some reshaping is likely.

The environment within which we are operating means that in future we will be expected to deliver better outcomes with better patient experience at a lower cost. The changes in commissioning and the greater need for critical mass means that we also need to move forward with expansion of our catchment where we can. Therefore our clinical strategy sets out our plans for maintaining what we currently do but expanding our footprint and improving our services with a strong focus on higher quality.

a) Providing the highest quality local hospital care in the most effective and efficient way:
We will provide outstanding quality hospital services for the local population in Dudley and beyond to drive to a catchment of 500k where it makes clinical and business sense to do so, with as much of the pathway as possible based out of hospital.
By 2018 we will:
• Be amongst the best providers for the safety, patient experience and outcomes of our local hospital care
• Have played a clinical leadership and partnership role in developing
improved, high quality and sustainable local hospital services in the Black Country and beyond
• Have maintained our current range of services and expanded those in which we excel and have a competitive advantage

b) Providing excellent integrated services enabling people to stay at home and be treated as close to home as possible:
We will work with primary care, social care and the third sector to deliver integrated services particularly focusing on those for long-term conditions or for older people.
By 2018 we will:
• Be amongst the best for the safety, patient experience and outcomes of our community services
• Deliver the majority of our care for long term conditions and older people at or near home, keeping hospital stays to a minimum
• Continued to have integrated our hospital and community services with social care and primary care services with people's needs at the centre.

c) Providing a series of specialist services across the Black Country:
We will be a leading hospital in the Black Country with a wide range of specialist services on the excellent Russells Hall site, giving us a high quality environment in which to care for patients with complex clinical needs.

By 2018 we will:

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• Be amongst the best for the safety, outcomes and patient experience and of our specialist care
• Have one of the most successful and effective aortic aneurism screening services for the whole of the Black Country
• Have superior outcomes to both regional and national figures for our specialised services including our pan Black Country vascular surgery service

Estates Strategy:
The Dudley Group Foundation Trust has an Estates Strategy, which was agreed by the Board of Directors in May 2013. The Strategy covers the three PFI hospital sites but at present excludes the Trust occupation of community buildings, which is being developed separately as part of the Trusts turnaround plan for the next two financial years.

The Trust operates from two main sites with multiple community facilities. The community facilities are operated in under a memorandum of occupation. Russells Hall Hospital is the largest of the three hospitals and is the trusts centre for all in-patient care. The site is shared with Dudley & Walsall Mental Health Partnership Trust, where Bushey Fields Hospital is located compromising mental health wards in single storey structures.

Russells Hall Hospital was built in 1975, further extended in 1984 and then transformed as part of the PFI build which was completed in 2005. The PFI project of 2005 means that all the buildings at Corbett and Guest outpatient centres are less than 10 years old. At Russells Hall, nearly 50% of the buildings formed part of the PFI and are therefore less than 10 years old. The trust therefore occupies relatively modern estate and in a good condition with many elements which were purpose built less than 10 years ago.

The Trust has not undertaken a comprehensive appraisal of the estate since the completion of the PFI transaction. This is as a result of a certain absence of estate information required for strategic planning purposes and is a point of discussion at present with the PFI company, Summit Healthcare, (Dudley). For example, whilst the estate condition is known and classified as condition B, other elements of the 6 facet estates survey are either partially or completely unappraised, (functional suitability, space utilisation and statutory compliance).

Strategically, the Trust's estates strategy was reviewed in the rapidly changing context of tariff deflation, patient choice, QUIPP programs and revealingly, NHS England's signalled intention to drive more radical service change and site reconfiguration in the medium to long term. As a result, the trust has agreed that it needs to;

1. Accommodate new technology within its services
2. Plan for substantial volumes of activity to no longer be provided in acute in-patient or out-patient settings
3. Improve the cost effectiveness of the retained care that is given on the hospital sites
4. Be prepared for a reconfiguration of significant elements of sub-regional and even district general hospital activity in future years

From a capacity perspective, modelling done both for the purposes of the estate strategy and more recently, for the two year operational plan, shows that the trust overall has sufficient in-patient beds but significant re-designation of these beds needs to take place as soon as possible. For example, length of stay gains are still to be made in acute and speciality medicine and a re-designation of the released beds then delivered to surgical specialities, to improve 18-week wait performance and achieve elective repatriation targets signalled in the two year operational plan.

The estate strategy recommendations have been set out on a themed basis and broadly summarised as follows:

1. **Emergency services**
   The Trust's emergency department is overcrowded and demand continues to increase marginally year on year. Whilst the trust is working collaboratively with Dudley CCG, to develop an integrated urgent

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care centre, as part of the emergency zone of Russells Hall Hospital (Opening April 2015), significant redesign is required to allow improved patient flow and meet accepted modern acute medical practice for the future. The Trust has agreed to the principle of a major redesign of the emergency zone of the hospital including, not exclusively;

- the relocation of the acute medical unit to the ground floor area, currently occupied by both elderly care and rheumatology capacity,
- the relocation of the paediatric assessment unit to the emergency zone of the hospital,
- the development of a non-elective imaging hub, integral to the emergency zone of the hospital and incorporating a third CT scanner,
- remodelling of the emergency department paediatric and follow up clinic area.

Whist it is accepted that during times of financial pressure, these principles whilst agreed, must all be tested in detail by full business case and submitted to scrutiny by the trust's investment panel, the Board of Directors has signalled a clear intention that urgent and emergency care needs to change both in terms of process of that care and also the physical estate which will support that process in the longer term.

2. Outpatient Services

The Trust's estate strategy concludes that the Russells Hall Hospital site runs "white hot" on certain days from an out-patient and ambulatory care perspective. As a result, a strategic intention is to relocate elements of the Russells Hall Hospital ambulatory care activity to the Guest Hospital site, which is currently considered to be significantly underutilised. The most significant of these proposals is the proposed relocation of the Ophthalmology service which again would be subject to business case, by virtue of the capital expenditure required on Ophthalmology operating capacity at Guest hospital site.

However, as Trust turnaround plans develop and commissioner's QUIPP schemes become clarified, it is becoming possible that the strategic intention described above will not be required because of significant out-patient activity reduction over the next five years on the Russells Hall Hospital, Corbett Hospital and Guest Hospital sites. The Trust will therefore consider whether an alternative use for the Guest Hospital site can be agreed, because divesting itself of that site will be extremely costly due to the terms and conditions of the PFI project agreement. One potential strategic development of the Guest Hospital site would be the planning of new primary care estate for federated GP practices in the north of the borough. It is also clear that because of its geographical location, the Guest Hospital site is close to the Trust's borders with Sandwell and West Birmingham Hospitals, whose referral activity will become more fluid as a result of their developing vision of a new general hospital in Smethwick.

3. Inpatient bed base

As already referred to in the recommendations around the emergency zone described above, significant re-designation and development of the in-patient bed base will be required over the next five years. The most significant of these are:

3.1 The move of the acute medical unit to larger foot print on wards A1 and A2 as part of the overall urgent and emergency care response planned by the Trust over that time period (including the urgent care centre development with the CCG).
3.2 The re-designation of medical beds for surgical and orthopaedic work in line with the plans developed and shared with Monitor over the next two financial years
3.3 The development of offsite step down and/or rehabilitation capacity in partnership with the CCG, in order to tackle the Trusts significant delayed transfer of care problems and the dispersed nature of intermediate care bed capacity across the borough.

4. Women's and Children's Services

Whilst the current location of the maternity unit is satisfactory, its physical design within its foot print is not deemed efficient and will not meet the planned increases in activity described in this five year plan, nor the organic growth in activity expected over the course of the next five years. To that end, it is planned to relocate the midwifery led unit to the ground floor of Russells Hall Hospital, thereby

creating capacity for a further 1000 births per annum in the maternity unit itself.

5. **Theatres and Endoscopy**
   Currently reported theatre utilisation rates are good, demonstrating that operating theatre efficiency is relatively high. However, it is widely acknowledged that our bespoke theatre information system may not be giving us the true indication of theatre efficiency and this is currently under significant scrutiny as part of the Trusts financial turnaround plan process. Depending upon the result of that analysis, the Trust may bring forward the business case which is currently being held in abeyance, for the creation of an additional theatre (hybrid theatre) on the Russells Hall site. If approved, this theatre will provide not just additional capacity to help the organisation meet the full year recurrent requirements of the two year operational plan commitments but also will meet the prospective standards set out by the Vascular Society of Great Britain and Ireland, thereby enabling the organisation to retain its status as of vascular surgery hub.

   A business case is also being worked up, which makes the case for additional day surgery recovery area capacity. Again, this will be developed during the course of the next 2-5 years, dependent upon the capacity and efficiency analysis of the current financial turnaround programme.

6. **Renal**
   Subject to the strategic decision of the Board regarding the Trust's renal medicine service and in particular, renal dialysis services, the estate strategy recommends the relocation of renal dialysis services on an out-reach model basis, thereby releasing the renal unit on the ground floor of Russells Hall Hospital, for alternative use. The 2 year operational plan sets out the intention to utilise that space for an expanded elective medical admissions unit, which is itself part of the overall length of stay reduction strategy set out in the operational plan and requiring bedding in and rolling out during the course of the 5 year plan timescale.
7. **Pathology**
   Having decided not to work collaboratively at this stage with Sandwell and West Birmingham Hospitals Trust, following the collapse of the Regional tender process for direct access pathology, the Board of Directors has agreed to the principle of the tendering of a new managed equipment service contract within pathology and the expenditure of capital monies (set out in the operational plan) on the creation of a blood sciences facility on-site at Russells Hall Hospital. Extensive industrial engineering analysis has been commissioned and reported on as part of the Trust's join planning with SWBH, which can be called upon should the Board choose to work jointly with SWBH again around any future re-configurations of pathology services in the West Midlands.

8. **Administrative areas**
   The Trust has acknowledged that its use of administrative areas is extremely inefficient, by virtue of not having planned long term for efficient open plan/hot desk working in clinical admin and non-clinical admin areas and also because the appropriate "follow me" information technology has not yet been procured to facilitate this. once both of these intended developments are in place, an efficiency improvement of up to 30% can be achieved, thereby a) releasing pressure on clinical administrative areas and b) potentially releasing areas of the Trust for alternative use by patient facing services in the future.

IT Strategy:
The Trust is currently going through a business case approval for a replacement Electronic Health Record. In line with the Trust board IT Strategy and endorsed by Dudley Care Commissioning Group (Dudley CCG), the stated vision of the new system is:-

"We will ensure our information systems make our services safer, more efficient and more effective for patients, carers and staff. We will share appropriate information to ensure the right information is available at the point of care using an electronic health record."

All stakeholders require one version of the truth, a single fully-integrated system that provides up to date and accurate information. This will enable all stakeholders to navigate across primary, community and secondary care and social care. This will optimise the delivery of safe care to a high quality.

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Transformation is fundamental to the future viability of the Dudley Group NHS Foundation Trust (the Trust). Currently the technology is a barrier. The Outline Business Case, (OBC), makes the case for technology to support change and enable transformation.

The focus in health information management and technology (IT) is now on systems that support the delivery of safe, high-quality and auditable patient care, partly by providing real-time, accurate, comprehensive and context-specific information to support clinical decision making and to manage care proactively across multiple care boundaries. Information systems should both guide and prompt safe interaction with patients managing the quality of care provided.

The Trust needs systems that will enable transformation of working practices, support the objectives of delivering excellent patient care and reducing clinical risk, allow proactive two-way engagement with patients, irrespective of the location of the clinician or the patient, while reducing operating costs. The Trust needs a platform for change to meet known and predicted needs and the inevitable but unpredicted needs yet to come.

Timeframe:
The proposed implementation plan will take six years to embed all the functionality within the Trust and thus fully realise the benefits. Initial planning has started. We have already established separate work streams to manage:

a) the current operations and management of the capital programme
b) management of the off-site data centre
c) termination and migration of the current IT contract and
d) the initiation of the EHR programme.

Detailed planning will be initiated upon a decision with regard to the outline business case.
The roadmap for the first three years includes:

- Phase 1: serve notice on the existing arrangements, whilst putting in place plan B.
- Phase 2: (running parallel to Phase 1) procure a new system and implement as a minimum the functionality currently delivered by Soarian, so that by T-2 the Trust can go live in the Emergency Department and wider Trust.
- In parallel a number of workstreams will be initiated to increase the functionality as safely and quickly as possible in conjunction with the requirements of the clinical body. This includes replacing the community services system, (currently NCRS), the provision of e-Prescribing, Theatres and Electronic Document Management.
- Phase 3 will then deploy decision support and care pathways in a phased manner. This will also cover the replacement of the Oasis patient administration system.

The Quality Strategy:
The Trust has an existing quality strategy which includes overarching strategic objectives for quality:

- To become well known for the safety and quality of our services through a systematic approach to service transformation, research and innovation.
- To provide the best possible patient experience

Underpinning the strategic objectives there are a number of principle outcomes, which are:

- To deliver effective clinical care to all patients.
- To maintain and improve patient safety
- To ensure that the patient receives a good standard of care from his/her perspective through excellent customer service every time to everyone.
- To work in partnership with commissioners and comply with agreed quality standards

There are a variety of key aims and initiatives at the Trust to produce the above outcomes. These are based on the three elements of quality:

- Patient Experience

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- Patient Safety
- Clinical Effectiveness

The Trust has specific aims/targets related to each of these three elements based on the response of patients to specific questions within the real time patient surveys; the numbers of MRSA and C.Difficile infections, the number and types of avoidable pressure ulcers, the results of nursing indicators related to nutrition and hydration care and our performance in reviewing patient mortality.

The Trust is presently reviewing and refining its quality improvement strategy, with a target date for completion of the end of quarter 2 2014. This will be expanded to incorporate service improvements, with defined targets.

Workforce strategy:
Nursing Workforce Strategy
As the new principals for Nurse to bed ratios become implemented and embedded into the organisation we continue to look for new and creative ways of growing this workforce.

1. **Novice Programme**

This will continue to be an integral part of the way we attract and retain our Health Care Support workers. Attracting new people to the Health Service and also people with previous experience of other types of Healthcare settings.
This has also proved to be a successful way of supporting people to develop their careers and moving on to full Nurse training.

2. **International Recruitment**

This way of recruiting fully trained Nurses in an ever scarce market will be part of our strategy for at least the next 3 years or until the UK market recovers.

3. **Specialist Nurses**

As we look for new patient focused, yet cost effective ways of delivery our services these categories will become increasingly important. Specialist Nurses for:

- Parkinson's and Lung Cancer
- Learning Disabilities

Have already been successfully established and more services will be implementing specialist roles over the coming years.

4. **Assistant Practitioner**

The Trust is actively developing an in house Assistant Practitioner programme which would be administered internally and the Trust would ultimately be the awarding body. The role has been proved to provide increased flexibility and an opportunity for succession planning. These roles can now be accommodated within the existing establishment and continue to flex their allocation between main theatres and day case. Assistant Practitioner's are hoped to relieve pressure on service by assisting with or undertaking some tasks presently 'owned' by qualified nursing staff.

Medical Workforce Strategy

Four key areas of delivery were identified as a result of the work at a Trust level. These four areas are:

1. **The impact of the reduction of junior medical staff**
2. **Difficult to fill roles**
3. **Growth of Physicians Associates (PAs) and ANPs**
4. **Seven day service and its impact on the workforce**

1. The impact of reducing the number of doctors in training will undoubtedly have an effect on the Trust and in particular in surgical specialties. In order to address these concerns the Trust has undertaken

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two main initiatives. The first is to continue to invest in Physicians Associates; the second is the investment in both junior and senior clinical fellowships. We are now in the second year of investment in these positions. These positions have been filled with overseas workers. A mirrored model is in place within medicine, however only at the junior tier (due to the talent available for senior roles). These rotations have proved successful in year one and supported the delivery of services.

2. The Trust has several difficult to fill medical roles. The most obvious of which is in Emergency Medicine at Registrar level. The Trust is in line with the national markets for these positions and is currently pursuing MTI candidates to support these rotas. Consultant recruitment in this Acute Medicine is very difficult with the amount of trainees becoming Consultants happening at a slower rate than the growth of services. There also remain challenging recruitment markets for Consultant level positions in ITU/Critical Care, Radiology and Ophthalmology. At the next tier down, the Trust has struggled to fill gaps which appear on the Medical Registrar rota. Recruitment markets in Registrar level jobs in Gastro, Respiratory and Elderly Care have been scarce and meant the Trust has resorted to using agency staff to cover some of these positions. Overseas recruitment for these posts is problematic as gaps on these rotas are often for a shorter period than appointments can be made for e.g. 9 month gap and overseas recruitment can take four-six months based on right to work issues.

3. The Trust continues to grow Physicians Assistants as discussed below and has a specific working group looking at the governance arrangements and training needed for both existing PA's and those in training.

4. The Trust has put together a group who are looking at the issue of seven day service and the impact on working patterns for medical staff.

There is a service change (which has been agreed) in Emergency Medicine with an expected 20-40% reduction in Emergency Department attendances. At this point the exact workforce modeling is not complete and therefore the impact on workforce numbers not predicted. There is recognition from both commissioners and the Trust that the acuity of sick patients will not change and therefore the impact is likely to be greater on the nursing workforce than the medical workforce. Definite numbers are not yet predicted.

The Trust has seen an increase in the number of leavers in medical jobs to take up positions overseas. Recently Consultants have taken up posts in the Middle East/Australia which attract significantly higher rates of pay which the Trust cannot compete with.

The rise in doctors in training working less than full time hours is having a significant impact on services with those vacancies being left 20-30% unfilled. The remaining time is not enough to recruit to, but is important to the delivery of service and often results in filling these gaps with bank or agency.

Service Line Option Appraisal

Of the seven specialities included in this appraisal, three have been recommended for growth:

- Vascular
- Stroke
- Maternity

With four recommended for redesign:

- Paediatrics
- Renal
- Care of the elderly
- Neonatal

The workforce implication of this have been considered by the relevant management teams in the growth areas.

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Maternity and Elderly Care will not only require additional nursing numbers but also additional Consultants, creative structure would need to be developed as both Nursing and Elderly Care Consultants are in short supply.

Additional Stroke Consultants would be required in addition to an increased workforce of Sonographers for Vascular, again both these categories are in short supply.

The four key areas of redesign are less challenging to react to and largely would be self contained reorganisation from a workforce perspective.

The Trust's current Strategic Objectives

SGO1.	Quality, Safety & Service Transformation Reputation	To become well known for the safety and quality of our services through a systematic approach to service transformation , research and innovation
SGO2.	Patient experience	To provide the best possible patient experience
SGO3.	Diversification	To drive the business forward by taking opportunities to diversify beyond our traditional range of services and strengthen our existing portfolio
SGO4.	Clinical Partnerships	To develop and strengthen strategic clinical partnerships to maintain and protect our key services
SGO5.	Staff Commitment	To create a high commitment culture from our staff with positive morale and a "can do" attitude
SGO6.	Enabling Objectives	To deliver an infrastructure that supports delivery

The aims of the Trust's strategic intention will be framed within the following principles:

- **Quality** – strong nursing standards, good governance systems, 24/7 cover in core district general hospital services, standardised medical best practice, excellent patient experience scores
- **Services** – clear decisions on future of our sub-regional specialist services and estate/IT strategy matching service need
- **Activity** – greater balance between core DGFT emergency and elective income, reduced emergency admissions, simplified urgent care model and consistent 4 hour target delivery, robust and significant surge capacity contingency, best in class standards on length of stay and outpatients
- **Workforce** – stable and well established nursing workforce, fully integrated health and social care teams, 24/7 cover where applicable
- **Finances** – improved liquidity, upper decile performance, capital developments with strong return on investment

The continued relevance of the current 6 strategic goals will be reviewed and refined within 2014/15, in

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preparation for the next planning round.

Identification of sustainable options for clinical services

Given the need to meet the economic and clinical sustainability challenges the Trust set up Specialty Rewiew workshops with each clinical specialty to review; SLR position, benchmarking, contract position, Commissioning intentions, a SWOT and workforce planning.

In parallel to this Portfolio Analysis was carried out.

A few shifts in tariff, (maternity pathway, marginal rate for emergency work, re-admission funding arrangements) would need to be overlaid against this analysis – the impact being that some of the specialties positioning may have changed through factors outside the immediate control of Trust. It is the intention that this analysis is repeated on an annual basis as part of the operational planning process.

Key Service Line Reviews

Financial scenario –

Risk to sustainability

The financial scenario has been developed with three strands of savings, namely internal to the Trust, Health Economy-wide and those that are wider than the current Health Economy. Internal savings are those that can be driven by the Trust and the development of Turnaround offers some surety regarding a full year opportunity of £18.8m. However, further plans are required for the remaining Turnaround requirement of £4.8m. A detailed review of specialties has identified the potential to grow, protect or exit.

Growth will clearly be contingent upon attracting additional activity from outside the borough and will require the release of current capacity in order to safely deliver the additional workload.

Exiting a service will also require careful negotiation to ensure that patient care is not affected and the requisite savings achieved.

The Trust plans assume a degree of price support from the CCG as tariff no longer reflects the true cost of undertaking emergency work. This is clearly a risk given the reduced level of funding within the NHS. On a wider context, a breakeven position in latter years will only be achieved with a wider review of the provision of health services across the Black Country. This represents a major risk as it is not within the Trust's power to enforce.

The Trust has a PFI contract which provides both facilities and soft services. Financial modelling over the

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five year period has highlighted the added liquidity risk that the PFI contract brings to the Trust's already difficult financial position. A surplus of £1.6m is required as a minimum in years 3-5 to cover the cash impact of the PFI contract over and above a break even position. This is also in the context of a base capital programme for those 3 years. The PFI contract increases by RPI each year and therefore provides the Trust with a non-influenceable rising cost each year.

Key Milestones, resourcing requirements, dependencies & risk mitigations

For all these actions initial scoping activity is already underway.

A detailed plan will be produced for each project which will be based on the structure and governance arrangements adopted for the Turnaround project.

Performance Monitoring arrangements and the process to amend plans to reflect any unexpected challenges

The implementation of the individual specialty plans will be monitored by the Clinical Divisions. Exception and mitigating actions will be reported through to the Finance & Performance Committee of the Board of Directors.

Corporate actions will be reported through the relevant sub-committee of the Board, Trust Management Executive, Finance and Performance Committee, Clinical Quality, Safety and Patient Experience & Workforce & Staff Engagement Committee

An update of progress will be reported to the Council of Governors

Communication plan

The strategic plan will be communicated widely and clearly to all stakeholders appropriately. This will involve a variety of different approaches targeted to the audience and phased in line with the plan.
The overall plan with service line recommendations will be communicated internally to all staff groups. Through a variety of methods including the CE update monthly face to face and video briefing, the intranet, targeted communications campaigns as appropriate, summary posters in staff areas, staff forum and live chat sessions to enable questions and answers with an executive director.
Local health economy partners, our Governors and patients will also be made aware of the plans and where engaged in development where appropriate. Summary documents will be produced to enable onward cascade of the key intentions.

Communication of the Trust Strategic Plan

1. **Service aim**

   Operational: to launch the trust strategic plan for the next five years, ensuring staff, partners and patients are aware of the strategic plan and any implications for services.

Comms: to raise awareness of the trust strategic plans to local stakeholders and highlight the availability of the summary of the plan on Monitor's and the Trust's website. Targeted communications campaigns and plans will be developed for the key seven service line recommendations as implementation commences.

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2. Situational analysis

- The Trust's financial situation is forecast deficit for 2014/15
- The Trust has placed itself into Turnaround regime to deliver the scale of service improvement productivity and efficiency required.
- The Strategic Plan sets out the trust's vision for the future of The Dudley Group and the seven key services integral to its core business.
- Where major service change becomes evident thorough engagement with key stakeholders will take place and full consultation where necessary.
- The Overview and Scrutiny committee and Health and Well being board will be presented with the summary plan

3. Key messages

- The Dudley Group vision is to be a highly regarded provider of healthcare where people matter
- The strategic plan gives a summary of the vision and operational plans required to ensure a successful trust for the future
- Fast, efficient, safe and specialist-delivered care
- Works collaboratively with its commissioners and LHE to deliver required

4. Key audiences

- As well as those listed below for each service line recommendation a through communications plan will be developed as the detail of the implementation plan becomes available for each phase of the plan.
- This strategic plan is designed only to raise awareness of the strategic plan and its intentions amongst key stakeholders

5. Barriers

- Challenging financial environment creating pressure amongst teams to deliver higher quality more efficiently
- Lack of interest and support from referring GPs
- Concerns around affects on NHS provision

6. **Objectives**

Operational objectives	Communications objectives
Develop and implement five year strategic plan	**Raise awareness among staff** • Ensure staff are aware of the strategic plan • Provide staff with clear communication and summary of the five year strategic plan • Tailor the communications to specific staff groups where appropriate for specific service line recommendations
	Raise awareness among patients • To ensure patients are made aware of the seven key service intentions and the summary plan to inform and raise awareness of the strategic vision for The Dudley Group.
	Raise awareness among partner organisations, GP's, CCG and LHE stakeholders • To ensure GPs (Dudley and surrounding GPs) are aware of our strategic intentions where appropriate

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		• To ensure CCG staff are aware of the strategic plan and its intentions and are able to articulate them through clear concise communications.

Capital planning & expenditure

The Trust has described capital plans to spend £16.1m over the two year period 2014-15 to 2015-16 in its operational plan submission.

For the remaining three years (2016-17 to 2018-19) the Trust has capital plans of £19.4m. £10.5m of this is funded from surplus cash with the remaining £8.9m funded by the PFI provider. The Trust has no surplus assets for disposal over this period. The estates strategy has driven the capital programme. As the Trust operates out of PFI buildings there is no requirement to fund back log maintenance from our capital resources, this is all the responsibility of the PFI Company. The capital schemes are detailed blow.

Development

Third CT Scanner

The total scheme is £1.6m of which all will be expended in 2016-17. Funding for the scheme is from surplus cash. The Trust has identified the opportunity to grow its current stoke service. The Trust has identified an opportunity to obtain HASU status. To acquire this investment will be required in a 3rd CT scanner which would also allow the increased activity to be managed in a safe clinical environment. This project will be developed with our PFI partners and will be subject to external review from the SPV's funders and technical advisors. Any slippage on timetable would result in the Trust not achieving the planned financial contribution. The risk has been mitigated by close working with the PFI Company around a strong project management team.

Maintenance or replacement capital expenditure

PFI Lifecycle

Total lifecycle plan of £4.1m over the three years. Under IFRS the Trust has to account for the lifecycle applied to the hospital by the PFI Company. This is a technical accounting transaction and the plan is based on information provided by the PFI Company. The Trust is reliant on the PFI Company providing the information to support the application of lifecycle expenditure. The risk is with the PFI Company to maintain the PFI assets to a specific level. It is this element of capital expenditure that carries the biggest risk for the Trust on achieving the capital plan. With expenditure outside the control of the Trust the application of the lifecycle fund by the PFI Company is rarely to plan as evidenced over the past two years.

Other Capital Investment

The Trust is investing £1.074m over the three years on other small capital schemes. £358k in 2016-17, 2017-18 and 2018-19. This spend relates to lifecycle of the remaining owned estate and minor works of a capital nature in the PFI buildings. There is also investment in replacement beds. This investment is subject to a rolling lifecycle replacement plan for North Block which is an owned element of the PFI hospital. The minor works are subject to a controlled process which is managed between the Trust and our PFI partners.

Other capital expenditure

Replacement of Imaging Equipment

The Trust is replacing various high cost imaging equipment during the three year period. This entails enabling works of £350k and equipment purchase values of £4.8m. All equipment is procured through the

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Managed Technology Service (MTS) within the operational PFI Scheme. The Trust needs to ensure that it has imaging equipment that incorporates the latest technology. This enables the Trust to operate efficiently and safely and keeps us ahead of our local competition. As part of the MTS in the PFI Scheme imaging equipment is replaced on an equivalent basis. The schemes form part of the Trust's PFI Contract. The enabling works are paid for by the Trust with the equipment funded through the PFI scheme. The risk is around the time taken to agree building works with our PFI Partners especially the external approval required by them to commence with the works. By working closely with them and having a clear project time table this risk is minimised.

IT Programme

The Trust has an IT investment programme for the 3 years with investment of £3.0m. Funding is from surplus cash. The investment assumes that the Trust has entered into an outsourced IT contract in year one of the five year plan. This will provide a fully managed operational IT service with the inclusion of a new EHR. system being implemented over that period. £1m investment in IT for each of the three years in question has been included in the plan which will be required to fund infrastructure replacement and local hardware.

Replacement Medical Equipment

Total three year investment of £4.5m. £1.5m for each year 2016-17 through to 2018-19. Funding is from surplus cash. The Trust has a rolling medical equipment replacement programme. The Trust has a clear replacement structure which includes a medical devices group which oversees the purchase of all medical equipment. All key stakeholders are involved in the replacement programme including all wards and departments, our MES provider Siemens and the Trust's Finance Department. The Trust has continued to develop the procurement process for the purchase of Medical Equipment introduced in 2010-11. This reduces the risk of any unnecessary purchases and ensured that resources are available for all required replacement equipment. New equipment has to follow the Trust business case process and is subject to appropriate scrutiny.

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