

NHS Walsall Strategic Commissioning Plan

Strategy Document

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Foreword

This Strategy document outlines our progress to date with respect to World Class Commissioning and the continued implementation of our plans that started last year and which will carry us until 2014. This strategy update details how we intend to invest our resources in collaboration with our partners, both providers and the local authority, over the next five years to improve the health status of the people of Walsall. We intend to approach this through an integrated care economy.

We have entered into an active and engaged dialogue with the people of Walsall about the their health and the health of our town implementing MyNHS Walsall as the primary vehicle for the people of Walsall to make their voices heard in the local health economy.

Through implementing this strategy we will ensure that citizens are aware of their entitlements and engaged in the debate about health and social care. We need the full involvement of citizens, patients and carers as well as NHS staff to help design, develop and improve the health care we provide in Walsall.

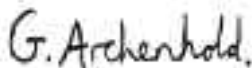
Time and again in this document you will read about our vision for a borough where health inequalities are much reduced, where the health of the poorest and most vulnerable becomes comparable to that of those with the best of health and life expectancy.

Detailed analysis of our commissioning and financial assumptions show that a number of

actions are required to ensure value for money in an increasingly challenging financial climate. These will include a redesign of services which will change the shape of our local NHS in order to bring care closer to people's homes while ensuring that they can access specialist services when required.

For our part we will use the tools we are developing through our approach to World Class Commissioning (WCC), better information, clinical leadership and engagement, an evidence based approach to service transformation, sound investment and close monitoring of outcomes to ensure we make progress towards our goals.

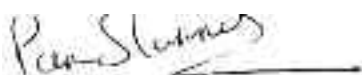
Together we can make this vision a reality.



Geoff Archenhold
Chairman



Denise McLellan
Chief Executive



Pam Skinner
Chair of Professional Executive Committee

Executive Summary

This updated Strategic Plan details how we intend to approach the provision of high quality healthcare in a time of increasing resource constraints and demanding population health needs. This document outlines the strategic aims and priorities of NHS Walsall and our improved strategy for delivering critical and measurable change for the people of Walsall. It will describe the key issues that we need to address in order to improve the health of local people, based upon local understanding of the reasons why we find ourselves faced with the health needs and inequalities that challenge us. As in other health organisations, NHS Walsall needs to respond to public expectations, political pressures, economic pressures and technological advances that impact our role in providing and managing the Integrated Care Economy. These factors are reviewed and presented alongside an outline of the decisions we have made with respect to how we will address the needs of the people of Walsall for the coming year.

Our refreshed WCC strategy has been underpinned by an approach that utilises the concept of the 'Integrated Care Economy.' This approach provides a framework for joint strategic and investment decision making processes that will impact how we deliver the appropriate health services to the people of Walsall. Essentially, we intend to invest our resources in collaboration and consultation with our partners, including our providers, the local authorities including Walsall Council, and educational providers, over the next five years

to improve the health status of the people of Walsall. The key benefits of this approach include a streamlined effort to provide a vast range of services and therefore reduce any potential duplication of effort and a key mechanism to ensure that knowledge, expertise and resources are appropriately used and deployed to address our Borough's needs. The Integrated Care Economy model means that we will act in concert with other local executives and decision makers to ensure that our resources are allocated appropriately from a range of perspectives. This approach is reflected in this document and consequently, this document provides a succinct look at how we are beginning to actively make this a reality.

We have endeavoured to engage all the necessary partners and stakeholders as we strive to implement an Integrated Care Economy. To achieve this and to continue to improve the health status of the people of Walsall, we must work together with all of our stakeholders, reflected in our key messages around the Integrated Care Economy. The role of NHS Walsall is to engage with the local community including citizens, patients, carers and clinicians to understand, analyse and address their concerns. We have entered an active and engaged dialogue with the people of Walsall about their health and the health of our town through the implementation of MyNHS Walsall as the primary vehicle for the people of Walsall to make their voices heard in the local health economy.

Our vision can be summed up in the acronym HEALTH: HEALTH - Health Service, not illness service, Evidence-based excellence, Alliances - the key to success, Listening to local people, True choice and accessible services, and Hitting the hard targets. Our values support this vision and our long term strategic aims and strategic goals remain the same: To invest to reduce inequalities in our Borough and raise the general levels of health by managing illness through high quality care.

It is our role to ensure that the services we commission, along with those at present that we continue to provide, operate to the highest possible standards of clinical safety and quality. It is no longer sufficient to provide those services in a universal one-size-fits-all way, nor is it appropriate any longer that the NHS is the sole agency responsible for the determination of the care provided or the evaluator of its outcomes. We now need to strive for care which is personalised, of the best quality and that genuinely meets the needs of the individual.

A change in the financial outlook for the NHS nationally has also formed a critical part of our approach to this strategic refresh and underpinned our need to rethink how we deliver effective and high quality services. This will result in changes in how we approach commissioning of services. Combined with an ongoing analysis of population needs, a review of our successes to date, and our commitment to an evidence based approach, we are pleased to present this updated Strategic Plan.

Document Overview

This document represents a refreshed strategic approach for NHS Walsall. We have utilised the Department of Health WCC Assurance Strategy Guidance to help ensure that our process for strategic refresh is thorough and represents the range of information required. The following sections are included in this document and outlined below:

Section 2: Vision and Values

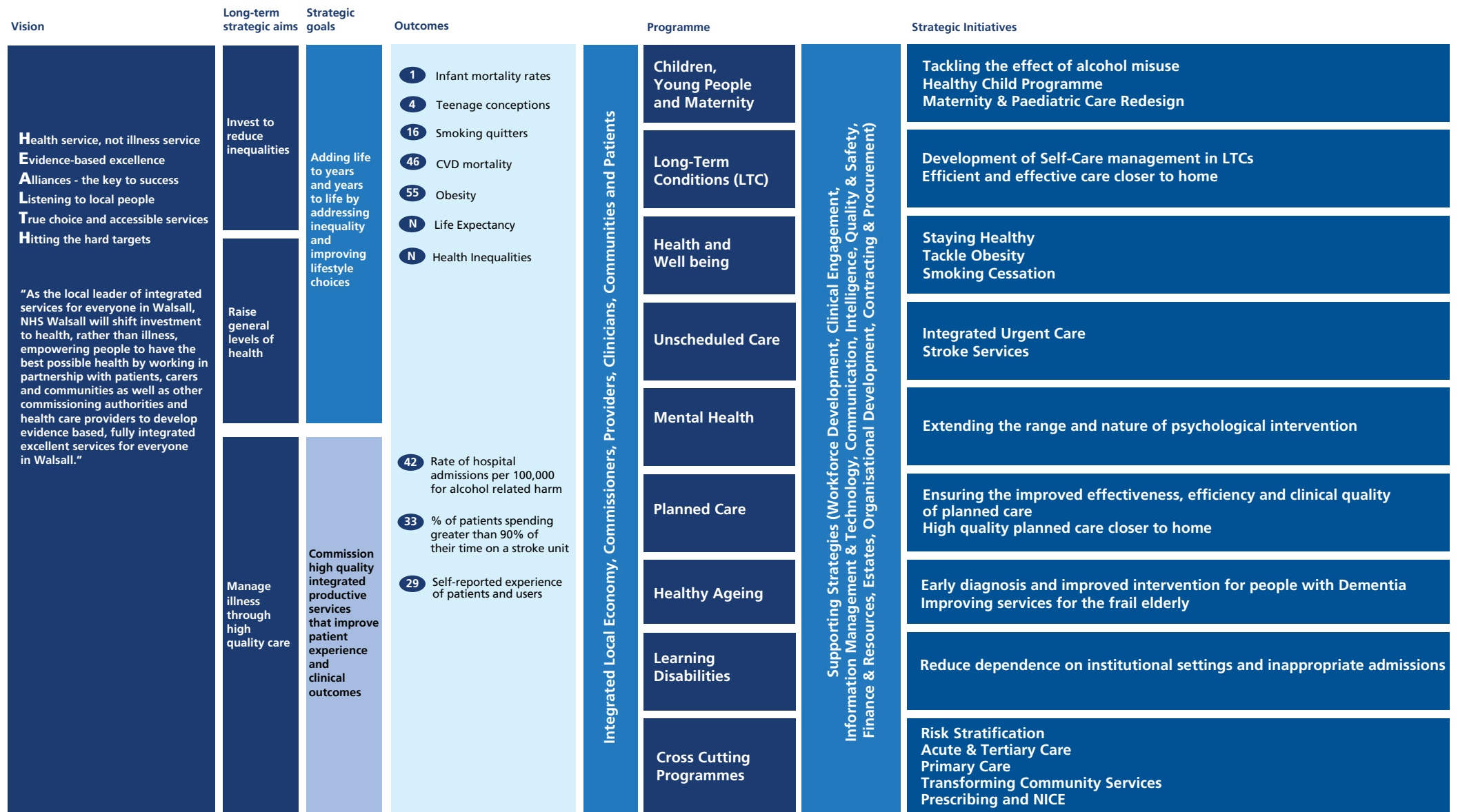
Articulates our direction and our key messages with respect to these important drivers.

Section 3: Context - This section provides a range of information and background on those factors that heavily influence our commissioning priorities and capabilities. We highlight contextual issues that impact how we determine our strategic priorities including: demographics, overall population health needs, social factors, stakeholder input, national and regional priorities, our current performance, a provider landscape overview, market management strategy, overall commissioned activity and our financial situation.

Section 4: Strategy - A comprehensive map of the way our vision, long-term strategic aims and our goals will be supported by a programme structure and initiatives (see strategic map) is presented with an overview of the processes that support how we defined our strategic direction including the role of partnership working.

Section 5: Delivery - This section contains all of those elements that will impact our ability to deliver on our vision, long-term strategic aims and our goals. It includes information on our overall delivery approach, our approach to quality management, our organisational enablers - workforce, estates and information technology, our risk management approach, and the potential impact on our providers. This section is then summarised to reflect on our major delivery elements and how they will ultimately impact on the ability to achieve our strategic vision and goals.

Strategic Map



2. Vision and Values

NHS Walsall Vision Statement

Our vision statement has been updated to reflect all the key elements of our vision and our renewed commitment to delivering positive outcomes in health as an Integrated Care Economy. It takes account of the need to work with all local partners to achieve significant change in how we deliver effective health management in Walsall. It also reflects a greater determination to ensure an evidence based approach underpins our commitment to integrated working.

During Year 1 of the World Class Commissioning process, NHS Walsall has followed a systematic process to involve our wider stakeholders and to obtain their views. This has informed our commitment to the current values of our organisation.

NHS Walsall continues to engage with patients, carers, the public and staff in order to ensure that their input is captured with respect to services provided and the quality of those services.



“As the local NHS leader of integrated services for everyone in Walsall, we will shift investment to health, rather than illness, empowering people to have the best possible health by working in partnership with patients, carers and communities as well as other commissioning authorities and health care providers to develop evidence based, fully integrated excellent services.”



Our Vision

We have summarised our vision for our services using the mnemonic HEALTH and we are committed to this. This vision highlights a number of key areas which remain recurrent themes throughout this strategy, continuing from last year. In particular, we will endeavour to achieve this through an integrated approach to developing services with all of our local partners to improve other areas of the lives of our population that impact their health and wellbeing. We recognise that we need to work in partnership with all local agencies as well as individuals in order to achieve this vision.

Improvements in health will be impacted by this approach as we recognise that as a proactive health management service, we have to work together with our partners to effect the type of change required to improve the health of the people of Walsall.

Our approach will be one based upon integrated working, evidence and commitment to quality and excellence.

H health service, not illness service

E vidence-based excellence

A lliances – the key to success

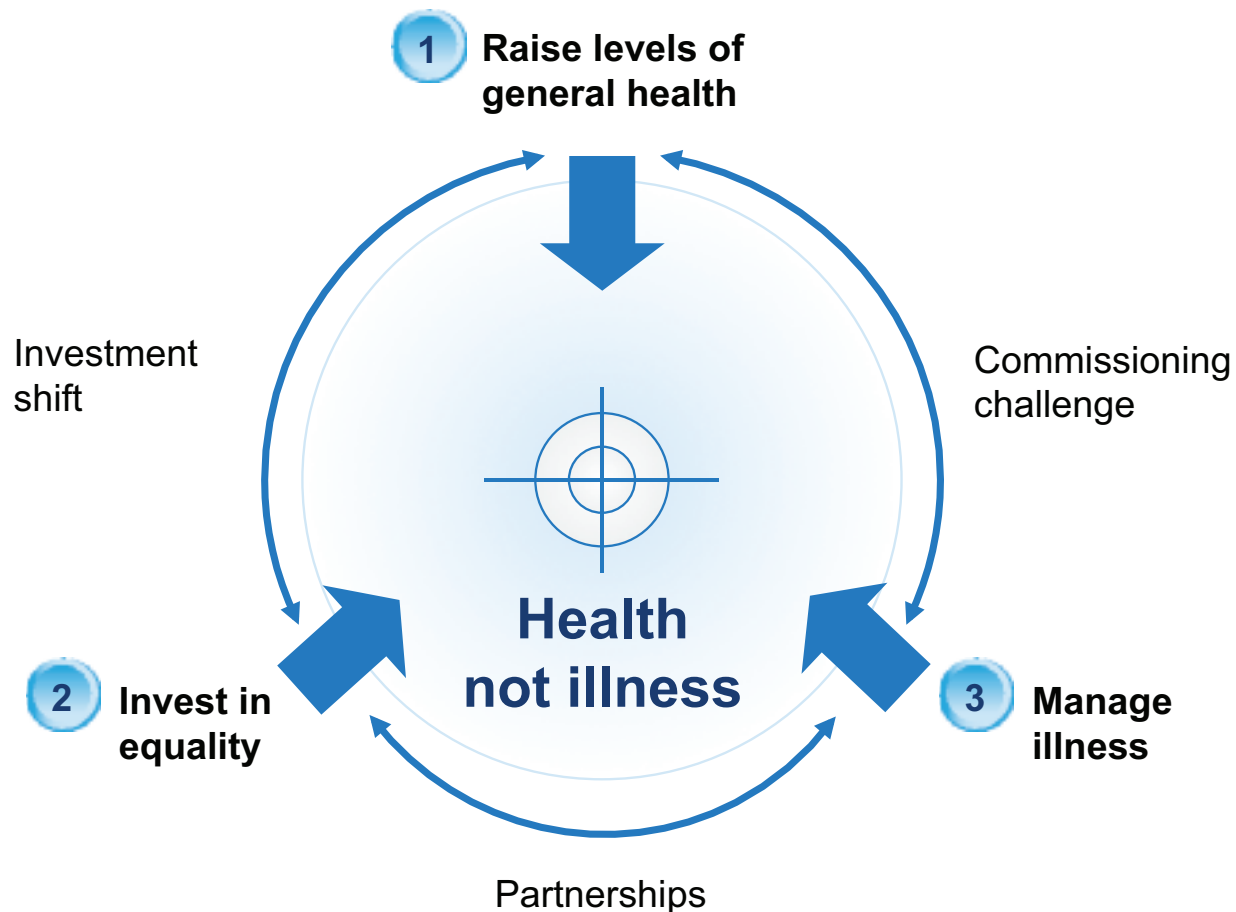
L istening to local people

T rue choice and accessible services

H itting the hard targets

Long Term Strategic Aims

Over the next five years our vision will be supported by our longer term aims and goals. In order to achieve the goals, our aims are to invest to raise the general levels of health, invest in equality, and to manage illness. We recognise that there are continuing challenges to these aims and key enabling factors such as an investment shift, the role of partnerships and challenging all of our commissioning assumptions are critical to these aims. Shifting the emphasis to health service rather than illness service remains a priority. Our resources must be best placed to influence real change. These are supported by our goals to add life to years and years to life by focusing our investment to reduce inequalities and improve healthy lifestyle choices. We have begun to shift our entire commissioning approach towards an Integrated Care Economy, utilising a partnership focused model of care to ensure that we continue to commission high quality, integrated productive services that improve patient experience and clinical outcomes. We recognise that in a period of resource reduction, a shift in investment alone will not be adequate and that a model of Integrated Care supported through remodelling the pathways of care is the most robust and logical approach.



Our Strategic Goals and Outcomes

We recognise that the broader agenda of delivering health improvement and prevention requires us to work in partnership with others. The NHS needs to be engaged in issues of regeneration in the broadest social sense if change is to happen. In particular, NHS Walsall will continue to engage with local people. The MyNHS Walsall initiative, (see section 3.2) is an initial step in the process to bring about a much deeper level of engagement with the local community. As well as listening to local people, we aim to maintain a robust dialogue which enables negotiation and debate about the difficult and challenging issues we face. NHS Walsall recognises that if it is to meet the needs of a diverse population, then it must create services which are truly accessible and an environment in which choice is promoted for individuals. Choice between providers will be the key which unlocks improvement in quality but this must be supported by an overall commitment to clinical quality which we will embed in all of our initiatives moving forward.

Adding life to years and years to life by addressing inequality and improving lifestyle choices

Commission high quality, integrated productive services that improve patient experience and clinical outcomes

The NHS needs to be engaged in issues of regeneration in the broadest social sense if change is to happen

1. High quality

Our patients deserve the best possible care and providing choice is an integral part of this challenge to ensure that a range of providers are available to provide care of the highest standard.

2. Integration

We recognise that the broader agenda of delivering health improvement and illness prevention requires us to work in partnership with others.

3. Productive services

We recognise that we must measure the impact of our services to determine the effectiveness of our programmes.

4. Patient Experience

In order to determine the effectiveness of our programmes, we must obtain feedback from our users - our Walsall patients. The MyNHS Walsall initiative is an initial step in the process to bring about a much deeper level of engagement with the local community. As well as listening to local people, we aim to maintain a dialogue with them and aspire to achieve an environment in which it is possible to negotiate and debate some of the difficult and challenging issues we face.

5. Clinical Outcomes

We recognise that we must clearly understand the clinical impact of our programmes to determine their effectiveness to ensure that these are appropriately defined and interventions are effective.

Our approach will be one based upon integrated working, evidence and commitment to quality and excellence.

Values

We want our organisation to be built on a foundation of strong values. NHS Walsall believes that the core values are critical to achieving our vision. These values have been reviewed and agreed with our board members as part of the refresh process. Most of our core values are already aligned to the national Quality Innovation Productivity and Prevention (QIPP) agenda but we have included two new core values to ensure that we are closely aligned with national priorities.

These are:

Productivity - We will monitor the effectiveness of our services and the impact on outcomes to ensure the best use of our resources.

Quality - We will continuously improve the quality of our services and demonstrate improvements to our public.



3. Context

Overview

The following sections 3.1 - 3.7 are intended to provide a succinct picture of all of the contextual drivers (demographics, social issues, partnerships, providers, finance).

3.1 Drivers for change: Demographics, Health Needs and Social Factors

NHS Walsall delivers services to a resident population of 255,400 and a registered GP population of 268,800.

Walsall has a diverse population with varied and significant health care needs. Wider determinants of health, such as education, work and unemployment, housing, and access to health care services, all affect a Walsall resident's experience of wellbeing and health. Life expectancy is lower than the national average, and someone living in the west of the borough has an average life expectancy eight years lower than a resident in the east.

When measured using the Index of Multiple Deprivation (IMD), Walsall ranked 45th worst out of 453 Local Authorities in England in 2007. Relative deprivation had increased since 2004, when Walsall ranked 51st. Over a quarter of children in Walsall live in poverty (26.9%) Income Deprivation Affecting Children Index (IDACI) 2007, and these indices are likely to worsen as a consequence of the economic

recession. These changes threaten health and wellbeing in Walsall.

Walsall is also a borough with great contrasts. Areas of great deprivation in the west of the borough lie close to relative affluence in the east. Differences in lifestyles, such as smoking, binge drinking, exercise and five-a-day fruit and vegetable consumption lead to much poorer health experiences for those living in the west. This translates into real differences in health outcomes for the people in these areas, including higher morbidity from coronary heart disease and diabetes. Reducing this inequality is important, and is a key driver in this strategy.

Performance against JSNA scorecard indicators

The Joint Strategic Needs Assessment (JSNA) aims to bring together all the information which is available on the needs of our local population. Our JSNA scorecard shows some of the key health findings of the JSNA. It uses a ‘traffic light’ code in the domains of:

- Indicator/Target
- Current Position
- RAG rating/Progress direction

The key to the JSNA priorities scorecard is shown below:

Key for the JSNA scorecard

Indicator/Target	Indicator	Indicator highlighted as plain text
	Target	Target highlighted as bold text
Progress Direction	↑	Improving
	=	No or little change
	↓	Deteriorating
RAG Rating	Green	Current trend on course to meet/exceed target
	Orange	Moderate risk of current trend not meeting target
	Red	High risk of current trend not meeting target
	-	Currently no target

The scorecard also highlights where key indicators are included as part of Walsall’s Local Area Agreement (LAA) and NHS Walsall’s WCC outcomes.

Indicator/Target	LAA	WCC	Current Position	RAG/Progress Direction	Peer Group
Headline Indicators					
All age, all cause mortality - males (directly standardised mortality rate from all causes, all ages per 100,000 males)	Y	Y	803.21 (2007)	↑	809.16 (2007)
All age, all cause mortality - females (directly standardised mortality rate from all causes, all ages per 100,000 females)	Y	Y	491.33 (2007)	↑	533.75 (2007)
Strategic Priorities for Improving Health and Wellbeing					
Improving Health and Life Chances for Babies, Children and Young People					
Infant mortality (deaths under 1 year per 1,000 live births)	N	Y	8.4 (05-07)	↓	-
Under 18 conception rates (conceptions per 1,000 females aged 15 - 17 years)	Y	Y	54.5 (2007)	↑	57.5 (2007)
Childhood obesity (% of obese children in YR and Y6)	Y	Y	31.2% (08/09)	↑	34.1% (08/09)
Improve Early Detection and Effective Treatment of Major Killers to Improve Life Expectancy					
Circulatory Disease (directly standardised mortality rate per 100,000 persons aged under 75)	N	N	95.6 (2007)	↑	101.81 (2007)
Cancer (directly standardised mortality rate per 100,000 persons aged under 75)	N	N	123.8 (2007)	↑	120.04 (2007)
Living Healthier Lives with Long Term Illness					
Cardiovascular disease (age standardised mortality rate per 100,000 persons aged 65 to 74)	N	Y	306.7 (2007)	↑	384.34 (2007)
Promoting Healthy Ageing					
Stroke (estimated stroke prevalence)	N	Y	1.6% (07/08)	↑	-
Reducing Lifestyle Inequalities					
Smoking (estimated smoking prevalence)	N	Y	21% men 20% women (2005)	↑	-
Obesity in adults (estimated % of obese adults)	N	Y	c. 19% - 33% (2005)	=	-
Promoting and Improving Wellbeing, Mental Health and Quality of Life					
Alcohol related admissions (alcohol related harm hospital admissions per 100,000 population)	N	Y	2000.00 (08/09)	↑	1866.67 (08/09)
Prosperity: Improving Life Chances for the People of Walsall					
Not in Education, Employment or Training (NEET) (proportion of 16 to 18 years olds not in education, employment or training)	Y	N	9.1% (Q2 09/10)	↑	-

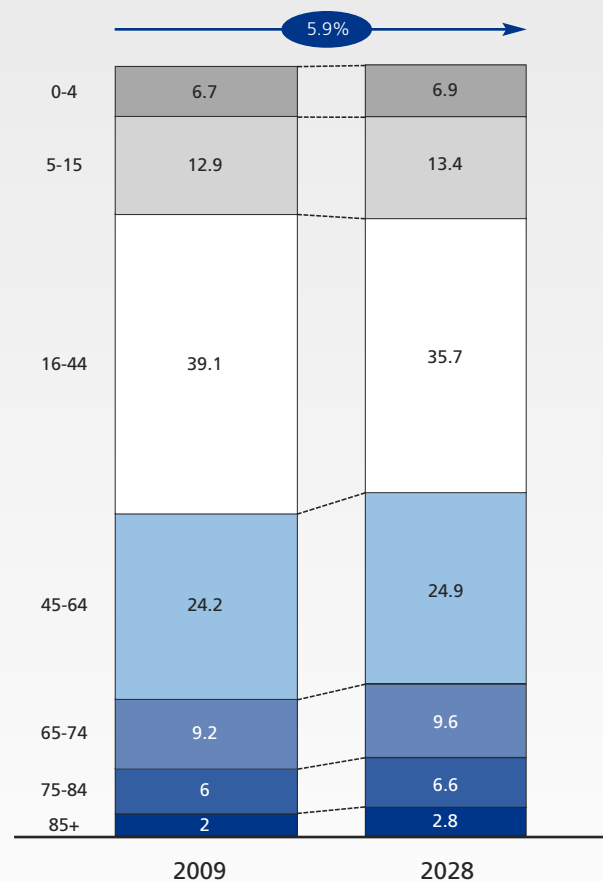
Source: Joint Strategic Needs Assessment, 2009; ONS, 2001

3.1.1 Demographics

The population of Walsall is predicted to grow by 3% over the next 10 years and by 5.9% in the next 20 years. In that time it is predicted that the population age structure will also change shape as the population ages. Although growth seems small as a proportion of the total population (0.8%), the over 85 age group will double in this period, with a corresponding reduction in the 16-44 age group of 3.45%. 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 population of Walsall has a slightly increasing growth rate impacting demand for all services

Percentage of the population, by age %



Source: ONS

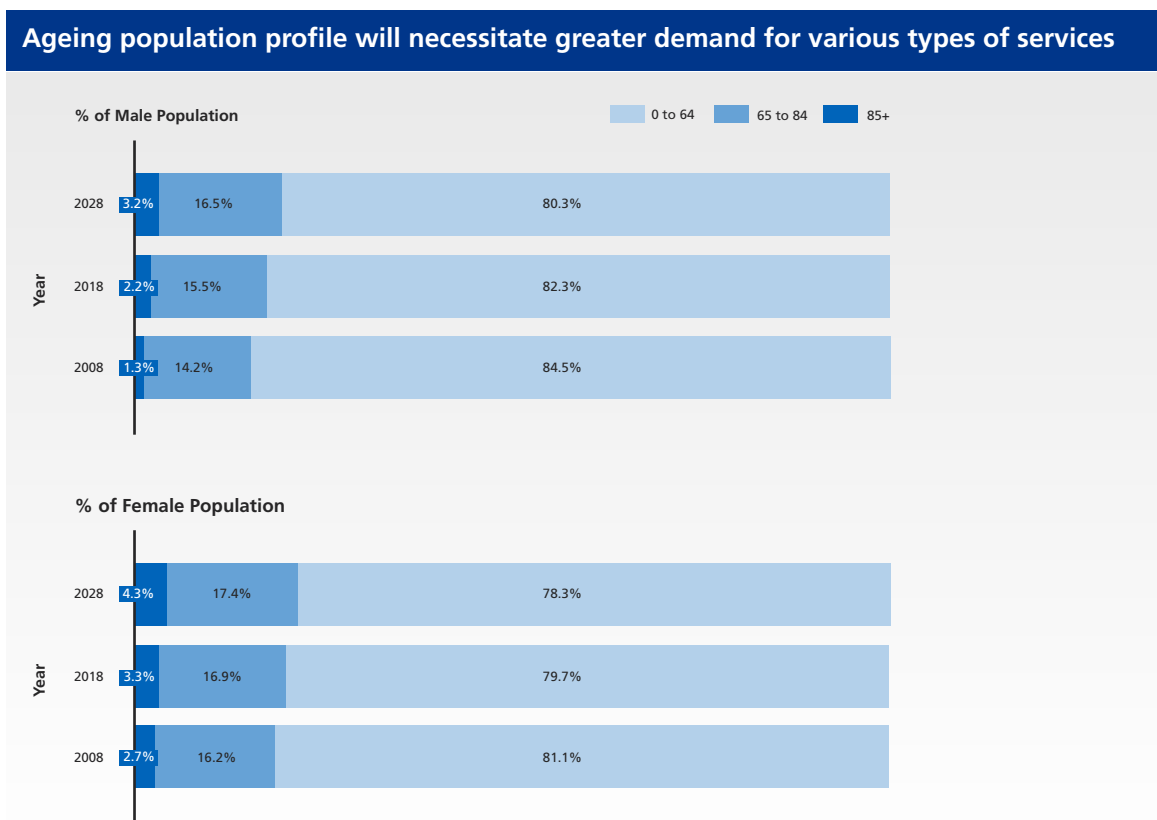
The Ageing Population of Walsall

The needs of this population have been highlighted by our JSNA, which gives more detailed information about the extent of the growth of this section of the population.

The overall growth in the population of older people as a proportion of the population of the citizens of Walsall by 2028 for both males and females is shown here. These shifts in demography will place a range of demands upon health and social care.

Services must therefore be prepared and targeted to a population who have a greater degree of frailty, an increased severity of long term conditions and a higher incidence of Dementia. Promoting healthy ageing, 'adding life to years', and planning increased capacity to meet the needs of a growing number of older people, are all key strategic priorities in Walsall.

It is generally estimated that Dementia of a moderate or severe extent will affect about 1 in 8 people aged over 80. As the number of people in this age group increases, we can expect an increase in people with Dementia from 3,300 to 5,300 by 2028. Alongside this, the care needs of the wider group of the frail elderly remain important.



Source: ONS

3.1.2 Inequality and Deprivation

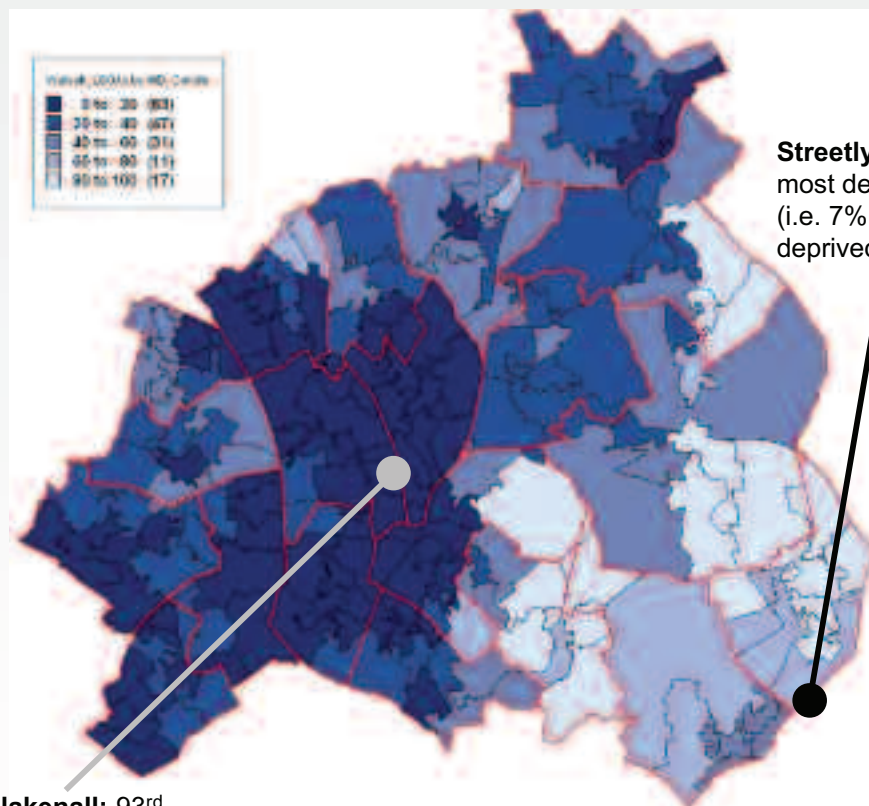
Health and Wealth Gap Between the East and West

Walsall has an above average gap in deprivation between the east and the west. Even with areas of relative affluence, Walsall as a Borough falls into the 20% of areas in England with the poorest health and highest deprivation indicators. The Government has identified that these areas require additional attention and resources to address their poor health profiles (one of the seventy spearhead authorities).

There is a significant geographical divide between the health experiences of those living in the east and those in the west of the Borough, with the west exhibiting much higher levels of deprivation. This inequality manifests, at its worst, as an eight year variation in life expectancy between the most and the least deprived. Teenage pregnancy rates, levels of obesity, death rates from coronary heart disease, stroke and cancer are all higher than the national and regional averages. High infant mortality rates are also found, especially in the deprived wards. In some areas, the figures are rising.

Nearly a third of children in Walsall live in poverty and there has been a 10% increase in the number of children living in poverty between 2004 and 2006.

Poor health outcomes are strongly linked to the high levels of inequality and deprivation in Walsall



Blakenall: 93rd most deprived (i.e. 1% most deprived)

Streetly: 7820th most deprived (i.e. 7% least deprived)

Source: Joint Strategic Needs Assessment 2009

Impact of Inequalities in Education, Employment and Housing on Health

As shown, there are wide variations in local levels of education, employment and housing. These have an enormous impact upon the health status of the populations within these local communities.

3.1.2.1 Education

One of the key determinants for securing employment in the 21st century is the ability to manage and manipulate information. With relatively low levels of educational attainment this is often not the case within the population of Walsall. We struggle to attract employers bringing in high or medium income jobs and the resulting overall depression in income levels of the population has an inevitable effect upon the health status of local citizens.

Until recently, Walsall's educational attainment for children at 16, (measured as 5 GCSEs at grades A-C), was half the English national average. Although educational attainment has improved, it is still considerably adrift from national standards.

3.1.2.2 Employment

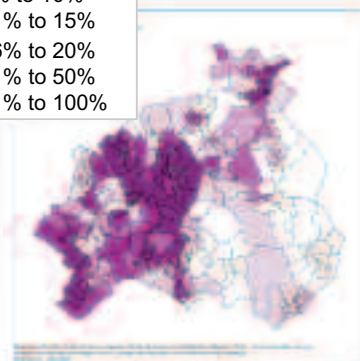
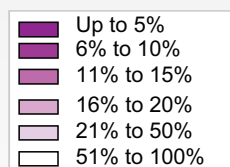
Although worklessness is around the levels experienced across the West Midlands, the average level of income for those in work is low. The proportion of working age people claiming Jobseekers Allowance (JSA) in Walsall is greater than regional and national levels (7.5% compared to 5.5% and 4.1% respectively as of October 2009). Birchills/Leamore ward has the highest proportion of claimants (11.0%) with Streetly, in the east of the Borough, the

Education Employment

- Historically, Walsall has had poor levels of education: 43% of Walsall residents aged 16-74 years in 2001 had no educational qualifications.
- There is also a significant inequality in the levels of education among those living in the east compared with the west.

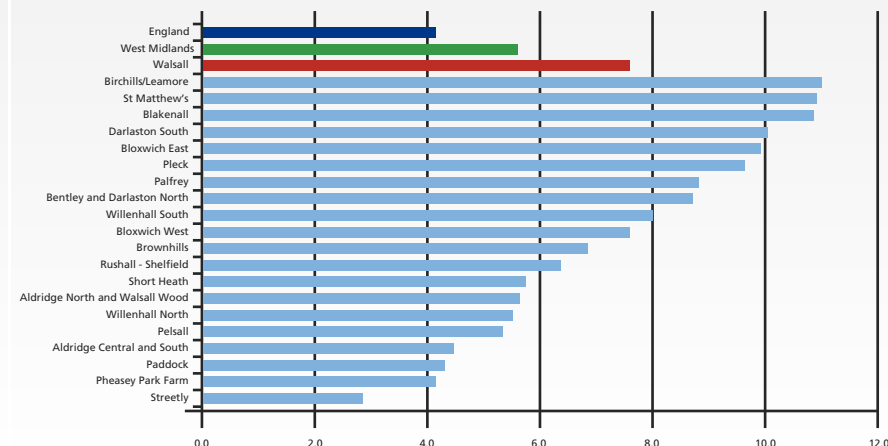
Index of Deprivation 2007: education, skills and training domain

% achieving five GCSEs A - C



- In 2007 76.8% of Walsall's population was economically active which is less than regional (77.1%) and national (78.6%) rates.
- Average income is significantly lower than national or regional averages and there is a significant variation across Walsall in economic activity and average incomes.

Jobseekers Allowance Claimants by Ward October 09



lowest (2.9%). The graph shows that in four of our local wards Job Seekers Allowance claimants are over 10% of working age people. Historically, Walsall has had difficulty attracting new industries into the town, as employers did not expect to find the levels of educational attainment and skill required to meet the challenges of 21st century business enterprise. Those who secured work generally had lower income levels because of the nature of work

available to them. However, Walsall College's brand new Wisemore Campus is at the heart of Walsall's regeneration and is one cog driving growth in local skills and knowledge, vital to the transformation of the Borough. Despite these challenges, we have a local economy where there is still a relatively solid base of economic activity and unemployment rates are not widely at variance with those to be found across the West Midlands.

3.1.2.3 Housing

Suitable housing is a key component in sustaining good quality of life. There is strong evidence to suggest a correlation between poor housing and ill health. Dampness and lack of central heating have greatest impact, although other issues such as overcrowding have also been linked to poor health outcomes.

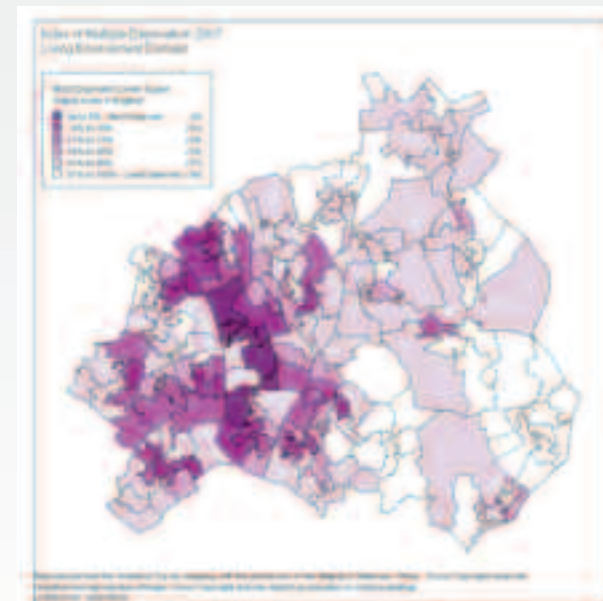
These issues can pose a particular threat amongst the most vulnerable in our communities – the very young, the very old, and those with long-term health conditions.

The government white paper, 'Saving Lives: Our healthier nation,' specifically recognises housing as a key health determinant. Due to the complex interaction between housing and health, there is a need to develop cogent, workable and sustainable programmes.

Housing

- Walsall has 101,333 households.
- **There is a large variation in the quality and ownership of housing across Walsall:**
 - 77% of houses in the east are owner occupied compared with 55% in the west.
 - There is twice the rate of overcrowding in the west than in the east
 - Average property prices in the east are 42% higher than the west
 - 24% of dwellings do not meet the requirements of the Decent Homes Standard

Index of Deprivation 2007: living environment domain



Health Needs of Black and Minority Ethnic Groups

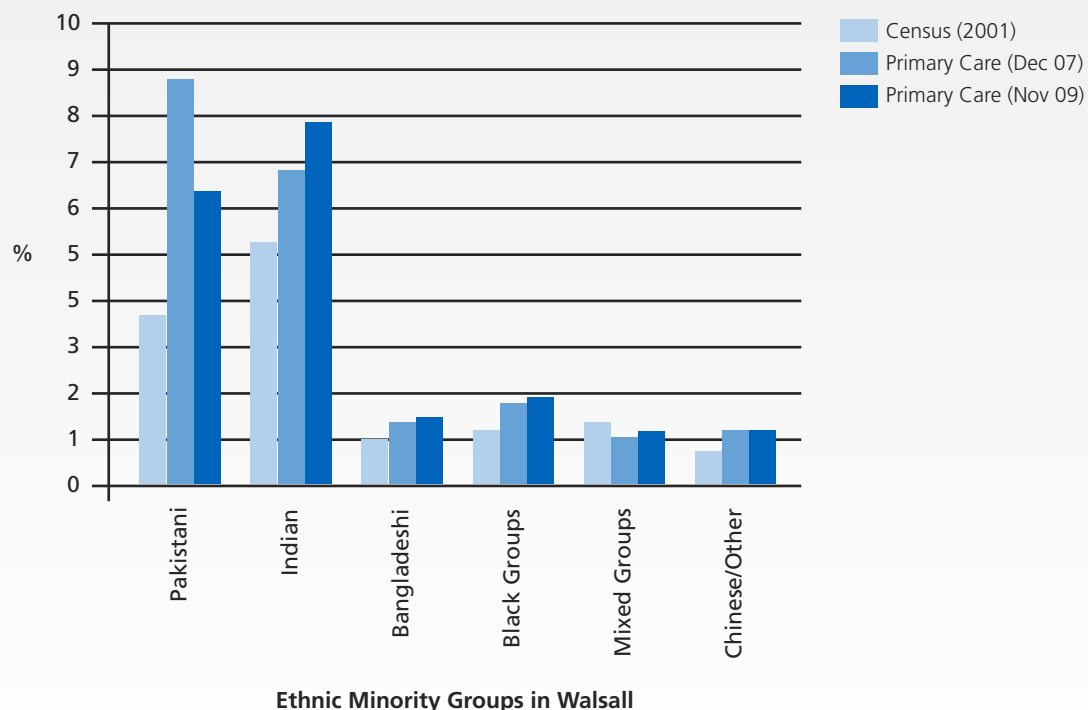
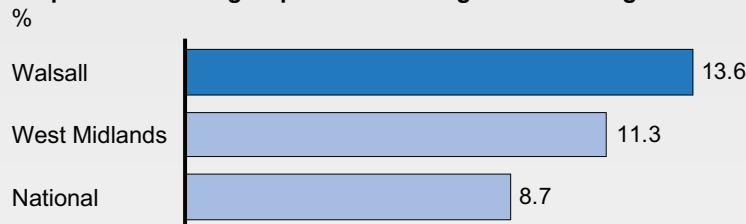
Amongst Walsall’s disadvantaged communities, those communities where there is a higher proportion of citizens from black and minority ethnic groups (BME) have particularly poor health and wellbeing outcomes. If you live in a BME community, there is a much greater likelihood that your community will be deprived.

Minority ethnic groups in Walsall have increased in recent years. The 2001 Census showed a BME population of around 14% compared to around 7% in 1991. Local estimates place the current level of BME population at around 20% and it is clear from schools’ registrations that there is an even higher percentage of children from BME groups. Recorded figures from NHS Walsall systems show that Indian, Pakistani and Bangladeshi groups form the largest ethnic groups in Walsall. Numbers for Indian residents have increased from 5.4% (13,766) in 2001 to 7.9% in 2009 (18,144).

In the last couple of years Walsall has become home to a number of asylum seekers, and the borough has also seen immigration of workers from Eastern Europe, particularly Poland. The 2011 census is widely expected to confirm these population trends. These changes impact on the overall deprivation experienced by Walsall residents. We are also seeing that pensioners from BME communities find it harder to access services appropriate to their needs, and we must respond to this. We must ensure equity in provision and personalised services as well as ensuring that they are delivered in a culturally competent manner.

Areas in Walsall with a high proportion of Black and Minority ethnic groups tend to suffer from the worst deprivation

Proportion of BME groups in Walsall is greater than regional or national rates



3.1.3 Life Expectancy and Infant Mortality

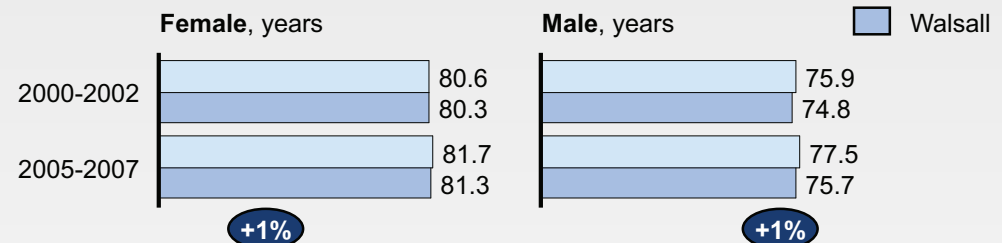
Life expectancy at birth in Walsall is lower than both regional and national average. Life expectancy by ward in Walsall for 2003-07 shows the very real east to west divide, with residents to the east living longer than residents in the west.

Whilst preventative strategies have succeeded in reducing levels of death from cancer and circulatory diseases in Walsall over the last years, male life expectancy is still 0.9 years below the national average and worsening. Female life expectancy is 0.4 years below the national average and this gap has also widened slightly in the past few years.

The main causes of death in Walsall in 2008 were circulatory (32.5%, mainly CHD), cancer (26.9%, mainly lung cancer) and respiratory disease, which reflects unhealthy lifestyles such as smoking and obesity. CHD mortality remains 16% higher than the national rate.

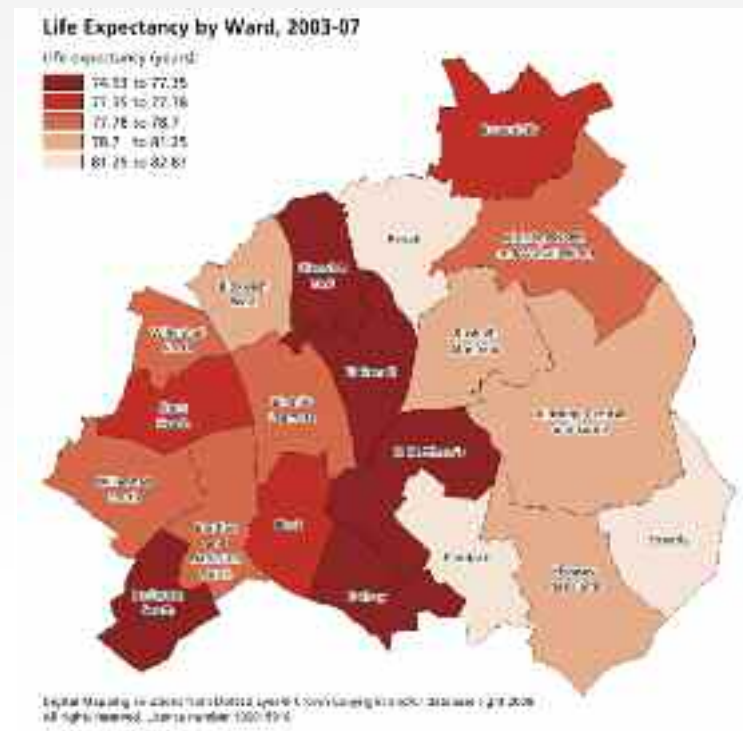
Life expectancy in Walsall is lower than national or regional rates with a wide gap between most deprived and most affluent wards reflecting high levels of inequality

Life expectancy is improving but still below national levels



Source: Joint Strategic Needs Assessment, 2009

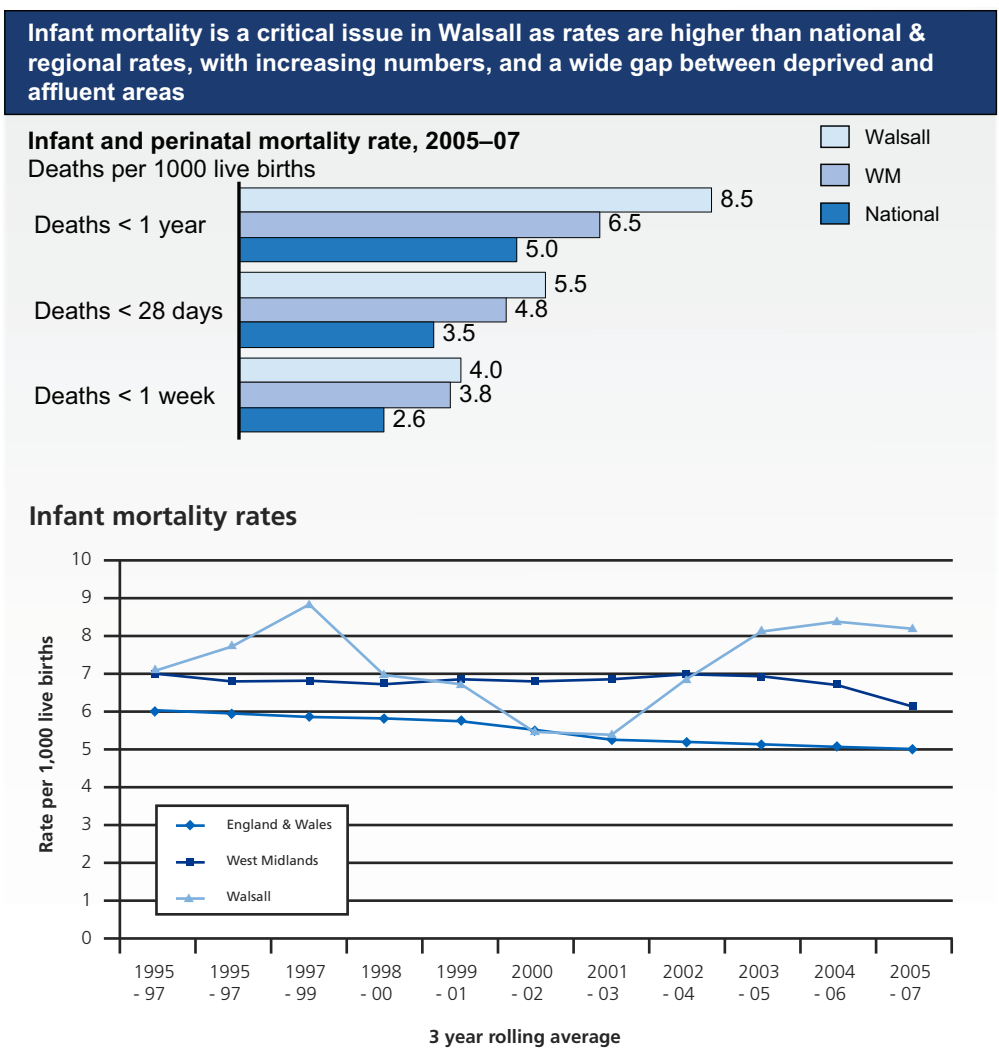
Life Expectancy in Walsall



Infant Mortality Rates

Walsall has a higher rate of infant mortality than both the national and the regional averages. After a decrease in infant mortality rates from 1996 to 2000, the rates have begun to rise again. In 2005/07 there were 8.3 deaths per 1000 live births, compared to 5.7 deaths per 1000 in 2000/02. The largest increase in death was seen in the perinatal period.

Over 50% of infant deaths and stillbirths may be preventable by addressing key factors associated with excess risk of stillbirth and infant deaths. These are smoking in pregnancy, deprivation, consanguineous marriages and high BMI. Current programmes focus on maternity services, breastfeeding, and the targeting of vulnerable groups through the Family Nurse Partnership and Community Genetics Services. However, these will only be successful alongside wider interventions to address the variations in the broader determinants of health.



Source: Joint Strategic Needs Assessment, 2009; West Midlands Perinatal Institute, 2005

Infant Mortality in the East and the West of the Borough

The lowest rates of infant mortality are found in the east of the borough at 1.2 per 1,000 live births.

The three wards that have the highest rates of infant mortality at over 13.2 per 1,000 live births:

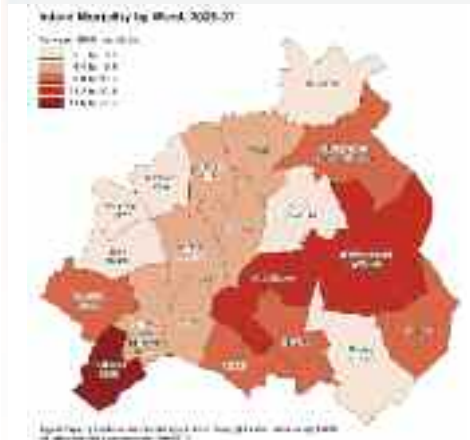
- Willenhall South
- St. Matthews
- Aldridge Central and South

By 2009/11 Walsall is aiming to have no more than 4.8 deaths per 1,000 live births which would equate to no more than 17 infant deaths per year.

Infant mortality rate's strong correlation with deprivation is shown by the wide variation across Walsall

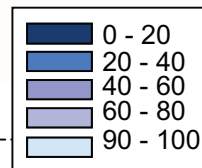
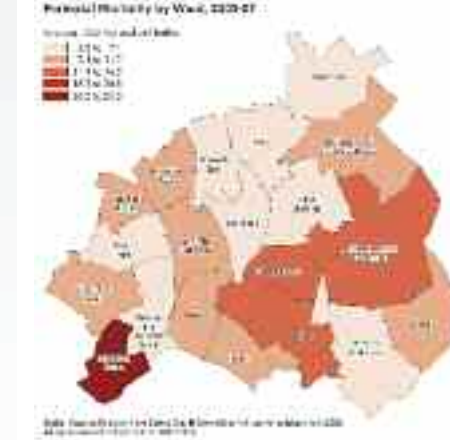
Infant mortality rate by ward 2005–2007

Deaths per 1000 live births

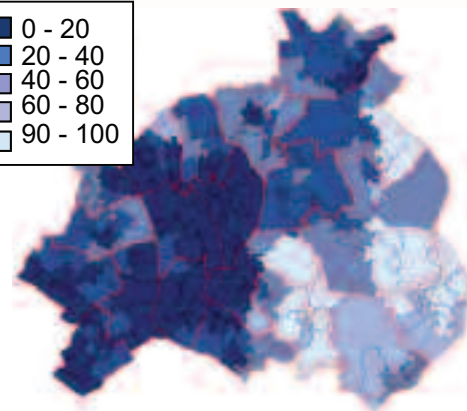


Perinatal mortality rate by ward 2005–2007

Deaths per 1000 live births



Index of Multiple Deprivation



Source: Joint Strategic Needs Assessment, 2009

3.1.4 Population Health Overview

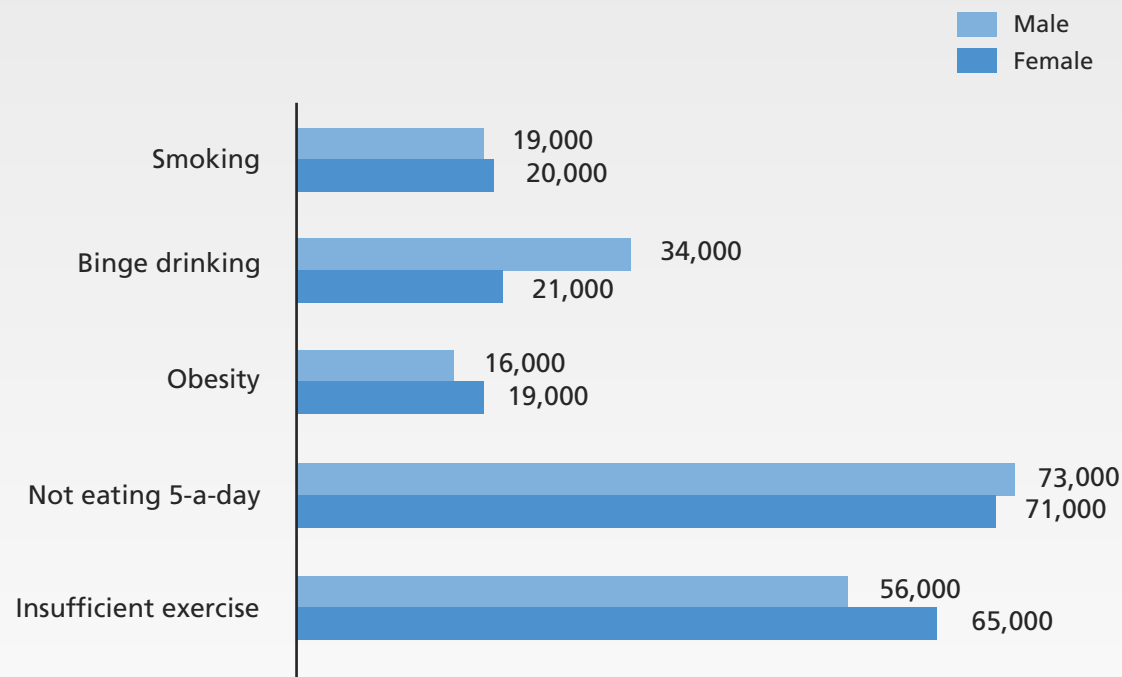
Prevalence of Unhealthy Lifestyles

Work undertaken in the Public Health Directorate shows the potential target number of adults in Walsall whose health could be improved by lifestyle changes. This graph shows the prevalence of smoking, binge drinking, obesity, not eating five-a-day (of fresh fruit and vegetables) and insufficient exercise in Walsall residents. Based on a total population of around 250,000, some of these numbers are high as illustrated for a range of lifestyle factors. For instance, three quarters of the population is failing to eat five-a-day equating to around 190,000 people.

Obesity is a significant problem. Obesity has a severe impact on the health of individuals, increasing the risk of type-2 diabetes, some cancers, and heart and liver disease. In the 2005 survey, about 19% of Walsall respondents were obese and 38% were overweight, equivalent to 48,000 obese people and 96,000 overweight people. The obesity rate peaks at over 25% in people aged 45-64 years, whilst the number overweight peaks at 47% in older people aged 65-74. Across ethnic groups in Walsall, the 2005 survey suggested that obesity was less prevalent in the Asian community (14%) than in the White population (19%). Nevertheless, over 30% of Asian, Black or White ethnic groups were overweight.

Prevalence of obesity and lifestyle factors among Walsall residents

Potential target number of adults in Walsall whose health could be improved through lifestyle changes
(Number of people)



Source: Joint Strategic Needs Assessment, 2009; 2001 Census; West Midlands Lifestyle Survey 2005

Long-term Conditions

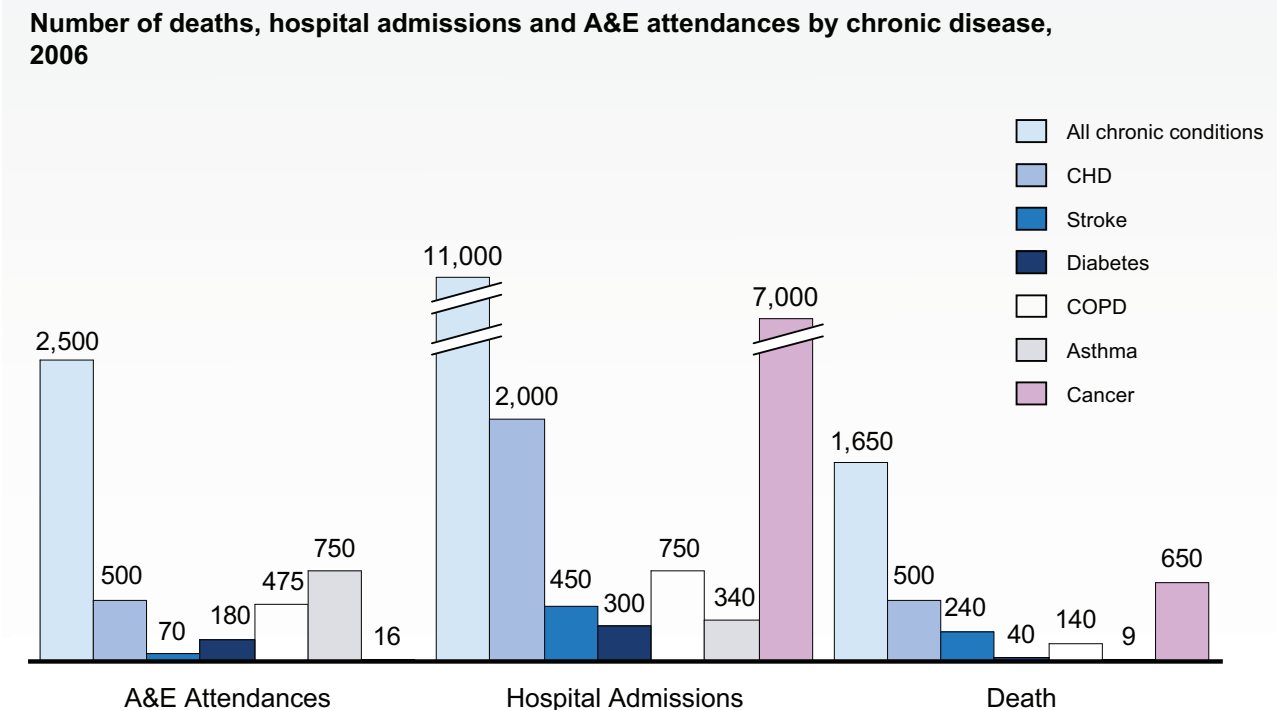
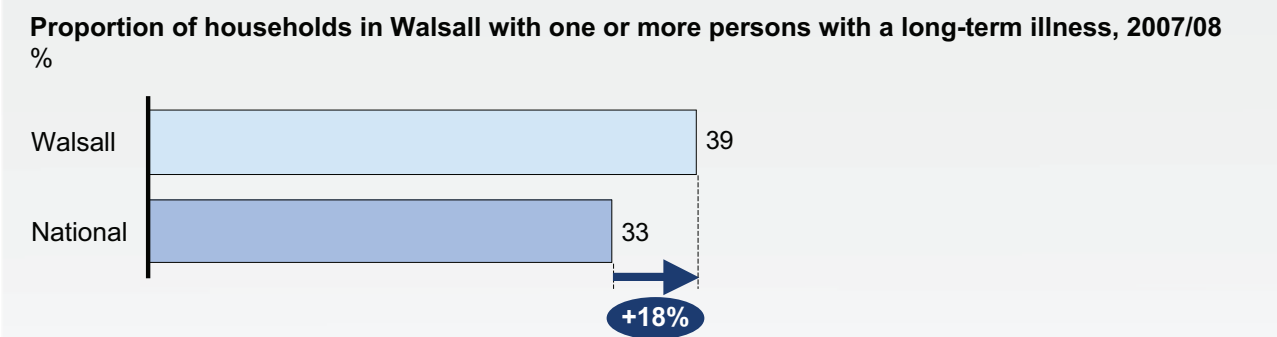
Long-term conditions are chronic illnesses that can limit lifestyle, such as Diabetes, heart disease, and Chronic Obstructive Pulmonary Disease (COPD).

An estimated 1 in 3 people in Walsall has one or more long-term conditions. In addition, 39% of Walsall households have one or more persons with a long-term illness compared with 33% of households in England.

Coronary heart disease is the main cause of death in Walsall, followed by Lung Cancer, Strokes and COPD. Mortality rates vary with deprivation across Walsall, with the highest rates in the North West.

Chronic conditions in Walsall account for 2,500 A&E attendances and 7,500 hospital admissions on average per year. In addition, a significant bulk of primary care is geared around long-term conditions. Targeting root causes and empowering people to take control of their own health and engage in community care closer to home has the potential to save a significant proportion of our resources.

Walsall has a higher than average proportion of long-term conditions resulting from unhealthy lifestyles and wide inequalities



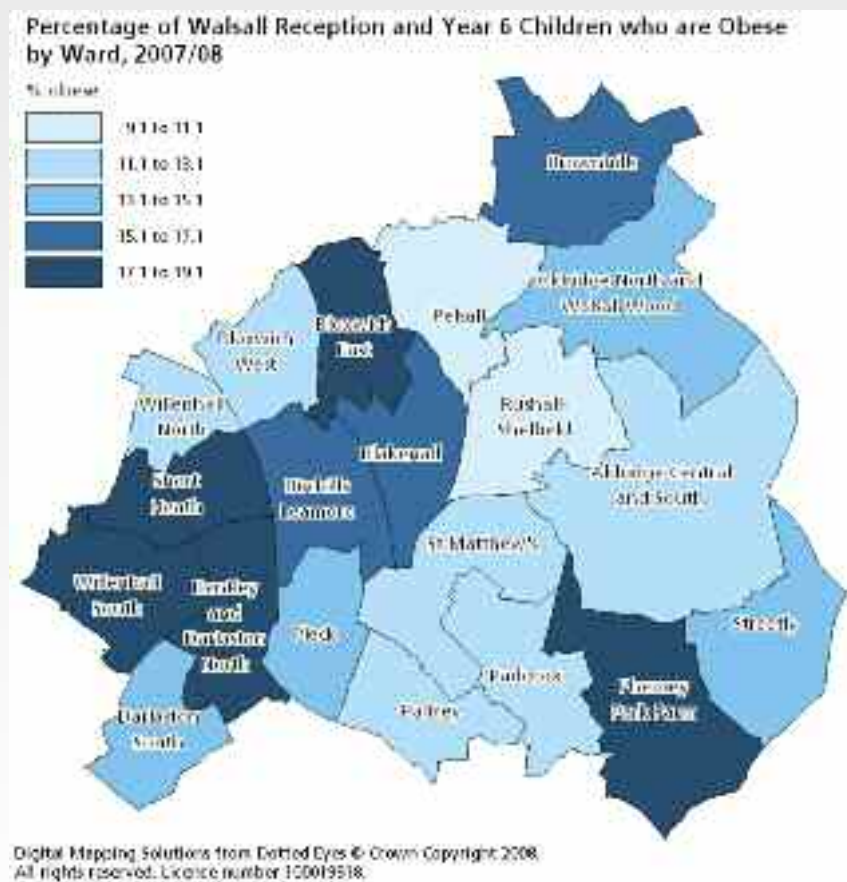
Source: Joint Strategic Needs Assessment, 2009; Walsall Director of Public Health's Annual Report on Long-term Conditions (2006); Physical Disability & Sensory Impairment Joint Commissioning Plan (2008-09): 2007; 8

Impact of adult and childhood obesity on chronic heart disease and other long-term conditions

Lifestyle choices, particularly those leading to both adult and childhood obesity, contribute to high levels of chronic heart disease and other long-term conditions. The figures for children give particular cause for concern as prevalence of childhood obesity in Walsall is higher than both the regional and national levels. There is a link between childhood obesity levels and deprivation, with a greater number of obese children in Reception and Year 6 living in the more deprived areas to the west of the Borough.

Walsall has a higher than average number of obese children in year 6. This is strongly linked to deprivation.

Percentage of Obese Children in Reception and Y6 combined, by Ward, 2007/08



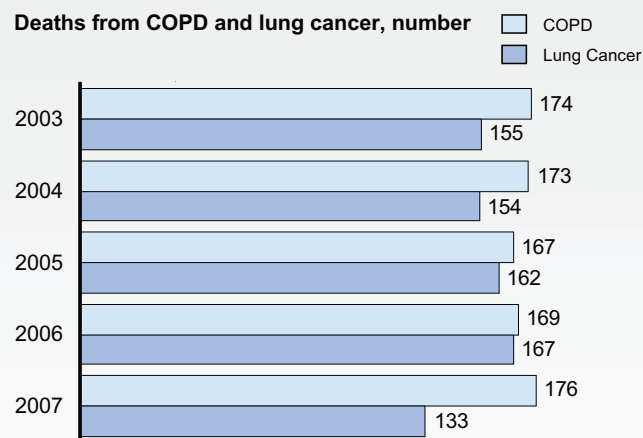
Source: NCMP

High Prevalence of Smoking Contributes to High Mortality Rates from COPD and Lung Cancer

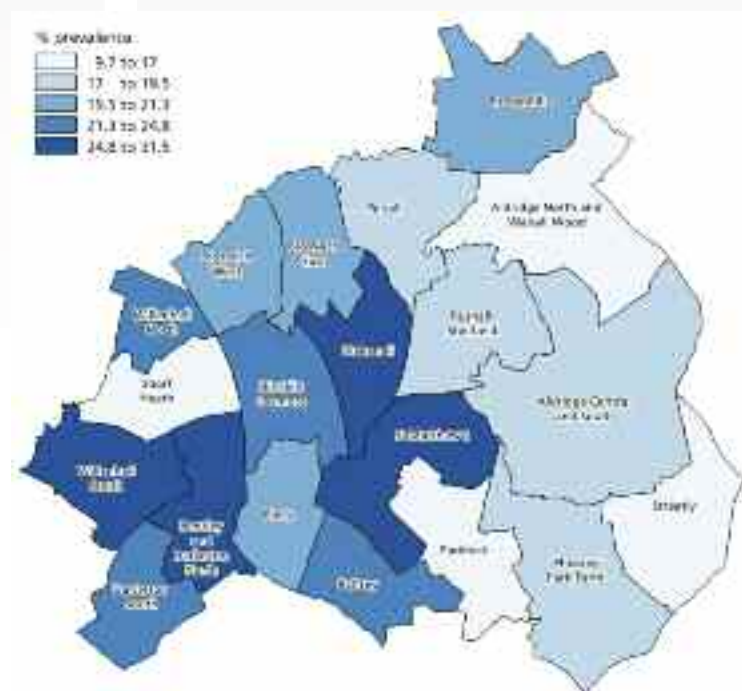
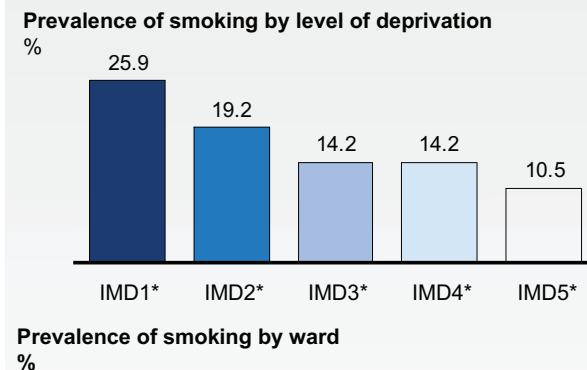
A relatively high proportion of the population still smoke and there are pockets of particularly high concentrations of smokers in the most deprived wards. Smoking is associated with poverty and smoking prevalence rates are over twice as high in the most socially and economically deprived groups. Whilst lung cancer is decreasing, the levels of COPD in the population have remained relatively stable over the last five years.

Smoking cessation services continue to be developed in the Borough. The 2005 regional lifestyle survey highlighted the fact that about 58% of Walsall smokers reported that they wanted to stop smoking.

Walsall has a higher than average rate of smoking which contributes to high mortality rates from COPD and lung cancer



Most deprived socio-economic groups in Walsall have a much higher prevalence of smoking than more affluent groups resulting in greater inequality in health outcomes



* IMD quintile with 1 most deprived and 5 most affluent
 Source: Joint Strategic Needs Assessment, 2009;
 Public Health Mortality Files, 2007

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Circulatory Disease in Walsall

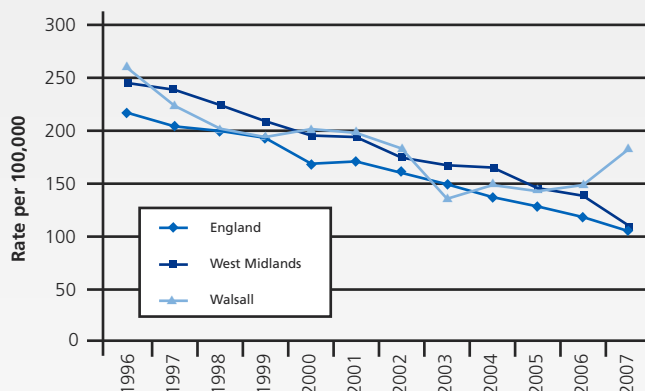
The population of Walsall continues to experience high levels of mortality for circulatory diseases, coronary heart disease and Stroke. This places a significant health burden on the resources of the local health economy.

While mortality from all circulatory diseases continues to decline year on year in Walsall, mortality rates are still consistently higher than the West Midlands and national average. However, there is evidence that there has been a narrowing of the gap in recent years as significant care pathway improvements have been made.

Stroke

- Strokes represent a significant health burden in Walsall, with rates above national and regional averages, reflecting unhealthy lifestyle choices and a tendency towards higher than average circulatory disease

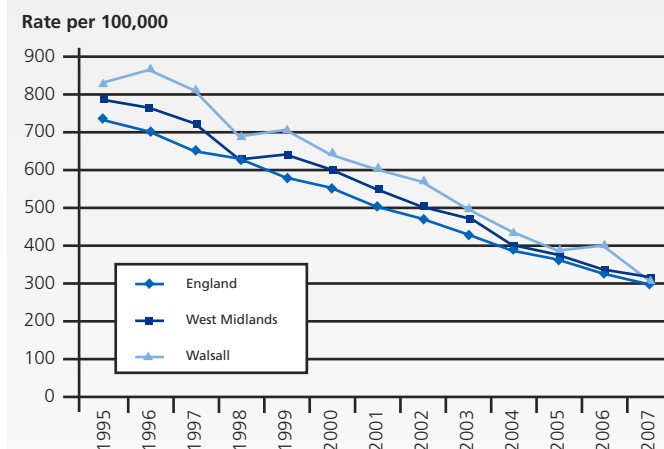
Age standardised mortality rate from strokes per 100,000 population aged under 75 years



Coronary Heart Disease

- Coronary heart disease (excluding angina) kills about 500 Walsall adults every year and is the biggest single cause of death
- Walsall rates have improved over the last year in the 65-74 age group, now being almost equivalent to the national average

Age standardised mortality rate from CHD per 100,000 population aged 65-74



- Key lifestyle factors to focus on in targeting coronary heart disease are smoking, obesity, lack of physical exercise and unhealthy eating, all of which are found in a higher proportion in Walsall than regionally or nationally

Source: Joint Strategic Needs Assessment, 2009; Our Healthier Nation, NHS Walsall, June 2008
 * Average annual reduction of -6%

Alcohol Harm

Alcohol misuse leads to a myriad of problems and impacts many areas of life. It could lead to social problems which impact upon the family, workplace and wider society. There are implications for safety and accidents. Alcohol misuse is related to increased crime. With regard to health problems, these include acute (alcohol poisoning, intoxication) and chronic (liver problems) problems. Alcohol misuse is also commonly associated with other psychiatric disorders and with other forms of substance misuse.

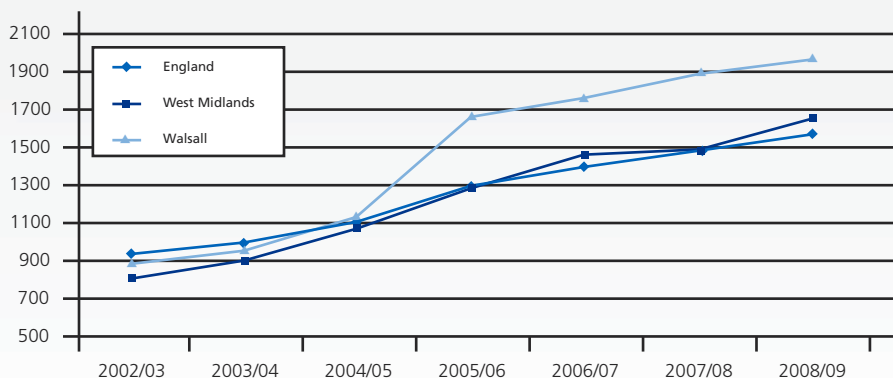
Walsall has a higher rate of alcohol harm related hospital admissions than the national average. Rates for admissions to hospital for alcohol related conditions in Walsall (1993.4) in 2008/09 have increased quite considerably over the last few years and are higher than regional (1655.8) and national (1561.6) rates, increasing the gap.

Although the number of people drinking declined from 2001 to 2005, frequency of drinking increased amongst those drinking and there has been little change in the number of people drinking excessively. About 23% of men (21,000 men) and 10% of women (10,000 women) in the 2005 survey were drinking in excess of sensible limits every week. This is further amplified by issues of “binge” drinking as well as excessive drinking.

High levels of binge drinking and excessive alcohol consumption in Walsall has led to a higher rate of hospital admissions related to alcohol harm than the national average

Alcohol harm related hospital admissions

N139: Standardised admission rate per 100,000 for alcohol-related conditions



Source: Joint Strategic Needs Assessment, 2009

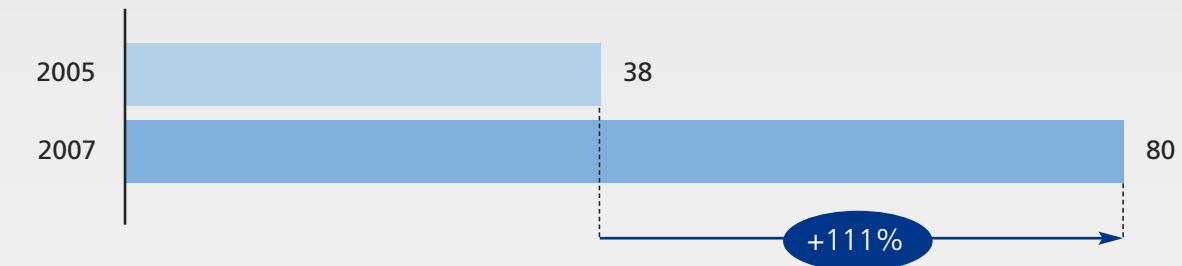
Teenage Pregnancy

The latest data from the Office of National Statistics Teenage Pregnancy Unit shows that the trend for Walsall is decreasing at a greater rate than the West Midlands and England, though the conception rate is still higher than the regional and national comparisons. Walsall saw the second highest reduction in the West Midlands. The rate in Walsall was 54.5 and was higher than Birmingham but lower than Wolverhampton (64.9) and Sandwell (58.0). High teenage pregnancy rates contribute to the high infant mortality rate.

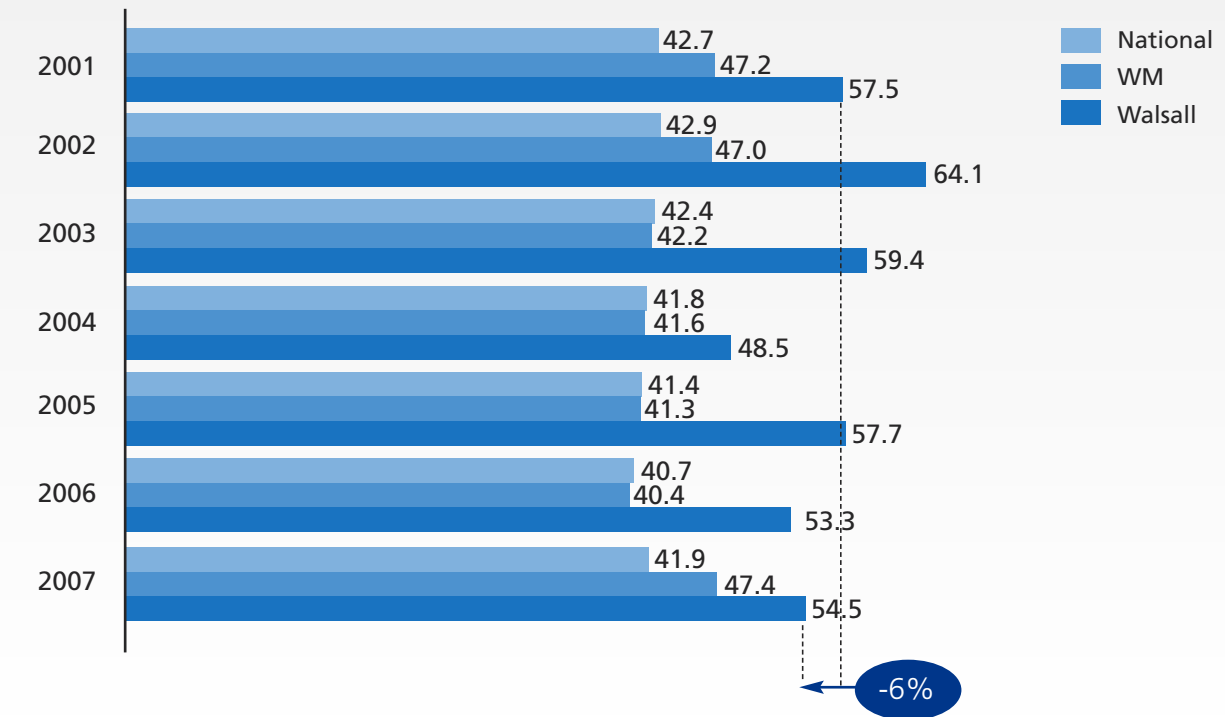
In recent years, Walsall has improved access to termination of pregnancy services and Genito-Urinary Medicine (GUM) services. There has been an enormous advance in access to appointments to GUM services within 48 hours between 2005 and 2007.

Improvement in access has not been accompanied by a significant reduction in teenage pregnancies

Percentage of appointments within 48 hours of booking
%



Under 18 conceptions, number per 1000



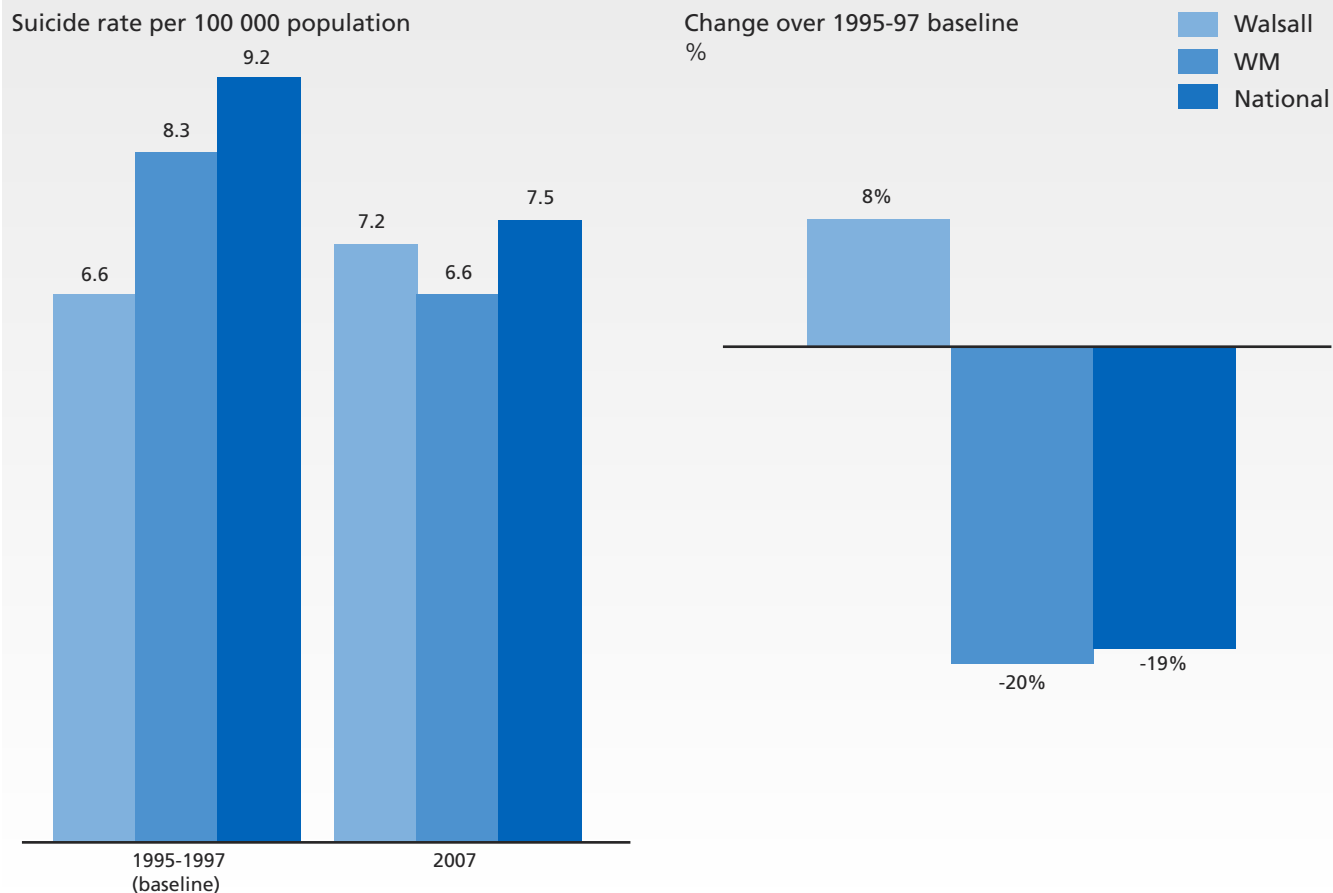
Source: Joint Strategic Needs Assessment, December 2009

Suicide Rates

Although only a crude proxy, the 8% increase in the suicide rate in Walsall since the period 1995-97 is suggestive of an overall decline in mental wellbeing, particularly when compared with an overall national and regional improvement in suicide rates. Likely factors contributing to the increased suicide rate in Walsall include high levels of deprivation and poverty, high levels of binge and excessive drinking, unhealthy lifestyles and the effects of long-term illness in the Borough.

The suicide rate of a population is a crude proxy for depression and mental health. In Walsall there has been a 38.5% increase in the suicide rate since 1995–1997

Suicide rates are rising, most likely contributed to by high levels of deprivation and poverty, high levels of binge and excessive drinking, unhealthy lifestyles, and high levels of long-term illness in Walsall



Source: Joint Strategic Needs Assessment, December 2009, Our Healthier Nation, NHS Walsall, June 2008

3.1.5 Social Factors

There are additional social issues that impact upon our ability to provide and manage health services in Walsall.

Crime

Crime is heavily concentrated in deprived areas, and closely associated with drug and alcohol misuse. Reducing crime and addressing its causes led to the national crime reduction strategy of 1999, which encouraged funding for a number of initiatives including use of CCTV; preventative services for children aged 4-12 years at risk of criminal involvement; youth inclusion programmes to reduce reoffending and truancy; locks for older people; school based interventions and drug arrest referral schemes.

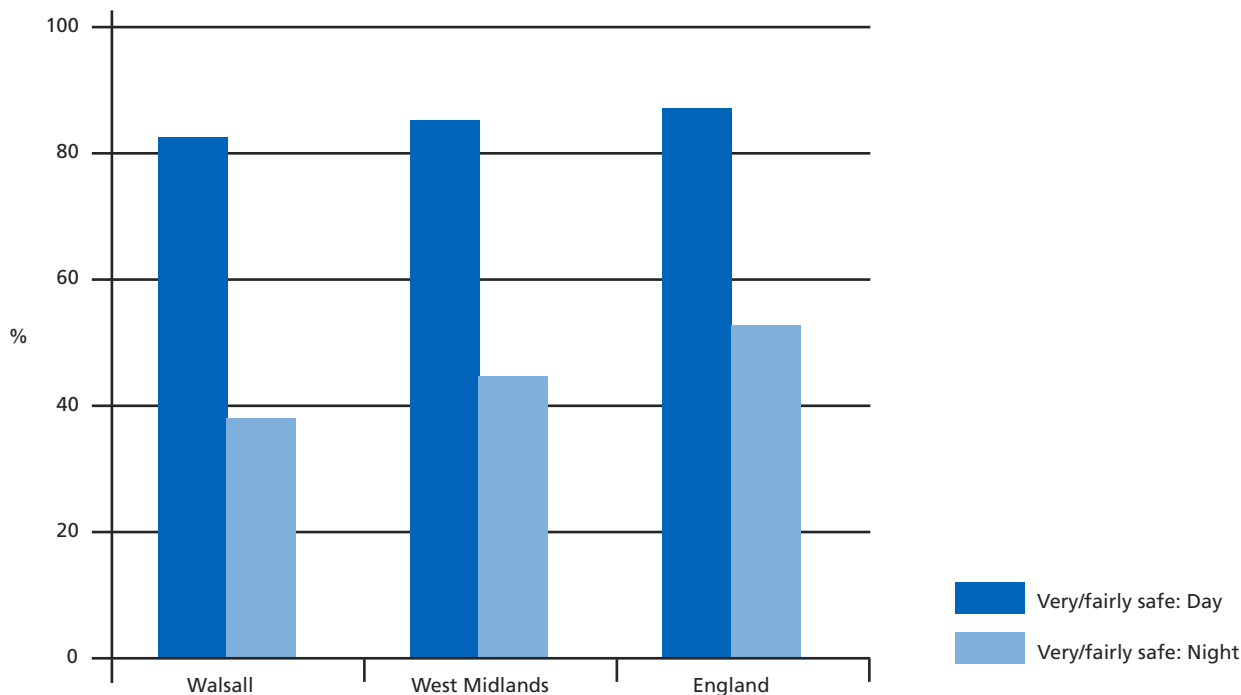
The graph on the right shows the response to a survey on how safe residents feel when outside their local area. This was carried out in 2008/09.

Generally Walsall residents feel much safer when out in their local area during the day, with 83.1% feeling 'very' or 'fairly' safe compared with only 37.2% feeling the same way at night. Residents in Walsall feel less safe in their local area during both the day and night than the regional and national average - in England overall, just over half of people feel 'very' or 'fairly' safe at night.

Over a quarter of residents believe anti-social behaviour is a problem in their area, which is higher than both the regional and national figure.

The Place Survey shows 68% of Walsall's residents feel that the most important Council priority should be to ensure that citizens are safe and secure.

How safe residents feel when outside in their local area



Source - Joint Strategic Needs Assessment, 2009

Residents' perceptions of anti-social behaviour, 2008/09

Region	Walsall	West Midlands	England
% people who think ASB is a problem in their area (NI17)	26.1%	21%	20%

Source - Joint Strategic Needs Assessment, 2009

Summary - The Need For Change

We have identified that the most pressing health challenges in the area are related to deprivation, low life expectancy, high infant mortality and unhealthy lifestyles. The complex population issues in Walsall including deprivation and inequalities both geographical and health, clearly drive our need to commission a vast range of services. Life expectancy in English local authorities is strongly associated not only with material deprivation, but with the local sociodemographic context. As a result, we as the NHS in Walsall cannot tackle health issues in isolation. We must work with our local authority and local educational partners to address the fundamental issues that drive these social barriers to better health. Through our Integrated Care Economy approach, we will be able to successfully move towards a series of programmes that can address the issues highlighted above.

Maintaining a clear and current picture of our local health needs is a critical part of our commissioning process. Our Joint Strategic Needs Assessment together with an ongoing programme of other local engagement activities has provided us with (and continues to provide) the necessary knowledge of those health and social issues that impact our ability to commission effectively. Our Public Health group have undertaken a series of health inequalities analyses at Practice Based Commissioning (PBC) cluster level and

developed a practice profile tool for easy evaluation of practice characteristics - demographic, case mix and spend patterns. This has included a series of locality and practice-based needs assessments that have been undertaken over the past three years in conjunction with partnership analysts. This has been particularly important as we strive to achieve a robust, evidence based process for commissioning and better decision making.

We are also reviewing the role of our Risk Stratification tool in looking at proactive health management. This may provide us with the ability to produce a population risk stratification analysis that could ultimately allow us to have:

1. A better understanding of our potential future hospital admissions by various segments of the population.
2. A better understanding of various segments of our population's risk of long term conditions.

This improvement in our forecasting abilities would ultimately allow our GPs and other community providers to look at lifestyle interventions and improved proactive case management.

Overall, NHS Walsall has, as a result of the work of our Public Health Directorate and JSNA,

identified the need to raise general levels of health, reduce inequalities and manage illness as the key interventions we will undertake to move towards the goals outlined. But the discussion above also highlights our potential ability to become more proactive in the health management of our population. The following sections now relate to our Strategy and detail how we will put these population needs into actionable programmes and initiatives to set out clearly where we need to go to make real change in the lives of our residents.

3.2 Drivers for change: Engagement of Stakeholders

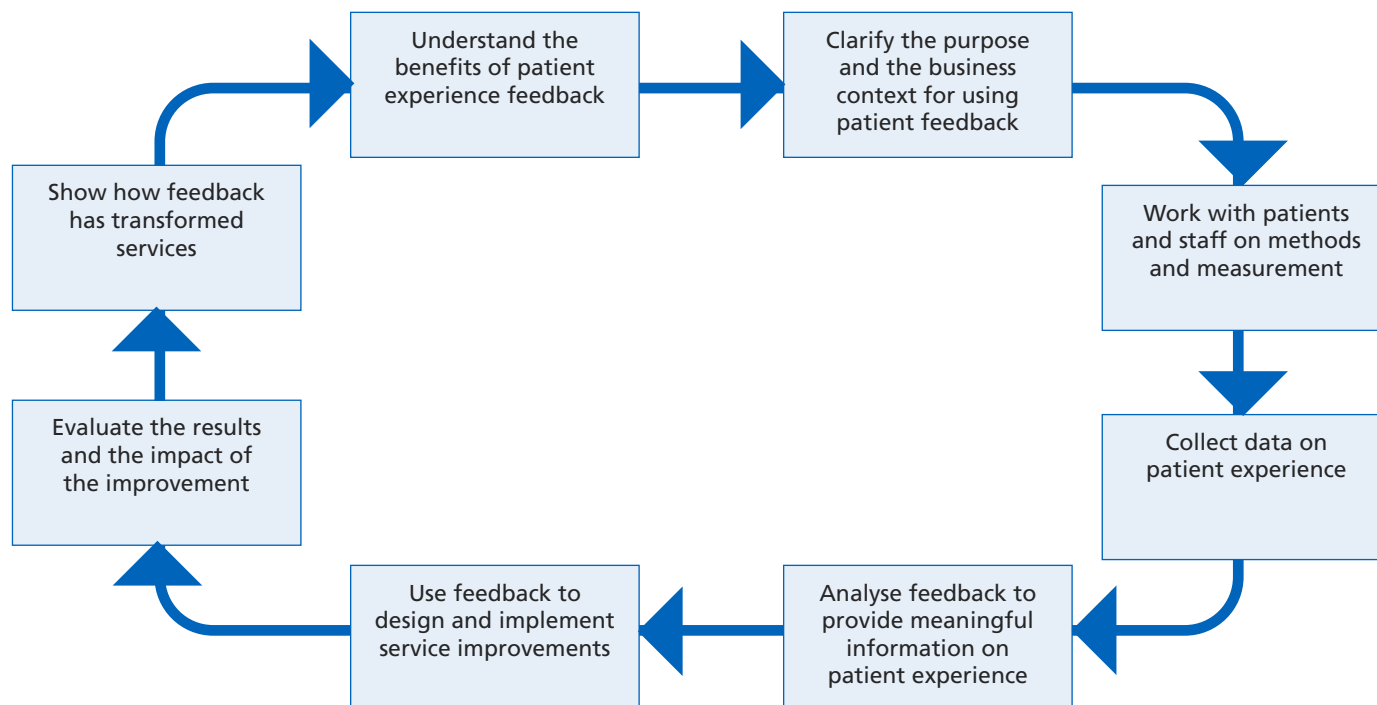
This year NHS Walsall has made good use of feedback gathered through a range of surveys including: the inpatient survey for acute hospitals, the inpatient survey for mental health services, primary care surveys and staff surveys. These are intended to improve the quality of the services provided and the patients' experience.

Each of our providers is now required to submit information about patients' experience as part of Commissioning for Quality and Innovation (CQIN). In 2009 a Customer Care Centre was established. We triangulate national information with our local intelligence to pick up trends to inform our commissioning processes and demonstrate our commitment to provide high quality services as demonstrated in the diagram shown.

NHS Walsall has expanded its approach to strengthen relationships with others and continues to identify new approaches to encourage ongoing dialogue, discussion and debate.

3.2.1 Public Sector Involvement

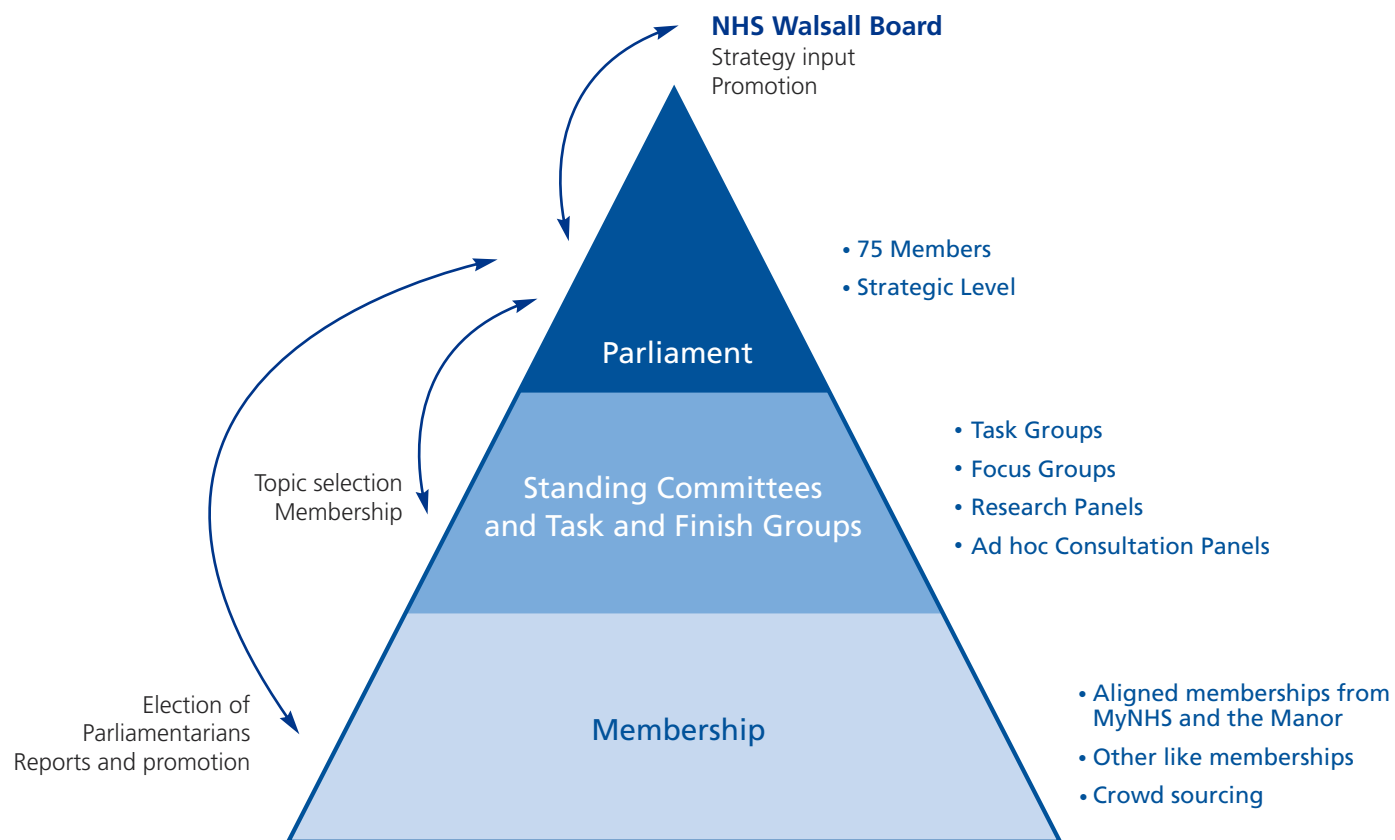
In 2009 a rolling programme of meetings between senior executive team members from NHS Walsall, Walsall Community Health, Walsall Manor Hospital, Dudley and Walsall Mental Health Partnership Trust and Walsall Council was introduced. This was enhanced with the introduction of a programme of regular Board to Board meetings where non-executive directors play an active role.



These rolling programmes were supplemented with joint learning events about matters of joint interest. For example in August 2009 a workshop about the forthcoming Comprehensive Area Assessment was held to increase understanding about how we all contribute to the Sustainable Community Plan. Feedback indicates that this will be an approach that we continue to facilitate. These meetings have successfully generated ideas where activities could be coordinated on a borough wide basis. NHS Walsall and Walsall Council are exploring ways to coordinate communications and engagement activities to avoid public fatigue from an uncoordinated approach to public sector involvement. A Sustainable Community Strategy has been developed for Walsall. The collective development of a forward looking vision for the borough that reflects local needs and priorities, and which is underpinned by specific measurable targets, is of critical importance for Walsall. It will provide a framework and direction which will govern the deployment of resources. To deliver the Sustainable Community Strategy, a new neighbourhood management model is to be introduced from April 2010. This model supports communications and engagement activity at a neighbourhood level and as a partner, NHS Walsall endorses this approach and will contribute resources to ensure its success.

3.2.2 Public Involvement - MyNHS Walsall
MyNHS Walsall is our primary public involvement tool. Soon to consist of 13,000 members it has a Parliament that will increasingly focus on strategic and organisational issues and will have a second tier of members that will be readily

MyNHS Walsall - Desired Model for the Future



available for snap polls, events, focus groups and other consultations as required. The bulk of the membership is just involved in formal and informal consultations.

MyNHS Walsall has been designed to take consultations out to the public in an increasingly targeted and streamlined way to reduce the costs associated with consultations, reduce duplication of effort and increase representative response rates. Our ethos is that

we ask only where decisions are waiting to be made and that we use the information we receive.

3.2.2.1 Recent Activity
Earlier this year the members of MyNHS Walsall were involved in a consultation on the preferred placement of Dental Services east of the Borough and 1,250 responses were generated and fed into the commissioning process. MyNHS Walsall membership debated

the launch of the NHS Constitution and how this could be interpreted locally. As part of the National Consultation about changes to the NHS Constitution we will rely once again on the dynamic involvement of the members of MyNHS Walsall. The MyNHS Walsall Parliament has worked on a number of topics through subcommittees during the last 12 months including two that resulted in submissions to the NHS Walsall Board. These submissions were endorsed by the Board and have since been raised through formal contract mechanisms with providers to make the necessary changes. Subcommittees are currently looking at the Liverpool Care Pathway; GP Inequality; Dementia; Out of Hours Services and Access to A & E Services.

3.2.2.2 Future Plans

During the first quarter of 2010 MyNHS Walsall involvement will be extended by the inclusion of the Manor Hospital's FT membership with a further intention that the tool will allow for similar memberships to be aligned into the structure.

Being centrally administered this will allow for joined-up consultative work across the health economy and a seamless experience for members. The best practice being developed around Public Involvement utilising this tool will then be more broadly used.

For our members there will be an enhanced opportunity for involvement with the second tier. People here will be involved in focus groups, surveys and health events. They may also be invited to do work with Parliament subcommittees.

3.2.3 Information Campaigns

To achieve greater engagement with seldom heard, hard to reach groups we have worked with Intelligence Walsall and Walsall Housing Group to develop a new workforce that is skilled to undertake targeted public information campaigns using social marketing

techniques. This increases the range of providers in the local market who can respond to future tenders for 'Mystery Shoppers', Community Researchers and Health Navigators and provides opportunities for potential employment in the future.

Feedback from MyNHS Walsall Members:

'I think it is very good for people outside the NHS to come along and voice opinions. Walsall does this very well and more of the local community should be involved. I think it has been a worthwhile day and I'm glad I came and participated.' Lesley Shephard, MyNHS Walsall (After attending the Strategic Plan Refresh, November 17, 2009)

Parliament member: Andy Brown - "It gives everyday people a chance to express their opinions and hopefully a chance to change things for the better."

Parliament member: Pat Etchells - "MyNHS Walsall Parliament is a new enterprise greatly welcomed for Walsall people. At the moment we are feeling our way through 'growing along the way'. As we progress I believe it will be an invaluable tool if used correctly for having the best health care available."

Parliament member: Cyril Richardson - "It's worthwhile because it allows ordinary citizens an opportunity to give feedback to this relatively new institution helping to provide an efficient National Health Service in Walsall."

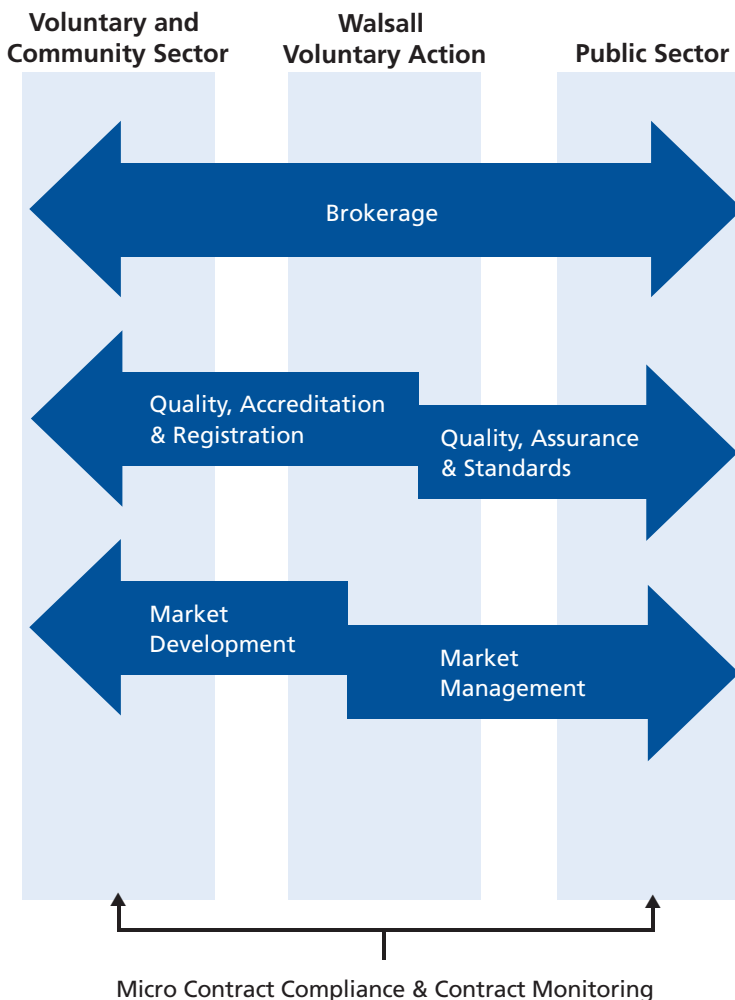
Parliament member: Flo Smith - "Means of communicating with NHS. You can be isolated from the NHS unless you have a problem. Keeps us up to date with what's going on and I can help other people with the knowledge."

All of the above Parliamentarians are on active subcommittees.

3.2.4 Voluntary Sector Partners

As NHS Walsall implements its approach to World Class Commissioning (WCC), its key function will be to commission health services from a growing range of providers including the Voluntary, Community and Faith Sector (VCFS).

On the 16 July a straw poll of over 100 voluntary organisations in Walsall revealed that only a small number had a positive experience of working with the NHS in the past. We are now signatories of the Voluntary Sector Strategy (VSS). Walsall Voluntary Action (WVA) will be the overarching infrastructure organisation for the whole of the voluntary sector in Walsall. WVA will provide and be accountable for the development of the Voluntary, Community and Faith Sector as a whole in Walsall. WVA will provide a brokerage service for the range of commissioners across the Walsall Partnership including NHS Walsall and the diagram shows how this will be implemented. There is an expectation that the public sector organisations within the Walsall Partnership will make clear, as early as possible, their commissioning intentions.



Walsall is continuing to find new ways to create a dynamic social movement for health improvement in Walsall by developing more equal and active partnerships with clinicians and the public

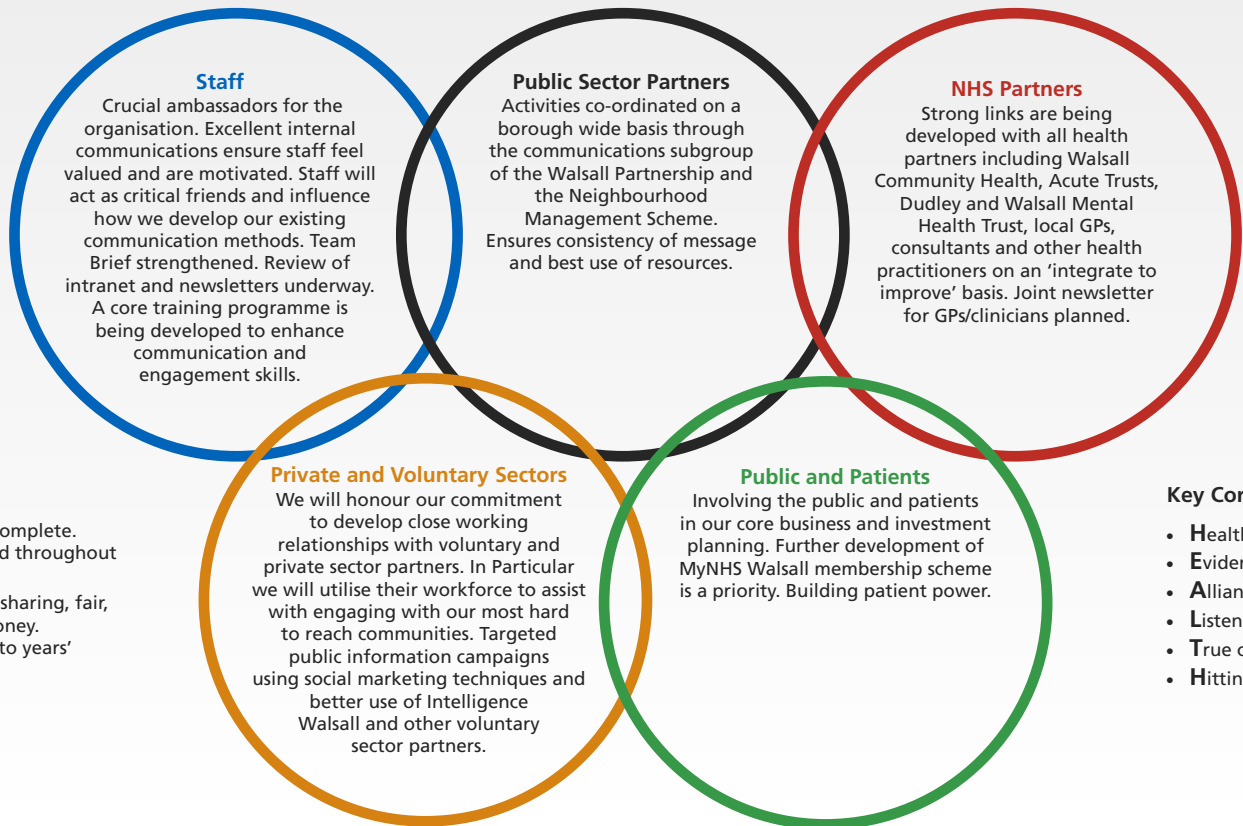
Communications and Involvement - a key enabling strategy

The communications and involvement teams have been merged under a new Assistant Director post. Our communications and involvement strategy has been re-focused to concentrate on target audiences.

Communications Objectives:

- To be excellent communicators - providing the right information at the right time to the right people.
- To actively involve our target audiences in two way dialogue.
- To foster mutual respect and encourage dialogue on a fair and equal basis.
- To firmly embed the principles of excellent communications and engagement within the organisation.

Key Target Audiences



Staff

Crucial ambassadors for the organisation. Excellent internal communications ensure staff feel valued and are motivated. Staff will act as critical friends and influence how we develop our existing communication methods. Team Brief strengthened. Review of intranet and newsletters underway. A core training programme is being developed to enhance communication and engagement skills.

Public Sector Partners

Activities co-ordinated on a borough wide basis through the communications subgroup of the Walsall Partnership and the Neighbourhood Management Scheme. Ensures consistency of message and best use of resources.

NHS Partners

Strong links are being developed with all health partners including Walsall Community Health, Acute Trusts, Dudley and Walsall Mental Health Trust, local GPs, consultants and other health practitioners on an 'integrate to improve' basis. Joint newsletter for GPs/clinicians planned.

Private and Voluntary Sectors

We will honour our commitment to develop close working relationships with voluntary and private sector partners. In Particular we will utilise their workforce to assist with engaging with our most hard to reach communities. Targeted public information campaigns using social marketing techniques and better use of Intelligence Walsall and other voluntary sector partners.

Public and Patients

Involving the public and patients in our core business and investment planning. Further development of MyNHS Walsall membership scheme is a priority. Building patient power.

Communications Principles:

- Clear and concise
- Jargon free
- Relevant and timely
- Accurate and honest
- Informative and transparent
- Dynamic and passionate

Branding:

- Re-branding to NHS Walsall complete.
- Brand values being embedded throughout the organisation:-
Listening, responsive, caring, sharing, fair, high quality and value for money.
'Adding years to life and life to years'

Key Corporate Messages:

- Health service, not illness service
- Evidence-based excellence
- Alliances - the key to success
- Listening to local people
- True choice and accessible services
- Hitting the hard targets

Source: NHS Walsall Communications and Involvement Strategy 2010 (December 2009)

3.2.5 Staff

Staff who work for NHS Walsall are crucial ambassadors for the organisation and as such are entitled to be well informed and to be heard. They provide valuable insights. In the last survey a year ago staff expressed the view that they felt well informed. The next staff survey results are due early 2010 and both our organisational development plan and our communication strategy will be adapted where necessary following the comments received as a demonstration of our commitment to continuous improvement.

As part of the process of developing commissioning plans, programme managers have been involved in the identification of our Strategic Initiatives. This involved an assessment of current work plans that were mapped against QIPP indicators as well as national and local priorities. As part of the Project Management approach, each Programme Manager will develop a communication and stakeholder engagement plan to ensure that staff are fully engaged in the development and delivery of plans.

3.3 Drivers for Change: Quality, Innovation, Prevention, Productivity (QIPP) National & Regional Priorities

The Next Stage Review and the Operating Plan for 2009/10 emphasise the importance of QIPP delivered through a partnership approach across the health, social care, third and private sector communities.

NHS Walsall has begun to focus on the QIPP challenges in a range of ways. We have developed scorecards at programme/pathway level which help us understand those areas of the QIPP agenda where we may need to focus our attention. We have also introduced a QIPP assessment into our business planning process to ensure that our prioritised initiatives have maximum impact across the QIPP dimensions. The development of the Inspiring Clinical Change document will also aid our drive towards the QIPP challenges. This document outlines how the process of addressing the QIPP challenges from a clinical perspective will enable us to achieve results.

Ten Clinical Champions posts have been created to take the lead at a pathway and programme level for each of the care pathways identified. These roles are pivotal in ensuring that we continue to have quality as the driving concern of all that we do: quality of outcome, quality of care, and quality of patient experience. Local clinical leads have strengthened clinical engagement through innovation and clinical

advice. They have contributed to the SHA approach as well as linking locally to the Professional Executive Committee. A document 'Inspiring Clinical Change' has been developed to drive this process further. These clinical leads will continue to actively engage with the regional leads to ensure that the regional Clinical Pathway Groups' recommendations are implemented across the NHS system in Walsall.

Transforming Community Services (TCS)

A nationwide mandate to review and change the way in which community based healthcare services are delivered (TCS) has impacted our strategy. The TCS programme 'aims to improve community services so that they can provide modern personalised and responsive care of a consistently high standard.' NHS Walsall recognises that a key part of its overall vision moving forward, especially with respect to the transformation of community services, is the need to integrate services across the whole health economy of Walsall. This has driven the need to ensure the implementation of an Integrated Care Economy to manage the changes demanded by this type of programme as all providers in the local health economy are affected and this in turn will impact the decisions we make around the commissioning of services.

Our major stakeholders including the PCT, the Manor Hospital, Walsall Community Health (WCH), Walsall Council and Primary Care have already begun the process of looking at integrating services to realise two important benefits: high quality patient care and cost efficient provision of care. NHS Walsall's vision is to shift investment to health rather than illness and community services are at the heart of this vision but integration is the key enabling approach.

NHS Walsall has responded to these challenges by developing its own programme board and strategy in order to lead the delivery of improved and 'fit for purpose' community services which complement the local health and social care economy and which facilitate the integrated care economy vision in the delivery of services. Further details are contained in the recent submission to the SHA.

Investing For Health

NHS West Midlands has identified the seven biggest challenges and five strategic priorities in which it needs to invest. It has also identified its strategic priorities by care pathways. Our strategic vision, goals and initiatives are closely aligned with these regional priorities.

3.4 Drivers for Change: Current Performance

NHS Walsall remains committed to building and utilising evidence that can be used to develop and improve local service activities.

Progress Against Our Outcomes

The table below summarises our achievements with respect to targets related to our locally agreed outcomes. Those outcome measures that have been rated 'Amber' indicate that we are moving in the right direction in terms of our interventions to address these issues and those rated 'Red' indicate our need to review the current situation to look at how to improve our commissioning and service delivery approach.

The main changes are the removal of the following two outcomes:

- CHD controlled blood pressure - % kept below 150/90
- CHD controlled cholesterol - % kept below 5mmol/l

And the inclusion of:

- Under 18 teenage conception rate
- Smoking quit rate per 100,000

In addition the obesity target has been revised to include children only. The rationale for these changes are as follows:

- Performance against both CHD targets had improved during the year and as such did not prove a significant challenge to the PCT.

- Performance in smoking quitters has not been reducing at the rate previously anticipated and required a greater focus in terms of targeted provision. Achieving a reduction in smoking prevalence is often the single most effective method of improving health and preventing illness.
- Walsall has a higher rate of teenage conceptions than the national average with almost 12 more per 1,000 than the national average. Teenage conception rates at local authority level show a strong correlation with deprivation and so it is a key health inequalities issue to address. This is also currently a measure in Walsall's LAA. Again, we have not seen the level of reduction anticipated.
- WCC Assurance Panel Feedback suggested reconsideration of our outcomes, particularly the number. We have considered this and reduced the number significantly enabling greater focus for ourselves and our partners.

Our Current Performance Against Our WCC Outcomes

Outcome Ref	Description	Latest period	Latest data	Current Benchmark	Distance from Benchmark		Year 1	Year 2	Year 3	Year 4	Year 5
1a	Health inequalities males - Slope index of inequality (5-year rolling)	2003-07	10.1	n/a	n/a	Current plan/trajectory	N/A	N/A	N/A	N/A	N/A
						Aspirational target	10.0	9.8	9.5	9.2	8.7
1b	Health inequalities females - Slope index of inequality (5-year rolling)	2003-07	6.7	n/a	n/a	Current plan/trajectory	N/A	N/A	N/A	N/A	N/A
						Aspirational target	6.6	6.5	6.3	6.0	5.6
2a	Life expectancy males (3-year rolling)	2005-07	75.7	77.0		Current plan/trajectory	75.8	75.8	75.8	75.8	75.9
						Aspirational target	75.9	76.3	76.8	77.6	78.5
2b	Life expectancy females (3-year rolling)	2005-07	81.3	81.9		Current plan/trajectory	81.5	81.8	82.1	82.4	82.7
						Aspirational target	81.5	81.9	82.5	83.2	84.2
3	Infant mortality rate per 1,000 live births (3-year rolling)	2005-07	8.4	4.9		Current plan/trajectory	7.6	7.7	7.8	7.9	7.9
						Aspirational target	7.6	7.3	6.7	5.7	4.4
32	Self reported experience of patients and service users (acute)	2007-08	73.4	76.8		Current plan/trajectory	72.7	73.3	73.8	74.3	74.8
						Aspirational target	73.6	74.1	74.8	75.7	76.8
36	% of patients spending greater than 90% of their time on a stroke unit	2009	59.0	84.0		Current plan/trajectory	59	N/A	N/A	N/A	N/A
						Aspirational target	66.0	80.0	82.0	85.0	88.0
44	Rate of hospital admission per 100,000 for alcohol related harm	2008-09	1993	1578.0		Current plan/trajectory	2121	2256	2399	2552	2714
						Aspirational target	2025	2050	2070	2082	2089
55	CVD mortality - standardised rate per 100,000 in under 75s	2007	98.9	88.1		Current plan/trajectory	91.4	86.4	81.6	77.1	72.8
						Aspirational target	91.4	86.4	81.6	75.0	61.9
4	Under 18 teenage conception rate	2007	54.5	89.7		Current plan/trajectory	51.0	49.7	48.4	47.2	45.9
						Aspirational target	51.0	49.9	47.7	44.4	39.9
n/a	Smoking quit rate per 100,000	2008-09	925	1158.9		Current plan/trajectory	941	913	886	860	835
						Aspirational target	941	962	1002	1063	1144
14	Prevalence of obesity in Year 6 children	2007-08	20.0	18.7		Current plan/trajectory	N/A	N/A	N/A	N/A	N/A
						Aspirational target	19.9	19.7	19.5	19.1	18.7

Benchmark for 1a and 1b set as England median value. Baseline year for 1a and 1b is 2003-07

Progress Against Saving Lives

NHS Walsall continues to show good progress against a number of our “saving lives” targets. These targets originally described as a consequence of “Our Healthier Nation”, provide a simple way to analyse the efficacy of NHS Walsall’s health interventions in key areas. This exhibit outlines the overall equation resulting in the saving of 244 lives per year.

This year 2008/09 NHS Walsall has been rated as Fair by the Healthcare Commission on the quality of its services and having made improvement compared to last year, our performance for use of resources has advanced from Fair to Good. We will strive to achieve Excellent in 2009/10.

243 total annual lives saved		Walsall target 2010	Reduction 2006, %	Annual lives saved 2006	Is Walsall on track to target?	Have inequality gaps been closed?*
All circulatory disease	50.7% reduction in mortality rate	41.6%	209	✓	Reducing gap between men and women	
Cancer	30.1% reduction in mortality rate	22.4%	24	✓	Reducing gap between men and women	
Mental health: suicide rate	20% reduction in mortality rate	N/A	N/A	✗	Previous favourable gap eliminated as Walsall’s rate had risen to 10% above the national rate, now Reducing again	
Accidents	41.7% reduction in mortality rate	28.8%	11	✓	Favourable gap created by reduced accident mortality in Walsall vs. a national increase	

• Between Walsall and England
 • Source: NHS Walsall Saving Lives: Our Healthier Nation, June 2008

3.5 Provider Landscape

Overview

NHS Walsall has endeavoured to build good working relationships with all of its providers (over 1,200 providers) and ensure high quality delivery of services to the people of Walsall. Currently our services are commissioned from the following providers:

- 67 GP Practices
- 70 Pharmacies
- 28 Dental Practices
- 30 Optometry Practices
- Walsall Community Health
- Dudley and Walsall Mental Health Partnership Trust (DWMHPT)
 - Primary Care currently provided by the Trust
- 79 Care Homes contracted with (including 12 Nursing Homes)
- Walsall Hospitals NHS Trust
- Specialised Services
- Other Acute Trusts

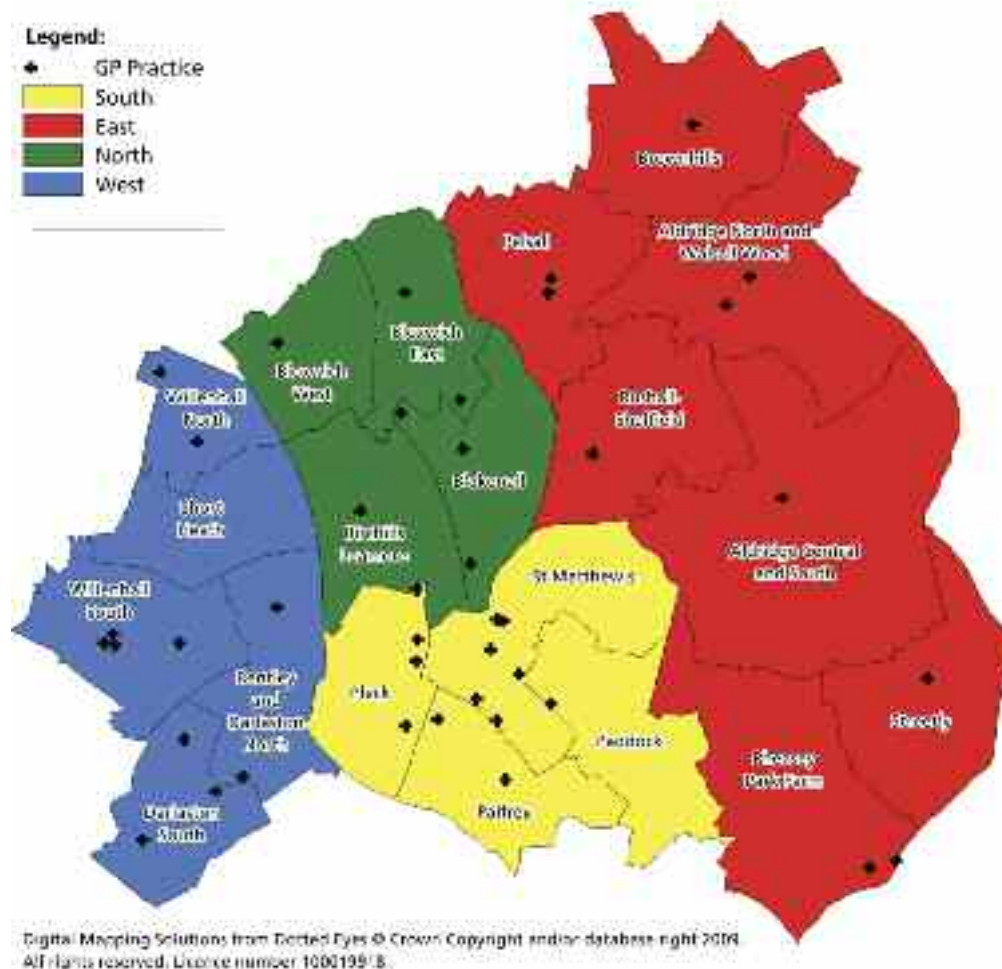
3.5.1 Primary Care

Primary Care providers are made up of GPs, Dentists, Opticians and Pharmacists. Providers in each of these sectors are largely categorised as “independent providers” in that they are independent of NHS ownership but form part of the NHS family.

3.5.1.1 GPs

We have made considerable progress with the quality of provision of GP services through the equitable access to the primary medical care procurement programme (EAPC).

GP Practices in Walsall

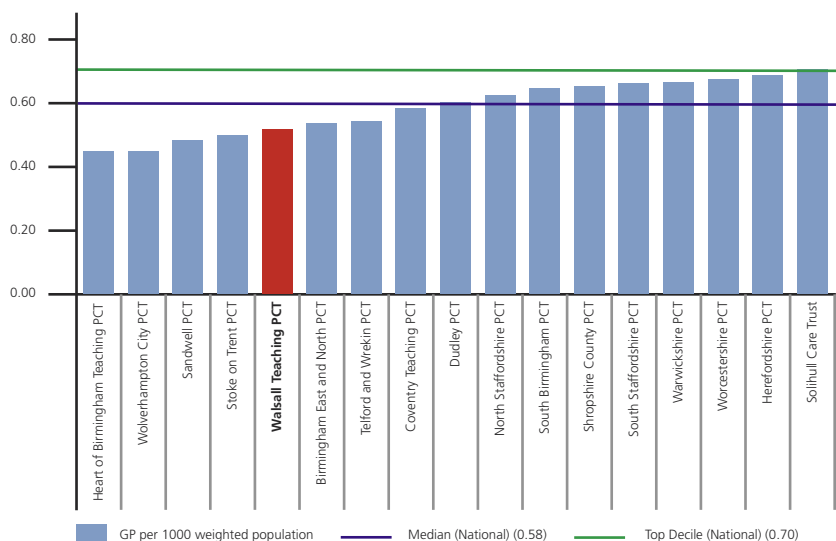


We have added an additional 12 whole time equivalent GPs to the primary care provision system and expect this number to increase by 4 GPs for a total increase of 16 GPs in 2010. NHS Walsall has located the three new GP Practices and the GP Health Centre, which offers walk in style services in areas of the Borough, where we believe we can have most impact on the issues of Primary Care inequality. A new walk in style Health Centre is based in the Town Centre and linked with the practice at the Hospital.

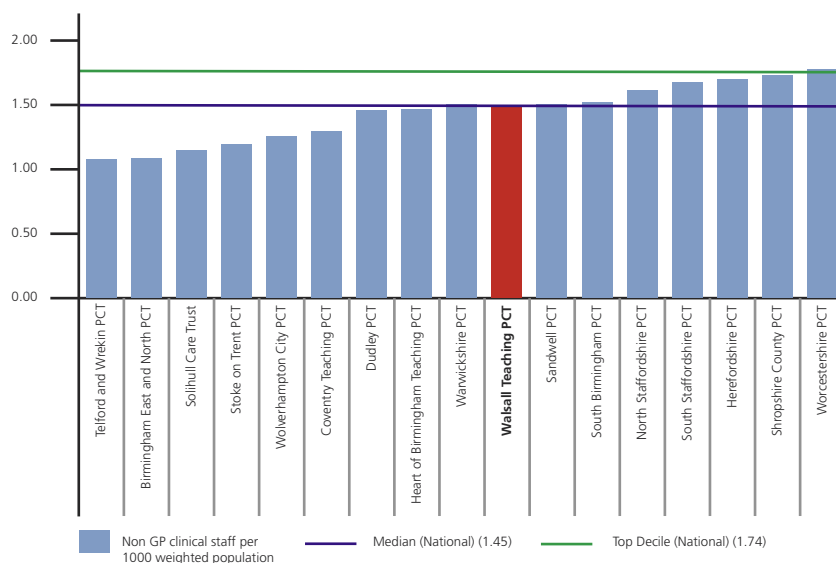
The key measure for Primary Care Inequality is current GP list size and we have used available information on these lists along with the information relating to inequality and deprivation to site the new premises. This new capacity will improve GP/patient ratios over a five year period. At present (01.01.10) there are 145.84 WTE GPs (Principals and Salaried) resulting in a patient to GP ratio of 1 GP to 1,846 patients. Between 2010 and 2013 there will be an increase of 16.56 WTE GPs which will then give a GP ratio of 1 GP to 1,657 patients. Benefits realised will include improved geographical access and improved access to a range of healthcare professionals. The new contracts also include a range of specialist enhanced services for the homeless, more specialised sexual health services, 'street doctoring' and services for drug and alcohol users.

The location of the new capacity was made using GP benchmarking data, GP/patient list sizes and public health data and overall it is expected that this improved access will impact upon our strategic goals and desired outcomes related to inequalities of life expectancy outcomes in the areas of Walsall where these are significant.

GP per 1000 weighted population
National ranking for **Walsall Teaching PCT**: 129 of 152



Non GP clinical staff per 1000 weighted population
National ranking for **Walsall Teaching PCT**: 78 of 152



Strengths

Overall, we believe the follow strengths are apparent in the provision of GP services in Walsall:

- Recently introduced increased capacity within Dentistry
- Good QOF performance
- Good access and choice
- Good geographical coverage
- GPs have a good mix of skills and many offer a broad range of enhanced services
- Good communication between practices and NHS Walsall
- Good clinical governance framework in place
- GP infrastructure is good with most contractors working from modern premises
- EAPC contracts provide for a range of innovative and flexible services.

Areas for Development

We also believe that the following are key areas for improvement and development:

- Walsall has many single handed practices with high list sizes
- Although QOF performance is generally good there are still gaps in many long term condition domains as practices are only rewarded for QOF thresholds achievement
- Consideration with respect to merging of various single handed practices
- Choose and Book issues to be addressed
- Consideration of workforce profile and number of GPs at retirement age

Moving forward, we expect that the development of a primary care strategy will address many of our key issues and will ultimately complement our strategic plan.

Our four PBC clusters will be producing business plans and these will clearly link to the delivery of WCC outcomes.

3.5.1.2 Dentistry

We have increased the provision of dentistry services in response to access issues reported by local people in particular parts of the Borough.

There are also significant variations in oral health with particularly high dental caries among children aged 5 in the more deprived areas of Walsall. Our response has been a review of GDS contracts to ensure value for money (VFM) and explore ways of incentivising contractors to undertake more preventative work with younger groups in the population. We are also in the process of procuring additional capacity and we have already implemented a mobile service that targets schools in the more deprived areas of Walsall, as well as offering check ups and treatment to older people living in residential and private nursing homes. These actions will secure NHS access to an additional 32,000 people in Walsall moving us from 52% to 64% of the population being able to access NHS Dentistry over the next two years, a 12% increase overall by 2011.

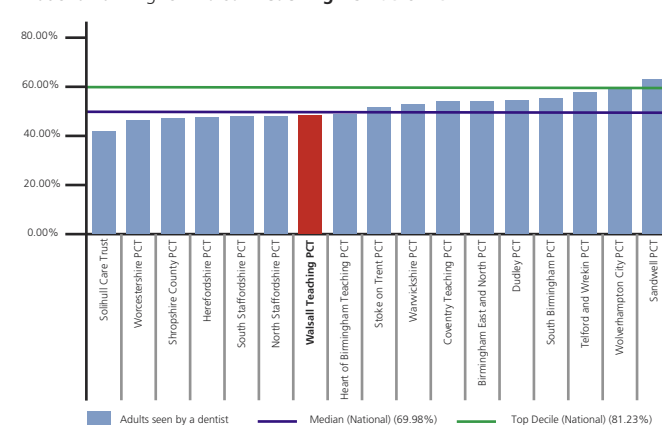
Strengths

- Recently introduced and increased capacity within Dentistry with two new Dental Practices

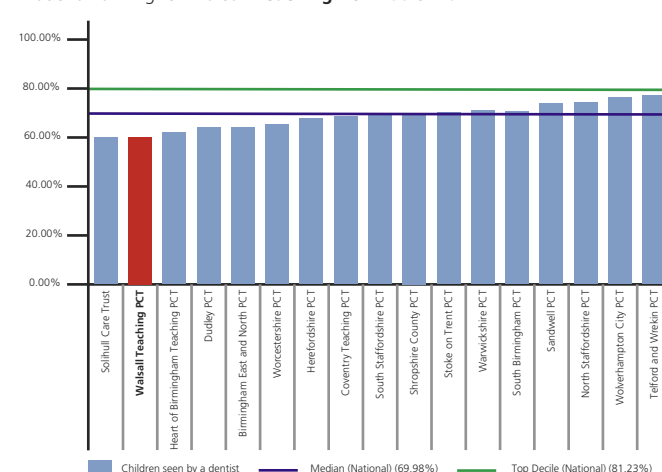
Areas for Development

- In the future, procure additional NHS dentistry access as required

Adults seen by a dentist
National ranking for **Walsall Teaching PCT**: 93 of 152



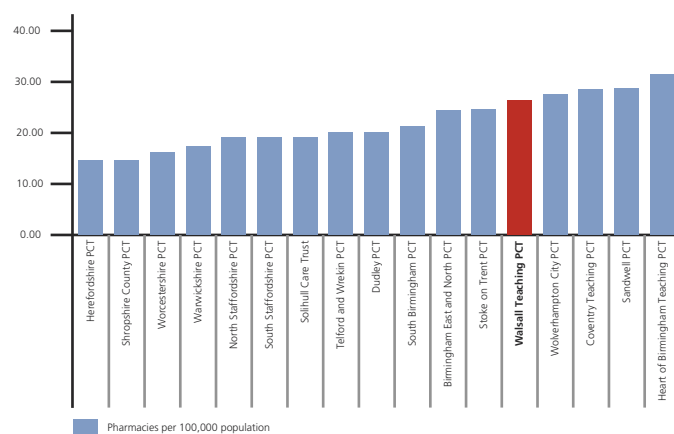
Children seen by a dentist
National ranking for **Walsall Teaching PCT**: 135 of 152



3.5.1.3 Pharmacy Services

Pharmacy services will continue to grow in importance and proactive management of these services has the potential to impact our strategic goals in the long term. The need to maximise the impact of the minor ailments LES and development of PWSI is required to support long term conditions care pathways particularly in primary care.

Pharmacies Coverage - per 100,000 population



3.5.2 NHS Walsall Arm's Length Provider - Walsall Community Health (WCH)

3.5.2.1 Organisational Form

NHS Walsall Community Health provides a wide range of services to meet the needs of the Walsall Community. Overall there are 67 various types of services provided by the organisation.

In the last 12 months, NHS Walsall and Walsall Community Health have endeavoured to work through a series of organisational challenges in the pursuit of the most appropriate provider organisational arrangement. A number of

systematic and thorough reviews have taken place to provide the right contextual information and evidence to facilitate critical decision-making. The range of considerations for organisational form have been considered and challenged. At a stakeholder event in 2007, the organisational form identified as delivering the pre-requisite criteria in a timely fashion was the formation of an Arm's Length Provider Organisation (APRO). This recommendation was discussed at various points throughout 2007 and finally approved at the NHS Walsall Board in December 2007 and a management structure and committee structure were approved. This option was seen to deliver the following advantages:

- A relatively stand alone provider organisation which could be integrated or developed into a more appropriate organisational form at a later date
- An organisation focused on the provision of services which was empowered to make appropriate decisions about the quality, effectiveness and value for money about the services it delivered
- Enable the PCT to focus its efforts on commissioning
- Enable the long-term future of community health services to be taken in the context of a more robust commissioning strategy for Walsall, i.e. this decision did not exclude any of the other organisational forms.

In September 2009 the Board of NHS Walsall concluded that WCH would remain at arm's length to the commissioning arm as a lever for transformation of the health economy.

However, we are reviewing the options for organisational form in the light of the 2010/11 Operating Framework and have a stakeholder event planned for February 2010. We will review the need for further changes to organisational form as we move towards an integrated health economy.

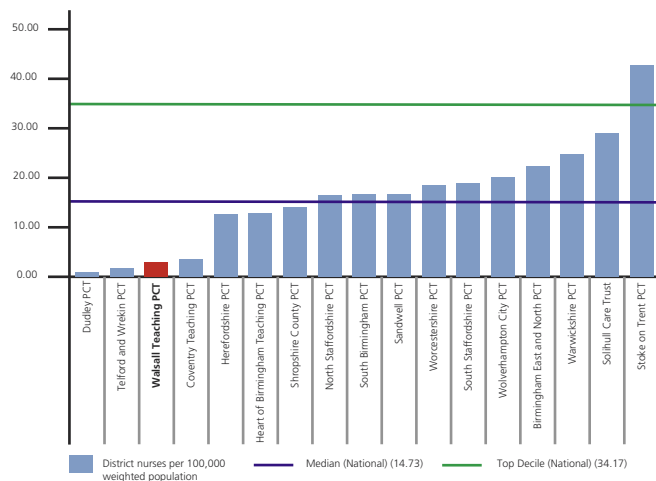
3.5.2.2 Transforming Community Services

In the last six months, we have convened a Transforming Community Services (TCS) Board. The board has ultimately been charged with ensuring that the TCS agenda is delivered. As part of the TCS initiative, a full review of Community Services, including the management arrangements for WCH, is being conducted. NHS Walsall understands that community health services face an increasingly complex workload as disease patterns shift from acute to chronic conditions. Improving the standards and 'fit' of community health services will not only improve the quality of life for many of the most vulnerable, but will also be critical to creating a sustainable health care system that can meet growing demands within financial limits. Organisational structures alone will not deliver benefits but we have sought to ensure that our community provider arm is organised in a way that ensures continuity and quality of services in Walsall. The real benefits arise from the core values, leadership and processes that underpin new structures and NHS Walsall are keen to emphasise that this is fundamental to our approach.

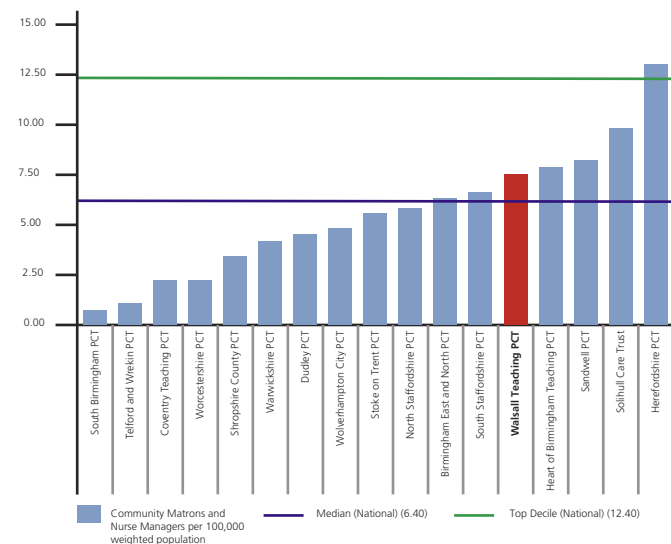
3.5.2.3 Community Services

The following graphs detail our ranking for specific community services.

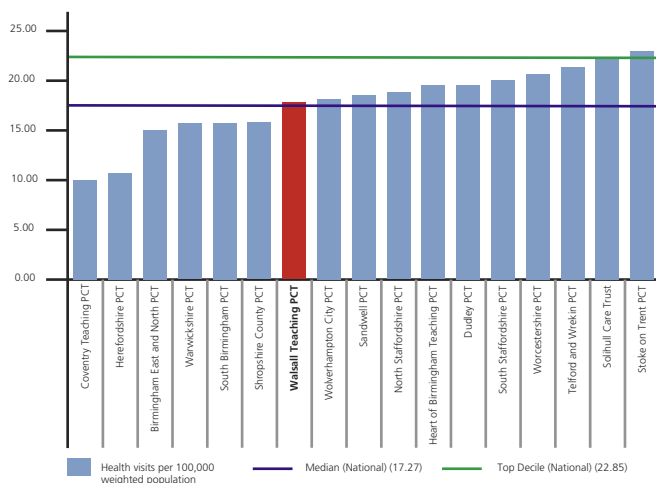
Community Services
District nurses per 100,000 weighted population
 National ranking for Walsall Teaching PCT: 145 of 149



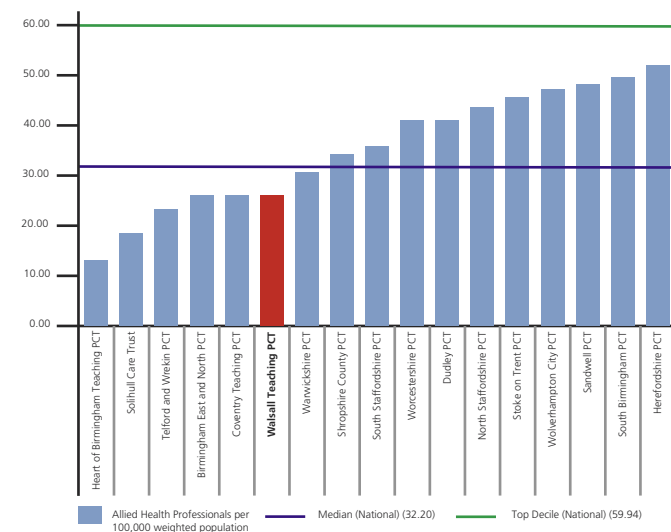
Community Matrons and Nurse Managers per 100,000 weighted population
 National ranking for Walsall Teaching PCT: 49 of 148



Health visitors per 100,000 weighted population
 National ranking for Walsall Teaching PCT: 68 of 150

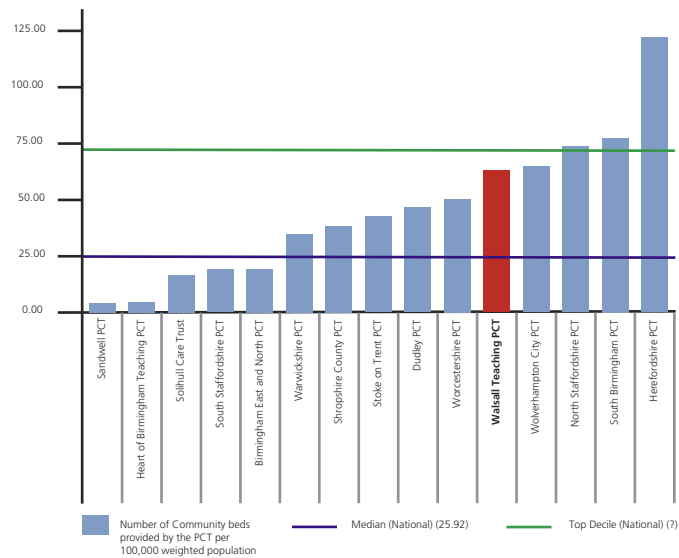


Allied Health Professionals per 100,000 weighted population
 National ranking for Walsall Teaching PCT: 90 of 148



Number of Community beds provided by the PCT per 100,000 weighted population

National ranking for **Walsall Teaching PCT**: 14 of 99



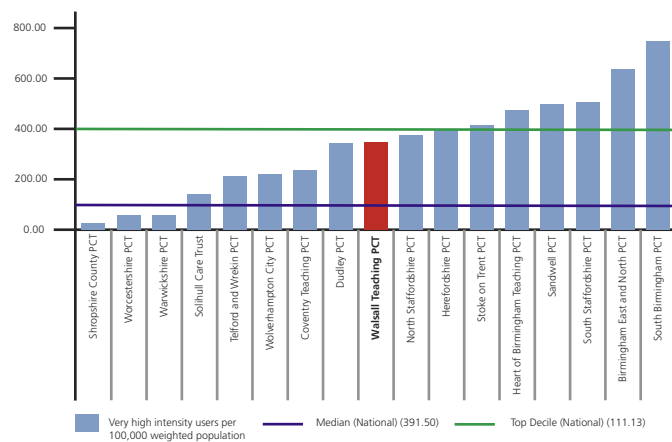
Development Plans:

- TCS Workstreams have been set up to review contracting mechanisms to replace existing block contracts
- Shadow cost and volume contracts are being reviewed
- Informatics
- Estates
- Workforce
- Organisational contracts

These development plans are outlined in more detail in the Transforming Community Services report.

Very high intensity users per 100,000 weighted population

National ranking for **Walsall Teaching PCT**: 55 of 152



3.5.3 Dudley and Walsall Mental Health Partnership Trust

The local mental health provision for adults and older people is predominantly supplied by Dudley and Walsall Mental Health Partnership Trust (DWMHPT). Mental Health accounts for 10% of our overall NHS Walsall spend.

During the latter part of 2007, Dudley and Walsall PCTs undertook a formal consultation on proposals to separate mental health services from the two PCTs and establish a single NHS mental health provider organisation, working in close partnership with Dudley and Walsall Local Authorities.

The new Trust is responsible for the delivery of all aspects of mental health services which were previously managed directly by the respective PCTs. This currently includes:

- All community and inpatient mental health services for adults of working age and older people. The main inpatient sites are Bloxwich Hospital and Dorothy Pattison Hospital in Walsall.
- All existing health-provided Child and Adolescent Mental Health Services (CAMHS).
- Substance Misuse Services.
- All elements of Psychology services.
- Mental Health Social Care Services which are managed by the Trust on behalf of the Local Authorities via partnership agreements.

The Trust's Older Peoples' inpatient services have been among the first to commit to achieving the new AIMS (Accreditation for Acute Inpatient Mental Health Services) standards. This quality programme, developed by the Royal College of Psychiatrists Centre for Quality Improvement, covers a wide range of inpatient service quality issues including policies and protocols, admission practices, advocacy, complaint handling and staff development. A performance framework has been developed and implemented so that we can monitor all performance information as we work towards improved and consistent performance across the whole organisation. Some significant improvements have already been achieved, for example, with Crisis Resolution/Home Treatment teams now gate-keeping all hospital crisis admissions and the focus for these teams will be achieving planned activity in Walsall. Increasing the capacity of the Early Intervention Team in the Walsall locality has resulted in a gradual increase in the number of people on the team's caseload.

The Trust is required to monitor and report any breaches against the Department of Health '18-week wait' target for GP to Consultant referrals for both inpatient and outpatient appointments. They have now established monitoring systems and report compliance with this indicator. Work has also progressed to monitor and report against delayed discharges (delayed transfer of care) and have good performance this year against this indicator. Undoubtedly, these results could not have been achieved without the efforts of all staff across the Trust.

The PCT has developed draft commissioning intentions to modernise the Mental Health provision in line with 'Living Well with Dementia' and New Horizons.

Dudley PCT and NHS Walsall are the commissioners. The money is paid 'in block' through a contract. This means that fluctuations against activity targets do not affect the level of resources paid to the Trust. However, for year 2010/11 the PCT will be moving towards a shadow cost and volume arrangement when a nominal reference cost has been established.

3.5.4 Walsall Hospitals NHS Trust (Manor Hospital)

Our local acute provider, Walsall Hospitals NHS Trust accounts for around 62% of our secondary care activity and 34% of our acute spend. They, in turn, are in receipt of 85% of their income from NHS Walsall.

The following table details our ranking with respect to our acute care services in the region.

The following strengths have been identified in relation to our acute provider.

Strengths:

- Good access
- Short waiting times
- Good choice and variety
- Currently achieving on most local targets
- Low hospital infection rates
- There is strong local loyalty to the Manor Hospital (80% of secondary Care for local residents)
- Good relationship between the Manor and NHS Walsall
- New hospital due to open in May 2010

Indicators	Value	Change from last period	Ranking in England	Ranking in West Midlands
Reducing length of stay				
Potential bed days saved as a percentage of all bed days				
Walsall Hospitals NHS Trust	13.23%	-0.79%	81	9
Heart of England NHS Foundation Trust	14.12%	-0.56%	143	18
Mid Staffordshire General Hospitals NHS Trust	13.39%	-0.48%	100	12
The Royal Wolverhampton Hospitals NHS Trust	12.27%	-0.64%	27	4
Sandwell And West Birmingham Hospitals NHS Trust	13.51%	-0.86%	105	13
Increasing day case surgery rates				
Day case rate for 25 procedures as a percentage of all operations				
Walsall Hospitals NHS Trust	83.02%	-3.60%	23	4
Heart of England NHS Foundation Trust	81.17%	2.20%	41	6
Mid Staffordshire General Hospitals NHS Trust	85.52%	-0.98%	9	3
The Royal Wolverhampton Hospitals NHS Trust	82.47%	2.86%	29	5
Sandwell And West Birmingham Hospitals NHS Trust	76.45%	0.29%	92	11
Reducing Non-Elective pre-operative Stay				
Non-Elective pre-operative bed days as a percentage of all bed days				
Walsall Hospitals NHS Trust	2.06%	-0.06%	74	6
Heart of England NHS Foundation Trust	2.02%	-0.10%	69	4
Mid Staffordshire General Hospitals NHS Trust	2.63%	0.34%	141	15
The Royal Wolverhampton Hospitals NHS Trust	2.25%	0.01%	117	10
Sandwell And West Birmingham Hospitals NHS Trust	2.41%	0.17%	131	12
Reducing Elective pre-operative Stay				
Elective pre-operative bed days as a percentage of all bed days				
Walsall Hospitals NHS Trust	0.05%	-0.01%	30	1
Heart of England NHS Foundation Trust	0.07%	0.00%	55	5
Mid Staffordshire General Hospitals NHS Trust	0.07%	-0.02%	58	6
The Royal Wolverhampton Hospitals NHS Trust	0.07%	-0.01%	60	7
Sandwell And West Birmingham Hospitals NHS Trust	0.08%	0.00%	84	10

Areas for Development

- Quality of stakeholder engagement varies
- Secondary care is not well integrated with local treatment pathways
- Quality of secondary care varies with provider and local economy
- Tertiary commissioning is at arm's length
- Led by Black Country Local Collaborative Commissioning Board

Development plans

Walsall Manor Hospital is nearing completion of its new PFI project and an ambitious cost improvement and transformation programme is exploring how it can provide a wider range of services on site in partnership with other organisations.

Making the services work at the new hospital

As part of our market management strategy detailed below, we are conducting a thorough review of services at the Manor Hospital as it is critical that the right amount of activity is anticipated and planned. As a PCT we are striving to take out further activity from the hospital - (outpatient, LOS for example and A&E) in line with national recommendations but the impact on our acute provider must be completely understood and the wider ramifications discussed.

Reconfiguration of services can only be achieved when the market management strategy has been implemented. We have to review the market and look at the range of providers and what can be done. We have created a specific strategic initiative to review these issues.

Indicators	Value	Change from last period	Ranking in England	Ranking in West Midlands
Reducing DNAs				
"Did not attend" rates a percentage of all outpatient attendances				
Walsall Hospitals NHS Trust	10.36%	-0.01%	121	16
Heart of England NHS Foundation Trust	9.72%	1.12%	111	14
Mid Staffordshire General Hospitals NHS Trust	9.03%	-0.30%	96	12
The Royal Wolverhampton Hospitals NHS Trust	8.40%	0.36%	75	7
Sandwell And West Birmingham Hospitals NHS Trust	10.48%	1.31%	125	17
Reducing New Follow-up Appointments				
Number of outpatients follow-up attendances against the number of outpatients first attendances				
Walsall Hospitals NHS Trust	2.75%	0.41%	147	16
Heart of England NHS Foundation Trust	1.54%	0.15%	22	4
Mid Staffordshire General Hospitals NHS Trust	1.85%	0.15%	41	7
The Royal Wolverhampton Hospitals NHS Trust	2.73%	-0.24%	143	14
Sandwell And West Birmingham Hospitals NHS Trust	1.37%	0.32%	13	2
Emergency re-admissions Rates*				
Number of emergency re-admission within 14 days of discharge as a percentage of the total number of admissions				
Walsall Hospitals NHS Trust	5.01%	0.20%	95	13
Heart of England NHS Foundation Trust	6.24%	-0.36%	159	17
Mid Staffordshire General Hospitals NHS Trust	4.66%	0.01%	74	10
The Royal Wolverhampton Hospitals NHS Trust	5.08%	-0.47%	102	14
Sandwell And West Birmingham Hospitals NHS Trust	5.01%	0.24%	94	12

Source: NHS Better Care Better Value Indicators

■ within the bottom 25% performing acute trusts
 ■ within the 25% to better than average performing acute trusts
 ■ poorer than average performing acute trusts

* Data for Q2 2009/2010 is unavailable. The data presented here is for Q1 2009/2010.

Auditors' Local Evaluation for Acute Care 2008/2009

Acute Care Providers	Auditors' Local Evaluation Rating 2008/2009
Walsall Hospitals NHS Trust	Fair
Heart of England NHS Foundation Trust	Fair
Mid Staffordshire General Hospitals NHS Trust	Weak
The Royal Wolverhampton Hospitals NHS Trust	Excellent
Sandwell and West Birmingham Hospitals NHS Trust	Good

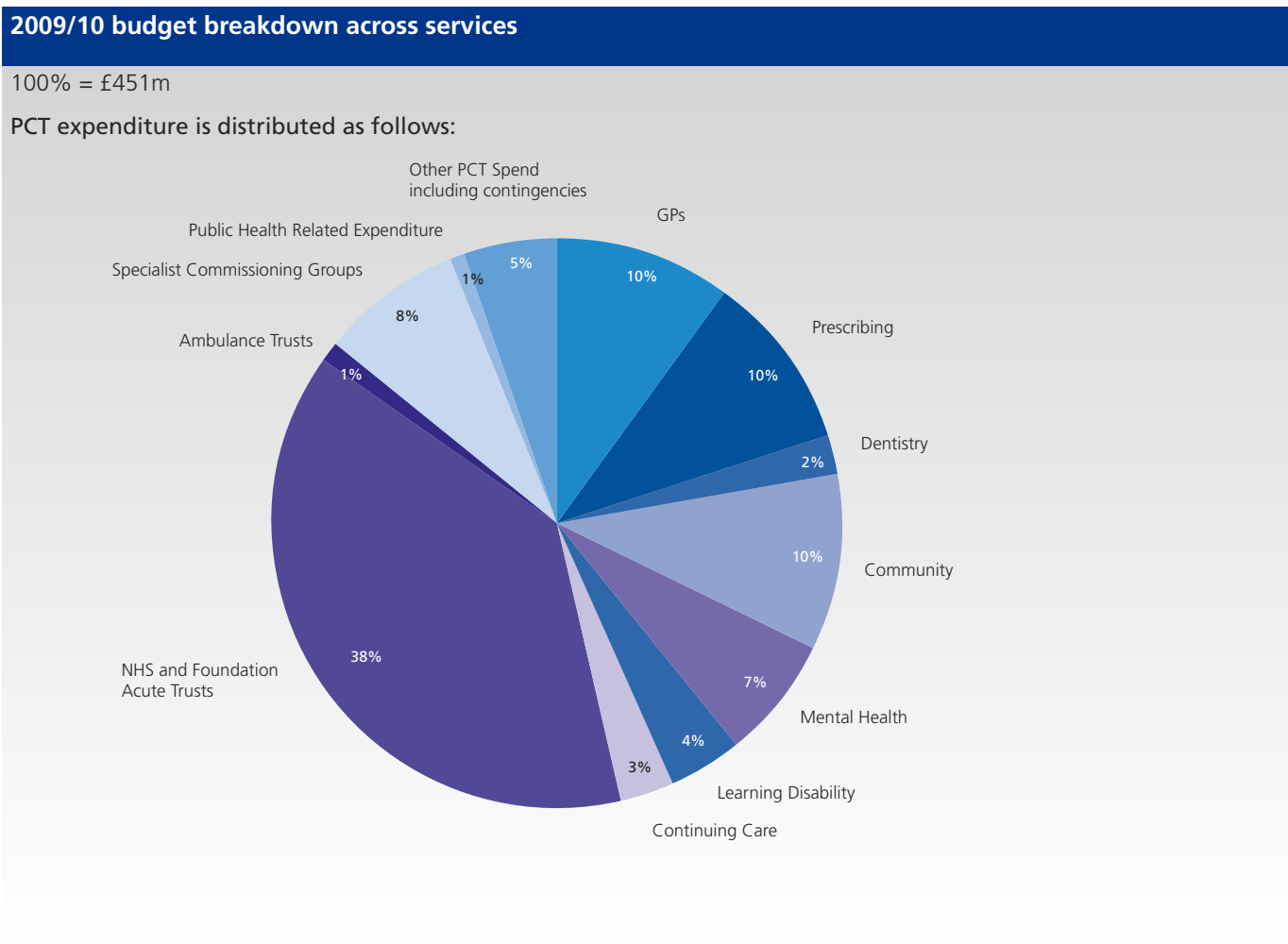
Source: The Care Quality Commission 2009

As part of our development of the Integrated Care Economy approach we intend to thoroughly review the provision of acute services to determine how we can commission and provide the best quality, efficient services to our population. We will work in partnership with the Manor Hospital as we expect them to be a major partner in the successful provision of our Integrated Care Economy approach.

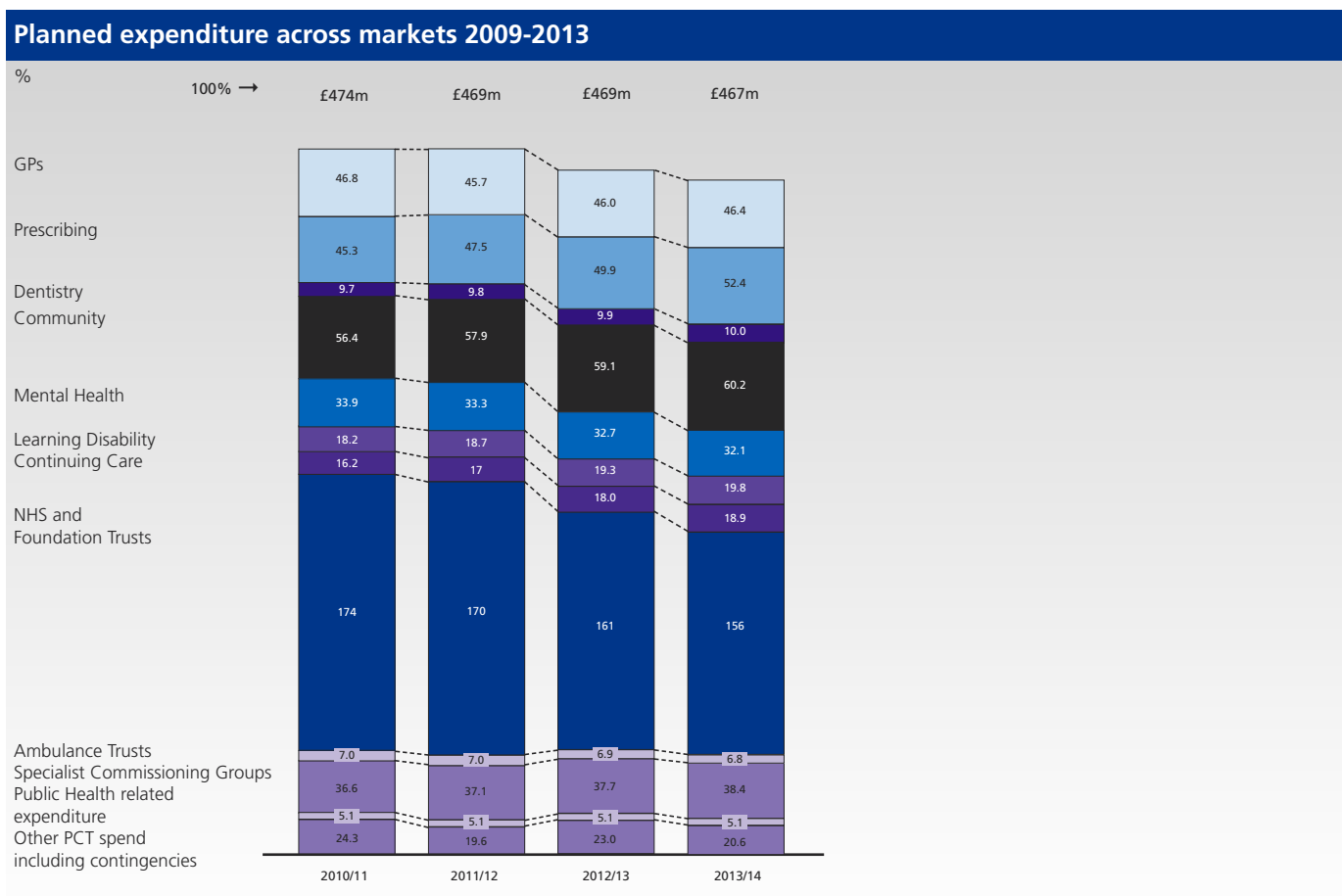
It is our belief that the pursuit of a strategy of integration will positively impact the provision of models of care which are located in an appropriate setting to respond to the needs of the people of Walsall. Our emphasis has to be to provide as much local service as possible in the most efficient way without compromising quality. We believe that our approach will allow us to achieve this.

3.6 Commissioned Activity

The chart to the right demonstrates the budget breakdown of NHS Walsall commissioned activity. The majority of our expenditure is in Acute and Tertiary Care with 34% of our spend accounted for by the Walsall Hospitals NHS Trust and overall the Acute sector accounts for 55% of spend and is provided by only 12% of the provider base.



NHS Walsall, in setting its five year financial strategy, has made a commitment to decommissioning acute activity and providing care closer to home by moving care from the acute sector to the primary and community sectors, where appropriate. Further detail regarding these plans is contained within section 4.2 (Our Prioritised Initiatives). The table to the right demonstrates the high level changes to planned expenditure across markets that these plans will have.



Drivers for change - Long-term Commissioning

At the beginning of 2009 we undertook a detailed analysis of our Long term Commissioning Plans. Using acute activity and identified spend from other key service areas we modelled activity against a variety of key drivers including population growth by age and sex, disease prevalence and technology. The impact over 10 years was derived.

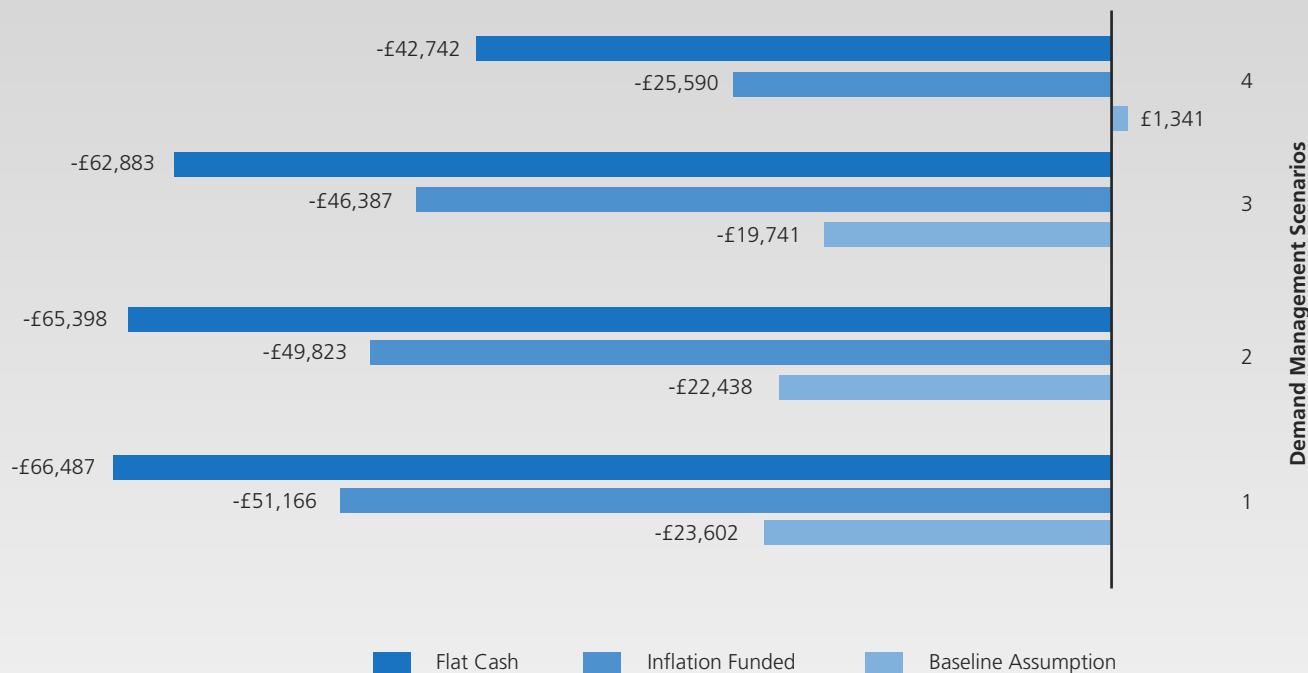
Using this as a base we modelled a series of resource and demand management scenarios to assess the degree of change required to respond to need and resources assumptions at the time.

The outcome suggested that current models and pathways of care are unaffordable in the face of significant increases in need, particularly for frail older people. This work was shared widely within the Local Health economy, including the Local Authority, providers and primary care.

Reductions in unnecessary procedures, duplication of activity and provision of care through integrated care pathways were considered to be the most appropriate responses requiring input from all partner organisations and significant clinical engagement.

The graph to the right demonstrates the range of options used and the output from the model. Clearly since that time greater detail on resource assumptions have become available which have been used in the development of our financial strategy.

Comparison of Demand Management and Funding Scenarios to 2018



Finance Scenarios

The three finance scenarios were based on an initial assumption regarding likely changes to allocation, the national tariff and inflation.

Demand Management Scenarios

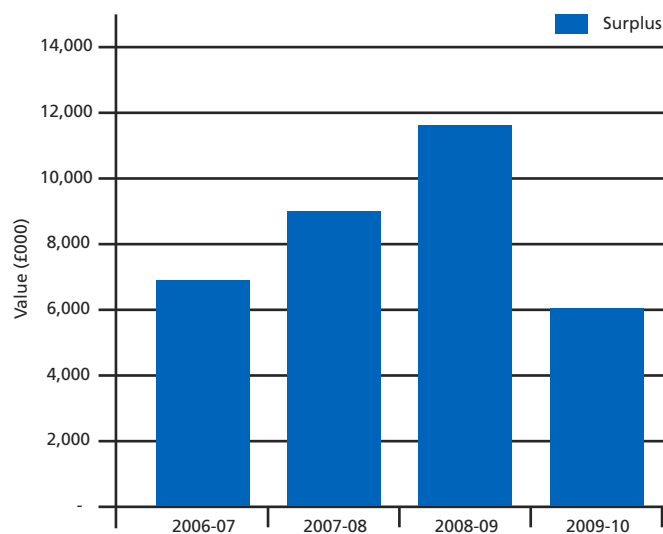
The four demand management scenarios were based on an assessment of the varying impact of our plans depending upon whether we achieved or exceeded current benchmarked best practice.

The chart shows a potential deficit for the PCT in 11 out of 12 scenarios.

3.7 Financial Plan

3.7.1 Overview

NHS Walsall entered 2009/10 in sound financial shape. As an enabling strategy to its medium term investment plan, the PCT delivered a planned surplus, or reinvestment reserve, of £11.6m during 2008/09, with the intention of releasing this over future years. This surplus was the continuation of the existing financial strategy and built on the surpluses of previous years, detailed in the table below.



During March 2009 the Board approved an annual budget for 2009/10 to both invest in priority areas and deliver a planned in year surplus of £5.5m, whilst retaining an underlying recurrent surplus of approximately £3m.

Financial performance during 2009/10 has remained on track to deliver the SHA agreed control total, subsequently revised upwards to

£6m once final allocations were confirmed. However, within this position, there are significant variances to plan that, going forward, must be addressed.

At summary level the year end forecast performance is as follows:

- Acute contracts will be £4.0m (1.9%) over plan. The key contributors to this are the out-of-borough providers, accounting for some £2.9m (3.5%) over their plans.
- Continuing Health Care is forecast at some £1.6m (11.8%) over plan.
- Primary Care commissioning will be £2.0m (2.0%) under plan.
- Application of financing items at £3.4m

The recurrent impact of the 2009/10 out turn and the changes to the national tariff for 2010/11 contracts is forecast at £6m. This has been included as a first call on funding available during 2010/11.

In terms of medium term financial planning, NHS Walsall has modelled three scenarios, each based on assumptions consistent with SHA guidance. The scenarios depict a base case alongside alternative upside and downside eventualities. Within each case the modelling utilises the best available guidance and information.

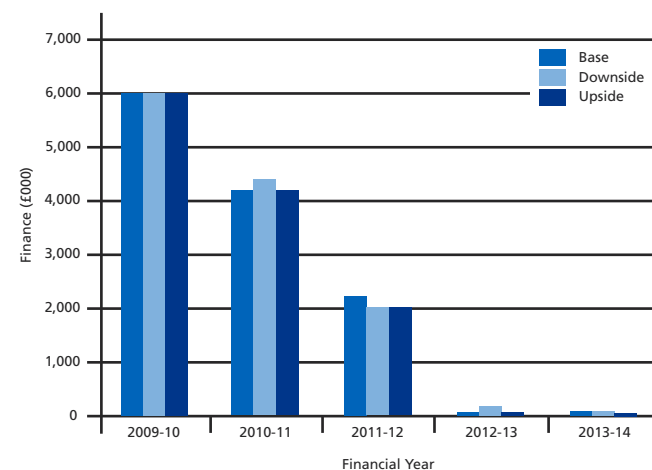
The key principles underpinning the modelling are:

- NHS Walsall will reduce its overall year end out turn to one of break even during the planning period.
- Within that bottom line break even NHS Walsall will have recurrent commitments of

98% of available resource and 2% non recurrent discretionary expenditure, deployed as prioritised initiatives targeted to deliver strategic goals.

- Underpinning the financial plan is an efficiency and disinvestment programme, aligned to QIPP, which provides additional financial headroom for discretionary investment.
- The absolute degree of discretionary investment is 'flexed' in a proportionate manner dependent upon the financial scenario i.e. base, upside or downside.
- In year the PCT will hold a general contingency equivalent to 0.5% of allocation to manage financial risk.

Crucially, as a result of modelling based on these principles and assumptions, NHS Walsall is not forecasting a deficit position at any point during the three scenarios. The bottom line for each year is represented in the graph below.



3.7.2 Summary Level Financial Analysis

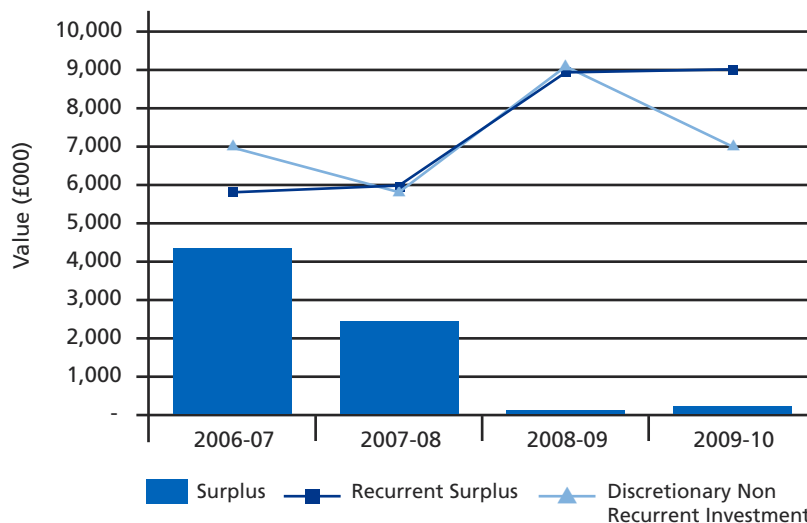
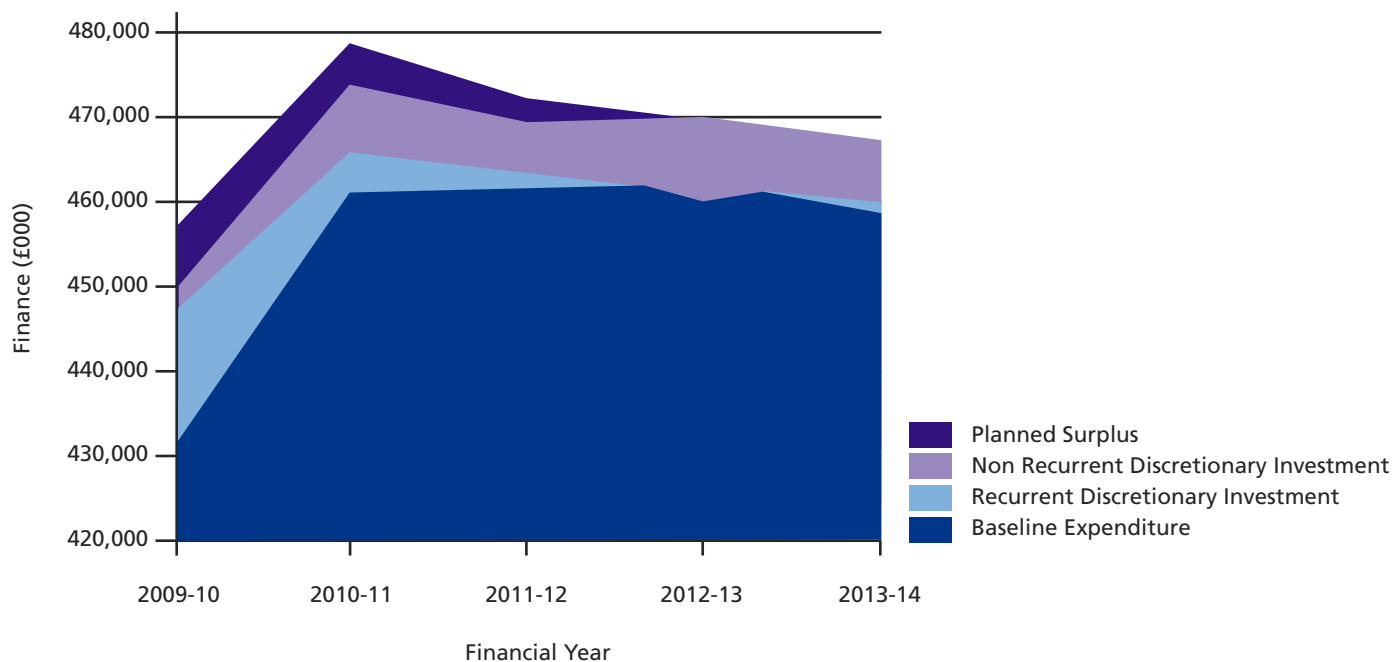
The relationship between absolute allocation, baseline expenditure, investment and surplus over the five year planning period, for each of the three financial scenarios, is complex. The summary level position, for each of the scenarios, is illustrated by the following series of charts.

Key features of this scenario are:

- Allocation growth ceases during year 2 followed by an overall decrease in absolute available resource in future years as the brought forward surplus is utilised.
- Net Recurrent discretionary investment during the period is £23.6m
- Non recurrent investment over the period is £32.4m

Within this scenario the profile of surplus, underlying recurrent position and compensating discretionary non recurrent investment is illustrated below.

Base Case Scenario

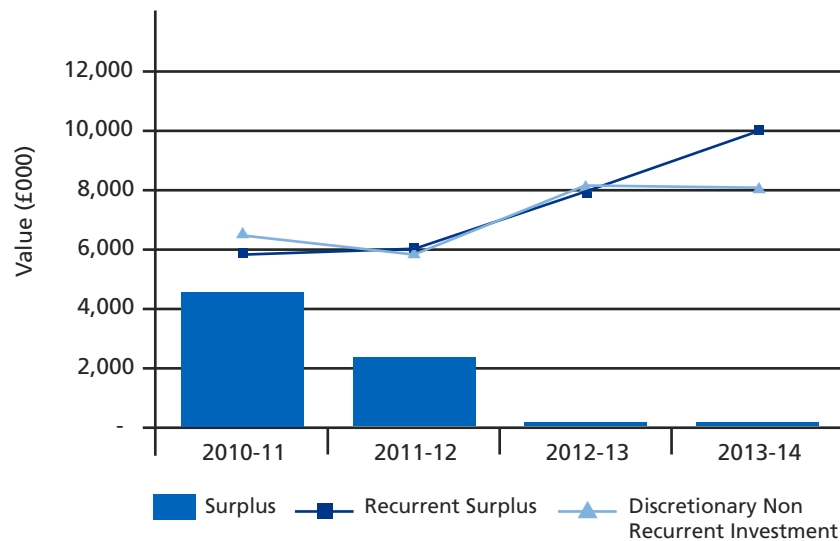
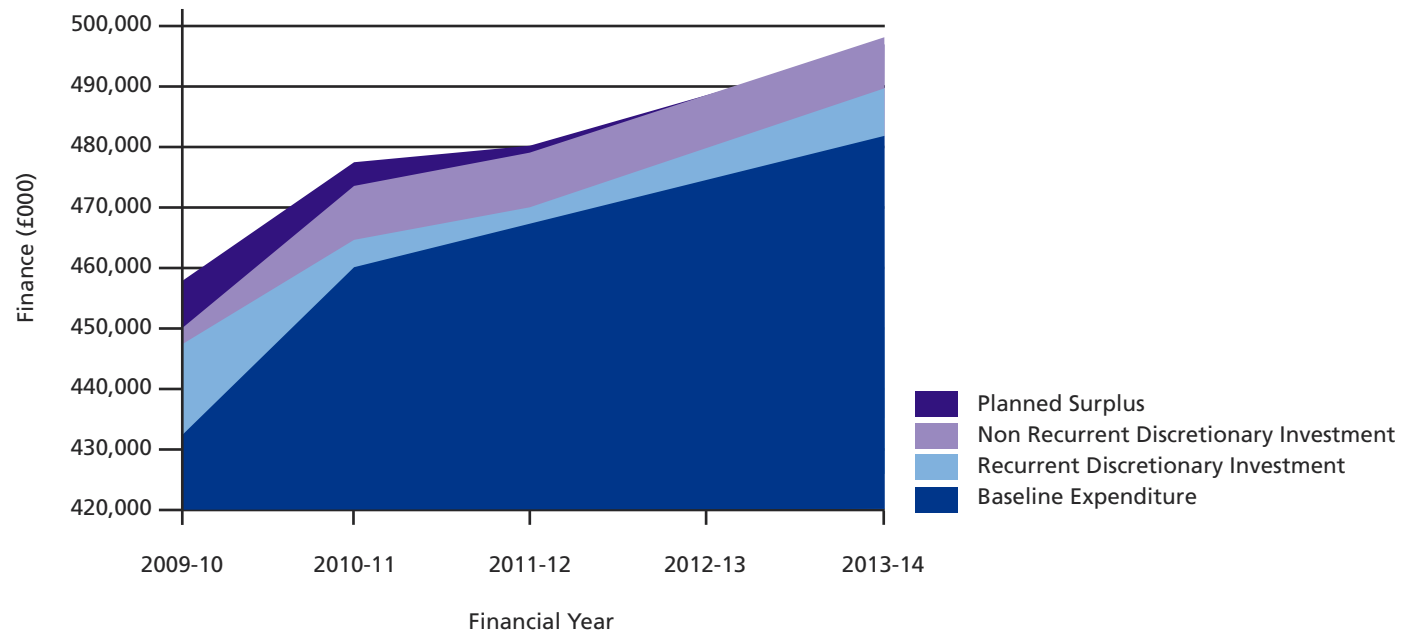


Key features of this scenario are:

- Allocation growth continues at a rate equivalent to the GDP deflator for years 3-5 of the planning period.
- Net Recurrent discretionary investment during the period is £36.4m
- Non recurrent investment over the period is £32.3m

Within this scenario the profile of surplus, underlying recurrent position and compensating discretionary non recurrent investment is illustrated below.

Upside (GDP Uplift) Scenario

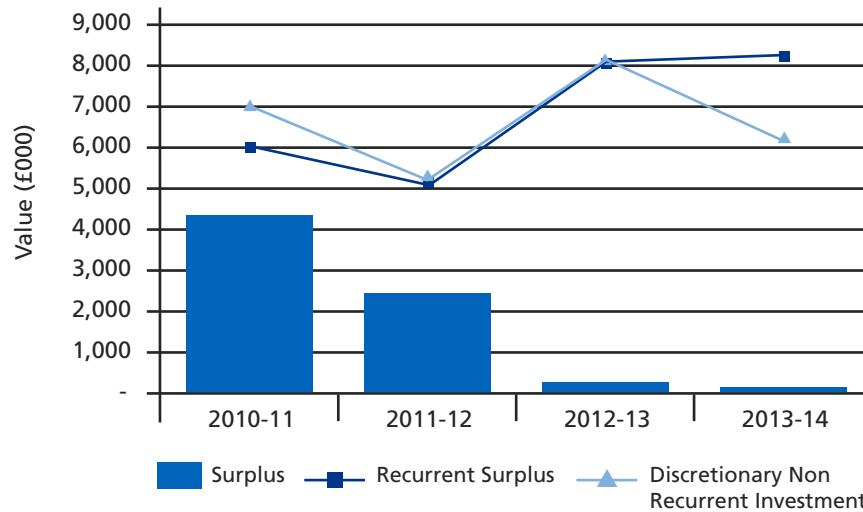
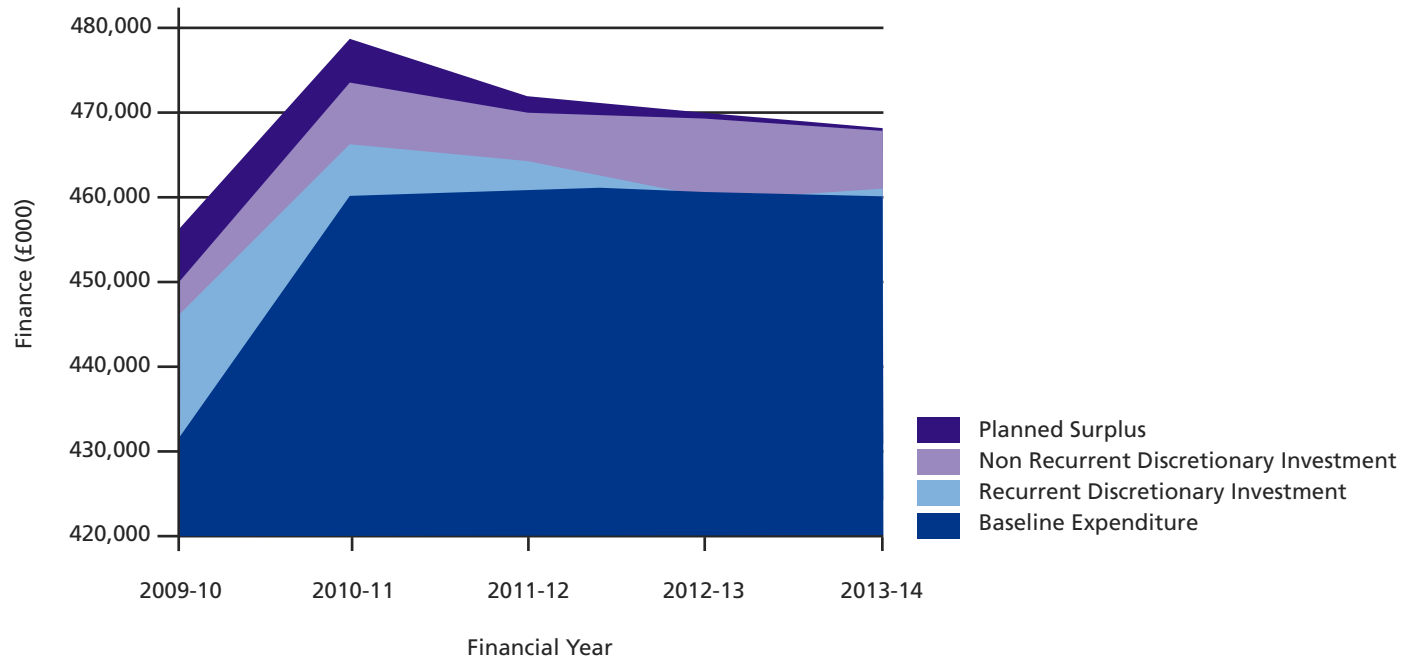


Key features of this scenario are:

- Allocation growth ceases during year 2 followed by an overall decrease in absolute available resource in future years as the brought forward surplus is utilised.
- Net Recurrent discretionary investment during the period is £20.4m
- Non recurrent investment over the period is £30.5m.

Within this scenario the profile of surplus, underlying recurrent position and compensating discretionary non recurrent investment is illustrated below.

Downside (Flat Cash) Scenario



3.7.3 Resource Utilisation

Underpinning the summary level financial assessments, set out above, are a number of crucial resource utilisation principles, derived from the commissioning strategy. Broadly, the principles can be categorised into the following three groups: changes to spend by care setting, strategic initiatives, savings and efficiency.

3.7.4 Changes to Spend by Care Setting

During the course of the five year period there are significant changes to the activity and associated finances when analysed by care setting. These changes are aligned to the commissioning strategy and reflect the overarching policy goals of high quality care, delivered via efficient and productive interventions in accessible ways, in locations that are closer to a patient's home than has historically been the case.

This is reflected by change to expenditure by care setting, as summarised in the table opposite.

From the table it can be seen that there is:

- An incremental investment in areas such as Specialised Services, Learning Disabilities, Continuing Health Care and Primary Care Prescribing that largely operate on a 'pool growth' basis.
- There is a modest to broadly neutral level of investment across Primary Care Contractors, Mental Health and Ambulance services.

Expenditure by care setting, £000s

		2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	CAGR*, %
Primary and Community	GPs	39,127	46,034	46,859	45,714	46,072	46,434	0.2%
	Prescribing	42,265	43,862	45,334	47,593	49,966	52,457	4.6%
	Dentistry	8,537	9,839	9,792	9,890	9,988	10,086	0.6%
	Community Provider Services	29,278	31,447	31,749	31,568	32,169	32,876	1.1%
	Pharmacies	3,693	4,210	8,020	8,058	8,098	8,138	17.9%
	Other							
	Walk In Centre	360	178	180	182	184	185	1.0%
	Polyclinics	-	-	-	-	-	-	n/a
	GP Led Health Centre	-	-	-	-	-	-	n/a
	Other	8,191	9,914	16,354	18,122	18,732	19,071	17.8%
Mental Health and Learning Disabilities	Mental Health	31,690	33,362	33,928	33,317	32,725	32,148	-0.9%
	Learning Disabilities	16,284	17,750	18,192	18,743	19,307	19,884	2.9%
Continuing Care	Continuing Care	13,137	14,274	16,205	17,099	18,005	18,925	7.3%
Secondary and Tertiary	NHS Foundation and Acute Care	156,945	170,860	174,313	170,028	161,610	156,070	-2.2%
	ISTC and Private Sector	-	-	-	-	-	-	n/a
	Ambulance Trusts	5,945	6,564	7,030	7,028	6,958	6,891	1.2%
	Other	-	-	-	-	-	-	n/a
Specialised Commissioning	Specialised Commissioning	32,930	35,066	36,618	37,161	37,785	38,497	2.4%

*Compound Annual Growth Rate from 2009/10 to 2013/14

- There is a significant disinvestment from acute hospital provided services, particularly within outpatients, representing both efficiency gains and qualitative gains from providing care closer to home. These reductions are partly offset by an increase in community provision.
- Community 'Other' exhibits a large increase, mainly due to technical changes to ophthalmic funding.

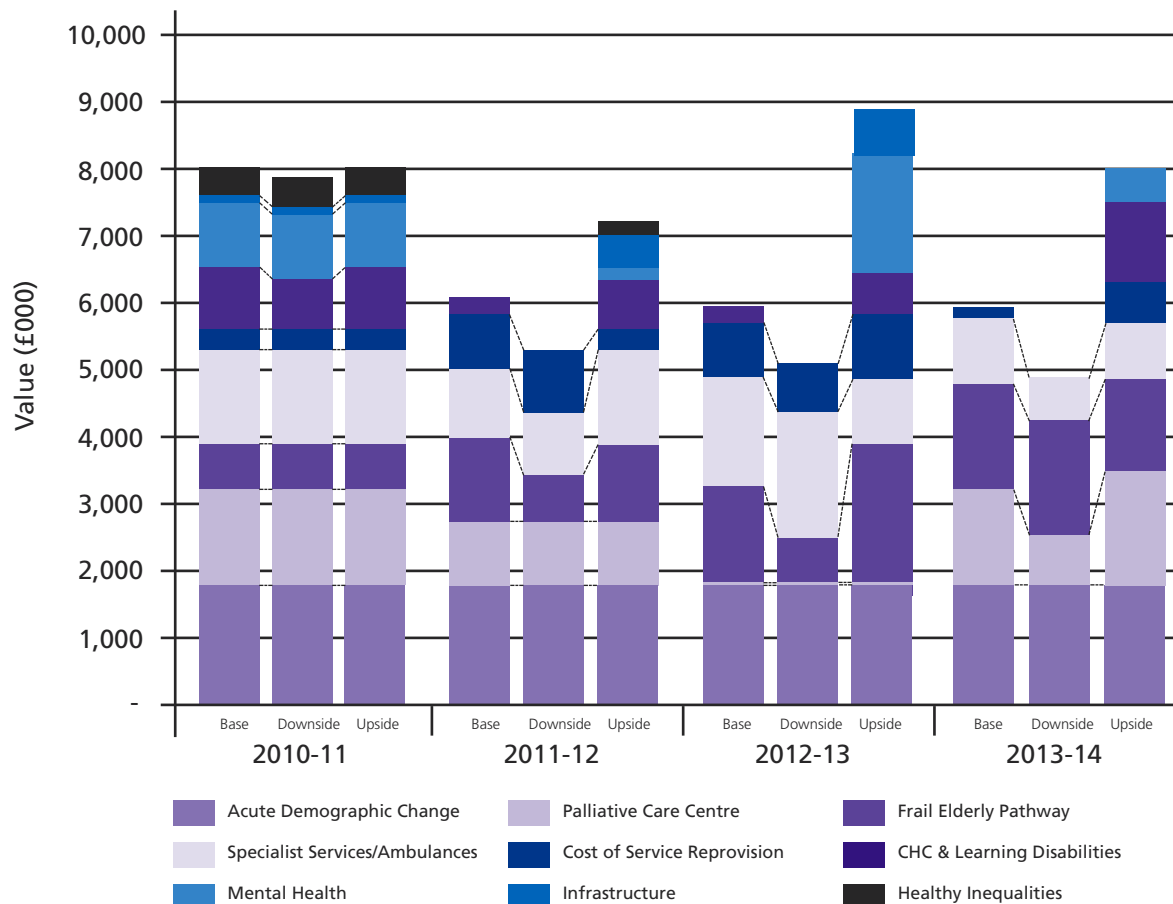
3.7.5 Strategic Initiatives

The delivery of key strategic initiatives underpins the Commissioning Strategy. The initiatives, set out in more detail within the initiatives section 4.2 of the document, are fully aligned to the financial plan. These initiatives have been prioritised as the most important areas of strategic change and therefore, as a consequence, resourced appropriately. However the quantum of funding available to the PCT to underpin the initiatives does vary depending on the financial scenario and as a result the level of investment within each initiative varies accordingly.

The chart below quantifies the level of investment, by finance scenario, for the strategic initiatives requiring the greatest input of funding.

From the chart it can be seen that:

- Under all three financial scenarios there is a significant level of investment across the initiatives.
- Investment within the base case scenario is £25.9m
- Investment within the downside scenario is £23.0m
- Investment within the upside scenario is £32.1m



3.7.6 Savings & Efficiency

A key assumption underlying the financial plan is a savings and efficiency requirement inherent within each financial scenario. This requirement is in addition to the nationally directed efficiency requirement, as set out within the national tariff, and thus automatically passed on to providers. These incremental savings and efficiency plans are aligned to the national and regional QIPP programmes (our approach to QIPP is set out in more depth in Section 5 of the strategy) and include an element of ‘flexing’ in respect of the alternate finance scenarios.

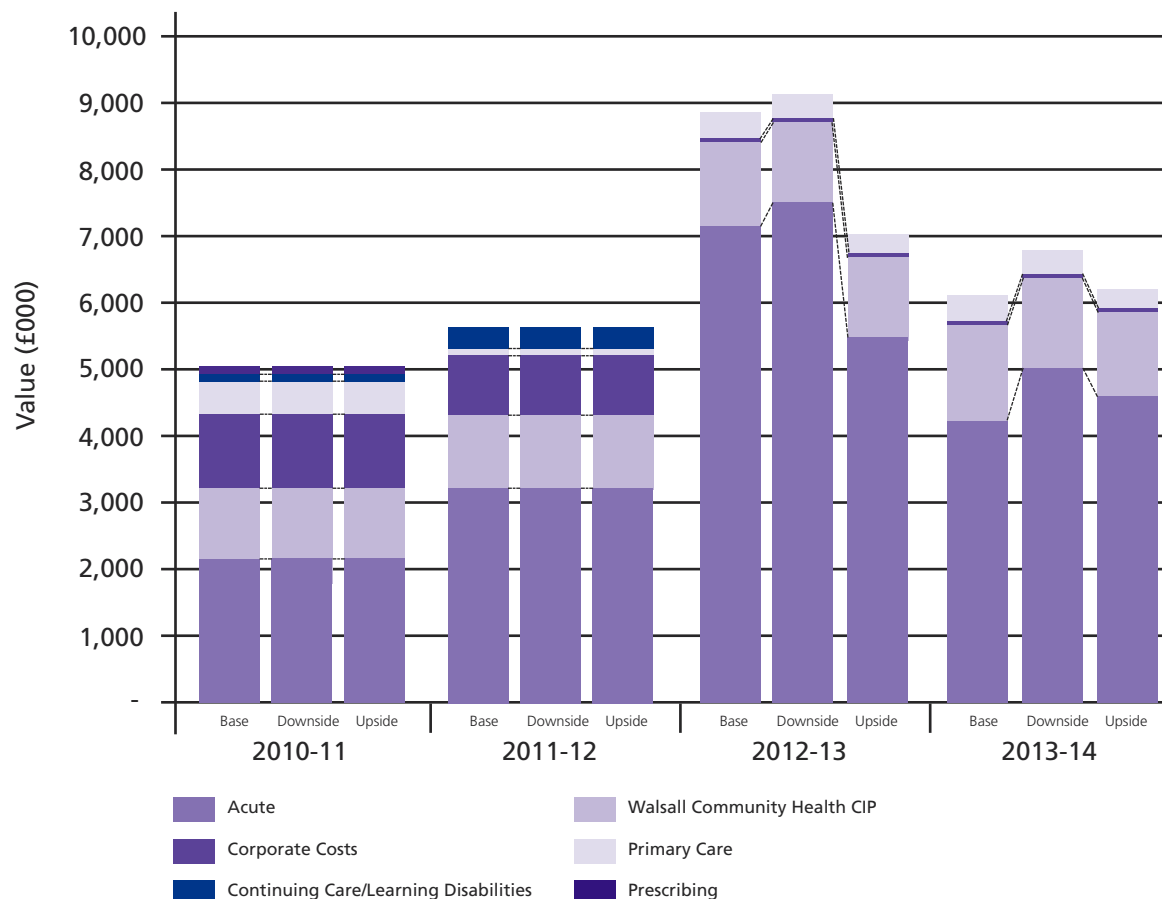
The chart to the right categorises the plans into several key groups, illustrating both the absolute values involved and how the targets are ‘flexed’ for the different scenarios.

From the chart it can be seen that across the six categories savings and efficiencies amount to some £25.7m within the base, £24.0m within the upside and £26.7m within the downside scenarios.

3.7.7 Implementing the Strategy

NHS Walsall will build upon its existing processes and mechanisms to control expenditure and improve quality. Mainstay components of this include:

- NHS contracts clearly and unambiguously specifying activity and finance plans, performance metrics, agreed demand management schemes and joint service development plans for the coming year. Contract performance management processes across acute, mental health and community provider services were embedded during 2009/10 and will be used to robustly manage contracts going forward. This approach is set



out within Section 5 of the document.

- Ring fenced recurrent CQUIN funding will be used annually on a non recurrent basis to incentivise providers on a scheme by scheme basis to deliver quality improvements, with particular emphasis on alignment to the QIPP agenda.
- Practice Based Commissioners will be full partners alongside PCT commissioners, providing clinical leadership and driving local developments. Section 5 of the strategy outlines this approach in more detail.

- The PCT utilised national Programme Budgeting information within its strategic delivery teams to help prioritise investment during 2010/11. In order to enhance this process, a bespoke exercise is underway during late 2009/10 to analyse Programme Budget information and improve the alignment to local delivery programmes. This analysis will be used to target resource allocation and be further developed during 2010/11.

3.7.8 Financial Risk Management

NHS Walsall is cognisant of a number of financial risks to the delivery of the commissioning strategy. Section 5.10 of the strategy provides a summary level assessment and quantification of those risks and the plans to mitigate them. However, at a strategic financial planning level, the PCT has identified two distinct approaches to mitigate and manage financial risks that do arise.

Firstly, the PCT has adopted the national guidance of seeking to commit only 98% of its resource recurrently at the budgeting startpoint each year. Of the remaining balance, the PCT will assess at the start of each year the proportion of resource that can be committed non recurrently immediately, to invest in strategic initiatives and the proportion to be held in reserve and committed in year, as circumstances permit. Clearly there is a balance to be struck here between the lead in time required to affect change in year and the assessment of prevailing financial risk.

Secondly, each year NHS Walsall will hold an unallocated risk reserve of 0.5% of allocation (approximately 2m) as a general contingency against in year cost pressures. This is a continuation of the local policy enacted during recent years.

3.7.9 Downside Sensitivity Analysis

Whilst formulation of the finances underpinning the commissioning strategy is based on the best currently available information as well as fully incorporating SHA guidance on assumptions, NHS Walsall is

cognisant of the prevailing macro economic conditions. Therefore, considerable thought has been given to a downside scenario that is worse than the formally modelled scenarios.

Consequently, the PCT is seeking to engage a partner organisation during late February 2010 to undertake a review of efficiency opportunities, both in terms of productivity and cash releasing gains, available to NHS Walsall. The programme will draw on the work of the existing internal delivery programmes as well as cross referencing with national and regional initiatives. As part of their remit the partner organisation will work with the PCT to not only identify a prioritised list of efficiency schemes and support NHS Walsall with the delivery mechanisms of the individual projects, but also to effect a significant transfer of knowledge and skills across to PCT officers.

4. Strategy

This section presents our strategy and prioritised initiatives and also reviews the process of how we have completed this strategic refresh.

4.1 Overview of Our Strategic Planning Process

We drew on a number of sources of information in order to establish the agenda for our strategic plan and these are detailed in Section 3 of this plan. There is a clear and direct relationship between the most pressing health inequalities (see page 66) in the region and the strategic goals that we have chosen to address, as shown in our Strategic Map (see page 65). We originally established a vision and set of values for the organisation alongside a series of aims and priorities as part of the WCC implementation last year. We have used a number of mechanisms (including a series of workshops) and have updated our comprehensive strategic map of the way in which our vision and strategic goals will be supported and delivered, ensuring that we have the most appropriate outcome measures relevant for our local needs. These have all been reviewed with our local partners, stakeholders (clinicians, staff, board members etc.) and representatives from our provider organisations in the last couple of months. Through these workshops we have both refined our priorities and, equally importantly, increased the capability of both individuals and the organisation to undertake this sort of analysis. A new programme structure will ultimately

provide the framework for the delivery of our strategic plans and initiatives.

Our Strategic Map shows how our overarching vision translates into our long-term strategic aims, our goals and then in turn how our programmes are translated into initiatives (actions) to reach our outcomes. There has been a huge amount of work over the years to identify the health needs of the people of Walsall and this information is updated regularly, particularly through our JSNA. We are clear on where there are significant local variations in health outcomes and what drives the issues of deprivation. We are also clear that there are a number of disadvantaged communities within the population whose needs can only be addressed in alliance with a range of other stakeholders - hence our need to implement our Integrated Care Economy approach.

We have a number of mechanisms of engagement with the local community and a range of stakeholder groups with whom we communicate including special interest groups and recently the MyNHS Walsall framework. All of these enable us to communicate with many thousands of Walsall citizens, ensuring that they

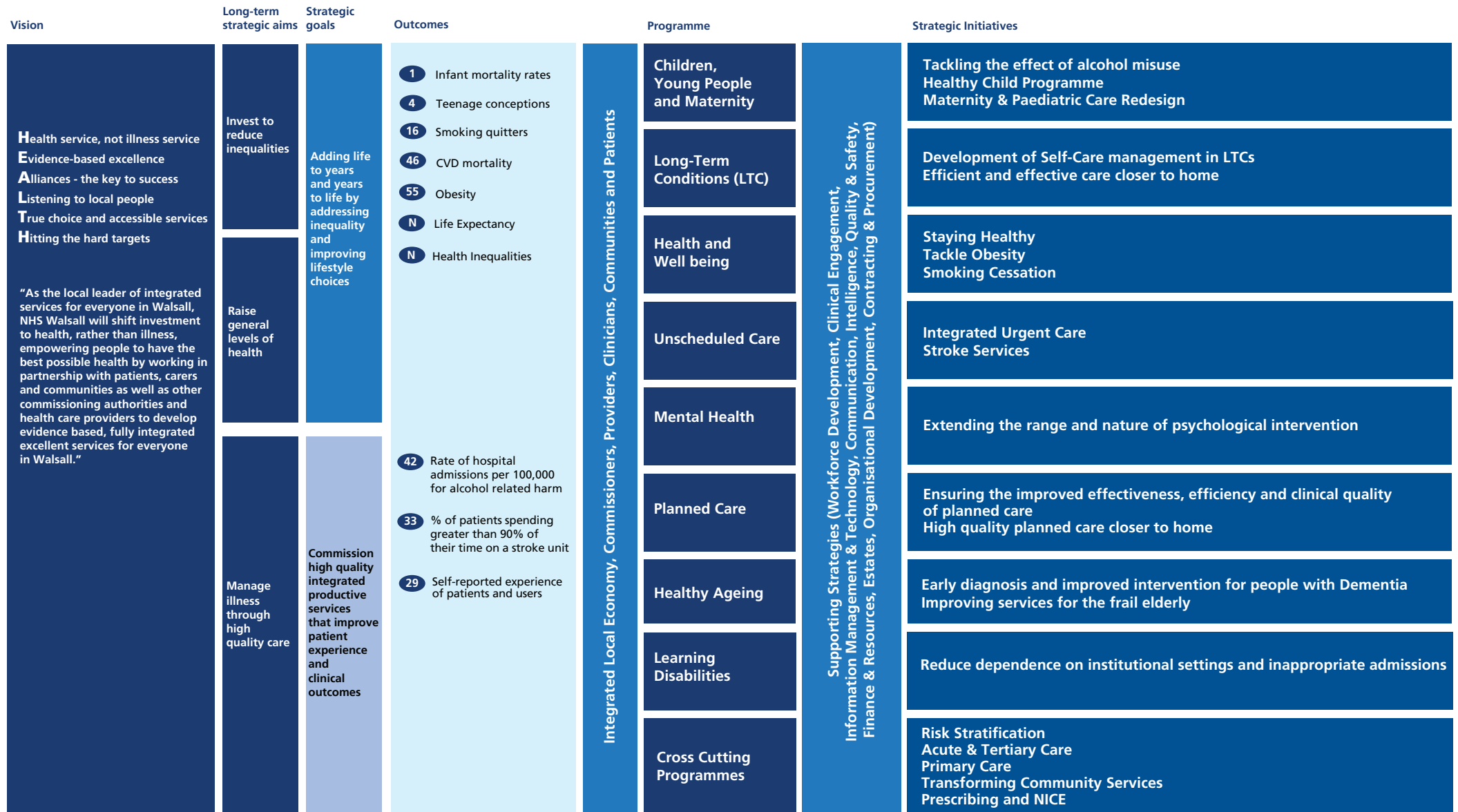
are aware of the agenda we have before us and - equally - the issues they believe we should address.

We have also been able to draw upon information from the Strategic Health Authority and in particular the IPSOS MORI telephone poll. These have identified a number of key priorities for us such as the provision of local hospital services and improvement in dental access, which we have acted upon. We can clearly demonstrate that our identified needs and priorities are in line with those that have been articulated at both a regional and national level.

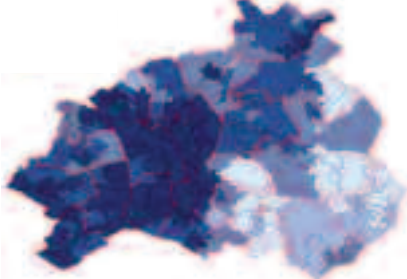
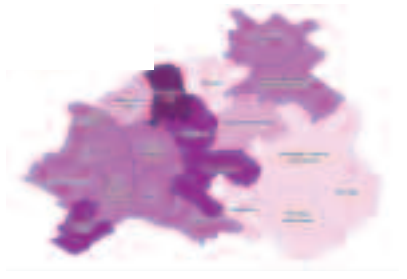







The outcomes that have now been agreed for NHS Walsall are shown against our long-term strategic aims and our strategic goals. If each of the strategic goals were realised we would see a substantial improvement in health of the people of Walsall.

The additional smaller maps presented after the strategic map illustrate the familiar pattern of the east and west divide in Walsall with issues of inequality and deprivation predominantly located in the west of the Borough.

Strategic Map



Strategic Goals and the Inequalities of the Region

Long-term strategic aims	Strategic goals	Walsall context*		
Invest in inequality	Adding life to years and years to life by addressing inequality and improving lifestyle choices	Index of Multiple Deprivation 	Life expectancy 	Infant mortality 
Raise general levels of health		Obesity 	Smoking 	Alcohol: binge drinking 
Manage illness	Commission high quality integrated productive services that improve patient experience and clinical outcomes	Chronic heart disease 	Lung cancer 	COPD 

* Darker shades indicate worse outcome/level of deprivation
 Source: Walsall JSNA summary and core data set, 2009; NHS Walsall Public Health Department

4.2 Our Prioritised Initiatives

4.2.1 Developing the Strategic Initiatives

NHS Walsall has developed a robust and engaged approach to prioritisation, begun as part of our preparations for last year's first WCC strategic plan. We agreed to significant changes to make the process both more systematic and robust. In the past there has been an implicit approach to prioritisation with no explicit explanation of criteria, but our approach this year illustrates our commitment to make the prioritisation process inclusive and evidence based. As illustrated in the next figure. The process is now thorough and systematic throughout, and key stakeholders are involved. The prioritisation of our health outcomes, as well as the development of our aims and goals is an iterative process involving workshops and considerable debate. Overall, we have held three prioritisation workshops involving key programme leads, members of the PEC, Practice Based Commissioners, GPs, Acute representatives, Public Health experts and all of our Executive and Non-Executive Board members. Through this approach we have identified a set of prioritisation criteria for ranking our strategic goals, programmes and initiatives.

In November 2009, we held a large workshop as part of the process of refreshing the Strategic Plan. Stakeholders within the local health, social care and third sector community attended including MyNHS Walsall parliament members and representatives from local voluntary sector organisations. Participants were asked to

develop and apply a set of criteria to prioritise the service transformation delivery programmes. This was designed in order to: inform the creation of a methodology and processes for making decisions regarding prioritisation; to help identify how the PCT should prioritise different initiatives and workstreams across our programmes; to tease out issues that the PCT needs to address in order to make prioritisation more effective; and identify where we need to do some short and longer-term development work. In the context of the Strategic Plan and the Business Planning Cycle, the work undertaken would also contribute to the review of the current commissioning plans at the programme level across the PCT.

After the event, the criteria and weightings identified by the whole group were categorised into the following themes:

- Needs Assessment, Best Practice, Benchmarking and Clinical Evidence
- Impact on Health Outcome
- Quality
- Affordability
- Engagement with Patients and the Public
- Prevention
- Partnership working
- Productivity
- Strategic fit
- Achievability

This democratic approach has been used in order to develop a prioritisation process that seeks to create an overarching core set of

criteria used to judge across and between programmes as well as programme specific criteria which are clearly linked to WCC outcomes and strategic goals.

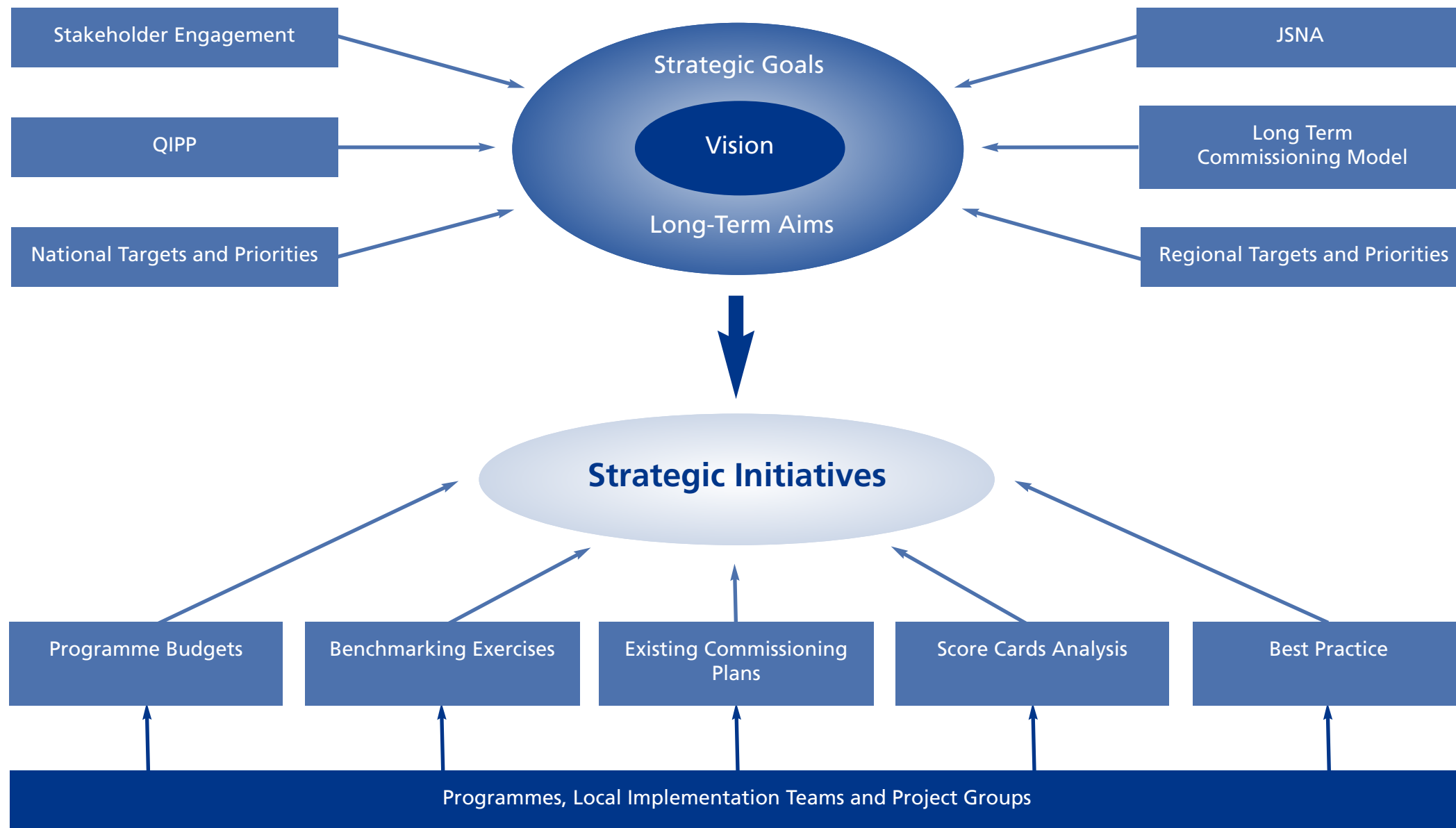
We achieved our goal of making the process of prioritisation clearly understood by all levels at NHS Walsall and by all key stakeholders. This in turn has ensured the support of both clinicians and providers.

4.2.2 Key Inputs to the Strategic Initiative Planning Process - Long Term Commissioning Model

The impact of our Strategic Initiatives have been calculated through a comparison with national best practice guidelines and benchmarking with high performing PCTs both in the West Midlands and with our ONS comparator group. These were then tested, in terms of impact through the use of our 'Long-term Commissioning Model' which employed a number of finance (allocation) and demand management scenarios in order to help inform the potential impact on the health economy over the next ten years. The model itself seeks to reconcile key financial assumptions (changes in resource allocation, national tariff and inflation, acute activity and identified spend from other key service areas) with key costs drivers (demographic change, disease prevalence, medical technology, access and prescribing rates) and saving strategies (demand management, service redesign, up-stream intervention) and is very much grounded in the approach taken by the Wanless Report).

Defining Our Strategic Initiatives

Note: Not exhaustive but illustrative of main influential factors



The modelling and analysis was undertaken at a high level and focussed on traditional PCT budget areas. The impact over 10 years was derived. Using this as a base we modelled a series of resource and demand management scenarios to assess the degree of change required to respond to need resources assumptions at the time. The outcome suggested that current models and pathways of care are unaffordable in the face of significant increases in need, particularly from frail older people. Reductions in unnecessary procedures, duplication of activity and provision of care through integrated care pathways were considered to be the most appropriate responses requiring input from all partner organisations and significant clinical engagement. This work was shared widely within the Local Health economy, including the Local Authority, providers and primary care and has been subsequently reviewed and informed our decisions around the strategic initiatives.

4.2.3 Key Inputs to the Strategic Initiative Planning Process - Programme Scorecards

In the development of the Programme Scorecards, the PCT has drawn together key performance information for each Programme and Clinical pathway along with relevant JSNA analysis and the (currently) notional Programme Budget information. This has been done in order to help prioritise the commissioning plans and strategic priorities for each of the programmes and therefore help to inform the link between our overall vision and values and strategic goals with the detailed commissioning work undertaken by our programme teams.

Going forward, this is our first step toward establishing the process of marginal analysis within our business planning and commissioning cycles in order to be able to address issues regarding the balance of investment between prevention and treatment in the services that we commission.

4.2.4 Key Inputs to the Strategic Initiative Planning Process - Decommissioning in Walsall

We have been developing our commissioning plans over the last 12 months; in particular we have been developing our approach to decommissioning of various services. These are reflected in our strategic initiatives and are based on the following principles developed as part of our commissioning strategy.

Our three principles are:

- Commissioning of best practice levels of activity as measured through national benchmarking and local analysis i.e. Better care Better Value and CBSA/PCT comparative analysis
- Development of programme budget approach
- Decommissioning procedures of Low Clinical Value. Building on the work the PCT has undertaken previously on prior approvals and working in collaboration with other PCTs.

These principals will ensure that commissioning plans which underpin the redesign of services address the impact on current provider capacity, so as to negotiate and deliver a reduction in capacity, thereby maximising value for money across the system.

Programme: Children, Young People and Maternity

Strategic Initiatives	WCC Target Outcomes	Target improvement 2013/14	Additional metrics specific to each initiative	Operational Milestones	Impact
<p>Tackling the effect of alcohol misuse</p> <p><i>Description</i> Commission integrated services on a continuum from prevention to structured treatment to address the impact of alcohol</p>	<p>Rate of hospital admissions per 100,000 for alcohol related harm</p> <p>Life Expectancy</p> <p>Health Inequality</p>	<ul style="list-style-type: none"> Reduce the number of annual hospital admissions by 625 against a baseline of 2714 2.6 year increase in life expectancy Reduce sloping index of inequality by 1.3 	<ul style="list-style-type: none"> Deaths from chronic liver disease Number of brief alcohol interventions delivered in primary care Number of referrals into open access alcohol service Number entering and completing care planned exits in structured intervention service Number of community detoxifications and inpatient detoxification 	<ul style="list-style-type: none"> Deliver 50 training sessions to NHS and partner agencies staff in brief interventions by April 2010 Reconfigure alcohol arrest referral and hospital liaison staff to support a weekend town centre partnership triage team June 2010 Review community and inpatient detoxification services by September 2010 and associated action plan to be delivered by 2013 	<p><i>Improvement in the quality and efficiency of Alcohol services in order to cap admissions related to alcohol to 2089 (annual) with an associated reduction in crime and social issues</i></p>
<p>Healthy Child Programme</p> <p><i>Description</i> Develop integrated cross-economy children's services to improve health</p>	<p>Teenage Conception</p> <p>Prevalence of Obesity in yr 6 children</p> <p>Infant Mortality</p> <p>Life Expectancy</p> <p>Health Inequalities</p>	<ul style="list-style-type: none"> Reduce teenage conceptions by 4.1 To reduce recorded Obesity in year 6 children from 19.9 to 18.7 Reduce infant mortality (per 1000 live births) from 7.6 to 4.4 2.6 year increase in life expectancy Reduce sloping index of inequality by 1.3 	<ul style="list-style-type: none"> Under 16 conception rate Increase numbers of young parents accessing Care to Learn funds Measure of the number of young adults not in education, employment or training Immunisation rates for HPV, MMR, Diphtheria, Tetanus, Polio, Pertussis, PCV Boster, Hib, MenC, MMR Access to respite/childcare for children with complex needs/disabilities 	<ul style="list-style-type: none"> 95% of schools to have embedded the 'whole school approach to teenage pregnancy' within their PSHE curriculum by 2011 Recommissioning of the Hospital at Home Service and agreed pathways for Children with complex health needs by 2011 A joint Disability Database in place by March 2011 Choice of short break for 3% of Walsall disabled children population by 2012 150 women enrolled in the FNP, by March 2011 95% immunisation rate for children aged 2 and 5 by 2011 The number of condom outlets in Walsall to be increased by 10% by 2012 	<p><i>Improved child development and emotional well-being. Early detection of, and action to, address developmental delay, ill health and concerns about safety, mental health problems and complex social issues. Improved quality of life for children with profound disabilities and their families</i></p> <p><i>Raise the aspirations of our young people and enable them to feel in control of their lives through making positive choices. Provide easy local access to prevention services for our young people to encourage them to take responsibility for their sexual needs</i></p>
<p>Maternity & Paediatric Care Redesign</p> <p><i>Description</i> Redesign of clinical treatment services to ensure the provision of effective and high quality services.</p>	<p>Infant mortality rate per 1000 live births (3 yr rolling avge)</p>	<ul style="list-style-type: none"> Reduce infant mortality (per 1000 live births) from 7.6 to 4.4 	<ul style="list-style-type: none"> Patients to have seen a maternity healthcare professional by 12 weeks and 6 days of pregnancy Infants have a recorded breastfeeding status at their 6-8 week check Caesarean section rates Breastfeeding initiation rates Proportion of smokers who quit during pregnancy 	<ul style="list-style-type: none"> Halt or reduce obesity in mothers with BMI above 35. 150 mothers recruited by March 2011 (IfH project 2b) Review of maternity service, agreed plan and SLA agreed and in place by March 2011. Delivery of the action plan by 2013 Reduce number of interventions per birth to benchmarked comparator PCT by 2013 Stage 11 baby friendly accreditation by 2012 	<p><i>Improvement in the quality and efficiency of Maternity and Children's services resulting in reduced demand for hospital-based services</i></p> <p><i>Combined saving £3,440,000 by 2014</i></p> <p><i>Reduce elective admissions by 132, reduce emergency admissions by 576, reduce outpatient appointments in secondary care by 2388 by 2014</i></p> <p><i>An investment of £734,000 is required</i></p>

Programme: Long-Term Conditions

Strategic Initiatives	WCC Target Outcomes	Target improvement 2013/14	Additional metrics specific to each initiative	Operational Milestones	Impact
Development of Self-care management in LTCs <i>Description</i> Development of services that allow patients to better manage their own condition	CVD Mortality Life Expectancy	<ul style="list-style-type: none"> • Improve CVD mortality in the under 75s (per 100,000 pop) from 98.9 to 72.8 • 2.6 year increase in life expectancy 	<ul style="list-style-type: none"> • Referral rates to Phase I cardiac rehab service • Referral rates to community pulmonary rehab service • Uptake rates of Telehealth, Self-care and Expert Patient Programmes 	<ul style="list-style-type: none"> • Reduce emergency admissions by 534 (as part of overall LTC target) by 2014 • Development of Self-Care Management Strategy by October 2010 • Full implementation of Self-Care Management Strategy by 2013 	<i>More patients able to manage their condition with the help of assistive technology, telehealth and social marketing support resulting in reduced demand for hospital-based services. Self-care management will support the delivery of service redesign in the management of long-term conditions and the impact on resource and activity has been modelled into the initiative below</i>
Efficient and Effective Care Closer to Home <i>Description</i> Redesign of services to ensure that they are accessible, of a high quality, cost effective and efficient	Self-reported experience of patients and users CVD Mortality Life Expectancy	<ul style="list-style-type: none"> • 2% improvement in patient satisfaction rates over baseline • Improve CVD mortality in the under 75s (per 100,000 pop) from 98.9 to 72.8 • 2.6 year increase in life expectancy 	<ul style="list-style-type: none"> • COPD Mortality Rates • COPD Prevalence • Diabetes controlled blood sugar • CHD controlled blood pressure • CHD controlled Cholesterol 	<ul style="list-style-type: none"> • Review COPD team by end April 2010. Agree action plan by May 2010. Review COPD pathway by November 2010 and implement changes by March 2011 • Reduce the number of secondary care Long-Term Conditions outpatient appointments by 1601 by 2014 • Reduce emergency admissions for Long-Term Conditions by 534 by 2014 	<i>More patients attending community-based outpatient, monitoring and treatment services for Long-Term Conditions and resulting in improvements in effectiveness and efficiency in the delivery of services, greater patient satisfaction and a reduction in the demand for hospital based services</i> <i>£126,000 saved on outpatients, £1,700,000 saved on emergency admissions by 2014</i> <i>Reduce outpatients in a secondary care setting by 1601 and emergency admissions by 534 by 2014</i> <i>Investment required £85,000</i>

Programme: Health and Wellbeing

Strategic Initiatives	WCC Target Outcomes	Target improvement 2013/14	Additional metrics specific to each initiative	Operational Milestones	Impact
Staying Healthy <i>Description</i> Improve the impact and choice of existing lifestyle management services	Life Expectancy Infant Mortality Health Inequality Teenage Conception CVD Mortality	<ul style="list-style-type: none"> 2.6 year increase in life expectancy Reduce infant mortality (per 1000 live births) from 7.6 to 4.4 Reduce sloping index of inequality by 1.3 Reduce teenage conceptions by 4.1 Reduce CVD mortality in the under 75s (per 100,000 pop) from 98.9 to 72.8 	<ul style="list-style-type: none"> Uptake rates for Health Checks Programme Screening uptake rates Frequency of physical activity in adults Proportion of the population eating five portions of fruit and vegetables per day GUM Access rates 	<ul style="list-style-type: none"> Commence implementation of the Sexual Health Strategy by 2011/12 Implementation of Fuel Poverty GP referral scheme 2010/11 Complete first cycle of Health Checks Programme by 2013/14 	<i>NHS Health Checks programme will, on average, prevent eight heart attacks and strokes and save at least three lives each year in Walsall. The programme could also prevent over 20 people a year from developing diabetes and detect at least 100 cases of diabetes or kidney disease earlier, allowing individuals to be better managed and improve their quality of life. £926,000 saving on emergency admissions and sexual health services by 2014. Emergency admissions reduced by 168, outpatient appointments in a secondary care setting reduced 6858 by 2014 Investment required £298,000</i>
Tackle Obesity <i>Description</i> To reduce obesity in the Walsall population	Prevalence of Obesity in Yr 6 children Health Inequality Infant Mortality	<ul style="list-style-type: none"> To reduce recorded Obesity in year 6 children from 19.9 to 18.7 Reduce sloping index of inequality by 1.3 Reduce infant mortality (per 1000 live births) from 7.6 to 4.4 	<ul style="list-style-type: none"> Prevalence of Obesity in reception and Yr 4 children No. of children accessing weight management programmes No. of children that have accessed a weight management programme who maintain their weight Patients accessing the adult obesity pathway Percentage of adults retained on weight management programmes Patients achieving a 5% weight loss at levels 2 and 3 of the adult obesity pathway Patients achieving a 10% weight loss above level 4 of the adult obesity pathway 	<ul style="list-style-type: none"> 90% of children will have their height and weight recorded in reception and Year 6 by end of 2011 1800 children will have accessed a weight management programme by 2013 800 children, who have completed a weight management programme, will have maintained their weight by 2014 6000 patients on levels 2 and 3 of the adult obesity pathway will have achieved a 5% weight loss by 2014 500 patients on level 4 and above of the adult obesity pathway will have achieved a 10% weight loss by 2014 	<i>It is estimated that between 37,000 and 66,000 adults in Walsall are obese. 10-15% of these will achieve a 5-10% weight loss through the weight management pathway by 2014</i> <i>10% weight loss is associated with a 20% reduction in total mortality rates</i> <i>30% reduction in diabetes related deaths</i> <i>40% reduction in certain cancers and reduction in type II diabetes prevalence</i> <i>Investment required £250,000</i>
Smoking Cessation <i>Description</i> To reduce the number of smokers in Walsall	Smoking Quitters Health Inequality CVD Mortality	<ul style="list-style-type: none"> Reduce the number of smoking quitters (per 100,000 pop) from 925 to 835 Reduce infant mortality (per 1000 live births) from 7.6 to 4.4 Reduce CVD mortality in the under 75s (per 100,000 pop) from 98.9 to 72.8 	<ul style="list-style-type: none"> Referrals to the smoking cessation service (Walsall Manor CQUIN scheme) Smoking during pregnancy 	<ul style="list-style-type: none"> Introduction of Tariff based payment system for Stop Smoking services from 1 April Full develop market and provider capacity for Stop Smoking Services in order to maximise impact by 2012. 	<i>Reduction in infant mortality rate of 0.3 per 1000 and an extra 750 smokers quitting. With a quit rate of 50% in preoperative patients, there will be 400 fewer post-operative complications, a saving of 264 bed days, and an associated cost saving of £110,000. By the end of year 2, all costs associated with supporting people to quit could be recouped. By year 5, cumulative savings are more than four times the original investment. For every £1 invested in smoking cessation in pregnancy there is a £3-4 cost saving Investment required £125,000</i>

Programme: Unscheduled Care

Strategic Initiatives	WCC Target Outcomes	Target improvement 2013/14	Additional metrics specific to each initiative	Operational Milestones	Impact
Integrated Urgent Care <i>Description</i> Development of an integrated urgent care service	Self-reported experience of patients and service users	<ul style="list-style-type: none"> 2% improvement in patient satisfaction rates over baseline 	<ul style="list-style-type: none"> 98% of people attending A/E wait no longer than four hours for treatment Ambulance response times to emergency calls Ambulance turnaround times Access to critical care from A/E Delayed transfers of care Hospital length of stay for emergency admissions Legible information from A/E to GP within 48 hours following attendance/discharge 	<ul style="list-style-type: none"> Opening of the Urgent Care Centre at Walsall Manor Hospital by end of September 2010 Full implementation of diversion pathways project by 2011/12 	<p><i>Greater efficiency and effectiveness in the delivery of urgent care services resulting in reduced A/E attendances and emergency admissions</i></p> <p><i>Saving of £731,000 by 2013</i></p> <p><i>Reduce emergency admission by 317 by 2013. Reduce Accident & Emergency attendances by 24,546 by 2014</i></p> <p><i>Investment required £1,522,000</i></p>
Stroke Services <i>Description</i> Development of Stroke services in order to deliver prevention, high quality integrated care and rehabilitation services	% of patients spending greater than 90% of their time on a stroke unit. Self-reported experience of patients and users	<ul style="list-style-type: none"> Improve to 88% by 2013/14 2% improvement in patient satisfaction rates over baseline 	<ul style="list-style-type: none"> TIA assessment within 24 hours Regional stroke standard for therapy time across stroke pathway Access to CT/MRI for suspected stroke admission 	<ul style="list-style-type: none"> Maximum length of stay in hospital for Stroke patients of 14 days by the end of 2010 Reduce Stroke mortality rate within 30 days by at least 40% by the end of 2010 Introduce early supported discharge for relevant stroke patients by end of 2010 Introduce revised model of TIA management by April 2010 	<p><i>Improvement in the effectiveness and efficiency of services to guarantee key national targets for Stroke patients, improve recovery, survival and outpatient satisfaction rates</i></p> <p><i>£185,000 saved in avoided emergency admissions by 2013</i></p> <p><i>100 emergency admissions avoided by 2013</i></p>

Programme: Mental Health

Strategic Initiatives	WCC Target Outcomes	Target improvement 2013/14	Additional metrics specific to each initiative	Operational Milestones	Impact
<p>Extending the range and nature of Psychological Intervention</p> <p><i>Description</i> Extending the range and nature of Psychological Intervention</p>	<p>Self-reported experience of patients and service users</p>	<ul style="list-style-type: none"> 5% improvement in patient satisfaction rates over baseline 	<ul style="list-style-type: none"> Waiting time for first contact from date of referral For IAPT - the number of people assessed as moving to recovery as a proportion of those who have completed a course of psychological therapy Numbers of patients commencing psychological therapy 	<ul style="list-style-type: none"> Commence procurement programme Feb 2010 Award contract August 2010 Full implementation April 2011 Undertake demand and capacity analysis for decommissioning acute provision 2013 Commence decommissioning some acute provision 2014 	<p><i>Improve the quality and effectiveness of early intervention services in order to help to regulate demand for complex services</i></p> <p><i>Investment required £382,000</i></p>

Programme: Planned Care

Strategic Initiatives	WCC Target Outcomes	Target improvement 2013/14	Additional metrics specific to each initiative	Operational Milestones	Impact
<p>Ensuring the improved effectiveness, efficiency and clinical quality of planned care</p> <p><i>Description</i> To ensure the improved effectiveness, efficiency and clinical quality of planned care including making disinvestment in those services with low clinical value</p>	<p>Self-reported experience of patients and service users</p> <p>Health Inequality</p> <p>Life Expectancy</p>	<ul style="list-style-type: none"> • 2% improvement in patient satisfaction rates over baseline • Reduce sloping index of inequality by 1.3 • 2.6 year increase in life expectancy 	<ul style="list-style-type: none"> • 18 week referral to treatment waiting times • Waiting times for diagnostics • Cancellation rates for Outpatient Appointments and Elective Surgery • Outpatient DNA rates 	<ul style="list-style-type: none"> • Implement action plans to reduce consultant to consultant referrals by 2011/12 and elective admissions by 2012/13 including procedures of low clinical value 	<p><i>Improvements in the efficiency and effectiveness of services provided to the population of Walsall resulting in a higher quality of care, improved patient satisfaction and efficiency savings</i></p> <p><i>Combined saving of £1,775,000 on elective admissions and consultant to consultant referrals by 2014</i></p> <p><i>Reduce elective admissions by 1737 by 2013/14 and consultant to consultant referrals by 3168 by 2013</i></p> <p><i>Investment required £45,000</i></p>
<p>High quality planned care closer to home</p> <p><i>Description</i> To redesign planned care services in order to deliver improvements in quality, choice and responsiveness in a way that contributes to the management of demand for services</p>	<p>Self-reported experience of patients and service users</p> <p>Health Inequality</p> <p>Life Expectancy</p>	<ul style="list-style-type: none"> • 2% improvement in patient satisfaction rates over baseline • Reduce sloping index of inequality by 1.3 • 2.6 year increase in life expectancy 	<ul style="list-style-type: none"> • GP referrals to acute providers • Cancer pathway waiting times • Measure of public confidence in the local NHS • Choose and Book slot availability 	<ul style="list-style-type: none"> • Commence implementation of outpatient triage and assessment services by 2011/12 and Chemotherapy and Hernia repair community based services by 2012/13 	<p><i>The creation of outpatient and minor surgical services based in a community setting resulting in improved patient choice, satisfaction and reduced demand for hospital based services</i></p> <p><i>Combined saving of £1,956,000 by 2014</i></p> <p><i>Reduce elective admissions by 2148 and outpatients by 44887 by 2014</i></p> <p><i>Investment required £1,969,000</i></p>

Programme: Healthy Ageing

Strategic Initiatives	WCC Target Outcomes	Target improvement 2013/14	Additional metrics specific to each initiative	Operational Milestones	Impact
<p>Early Diagnosis and Improved Intervention for people with Dementia</p> <p><i>Description</i> Develop services for early diagnosis and improved treatment for patients with Dementia in order to address predicted increases in demand</p>	<p>Self-reported experience of patients and service users</p>	<ul style="list-style-type: none"> 2% improvement in patient satisfaction rates over baseline 	<ul style="list-style-type: none"> Reduction in nursing/residential home admissions for Dementia through increased access to community care Waiting time from referral to first contact for Dementia patients 	<ul style="list-style-type: none"> 10% increase in new referrals to the memory service by 2011 Reduce unplanned mental health hospital admissions by 10% by 2011 Achieve National Dementia Strategy objective of 65% of prevalence by 2014 	<p><i>Improvement in the early detection and treatment for Dementia, helping patients to manage their condition and regulating demand for hospital based services for those patients with advanced Dementia. This will reduce the percentage of people with undiagnosed Dementia, reduce inappropriate admissions to hospital for people with Dementia, improve the management of people with diagnosed Dementia and the quality of life of carers of people with Dementia</i></p>
<p>Improving Services for the Frail Older People</p> <p><i>Description</i> Develop integrated cross health and social care economy services for the frail elderly that promote self care, independence and quality of life</p>	<p>Self-reported experience of patients and service users</p>	<ul style="list-style-type: none"> 2% improvement in patient satisfaction rates over baseline 	<ul style="list-style-type: none"> Emergency admissions and readmission rates for frail older people Hospital acquired infections for this patient group Reduction in long-term nursing and residential home placements Measure of public confidence in the local NHS Hospital length of stay for this patient group 	<ul style="list-style-type: none"> Establish Frail Older People Integrated Pathway by 2011/12 	<p><i>Frail Older People will be cared for by a multidisciplinary health and social care team based in the community allowing patients to stay at or close to home</i></p> <p><i>£2,812,000 saving by 2013</i></p> <p><i>Non-elective admissions reduced by 1,125 by 2013</i></p> <p><i>Investment required £886,000</i></p>

Programme: Learning Disabilities

Strategic Initiatives	WCC Target Outcomes	Target improvement 2013/14	Additional metrics specific to each initiative	Operational Milestones	Impact
<p>Reduce dependence on institutional settings and inappropriate admissions</p> <p><i>Description</i> Complete resettlement of all people from long stay hospital or NHS residential provision</p> <p>Reduce the number of adults in residential placements overall; reduce 'out of area' placements</p>	<p>Self-reported experience of patients and service users</p>	<ul style="list-style-type: none"> • 5% improvement in patient satisfaction rates over baseline 	<ul style="list-style-type: none"> • Measure of number of people living independently or supported to live independently 	<ul style="list-style-type: none"> • Complete the resettlement programme by October 2010 with the agreement of individual plans for ten people currently within residential care • 20% reduction in the number of people in residential care by 2013/14 (5% annual reduction) 	<p><i>People who have learning disability will enjoy an improvement in their level of independence and feel better integrated into their local communities. There will be improved levels of quality in the care received and better access for families and carers</i></p> <p><i>£100,000 saving through the use of a tendered service with Walsall Council for Continuing Care by 2011</i></p> <p><i>Predicted growth in funding £6,784,000</i></p>

Programme: Cross Cutting Programme

Strategic Initiatives	WCC Target Outcomes	Target improvement 2013/14	Additional metrics specific to each initiative	Operational Milestones	Impact
<p>Risk Stratification</p> <p><i>Description</i> Development of Risk Stratification mechanisms to support and inform the development of services that seek to prevent patients becoming unwell or their condition worsening</p>	<p>Life Expectancy</p> <p>CVD Mortality</p> <p>Health Inequality</p>	<ul style="list-style-type: none"> 2.6 year increase in life expectancy Improve CVD mortality in the under 75s (per 100,000 pop) from 98.9 to 72.8 Reduce sloping index of inequality by 1.3 	<ul style="list-style-type: none"> GP Uptake of Unique Care Emergency admissions LTCs 	<ul style="list-style-type: none"> Implement Unique care by 2011 Implement strategic PCT population risk management system by 2011 	<p>GPs will play a proactive role in identifying patients at risk of an acute exacerbation of their (long-term) condition in order to co-ordinate the necessary intervention, care, advice and guidance so as to avoid an emergency admission to hospital. The PCT will undertake whole population analysis in order to predict future demand, identify high risk and high reward opportunities, target resource to maximise benefit and review and evaluate in order to continuously inform the commissioning process</p> <p>Investment currently required £160,000</p>
<p>Acute and Tertiary</p> <p><i>Description</i> Development of supporting systems and processes that facilitate the management of variation in activity, referral and use of services for secondary and tertiary acute services</p>	<p>Self-reported experience of patients and service users</p> <p>Health Inequality</p> <p>Life Expectancy</p>	<ul style="list-style-type: none"> 2% improvement in patient satisfaction rates over baseline Reduce sloping index of inequality by 1.3 2.6 year increase in life expectancy 	<ul style="list-style-type: none"> Variation in surgical thresholds - relative level of surgery for five key procedures GP referrals to acute providers Variation in outpatient appointments - relative levels of appointments and attendances Variation in emergency admissions - benchmark variations for 19 conditions 	<ul style="list-style-type: none"> Undertake acute services review by 2011 Implement agreed action plan from acute services review by 2012 <p>Note: See also Planned Care Programme Operational Milestones</p>	<p>Reduction in variation (as benchmarked against comparator PCTs) in referral rates for and in the use of services in order to maximise productivity and commissioning impact at programme level</p> <p>Decommissioning of procedures of low clinical value. Inter-dependent with Planned Care Programme</p> <p>Current growth estimated £16,715,000</p>
<p>Primary Care</p> <p><i>Description</i> Development of Primary Care in order to ensure that it has the maximum impact upon the health of the population</p>	<p>Self-reported experience of patients and service users</p> <p>Health Inequality</p> <p>CVD Mortality</p>	<ul style="list-style-type: none"> 2% improvement in patient satisfaction rates over baseline Reduce sloping index of inequality by 1.3 Improve CVD mortality in the under 75's (per 100,000 pop) from 98.9 to 72.8 	<ul style="list-style-type: none"> Eight main domains of the national GP survey Variation in referral rates Variation in QoF scores Primary care strategy development, development of the implementation plan and delivery of agreed actions 	<ul style="list-style-type: none"> Primary Care Strategy to be agreed by PCT Board June 2010 Implementation of Primary Care Strategy by 2012 	<p>Primary care services will be improved in order to provider better access, quality and choice to Walsall residents</p> <p>Additional 111,930 GP attendances by 2013 and 55,248 Dentist attendances by 2011</p> <p>£4,145,000 on expanding GP capacity, £990,000 on Dentistry</p>

Programme: Cross Cutting Programme cont.

Strategic Initiatives	WCC Target Outcomes	Target improvement 2013/14	Additional metrics specific to each initiative	Operational Milestones	Impact
<p>Transforming Community Services</p> <p><i>Description</i> Development of Community based services in order to maximise impact on the treatment and ongoing management of patients in a community setting</p>	<p>Self-reported experience of patients and service users</p> <p>Health Inequality</p>	<ul style="list-style-type: none"> • 5% improvement in patient satisfaction rates over baseline • Reduce sloping index of inequality by 1.3 	<ul style="list-style-type: none"> • Efficiency ratings • Delivery against agreed action plans 	<ul style="list-style-type: none"> • TCS Strategy agreed and action plans for delivery by 2010 with the associated delivery of planned actions by 2012 • Development of an efficiency programme for Walsall Community Health to deliver efficiency savings by 2013/14 	<p><i>Community services will be improved in order to provide improved access, choice and range of services in order to prevent patients requiring a hospital admission</i></p> <p><i>Cost efficiency saving of £5,900,000 by 2013/14</i></p>
<p>Prescribing and NICE</p> <p><i>Description</i> Development of guidelines and processes which seek to maximise the impact of Prescribing activity and NICE guidance on the health of the population</p>	<p>Life Expectancy</p>	<ul style="list-style-type: none"> • 2.6 year increase in life expectancy 	<ul style="list-style-type: none"> • Prescribing Incentive Scheme • Use of Statins, Proton Pump Inhibitors and ACE Inhibitors benchmarked against best practice 	<ul style="list-style-type: none"> • Implementation of Medicines Management Strategy 2011, development, refresh and implementation of Strategy 2011-2014 • Maintain upper quartile performance (in the context of reduced growth) in all prescribing benchmarks through to 2013/14 	<p><i>Efficiency programme to maximise the impact of prescribing through benchmarking, moderation of scripts issued against national benchmarks and benchmarking in the use of generic prescribing</i></p> <p><i>£1,441,000 efficiency savings by 2014</i></p> <p><i>Estimated underlying growth required £15,476,000 by 2014</i></p>

4.2.5 Summary of Programme Budgets and Strategic Initiatives

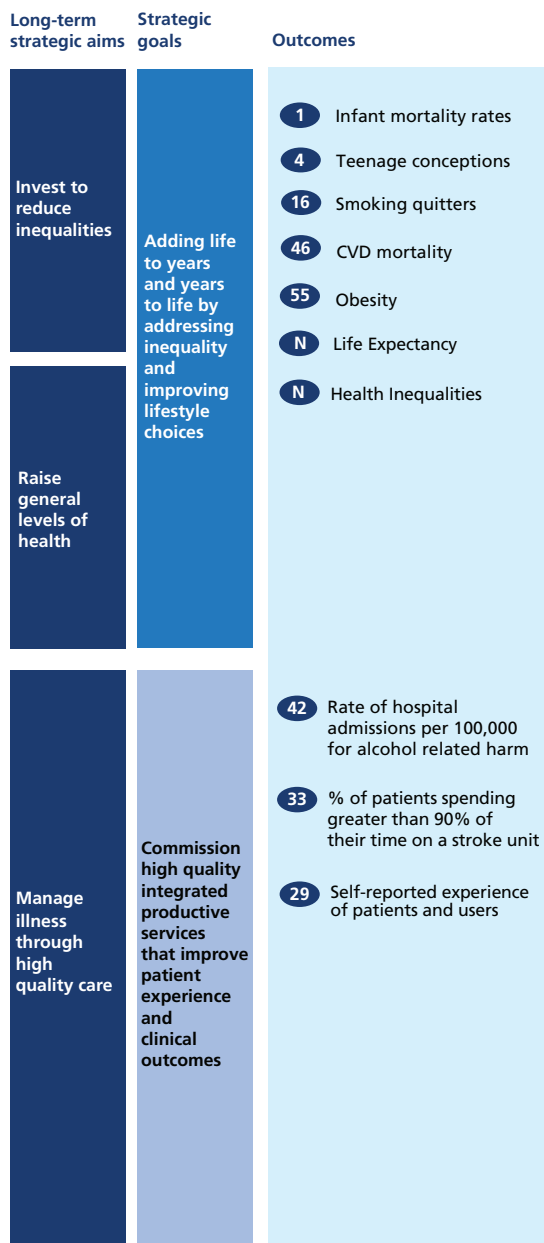
We have been able to relate our initiatives to our Target Health Outcomes and we have focused on the impact that they will have as well as the required recurrent investment.

Programme	Notional Programme Budget	PCT Comparator	Strategic Initiatives	Investment	Net Saving
Children, Young People and Maternity	£7.3m per 100,000 pop	-0.4m	Tackling the effect of alcohol misuse Healthy Child Programme Maternity & Paediatric Care Redesign	£734,000	£3,440,000
Long Term Conditions	£15.7m per 100,000 pop	-0.45m	Development of Self-Care management in LTCs Efficient and effective care closer to home	£85,000	£1,827,000
Health and Well being	£7.1m per 100,000 pop	+2.7m	Staying Healthy Tackle Obesity Smoking Cessation	£298,000 £250,000 £125,000	£926,000
Unscheduled Care	£23.25m per 100,000 pop	-0.4m	Integrated Urgent Care Stroke Services	£1,522,000	£731,000 £185,000
Mental Health	£15.17m per 100,000 pop	-2.92m	Extending the range and nature of psychological intervention	£382,000	
Planned Care	£36.15m per 100,000 pop	-2.75m	Ensuring the improved effectiveness, efficiency and clinical quality of planned care High quality planned care closer to home	£45,000 £1,969,000	£1,775,000 £1,956,000
Healthy Ageing	Programme Budget not yet identified		Early diagnosis and improved intervention for people with Dementia Improving services for the frail elderly	£886,000	£2,812,000
Learning Disabilities	£7.59m per 100,000 pop	+2.17m	Reduce dependence on institutional settings and inappropriate admissions	£6,784,000	£100,000 saving on growth with the opportunity for further efficiency
Cross Cutting Programmes	Programme Budget not yet identified		Risk Stratification Acute & Tertiary Care Primary Care Transforming Community Services Prescribing and NICE	£16,715,000 £5,135,000 £15,476,000	Not quantified Savings spread across other Strategic Initiatives Savings spread across other Strategic Initiatives £5,900,000 £1,441,000

We drew on a number of sources of information in order to establish the agenda for our strategic plan. There is a clear and direct relationship between the most pressing health inequalities in the region and the strategic goals that we have chosen to address, as shown in our Strategic Map. The outcomes that have now been agreed for NHS Walsall are shown against our long-term strategic aims and our strategic goals. If each of the strategic goals were realised we would see a substantial improvement in health of the people of Walsall.

We believe that these initiatives will deliver the outcomes we have identified for each of our programmes.

Expected Impact of Realising our Strategic Goals



Achievement of these targets and successful delivery of our initiatives will result in the following expected changes over the next five years:

- **A&E attendances**
- reduced by 24,546
- **Outpatient attendances**
- reduced by 58,320
- **Planned same day procedures**
- reduced by 4332
- **Non-elective activity**
- reduced by 3000

5. Delivery

This section outlines our approach to securing delivery and includes the elements we have in place to support the organisation in the delivery of our strategy, our management of risk, and the likely impact this strategy will have upon the Provider environment. Some assessment of our past successes has also been reviewed.

5.1 Programme Approach - Delivering Our Strategy

Building on our restructuring of the organisation last year, we have embarked on the development of a programme management based approach to commissioning. Appointments were made during 2009 to strengthen our programme and project management capability and we are developing an integrated methodology that will bring together the best practice model for commissioning and nationally recognised programme and project methodologies. This will be delivered through a major organisational development programme that will provide:

1. A fully integrated Commissioning/ Programme Management model that will embrace portfolio management and link strategic goals and objectives with programme outcomes and project outputs.
2. A set of supporting business processes, products and tools that will consistently embed best practice throughout the organisation.
3. A people development programme to ensure that our staff have the right skills, knowledge and support mechanisms to deliver our aims.

The programme management office will become our centre of excellence and will be responsible for developing and embedding our approach as well as providing the capability to track and monitor progress against our plans. The initial phase of our plan was to review the current position of our programmes and their future plans. We used the vehicle of Confirm and Challenge as a lever for programmes to take stock and start the detailed planning process around a closely reviewed set of priority objectives.

The next step was to link the outputs of the Confirm and Challenge process with our strategic business planning process. Aside from the obvious planning and operational benefits this course of action achieved, the whole process was designed to establish the culture and behaviours the organisation needs to adopt as we develop our formalised approach.

In early 2010 we will develop our formalised approach by integrating the World Class Commissioning cycle with OGC Programme and Project Management methodologies (MSP and PRINCE2) and testing it through four of our

identified commissioning programmes (the remainder will follow on quickly in a second tranche).

Using this approach we will ensure that there are clear and well defined Programme Strategies and robust Commissioning Programme Plans that can demonstrate alignment with our strategic objectives and will become the basis of our Annual Operating Plan. Establishing the right Programme Governance and stakeholder engagement is a key feature of this stage.

Throughout this programme there will be a real focus on prioritisation, delivering change and realising benefits, to ensure that resources and effort are invested in those initiatives that will deliver our strategic goals.

5.1.1 Programme Approach

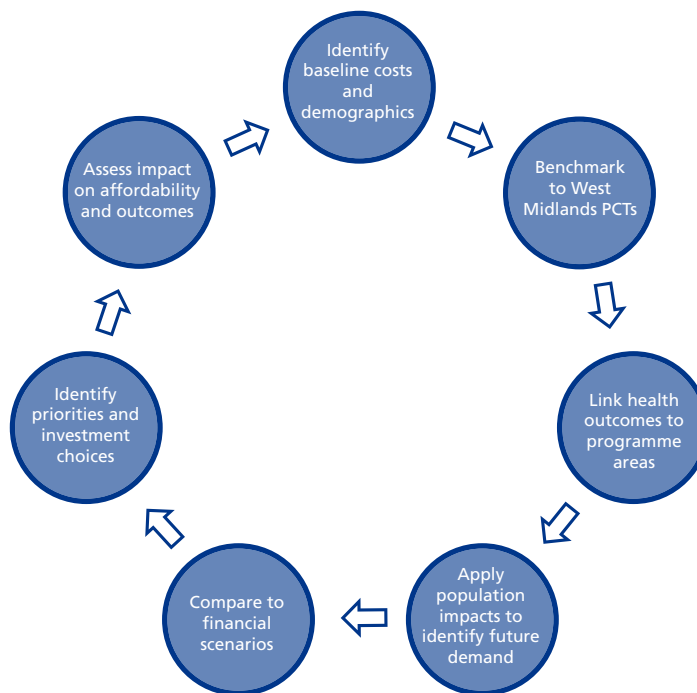
The internal management processes have been set up to address the complexity of our organisation and the range of important tasks that must be undertaken to identify healthcare needs as well as the best approach to address them - hence the separation of commissioning and providers. We are committed to making the best use we can of our available resources and capabilities and we have implemented the separation of commissioning and provision. We have long believed that it is critical to have a focus on developing commissioning capacity if we are to be positioned to make a fundamental change to the health status of the population we serve.

Therefore, action and change will be delivered through a matrix management approach with a programme office whose role is to ensure consistency across all initiatives. Our outcomes will be linked to those programmes that will ensure they are met by the development of initiatives led by dedicated commissioning professionals in our organisation. Our key delivery programmes are translated into a set of initiatives that will essentially embody the actions needed to make the achievement of these outcomes a reality for Walsall. The link between the outcomes and our goals and consequently the link between the programmes and the initiatives clearly demonstrates how the achievement of our goals translates into identifiable actions.

In order to support the process of Programme Commissioning, NHS Walsall is undertaking further development work in order to do the following:

- Identify the impact of population changes over a 10 year period across programme areas
- Compare to future funding scenarios
- Identify potential investment changes based on local priorities and estimated impact on affordability and outcomes
- Create a framework for the future

The following schematic identifies the modelling process:



This process will have the following outputs:

- Model for future iterations
- Assessment of growth across programme areas led by population changes
- Assess impact of moving to financial balance on future investment areas

The key benefit to the organisation will be how this process informs programme commissioning plans, particularly in regard to the balance of investment between prevention and treatment services and the need to drive efficiency throughout the commissioning cycle and in the services that we commission.

5.2 Delivery, Performance and Market Management

5.2.1 Performance Management Framework

The PCT performance management framework provides the Board with adequate assurance with respect to the performance of the PCT in delivering its key objectives in its Operational Plan and World Class Commissioning Strategy document. This framework details the key deliverables, the lead director, and frequency of reporting to the Board and also embraces the wider context of partnership performance across Walsall through the Local Area Agreement (LAA), which defines the shared priorities of the local strategic Partnership. The framework is refreshed annually and approved by the Board.

All the key performance indicators are reported to the Board via the presentation of a monthly scorecard and so are now fully aligned to the NHS Walsall Programmes. This is intended to support NHS Walsall's approach in delivering its vision through structured programmes which have identifiable, prioritised initiatives and associated key performance indicators. In addition, the Board also receives detailed reports on quality and financial performance which underpin our strategic aims and goals.

Performance information is timely and covers a range of metrics and outcomes comprising finance and activity, performance targets, quality and safety, user experience and service developments. Data to support this process is current (i.e. less than six weeks old). However for some areas we work within the national

system constraints e.g. dental access or prescribing.

Additionally longer term trends are also used where appropriate. The PCT holds monthly contract meetings with major providers as well as monthly clinical quality meetings both of which are founded upon the underpinning contract.

5.2.2 NHS Walsall Market Management Overview

NHS Walsall is currently developing a systematic Market Management Strategy. This sets out the way in which NHS Walsall will develop an innovative healthcare market to support delivery of this Strategic Plan. The strategy will identify the principles by which the organisation will enable the development of an appropriate provider market to meet local needs and improve patient experience. The aim is to have a managed market of high quality healthcare providers, and the appropriate balance of plurality and patient choice. This strategy will support and inform the NHS Walsall approach to procurement (the way in which the organisation secures provision through a number of different contractual routes) and the Procurement Strategy. Together, these documents form an integral part of the organisation's approach to system management and the ways in which we will ensure transparency and fairness with providers, a proportionate response to the rules that underpin co-operation, competition and choice and the development of a sustainable market of healthcare provision.

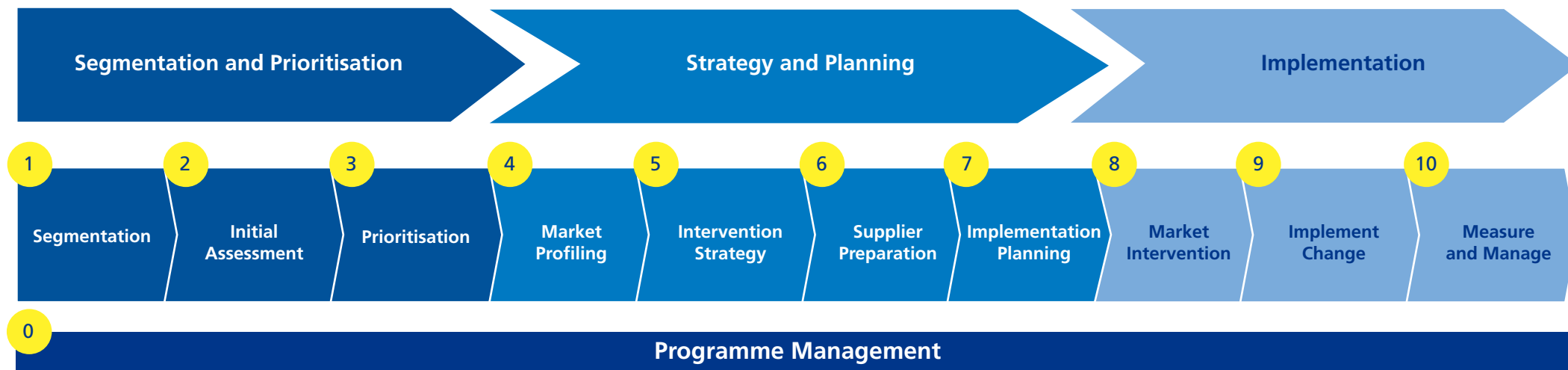
The delivery of the vision will require close integration with Programme Managers and Contracts Managers to ensure that programmes and contracts are appropriately evaluated so that market management is embedded into the commissioning cycle. In doing so, market management can actively contribute to an improvement in patient care for the people of Walsall.

5.2.2.1 Approach to Market Management

The NHS Walsall approach to market management will focus on two clear activities; market analysis (including robust procurement processes) and market development. The development of the Market Management Strategy will take the best practice currently available along with expertise available within NHS Walsall. It will be done at several levels: strategic, programme and by specific pathway.

Each Health Market Analysis will include baseline information including: a geographical map showing providers within the area, needs to address, transformation opportunities, market issues, SWOT or PEST analysis, a competition dashboard, commentary on providers, sector, market share and capacity. A key element of this will be the development of a methodology for systematically assessing provider economics and the impact of our plan as well as an overarching capacity management system to ensure that our markets and providers are capable of delivering efficient, effective and quality service to the people of Walsall.

NHS Walsall Market Management Approach



We will develop a competition dashboard that shows choice within a certain time range from GP practices, concentration of providers, predicted switching, rivalry and quality. The local needs that should be addressed will be informed by access, value for money, quality, capacity, choice, demand, unmet need and strategic priority. Similarly the transformation opportunities will be informed by outreach, change in setting, pathway redesign, new technologies, patient empowerment and integration.

Delivering the outputs will require joint working across the commissioning directorates within NHS Walsall making full use of the virtual team matrix identified for each commissioning programme. Data sets to support progress through the steps

will be required from a number of functions and could pose a significant challenge with regards to the way in which information is shared across the organisation. It is recognised that the data sets required to support market analysis also support delivery of all stages of the commissioning cycle, market analysis (as described above) will be part of the organisation's approach to Knowledge Management.

NHS Walsall will undertake a number of activities to support the development of existing and potential providers. The Provider Landscape and the Strengths and Weaknesses assessment presented in this document represent the initial high level analysis of our healthcare markets. Overall, we will endeavour to ensure the following with respect to our Providers:

- Support the development of existing and potential providers
- Develop Provider Competence and Capability

Essentially, the dual functions of market analysis and market development will support delivery of the NHS Walsall commissioning intentions and ensure that the principles of transparency, fairness and proportionality are applied in the development of a sustainable healthcare market. Crucially, this strategy will outline an approach which is not an end in itself but, by identifying the steps to developing an innovative and sustainable healthcare market, will enable NHS Walsall to commission for improved patient outcomes and reduce health inequalities caused by poor access and patient choice.

5.2.2.2 Provider Economics - Walsall Hospitals NHS Trust

In developing our forward plans we have undertaken a high level exercise aimed at understanding the impact of the full implementation of our Strategy on our main acute provider, particularly in addition to national and pre existing local efficiency requirements.

This has involved:

- Analysis of current and future estate configuration, overlain by specialty assignment. This has then been further assessed to determine actual space utilisation, with the aim of identifying efficiency savings through driving asset utilisation.
- Developing an understanding of income and contributions of specialty areas using Service Line Reporting data and contract information. This is then linked to proposed 'target' contributions to identify potential efficiency gains.
- Developing real clarity regarding the financial impact of proposed demand management schemes on the provider in terms of freed up capacity and available savings across the economy.
- Improved understanding of the impact of the cost of the PFI and remaining health economy wide estate.
- Developing a number of hypotheses regarding configuration to achieve sustainability.

Although this work is not complete, it is clear that a joint plan is needed to address the

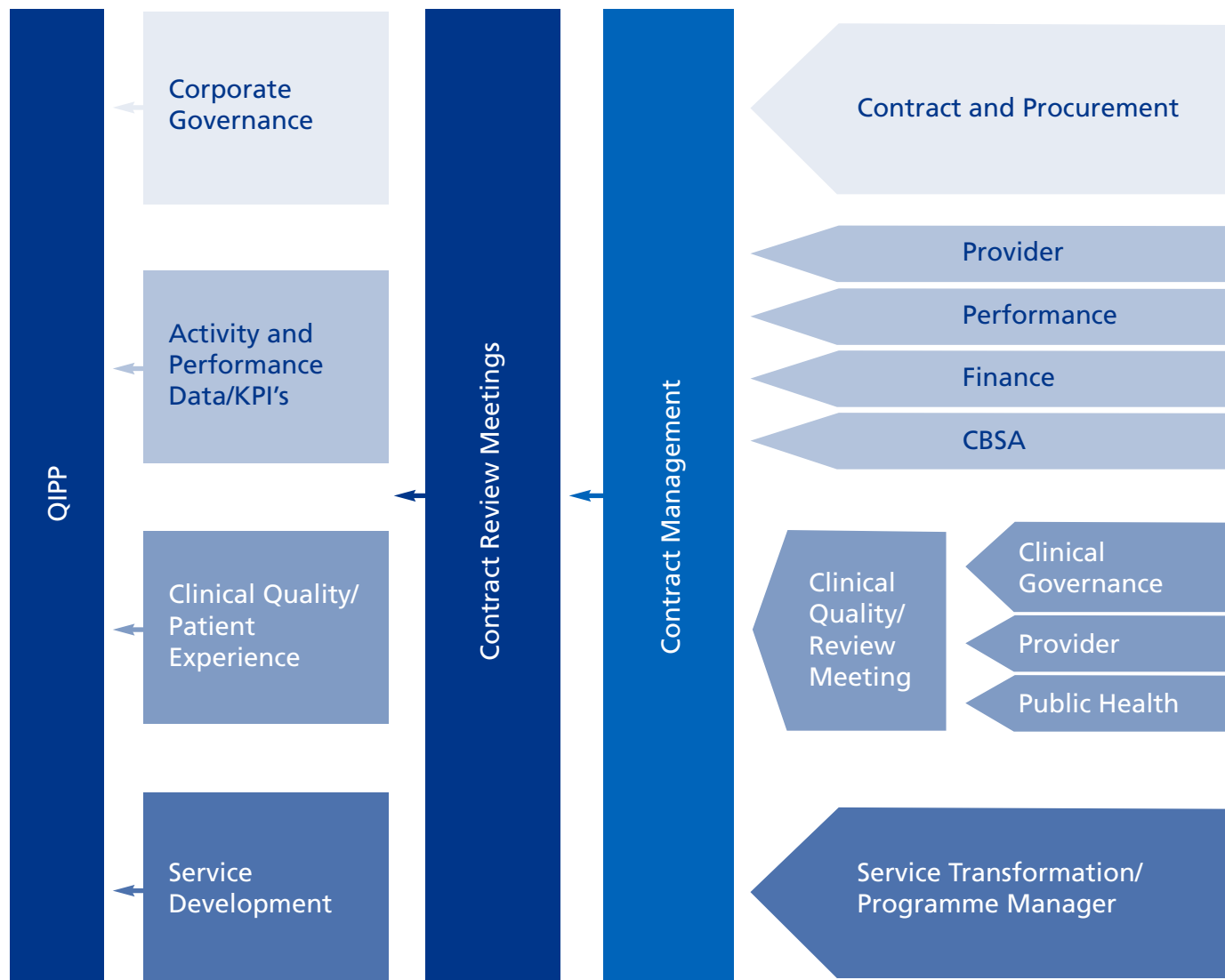
challenges over the strategic period. Links to the development of effective integrated care pathway and provision approaches, both within the Health and Social care economy and supporting potential alliances with neighbouring providers are relevant to the potential outcomes.

5.2.3 Contracting and Procurement

An essential element in the delivery of effective high quality patient care is a robust contract management process and this forms a key part of NHS Walsall’s procurement strategy. As described in more detail in the recent Provider Report, structured contract management arrangements are in place for the major NHS contracts (Acute Contract with Walsall Hospitals NHS Trust, Community Contract with NHS Walsall Community Health Services, and Mental Health contract with Dudley and Walsall Mental Health Partnership Trust) and the inputs to this process, the role of Contract Managers in co-ordinating it and the areas of activity covered are summarised in the figure to the right.

This multi-disciplinary approach to contract management co-ordinated by the Contracting and Procurement team will continue to be refined and will increasingly be applied to other contracts so that it maximises the contribution that contracting and procurement can play in delivering QIPP.

For primary care contracts, the Assistant Director of Primary Care is currently implementing a Primary Care Contract Sanctions and Improvement Policy and conducting a formal review of GP PMS Contracts and he is being supported in this activity by the Contracting and Procurement team.



5.2.3.1 Contracting for QIPP (Quality, Innovation, Productivity and Prevention)

Given the current economic climate it has been recognised that there must be greater emphasis in commissioning and contracting services on delivering quality health outcomes, but at the same time promote increased productivity and efficiency.

Using the appropriate contracting and procurement processes will make a major contribution to driving this agenda.

Mechanisms we will use include:

- Encouraging innovative solutions within specifications and tender invitations.
- Utilising the Contracting for Quality and Innovation (CQUIN) framework.
- Ensuring that contracts include appropriate Vital Signs and challenging KPI's and metrics.
- Maximising the use of the QOF framework in General Practice contracts.
- Reinforcing compliance with Care Quality Standards
- Utilising Quality Accounts and Quality Observatories.

Many of these mechanisms form part of the standard NHS contracts (including those for Acute Community, Mental Health services and the standard contracts for Primary Care such as APMS, and PDS) and these type of contracts will be used wherever appropriate.

5.2.3.2 Practice Based Commissioning

The above processes apply equally to the conduct of Practice Based Commissioning (PBC) which in NHS Walsall is delegated to four clusters.

To date some LES and AWP contracts, such as minor surgery, ENT and gynaecology outpatients, have been initiated through PBC and have been overseen by the Accreditation Group.

It is acknowledged that as PBC activity increases strong relationships will need to be developed between the PBC clusters and the Contracting and Procurement team. This will include working together to determine appropriate services to be commissioned under PBC, issuing more detailed guidance regarding the use of the Any Willing Provider process and organising training events about procurement processes.

Key Principles to be applied to contracting and procurement

The following key principles will guide the contracting and procurement process:

NHS Walsall Value	Application of NHS Walsall Value	Key Principles of Procurement
Respect and Value People	Personalisation of service and choice are at the core of the delivery agenda	<ul style="list-style-type: none"> To award and proactively manage contracts which provide high quality services, personalisation of care and deliver healthy outcomes.
Listening to and engaging with local people	We are committed to involving patients, carers, clinicians and communities in the design and improvement of their services.	<ul style="list-style-type: none"> To ensure that there is appropriate public and patient engagement in the award and management of contracts.
Clear accountability and Transparency	We value feedback and a clear sense of accountability and responsibility for our decisions.	<ul style="list-style-type: none"> To work ethically and with transparency, non-discrimination, equity and proportionality and in accordance with the Department of Health's "Principles and Rules for Cooperation and Competition". To work efficiently and productively using electronic systems wherever possible. To award and proactively manage contracts which deliver best value.
Clinical Leadership	We recognise the need for and will support clinical leadership in service planning and re-design to ensure highest growth levels of quality and efficiency.	<ul style="list-style-type: none"> To ensure that there is appropriate clinical and stakeholder engagement in the award and management of contracts.
Innovation	We will make the best use of all new technology, particularly to be at the forefront of innovation and exploitation of information technology to assist patients, in their own homes.	<ul style="list-style-type: none"> To promote the use of innovation and technology amongst providers and to use innovative methods in awarding and managing contracts. To award and proactively manage contracts which help prevent poor health and promote healthy lifestyles. To award and proactively manage contracts which promote sustainability and corporate social responsibility and which support the economic regeneration agenda within Walsall.
Prevention	We will work to prevent poor health starting early, before birth and working through the whole life cycle.	<ul style="list-style-type: none"> To award and proactively manage contracts which help prevent poor health and promote healthy lifestyles. To award and proactively manage contracts which promote sustainability and corporate social responsibility and which support the economic regeneration agenda within Walsall.
Partnership	We will work closely with our partners in the health, local authority, and voluntary sectors to ensure an holistic approach to promoting health and equality in the community.	<ul style="list-style-type: none"> To work positively in partnership within and outside NHS Walsall including with other NHS Walsall colleagues, with other commissioners such as the local authority, with current and potential providers, with other PCT's and with other healthcare procurement organisations.
Fairness and Equality	We will maintain a focus on disadvantage in communities ensuring that they have genuine opportunities to access health services. We intend to promote a sense of a right of entitlement within our communities.	<ul style="list-style-type: none"> To award and proactively manage contracts which promote health equality, and which provide services which are accessible to the community and which offer choice. To comply with the PCT Procurement Guide for Health Services and other appropriate public procurement legislation and regulations. To promote the development of a diverse provider base consistent with the principles of equality and diversity.

5.3 Delivering Our Strategy - Partnership and Integration

Our vision has outlined the need for us to lead the way forward towards an Integrated Care Economy. Section 3 detailed the many critical issues that we face in this Borough including the prevalence of unhealthy lifestyles, deprivation and general ill health. Section 4 detailed the strategic initiatives that we wish to emphasise in the delivery of that strategy.

Overall, NHS Walsall believes that our integrated Care Economy approach will be the fundamental enabler in our strategy to address these issues effectively and to ultimately deliver high quality, accessible care that gives value for money. NHS Walsall has long recognised the interdependency of its work with partner agencies, especially commissioners, within the public sector. We have a well defined approach to strategic partnership which is outlined in this section along with the planning framework within which it is set. Beginning with the Local Strategic Partnership and cascading through the Local Planning Groups and Local Implementation Teams (LIT) there is a framework to ensure the engagement of agencies and citizens in defining both the strategic agenda and our collective and collaborative approach to reducing health inequality.

NHS Walsall also remains committed to delivering the fully engaged approach where citizens and communities are empowered to make decisions, understand their entitlements and are properly engaged in the process of

transforming the health and social care system. This is being achieved through the implementation of MyNHS Walsall.

NHS Walsall is deeply committed to the ethos of truly integrated provision of healthcare in Walsall. Working more closely with our local authority partners, clinicians and population is expected to result in enormous benefits. Ultimately, we expect that there will be an improvement in service user experience and outcomes and that is what we strive to achieve. This is also a critical approach where resourcing is concerned. Now, more than ever, we need to work with all the relevant organisations within our local health economy to ensure that resources are deployed efficiently and make any necessary reductions in duplication of effort.

A key stakeholder event last year resulted in the creation of a 'Frail Elderly' pilot programme nominated to utilise the Integrated Care approach to this pathway. We are firmly committed to understanding how this will impact our overall provision of services as part of an integrated health economy and illustrates Walsall's commitment to a local health economy. Our work on the design of the 'Frail Elderly' pathway represents our first structured attempt to pilot this approach.

5.3.1 Operating Models

There are a range of opportunities and models that we will review and understand to determine our best fit for this approach. These include:

1. Integrated care organisations
 - Formal structural change i.e. Care Trusts (health and social care),
 - Vertical Integration (linking different levels of care primary, community, secondary, tertiary)
 - Horizontal Integration (linking similar levels of care overcoming professional and departmental boundaries or organisational boundaries)
2. Integrated care partnerships - using clinical systems, IT and funding flexibilities and to create new streamlined care management
3. Integrated care pathways - providing clarity regarding the care, roles and responsibilities between the range of contributors to a person's care.

The opportunities around the range of approaches illustrate that any combination of the above can be considered. We believe that minimising organisational barriers will result in streamlined processes for assessment and decision making, and therefore achieve swift delivery of whatever help/treatment is needed. It implies that there will be a reduced risk of errors and unnecessary stages in the process and that ultimately this way of working and organising delivery in healthcare will create superior opportunities to increase quality of healthcare. Therefore as we move forward towards our vision of an Integrated Care Economy, we believe that we must carefully review the range of options that are available to us and ultimately make the choice that reflects the best interests for our population.

5.3.2 Working as an Integrated Care Economy - Currently Integrated Working Practices

We have already begun this important process of working together with our local economy partners, both providers and other local authorities, to begin to determine a governance approach. Our first step has been to implement quarterly meetings between executive teams to share key strategic issues that we all face as overseers and providers of health services and related social services in Walsall. The attendance at these meetings is made up of members of the Walsall Borough Council, our partners from the Dudley PCT in the provision of Mental Health services, our Acute provider, Primary Care providers and Walsall Community Health. We see this as a critical first step in ultimately determining how we can all work together effectively. By sharing our issues as well as our insights into how we think we can address these issues, we believe that we can begin to take steps now that will form the foundation to our successfully integrated future working practices.

We are currently in the process of developing documentation around governance that will be reviewed by our partners in the local health economy and this will provide the starting point for formalising our integrated working arrangements.

5.3.3 Strategic Partnerships and Joint Commissioning

Working in Partnership with other local agencies and our providers is critical to our Integrated Care Economy. It is increasingly acknowledged as the most important solution to the range of problems that single agencies

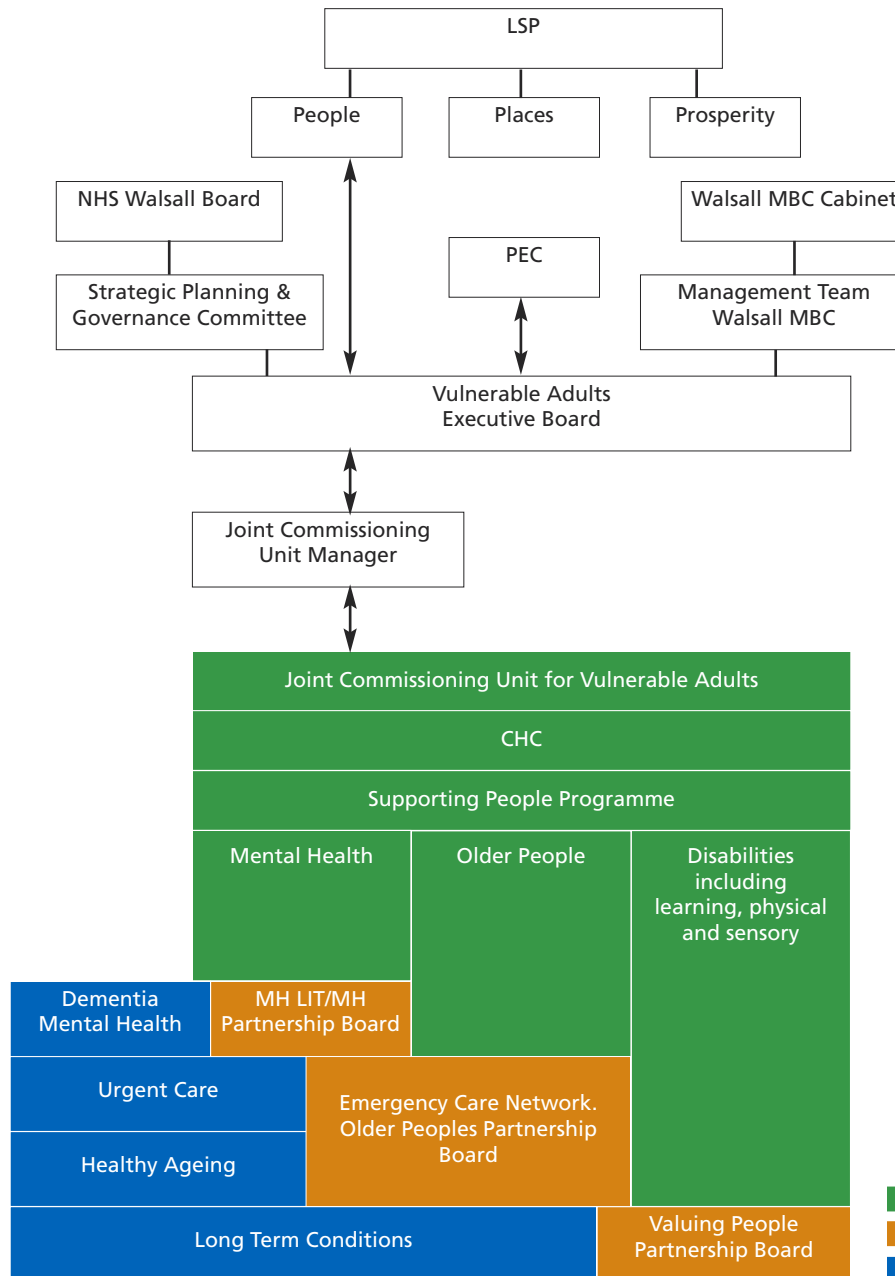
cannot solve. Improving services that users receive and enhancing co-ordination of services across organisational boundaries will provide extensive benefits to the people of Walsall.

National policy and best practice has led to an ever greater emphasis on the need for joint commissioning between the NHS and the Local Authority. In order to deliver on this agenda and to ensure that the services that we pay for are appropriate to the needs of local people, are of consistently high quality and represent value for money, Walsall Council and NHS Walsall have employed dedicated commissioning staff for a range of services. In the spirit of collaborative commissioning a number of these posts are jointly funded and successfully managed across both agencies with financial arrangements which allow for the controlled pooling of resources where appropriate. This arrangement has served us well for several years, but it has become increasingly apparent that in addition to the benefits already derived from this model of collaboration, further benefits and increased efficiency of energy and resource can be derived from its further development.

The creation of a Joint Commissioning Unit (JCU) for vulnerable adults (see diagram on page 92), underpinned by a Section 75 agreement, is the first phase of a strategic approach to better align the commissioning of services between Walsall MBC adult social care and inclusion, Walsall MBC Children and Young Peoples Directorate and NHS Walsall. Pulling together the resources of commissioning of public services in this way will ensure that the

most efficient use is made of financial and human capacity thereby delivering the best possible outcomes to the people of Walsall.

Joint Commissioning Unit Governance



‘Check and Balance’ in the system to ensure the economies in Walsall are working well together. Economy wide strategic planning for implementation of the sustainable community strategy and reporting performance through the comprehensive area assessment.

PCT and LA retain executive accountability and responsibility for setting high level strategic direction and for commissioning decisions/investment planning. Informs and informed by the Vulnerable Adults Executive Board.

Strategic options development; design, implementation and oversight of arrangements for co-ordinated commissioning; high level performance management; policy development; leadership of the joint commissioning unit for vulnerable adults; integrated working with NHS Walsall programme structure/pathways and clinical champions/networks.

JCU Manager employed to lead the team and work across Health and Social Care. This post would be employed formally by NHS Walsall, but managed jointly by the Director of Partnerships (NHS Walsall) and the Executive Director (Social Care and Inclusion).

The JCU will have the following features:

Placing the shared and specific staff of Social Care and Inclusion and NHS Walsall who commission shared services within a single team and shared accommodation. An establishment of 37 staff.

Further developing work practices that ensure the sharing of resources and best practice across services for Learning Disabilities, Physical Disabilities, Mental Health, Older People, Continuing Health Care and Supporting People.

Aligning consultation and engagement processes and mechanisms. Building on the current partnership board arrangements, citizens panel and MyNHS Walsall.

5.3.3.1 Dudley and Walsall Mental Health Partnership Trust (DWMHP)

Currently NHS Walsall and Dudley PCT commission services from Dudley and Walsall Mental Health Partnership Trust independently of each other. Each PCT has an individual contract with the provider for services which equate to approximately £56 million combined. Each contract is managed individually with separate review and monitoring arrangements.

Following a meeting between the Chief Executives of NHS Walsall and Dudley PCT in August, it was agreed that from 2010/11 onwards there would be the joint commissioning by NHS Walsall and Dudley PCT for the services provided to them by Dudley and Walsall Mental Health Partnership Trust. The commissioning process would include a joint contract for the services with a single contract review and monitoring process. It was agreed that NHS Walsall would lead on this process.

A joint commissioning group has formed and met initially on the 1 September 2009 and agreed a range of actions to ensure that we will be in a position to sign off the mental health contract with the DWMHP Trust by 22 February 2010.

5.3.3.2 Walsall Children's Trust

Our Children's Trust is located within the local strategic partnership, 'Walsall Partnership,' which is organised around People, Places and Prosperity Executive Groups and has been in place since 2004. Walsall Children's Trust ethos is based on working together to deliver better outcomes and the key to our transformation is integration, breaking down barriers between

agencies and job roles. We work closely with the voluntary and community sector as more than 200 voluntary and community sector organisations are helping to improve outcomes for children, young people and their parents. The CEO of Walsall Voluntary Action is a member of Children and Young People's Executive and the Strategic Commissioning Group to ensure the third sector is at the heart of our Children's Trust.

The purpose of Walsall's Children's Trust is to:

- Improve the well-being of all children
- Improve their prospects for the future
- Redress inequalities between the most disadvantaged children and their peers

Joint Commissioning will deliver on the Every Child Matters Outcomes:

- Being Healthy
- Staying Safe
- Enjoying and achieving
- Achieving Economic Wellbeing
- Having a positive contribution

5.3.3.3 Black Country PCTs

We are building improved links with commissioning colleagues in the neighbouring PCTs of Dudley and Wolverhampton to ensure greater impact within our redesign and commissioning through sharing good practice and intelligence. Areas where collaborative approaches are being considered are:

- Review of high cost secondary care drugs commissioning

- Consideration of strategic configuration for maternity and paediatric services and paediatric surgical services
- Greater collaboration regarding key pathways affecting Specialist Commissioning through reviewed use of the LCCB meetings including sharing our health outcomes and developing more alignment with our priorities.

5.3.3.4 Specialised Services Commissioning Team (SCT)

The SCT commission services from specialist providers who provide high cost/low volume treatments. We are looking to work more closely with them to support the need to achieve greater control of demand and costs in this portfolio which has historically required higher rates of growth for developments through NICE etc.

The SCT have identified a draft long term commissioning plan which provides:

- Cost savings based on changes and efficiency commissioned through existing contracting mechanisms.
- Longer term commissioning of care pathways for a group of areas for example neuro-rehabilitation, cancer, renal, and paediatrics.

The Black Country Commissioners have agreed that given the direct connection with pathway redesign being undertaken, effective collaboration is required at Programme Management level. This is to ensure that changes in models of care at either primary or secondary care do not impact negatively on tertiary care or vice versa and the potential impact on all commissioners forms part of all commissioning plans.

5.3.3.5 Local Area Partnerships

Partnership working within local areas has become increasingly important throughout the public sector in Walsall. As an active partner in the Local Strategic Partnership, NHS Walsall is supporting the development of a new model

for Neighbourhood Management. As well as joining up public sector front line service providers it will act as an effective mechanism for improving interest in local commissioning processes and procedures. To ensure that we reduce the potential for public consultation overload, the PCT and Local Authority will optimise the potential to include health questions into the annual programme of routine formal consultations e.g. the Places Survey undertaken by the LSP and LA.

Proposed Borough Mapping Model for Neighbourhood Management



Based on proposed areas version 3, created 9 July 2009

5.4 Quality Approach in Our Organisation

5.4.1 Overall Approach to Quality

NHS Walsall believes that a robust and systematically embedded approach to quality will be a key enabler in delivering our required outcomes and other associated targets. We recognise that a quality agenda must be implicit in everything that we do. A recent Health Foundation report stated that one in ten hospital patients suffer an adverse event and a significant number are harmed and need extra treatment. There is also growing failure in transfers, issues with coordination of care between providers, ineffective treatments/tests and issues with service delivery organisations, all of which could also be considered poor quality. NHS Walsall is committed to commission high quality services that both improve patient experience and quality of care and we are developing a strategy that outlines our approach to ensure that high quality care and outcomes are achieved.

Overall, our Integrated Care Economy approach will be one of the critical ways that we can work towards the best quality services possible for our local people.

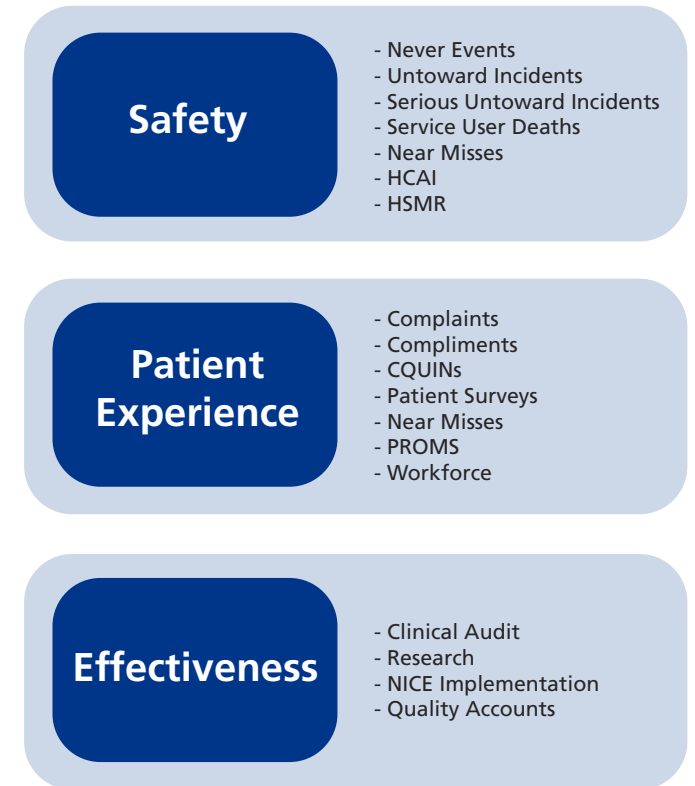
The Local Quality Framework

"We can only be sure to improve what we can actually measure"

Lord Darzi, High Quality Care for all, June 2008

Embedding quality throughout NHS Walsall is dependent upon the identification and development of quality metrics incorporated into contracts and service level agreements. NHS Walsall will work in partnership with providers whilst ensuring that evidence based, safe, high quality services are delivered.

The figure below identifies the framework that all providers will be expected to report on:



Overall, our Integrated Care Economy Approach will be one of the critical ways that we can work towards the best quality services possible for our local people.

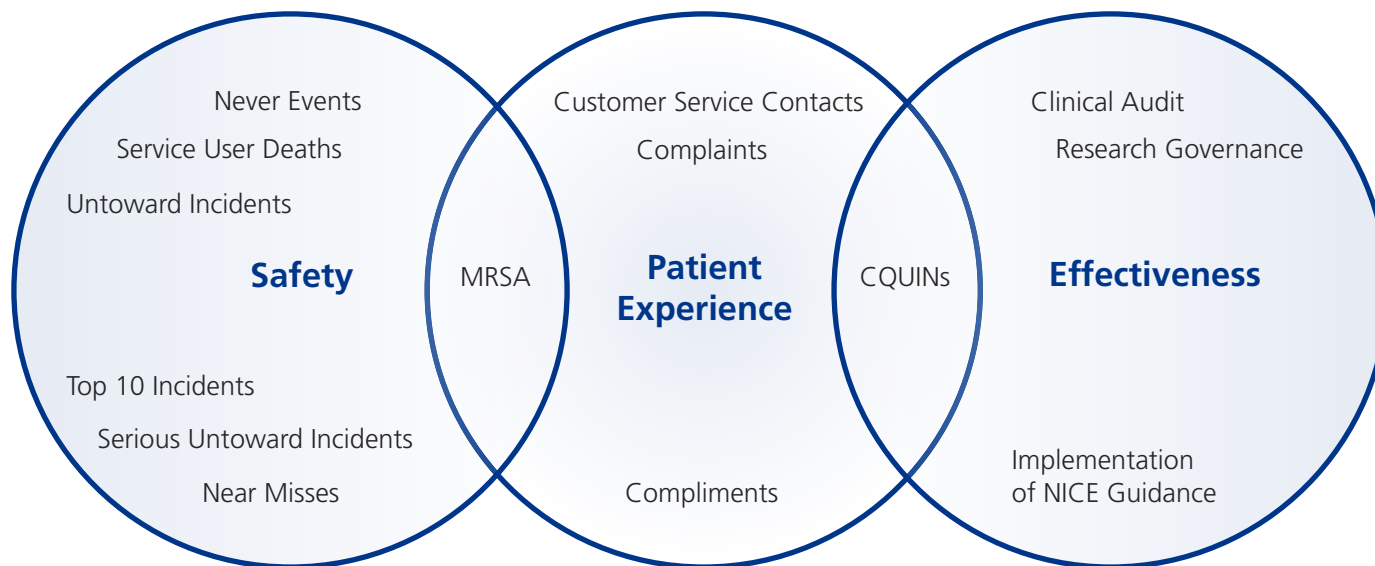


This diagram shows the information and standards chosen by NHS Walsall which will be monitored through the Clinical Quality Review meetings for provider services.

Providers will also be expected to ensure that:

- Effective clinical and corporate governance arrangements are implemented
- Care Quality Commission registration is achieved
- National targets relating to quality are achieved

The achievement of embedding quality throughout NHS Walsall is dependent upon the identification of quality metrics incorporated into contracts and service level agreements. NHS Walsall will work in partnership with providers to ensure that evidence based, safe, high quality care is delivered to the people of Walsall.



Seven Steps to Achieving High Quality Care

We have taken the seven steps and put them into a local context. These local steps are described opposite.

Achieving high quality care in Walsall**Bring Clarity to Quality**

NHS Walsall will ensure that quality schedules are implemented in all provider contracts, service level agreements and service specifications. Standards will be evidence based and resources such as NHS Evidence will be utilised to ensure that current clinical and non-clinical best practice is implemented.

Measure Quality

Quality will be measured using national and local metrics as discussed in figure 2 and all providers will use clinical audit as a process to support continuous quality improvement within their services.

Publish Quality Performance

From April 2010 Quality Accounts will be published which will provide the public with information on the quality of care they can expect within Walsall. To support this process, providers will be required to produce regular quality reports outlining the quality of the services their organisation offers, their priorities for improvement and any actions they intend to implement to secure these improvements.

Recognise and Reward Quality

Through the Commissioning for Quality and Innovation (CQUIN) payment framework, locally agreed schemes will be implemented with providers. This will ensure a proportion of providers' income is conditional on quality and innovation.

Raise Standards

Clinical leadership and engagement will be strengthened throughout NHS Walsall utilising the World Class Commissioning Programme and the implementation of local care pathways. Clinicians will be involved planning and service development to drive improvements in health outcomes.

Safeguard Quality

NHS Walsall will ensure that providers are compliant with any registration requirements for quality and safety and encourage the development of systems which demonstrate how they are delivering positive outcomes and capturing information to demonstrate how people experience the services they provide. We will also monitor providers to ensure there are no breaches of the regulations.

Stay Ahead

The introduction of Comprehensive Local Research Networks (CLRNs) has provided NHS Walsall with the opportunity to join large portfolio research projects while maintaining and supporting robust non-portfolio projects.

Our strategy describes how we intend approach the provision of high quality health care in a time of increasing resource constraints. Our vision, long-term strategic aims and goals describe how we are committed to commissioning high quality integrated productive services that improve patient experience and clinical outcomes. We have aligned our values to the QIPP agenda and have specifically included 'Quality' as one of these values.

Locally we continue to develop and improve the ways in which we are monitoring patient quality, safety, experience and effectiveness of our service providers. A monitoring framework is in place which is assisting our providers to meet the demands of the high standard we want to and need to achieve.

Patient experience in particular is an area we are keen to develop further and lead on across the health economy, along with a rolling programme of appreciative enquiry and the input into the review of quality and safety of care in nursing and residential homes.

Appreciative Enquiries

NHS Walsall has agreed a programme of appreciative enquiries for each of the main providers. The appreciative enquiry is themed around the patient experience in five domains of safety, facilities, experience, clinical standards and staffing.

The programme combines data analysis of national reports and surveys, documentary

evidence, and visits to the organisation by an executive team to give an overall picture of the quality of care delivered.

The data analysis helps inform the areas of focus for the visits which are both announced and unannounced. Information is gathered by the visiting team through a combination of interviews, focus groups and walk-about.

The executive team report both observations and recommendations for the organisation to consider and the resulting action plan is monitored through the Clinical Quality Review meetings, as part of the contract management process.

Commissioning for Quality and Innovation (CQUIN)

'High Quality Care for All' included a commitment to make a proportion of providers' income conditional on quality and innovation, through the CQUIN payment framework.

Together Walsall Hospitals Trust, Walsall Community Health Trust and Dudley and Walsall Mental Health Partnership Trust agreed 10 CQUIN schemes for 2009/10, themed on Patient and User experience, Safety, Innovation and Effectiveness. The discussions for the 2010/11 schemes are focusing on the patient's journey with Walsall Hospitals Trust and Walsall Community Health Trust working jointly on schemes for pressure sores and falls.

5.5 Clinical Engagement

5.5.1 Overview

Harnessing the expertise of clinical staff is at the heart of Walsall's commitment to improving health, reducing inequalities in health outcomes and securing safe, high quality services for local people. This is a key part of a successful integration agenda and does not just mean consulting local clinical staff from all Providers but actively engaging them in the design of services which are clinically effective, acceptable to patients and provide best value for money. We see clinical engagement and clinical leadership development as co-dependent, and crucial for safe commissioning.

Walsall's approach to clinical engagement has been developed over a number of years and external assessments have identified many examples of good practice which already exist in Walsall. However, we recognise that there is considerable further potential to engage clinicians in the work of the PCT and its partners. With this in mind, a number of specific events and discussions have taken place over the last year at which directors and senior PCT staff, together with independent contractors and clinicians from provider organisations, have explored ways of embedding clinical engagement across all the business processes of the PCT.

A Strategic Framework for Clinical Engagement has emerged from these discussions and describes how NHS Walsall is carrying forward its commitment to securing effective engagement with those in the front line of

service delivery. This is an organic framework to ensure that the PCT is at the forefront of best practice and innovation in commissioning health care for its population.

5.5.1.1 Practice Based Commissioning

Over recent months we have been working more closely with Practice Based Commissioners (PBC) both to reinforce our support and to revise the PBC Governance Framework and clinical/management structures which will support this renewed focus as described in 'Reinvigorating Practice Based Commissioning.' We anticipate that a clearer governance framework will emerge from this process and that this will increase engagement of GPs in strategic decisions and wider aspects of the delivery of our targets with respect to the chosen outcomes.

We are currently developing clusters through the creation of the Chairman role and developing a clinical engagement strategy. The clusters will be producing business plans for 2010 and these will link to the delivery of WCC outcomes. We anticipate that this will result in an increase in the number of initiatives arising from PBC over the coming years. Current PBC Plans include the following key areas as high priorities for their work over the coming years:

- Reduction in non elective activity
- New to follow up outpatients ratios
- More care closer to home

To support this, regular meetings between primary care and secondary care clinicians have

begun to identify key areas for joint working and development including integrated clinical pathways. Each of our programmes incorporates engagement of PBC and we intend to make closer connections wherever possible through our programme management approach.

5.5.1.2 Clinical Engagement Strategy

NHS Walsall's Strategic Framework for Clinical Engagement recognises that an important part of achieving our outcomes requires a step change in the way clinical engagement is undertaken. This is not primarily a matter of resources but more about reducing the barriers and increasing the incentives for clinical participation. Over the last few years Walsall has made steady progress in engaging clinicians in a range of activities to take forward the PCT's strategic objectives. The PEC, with the active support of the Medical Director/Director of Public Health, has taken a leading role in fostering this process, including the development of principles which should govern clinical engagement and supporting processes to make it a reality. The key elements that will impact the delivery of an effective clinical engagement process within Walsall include an appropriate structural arrangement as well as key processes and the highlights are outlined below.

1. The PEC Chair and the Medical Director/ Director of Public Health will be jointly accountable to the PCT Board for developing clinical engagement within this Strategic Framework, which itself will be kept under annual review.

2. The PEC as a whole is accountable for ensuring that appropriate processes are established so that clinical input is available for all aspects of developing and implementing the PCT's strategic objectives.
3. The PEC acts as the corporate clinical reference group and engages clinically across commissioning/procurement/clinical quality monitoring/accreditation/R&D.
4. With the development of programme boards around care pathways/redesigned initiatives and an integrated approach to the health economy, the PEC membership has already been broadened to include a variety of clinicians from a broad range of providers. Whilst the PEC will always comprise strong representation from the GP and nursing community, explicit agreements will be reached to ensure that Pharmacists, Opticians, Dentists, and allied professionals also have a strong input into the work of the PEC.
5. The PEC will be engaged as early as possible in the key business process of the PCT, particularly those which are relevant to the clinical strategy of the PCT and the quality of services provided to the local population. A key task is to assure the quality of clinical services being provided to the local population. PEC members will therefore be integral members of the Clinical Quality Monitoring Groups established by the PCT. In addition, PEC will ensure that there is full clinical involvement in appreciative enquiry as well as unannounced visits to services.

6. In addition to encouraging the one-to-one contact between General Practitioners and hospital clinicians, a new Joint Clinical Forum has been established in Walsall. This brings GPs, hospital Consultants, PCT Directors including the PEC Chair and the Medical Director/Director of Public Health, together on a regular basis, so as to seek joint solutions to operational as well as strategic issues. Members of the PCT Board and PEC will undertake regular visits to meet clinicians in their places of work to develop a better personal understanding of the environments in which services are being provided to patients, the key issues faced by frontline staff in service delivery, and views on how the quality of services for patients could be improved and the support required by staff to enable this to happen. A brief written summary of these visits will be made available to PCT and PEC Board members with clear recommendations for any action to be taken.
7. Appreciative Enquiries to Provider Services will enable the Board to assure itself of the quality and safety of care.

A number of successful models already exist in Walsall for broadening the engagement process so that clinicians find it easier to contribute to the process of service redesign and improvement in quality in their service/specialty. A key to success is to have a clear focus on the task and provide the appropriate managerial and information input in support of the clinical agenda. Thus far, excellent outcomes have been achieved in the pathway redesign work

undertaken on weight reduction, COPD, and services for the frail elderly. This model will be extended to other high priority service reviews.

This strategic framework sets the ambitious aim of securing the highest possible levels of clinical engagement within the commissioning process in Walsall, so as to achieve level 4 of the WCC Competency 4 within 3 years. The framework will guide the work of NHS Walsall and its Commissioning partners in supporting the structures and processes necessary for achieving this ambitious goal. In particular, NHS Walsall will pursue an active programme of leadership development for the local clinical community, as well as enabling more clinicians to influence the design and quality of services to the community. The PEC will be working to an action plan to achieve the rapid progress in clinical engagement required by this framework, and indeed needed by the PCT to deliver its strategic commissioning objectives. This framework and the progress against the action plan will be reviewed annually by NHS Walsall working with the PEC, so as to advise the PCT Board on the further actions necessary to achieve the intended outcomes.

5.6 Enabling Strategies - Workforce

Our World Class Commissioning Strategy has identified ambitious goals over the next five years to improve the health of the people of Walsall and to reduce health inequalities. The workforce are our most valuable asset and it is they who will manage and deliver the range of services, projects and programmes that will make the strategy a reality.

We are currently developing a Workforce Strategy that provides a framework and sets out the objectives for the development of the current and future workforce across the Walsall Health Economy to deliver World Class Commissioning and World Class Provision over the next five years and beyond. The Workforce Strategy seeks to embed the corporate vision and values throughout the workforce of the organisation.

The Workforce Strategy has been developed based on three main principles:

1. To ensure the health economy has a workforce now and in the future with the right knowledge, skills, behaviours and competencies to deliver improved wellbeing, reduce health inequalities and ensure the delivery of safe, effective services
2. To ensure the workforce reflects the community it serves and is aligned to services that need to be delivered
3. To plan, develop and deliver an integrated workforce to meet future service needs that is flexible and adaptable

4. To be able to respond to a changing environment and ensure that there are the right numbers of staff in the right place and at the right time across the local health economy.

The following objectives support these three main principles:

- To ensure service, financial and workforce development plans are aligned and established to address local health priorities including the design and deployment of appropriate roles to deliver these.
- To work in partnership with staff and staff side representatives to ensure effective communication, engagement and service development.
- To identify and develop organisational leaders to deliver World Class Commissioning from within a talent management and succession planning framework.
- To have robust/effective workforce information systems in place to ensure effective monitoring of key objectives and to establish key performance indicators aligned to a performance framework.
- To ensure effective utilisation of a workforce that will deliver quality, cost effective services across the health economy.
- To ensure statutory obligations are met and the health economy works within nationally agreed frameworks demonstrating compliance with relevant national standards.

- To promote behaviours and best practice through the recruitment process, induction, competencies (using the Knowledge and Skills Framework and Skills for Health Competence Framework) and reward recognition.
- To ensure the workforce operates in a safe environment promoting courtesy, respect and value for money, challenging discrimination and waste and promoting health wellbeing and effectiveness.
- To promote partnership working with stakeholders including NHS Providers, Higher and Further Education Institutions, the private VCFS and independent sector, the Local Authority and patients and the public.
- To promote continued successful partnership working in our existing partnership arrangements, for example the Children's Workforce Framework.
- To ensure NHS Walsall is a model employer and employer of choice with the workforce developing effective people management skills.
- To demonstrate commitment to developing and retaining the workforce through effective and consistent HR practices and lifelong learning.
- To identify and implement best practice from other sectors through effective benchmarking and change management.

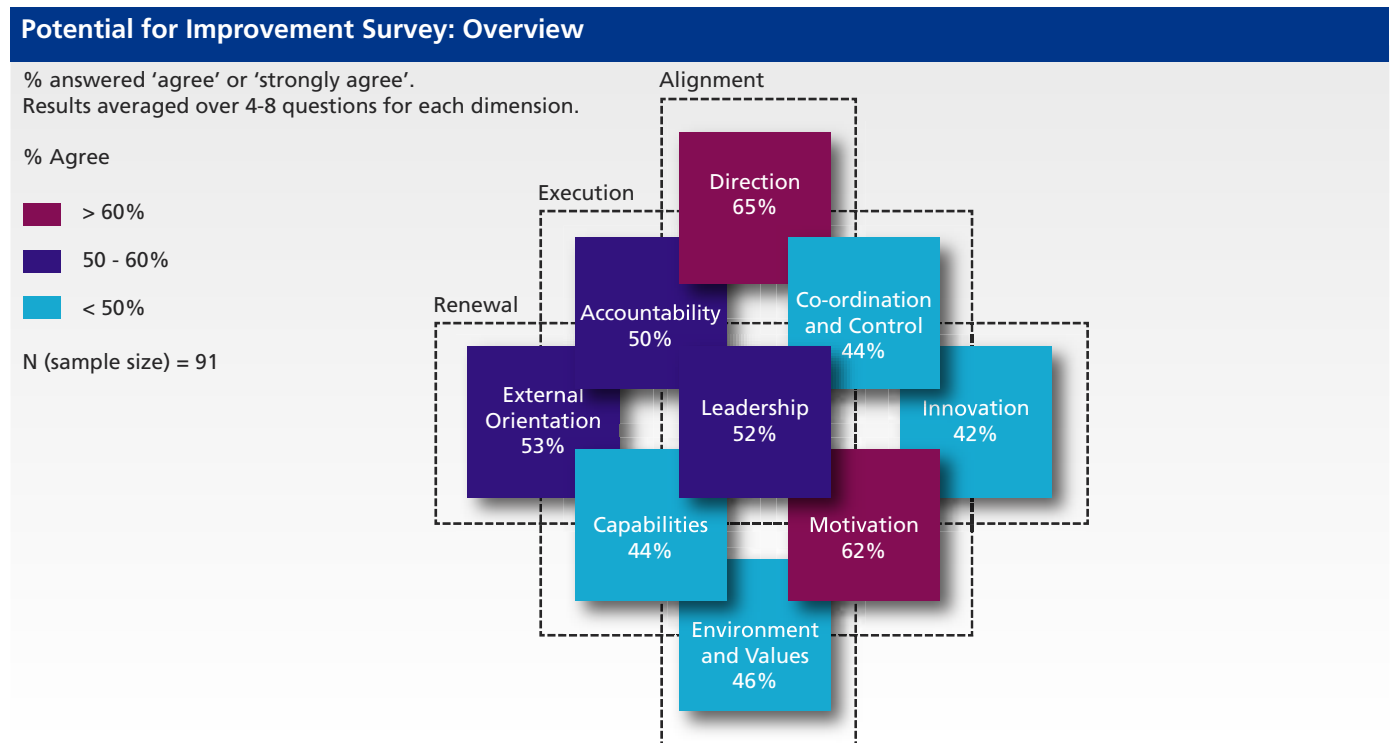
5.7 Organisational Development - Supporting the Delivery of World Class Commissioning

Our Organisational Development plan details the changes we will implement (and have been implementing over the last year) to plan and support the changes and improvements required in systems, people and culture to work towards the strategic goals set out in our World Class Commissioning Strategy. This plan sets out how the PCT will align itself to deliver its vision and goals over the next five years. The Organisational Development Plan is a live document reviewed on a monthly basis, updated as different needs are identified within the organisation and refreshed annually.

Implementing the initiatives described in the Organisational Development plan will help us to create an organisation that commissions high quality services, helps to enhance life-style choices and improve the life expectancy of the people of Walsall. Critically, it will also offer excellent employment opportunities and development for our staff and the local community. Further details can be found in the NHS Walsall Organisational Development Plan 2010.

Staff Survey

Staff views were obtained again this year utilising the 'Performance for Improvement' questionnaire. The overview of the results from the survey are shown to the right. The outcomes of the survey are summarised in terms of 'Alignment' and this is a measure of the extent to which NHS Walsall's objectives and goals are embedded within the capacity of the



organisation to deliver. 'Execution' refers to the ability of our organisation to deliver the proposed strategic changes we wish to implement, and 'Renewal' refers to the organisation's ability to refresh and regenerate itself, as it must, in order to successfully deliver the change agenda.

The organisation proved to be relatively strong in a number of key areas, particularly motivation, having the right sense of shared values and purpose for everyone in the

organisation to impact the drive towards health improvement. The survey did, however, identify some key weaknesses in the areas of innovation and, although staff value continuous improvement, the results show the PCT needs to work on the speed with which it adopts new ideas. The second area of weakness highlighted by the survey results was 'Capabilities' and further work needs to take place to develop the right skills to deliver our goals in order to be a highly effective commissioner.

5.8 Enabling Strategies - Information Management and Communication Technologies

5.8.1 Informatics Shared Service Approach - Transforming Community Services

All Local Health Economy organisations are signed up to the shared service approach called 'Walsall Informatics Service'. This is now a well-established and experienced shared Informatics team who deliver all aspects of informatics development, ICT support, business change management, information systems, application development, training and support. An integrated approach has always been the philosophy in Walsall and this enables high cost specialised staff to be utilised across the trusts enabling economies of scale and skills diversity.

The senior representatives of the following Trusts have therefore agreed to continue to work together in partnership:

1. NHS Walsall (Commissioner)
2. Walsall Hospitals NHS Trust (Provider)
3. Walsall Community Health (Arms Length Provider to NHS Walsall)
4. Dudley and Walsall Mental Health Partnership NHS Trust (Provider)

This way of working recognises the different responsibilities between commissioner and provider and includes a robust governance structure and stakeholder involvement at all levels. User group specific interests or common themes are integrated and recognised when appropriate also. The priorities are managed

through the Walsall LHE IT Board and this is the primary decision-making body.

The Informatics Service has developed an over-arching ICT Strategy that covers the whole local health economy. An ICT plan "Walsall Local Health Economy Informatics Plan 2009-10 to 2011-12" expands that high level strategy and describes the specific implications for the Walsall Health Economy.

5.8.2 Background and Success to Date

Walsall Local Health Economy has always been at the forefront of the development of Electronic Patient Records in the NHS. This is mainly due to being part of the Electronic Record Development and Implementation Programme (ERDIP). The product born out of this programme was Fusion, which created a patient-centric view across a range of systems in which patient information is stored. This information is drawn from a variety of information systems across the Health Economy through a data sharing policy. It currently has in excess of 2500 users. The NHS number record linkage policy in the health economy is a critical success factor for all these systems to interface and will ultimately have a profound impact on the ability to deliver better, more effective services.

This system and the associated approach has demonstrated the following benefits (as an interim solution until Connecting for Health functionality is realised):

- Allowing either a top down summarised view of patient care, pulling summarised or detailed information from linked systems, or, a functional centred view for specialist clinical input, e.g. for A&E staff and Out of Hours Staff.
- Extending and enhancing current access to health professionals outside the Acute system sphere to obtain instant results/reports, PACS images, e.g. General Practitioners, Community Matrons, CPNs.
- Allowing front end reporting to be rapidly developed, as development would be controlled in-house, as opposed by third party suppliers.
- Enhancing flexibility for users against system change in the immediate future by linking systems to a central interfacing module as opposed to a central Patient Administration System, which when changed, would require a period of significant change to the other linked clinical systems.
- Provides Care Pathway information to all healthcare professionals e.g. the Health Economy CHD pathway, Stroke pathway.
- Electronic Discharges Summaries from secondary care to primary care.

The key themes of the Walsall Informatics Plan are 'Managing Change' and 'Integration' as these are recognised as key enabling factors in our Strategy:

- a) 'Change' because this strategy through delivering solutions to business and clinical service improvement programmes signals a step-change in the way the local health economy manages, perceives and invests in information and technology.
- b) 'Integration' because it is the best way that we will tackle the problems and risks caused by fragmented information in IT systems environment we find ourselves in, and the huge amounts of resources wasted in duplication. This is why Fusion is, and continues to be, an important part of our medium term strategic plan until Connecting for Health offers the functionality and systems integration for our clinicians.

The following two examples demonstrate how ICT has impacted or is impacting the delivery of some of these services, both current and future.

Frail Elderly

As enabler to the project, the concept of a 'Virtual Ward' in the community has been developed. This is in the early stages of discovery where a specification is being written on the business needs to understand the requirements. In parallel a piece of work is being carried out to identify potential technology solutions to support this way of thinking. This will be a combination of mobile technology devices and solutions integrated into our current solution set for our clinicians.

The specification is expected to be completed by December 2010 where a full business case will be developed.

COPD

There are three main workstreams in terms of informatics project to support the pathways:

1. Continued development of Fusion pathways for COPD as part of seamless care across care settings.
2. Extend the Self Care Programme and increased access to Telehealth as this will further extend the impact across a number of Long Term Conditions programmes and services. A project is in place to integrate the information from Telehealth systems into the Fusion Clinical Portal.
3. Development of dashboard within the CDR Business Intelligence project.

5.9 Enabling Strategies - Supporting Estates Model

The NHS Walsall estate portfolio has undergone significant change over the last 5 years. In terms of Primary Care provision, we have moved from a position of having a large number of single handed practices in sub-standard accommodation, to new purpose built modern Health Centres. These centres also incorporate a range of Community Services. Our remaining priority areas for investment are detailed within our Estates Strategy and Strategic Service Development Plan (SSDP). These two key strategies are described in more detail below. The Trust Board has agreed that all estates assets will be retained and managed by the Commissioning function and formal agreements will be put into place with its provider arm, Walsall Community Health in respect of rights and obligations, etc.

Estates Strategy

The Estates Strategy covers the period 2008 - 2012 and was developed in parallel with the SSDP. It describes how the organisation will implement the Walsall Local Health Economy Overarching Vision. The scope of the study included all of the premises from which primary and community services are delivered, but did not incorporate general dental, community pharmaceutical or optometry services. This is the key difference in scope in comparison with Transforming Community Services initiative. The Estates Strategy incorporates the outcome from the '6 Facet' property review carried out in April 2009.

Strategic Service Development Plan

The organisation developed a five year strategy and a Local Health Economy vision for delivery of effective services that promote good health, reduce health inequalities and treat illness. The SSDP was derived from these two key documents and provides detail about how the capital development programme will support service improvement. The SSDP was ratified by the Board in July 2008 and provides a strategic framework for the development of the estate for the period up to 2013.

Commissioners' Investment & Asset Management Strategy (CIAMS)

The introduction of the Transforming Community Services initiative requires a fresh assessment of the assets we deploy within primary and community services. Whilst we have a relatively good understanding of our assets, we have undertaken a further review of the estate, utilising the Commissioners' Investment & Asset Management Strategy (CIAMS) toolkit. NHS Walsall has populated the CIAMS 'tartan rug' spreadsheet and this document will be used to support the development of a revised estates strategy to support the TCS service strategy currently being developed. This new estates strategy will be completed by April 2010.

Next steps

Two main areas of incomplete data have emerged from an initial assessment of the CIAMS output

and these are currently being addressed in two further strands of work as follows:

Review of the Independent Primary Care Estate

The organisation's estate strategy included an assessment of the independent primary care estate. This survey was completed in 2006 but was incomplete in terms of its scope. This survey will therefore be repeated by the end of March 2009 and will commence with premises not included in the original scope and will include a simple '6 Facet' assessment of the premises and will highlight any 'duty of care' concerns that are evident.

Space Utilisation Detailed Review

The organisation places great emphasis on the effective use of assets, whilst the 6 Facet review takes a high level look at asset utilisation, it does not give a detailed understanding of how buildings are used and in particular, how buildings could be more intensively used to maximise the opportunity for more effective utilisation.

We shall therefore be carrying out a detailed survey of all of the assets we own or directly lease to give a sound understanding of use and opportunity. This data will be collated and entered onto a new CAD based software system that can identify use, apportion cost and provide us with a tool to manage space more effectively.

Joint Agency Asset Review

NHS Walsall is actively working with all of the local Public Services agencies (Health, Local Authority, Police etc) within the Borough to evaluate our current portfolio of fixed assets. The objective will be to identify opportunities for shared occupation of property to maximise the effective utilisation of space and disposal of surplus assets. The group will also evaluate proposed new developments to identify similar opportunities for joint facilities.

Premises Assurance

NHS premises play a vital role in the delivery of high quality, safe and efficient health care. The new Premises Assurance Model (PAM) being introduced in April 2010 offers a real opportunity for Commissioners to gain high level assurance on the performance of our key providers. The system will identify performance of providers against the key metrics of safety, effectiveness and patient experience. It will also identify 'best in class' providers to encourage improved performance targets where appropriate.

5.10 Risk Management

In common with many organisations within the NHS, we use a system to assess risk by multiplying the impact by the likelihood to obtain a risk level. Impact and likelihood are measured on a scale of 1-5, where 5 is most severe and 1 is least severe. The diagram shows the assessment we have made on delivery of risks to the Strategic

Plan. If the level of risk is 12 or below, then it is considered to be manageable at a Directorate or Programme level. A risk level above 12 requires that the issue is monitored directly by the Board. In order to ensure ownership and accountability for addressing the identified risks, individual staff members are assigned to

each. They are accountable for ensuring the risk is appropriately addressed.

Financial risks are assessed using a similar scale. The Board receives detailed information on all aspects of governance and performance including finance at each of its meetings.

Delivery risks to our strategic plan and how we plan to mitigate

- We manage our risks based on the overall level.
 - If the level of risk has a score of 12 or less, the risks are managed at a directorate/programme level
 - At a level above 12 the risk is elevated to being monitored monthly by the board
 - Individual staff members are assigned to each risk to encourage ownership and accountability

Risk	Impact	Likelihood	Level	Plan for how to mitigate
1 Walsall Hospital Trust Long Term Financial Sustainability	5	3	15	<ul style="list-style-type: none"> • Repatriate Walsall patients • Integrate to improve Board • Reconfiguration of site usage • Increased efficiency
2 Sustainability of local health economy provider market	5	3	15	<ul style="list-style-type: none"> • Integrate to improve work • Development of effective integrated care pathways across organisations • Reconfiguration of provision across providers • Effective market management
3 Inability of primary and community services to deliver the required changes to redesign services due to capacity shortfalls, thereby reducing value for money	5	3	15	<ul style="list-style-type: none"> • Work with primary care and community services to develop appropriate capacity and capability • Deliver agreed integrated care pathways • Transforming Community service

* Although Community Health APO carries delegated responsibility for managing its own income and expenditure position, NHS Walsall remains ultimately responsible
 Source: NHS Walsall Budget Allocations 2008/09, Commissioning Function; client interviews

Delivery risks to our strategic plan and how we plan to mitigate (cont.)

Risk	Impact	Likelihood	Level	Plan for how to mitigate
4 Existing providers fail to co-operate or engage with major changes (which provide a range of opportunities and threats to current providers)	5	3	15	<ul style="list-style-type: none"> Continue to find new ways to work alongside providers and clinicians and strengthen clinical leadership to empower partners e.g. frail elderly Fully engaged strategy to engage stakeholders Development of integrated care approach
5 Insufficient recurrent resource in NHS Walsall to recruit and retain sufficient staff to deliver on its initiatives	3	4	12	<ul style="list-style-type: none"> Continue to strengthen and develop a good working environment to ensure that staff remain motivated Develop a robust workforce planning strategy so that required changes in workforce are foreseen and acted on well in advance
6 Insufficient capabilities within programmes to deliver change efficiently	3	3	9	<ul style="list-style-type: none"> To be addressed under the organisational development plan To include a robust competency acquisition and development plan Use experienced and competent programme and project members to teach those who lack competency to deliver on strategic goals Options include a mentoring system and quarterly meetings where key learnings are shared Develop more formal training mechanisms i.e. MSP
7 Workforce implications of new initiatives/strategic goals not adequately quantified or managed	4	2	8	<ul style="list-style-type: none"> Detailed planning to identify workforce changes/issues early Detailed analysis of stakeholders in each programme with full engagement of stakeholders at all stages of programme/workforce planning
8 Market place under-stimulated and cannot provide new services	4	2	8	<ul style="list-style-type: none"> Robust procurement strategy and plan Further develop and strengthen partnerships
9 Failure to sufficiently engage people to improve their lifestyle choices and take control of their own health	4	2	8	<ul style="list-style-type: none"> Adequate resources and management support to implement and deliver the fully engaged strategy, in particular MyNHS Walsall
10 Failure to demonstrate continuous quality improvement identified through inspection and enquiry	4	5	12	<ul style="list-style-type: none"> Robust monitoring systems in place Include mandatory measuring of quality and safety in service provider contracts

Financial risks to our strategic plan and how we plan to mitigate

Risk	Likelihood	Financial impact	Risk adjusted financial impact	Actions taken to mitigate risk
1 Over performance with main acute providers including Walsall Hospital NHS Trust.	30.0%	12,000	3,600	Contingency Reserve held and for the period 2010-11 to 2011-12 any over-performance at the local provider will be offset against non recurrent support in the two financial years of £4m and £4.8m respectively.
2 Technical issues around the confirmation of central allocations and the adoption of HRG 4.0 for the application of the new PBR tariffs.	20.0%	8,000	1,600	Use of contingency reserve non recurrently to smooth the transition to revised plans.
3 Increase in continuing care activity and costs. Due to inability of LA and Trust to manage market, pressure from Acute Trust to reduce length of stay and perceived view from the LA that the PCT should fund this cost. Shown in the reference costs by above average investment in social care. The impact of the latest guidance may have been understated and there may be appeals.	10.0%	4,000	400	Work with the local authority to effectively manage the market whilst ensuring guidelines are followed and cases reviewed by professional staff.
4 Reshaping of Acute and Community care configuration. There is an inherent risk that a financially viable local health economy may not be achieved.	n/a	-	0	Health economy modelling has been undertaken with the Acute Trust which has secured agreement for 2010-11 and 2011-12. There is an agreement to engage with all organisations in health and social care overseen by an integrated improvement board.
5 Prescribing volumes may exceed planned levels.	10.0%	4,800	480	The PCT has engaged GPs and is developing an efficiency programme focussing on repeat prescribing and the use of drugs in care homes.
6 Management capacity to deliver a range of competing priorities against the backdrop of corporate overhead reductions whilst ensuring quality, safety and implementing the World Class Commissioning agenda.	n/a	-	0	The development of a strategy focussing on what matters.
7 Risk associated with the failure to deliver demand management programme and associated change in care provision strategy	19.8%	11,000	2,175	Contingency Reserve held and for the period 2010-11 to 2011-12 any over-performance at the local provider will be offset against non recurrent support in the two financial years of £4m and £4.8m respectively. Further provisional non recurrent funding of £2m per annum has been identified in 2012-13 and 2013-14

5.11 Impact on Providers

	Provider	Impact	How?
Promotion of health & wellbeing	<ul style="list-style-type: none"> Walsall Community Health Walsall MBC - Primary Care Secondary Care Private Sector 3rd Sector 	<p>We need to develop providers and markets to deliver choice, quality and innovation in the delivery of health promotion.</p> <ul style="list-style-type: none"> Greater range and number of providers Market development in stop smoking services (planned for 2012) Market development for weight management services. 	<p>Greater clarity will be delivered through:</p> <ul style="list-style-type: none"> Programme level pathway redesign Detailed Health Market Analysis and market development
Self Care	<ul style="list-style-type: none"> Walsall Community Health Walsall MBC - Primary Care Secondary Care Private Sector 3rd Sector 	<p>We need to develop providers and markets to deliver choice, quality and innovation in the delivery of health promotion.</p> <ul style="list-style-type: none"> Greater range and number of providers Market development for self-care services (planned for 2013) 	<p>Greater clarity will be delivered through programme level pathway redesign</p> <ul style="list-style-type: none"> Detailed Health Market Analysis and market development
Primary Care	<ul style="list-style-type: none"> 67 GP Practices 70 Pharmacies 28 Dental Practices 30 Optometry Practices 	<p>The impact will be on changing the emphasis in the way GPs work which will be dictated by the development of the Primary Care strategy. Currently this may mean the development of Primary Care based assessment and treatment services, Risk Stratification and Unique Care.</p> <ul style="list-style-type: none"> Additional 111,930 GP attendances by 2013/14 181,578 reduction in the number of prescriptions issued 55,248 increase in dental UDAs 32,076 increase in outpatient attendances Capacity has recently been increased across Dental and Pharmacy services. 	<p>Primary Care Strategy</p>
Community Services	<ul style="list-style-type: none"> Walsall Community Health Urgent Care Centre Intermediate Care Palliative Care 	<ul style="list-style-type: none"> 2036 increase in elective spells 280 increase in non-elective spells 24,546 increase in urgent care attendances <p>Note: TCS and integrated care will significantly impact Community Health services.</p>	<p>TCS, Primary Care Strategy, Integrated Care approach</p>
Acute and Tertiary Care	<ul style="list-style-type: none"> Walsall Hospitals NHS Trust Specialised Services Other Acute Trusts Dudley and Walsall Mental Health Trust 	<ul style="list-style-type: none"> 4,332 reduction in planned same-day procedures 3,000 reduction in non-elective spells 58,320 reduction in outpatient attendances 24,546 reduction in Accident & Emergency attendances 	<ul style="list-style-type: none"> Integrated Care Approach Programme Management and Service Transformation Provider economic analysis

Note: Commentary regarding how we are addressing the impact on our providers (particularly in the secondary acute sector) is contained within Section 5.2 (Delivery, Performance and Market Management).

5.12 Past Delivery Performance

Our Health Inequalities National Support Team (HINST) visit in September provided valuable feedback on some of our activities to date. Overall, the feedback was that we have strong current partnerships, commitment and actions. We have reviewed some of our key projects which have delivered significant improvement over the last year summarising what worked well and our major challenges/opportunities for change.

Examples of initiatives over the past few years

	Overview	Year	What is working	Challenges/opportunities for change
Secondary prevention of CVD	Encompasses all programmes that address the population needs within this category	2008-2009	<ul style="list-style-type: none"> The CVD death rate in Walsall is reducing and the gap is closing between the Walsall rate and national average. Actions are set out in the PCT Operating Plan and WCC Strategic Plan to continue the downward trajectory. A mature CVD LIT with a wide membership and associated work plan together with a strong team working ethos across partners, supporting joint actions to address premature CVD mortality. <p>An excellent and well regarded cardiac rehab service providing high quality services for a range of patient groups.</p> <p>Excellent information materials for patients from BME communities to support self-management of their condition.</p> <p>Use of CDR Intell software and the LES (Local Enhanced Service) for CVD risk encourages a pro-active approach to:</p> <ul style="list-style-type: none"> Develop registers of patients at high risk of CVD Achieve register prevalence rates in line with modelled expected rates Undertake assessments of high risk patients and managing those patients. <p>Very good medicines management programme:</p> <ul style="list-style-type: none"> Walsall has one of the highest rates of generic statin prescribing Uses data from Keele University around combining and sharing data on prescribing costs and QOF outcomes by practice to systematically drive up quality in key therapeutic areas Regular audits of practice prescribing and routine feedback to improve prescribing practice. 	<p>Consider raising expected standards on clinical outcomes beyond those in the national QOF.</p> <p>Review local incentives to raise the ceiling of achievement on targets (eg extra payments to reduce exemptions or lack of progress beyond national targets).</p> <p>Build on work already undertaken around reducing 'exception reporting by developing a strong and vigorously implemented 'exceptions strategy.</p> <p>Review the capacity and skill mix of the Primary Care workforce committed to the register management process.</p> <p>Develop further the existing CVD action plan in order to clearly articulate the activities, metrics, costs and volumes/activities and health outcomes attributable to specific actions.</p> <p>Review services to ensure access to 24 hr blood pressure monitoring for all patients.</p> <p>Ensure appropriate resource materials are in place to support self-management for people with learning disabilities.</p> <p>Ensure there is a realistic assessment of the size of the CVD problem among ethnic minority groups by stratifying the extent of need among the specific groups.</p> <p>Strengthen LA and User membership in the CVD LIT.</p> <p>Collect, share and use data more strategically to drive change by:</p> <ul style="list-style-type: none"> Improving data capture to support a range of proposed CVD Health Equity audits to inform service planning Audit of CVD deaths linked back to practice specific data about the patient Producing comprehensive practice profiles <p>Developing practice specific 'dashboards' bringing together a range of measures of care related to major conditions into one A4 page and allowing benchmarking of practice performance.</p>

Examples of initiatives over the past few years cont.

	Overview	Year	What is working	Challenges/opportunities for change
Acute Management of CVD	Acute Services for CVD	2008-2009	<ul style="list-style-type: none"> CVD under 75 mortality rates are falling and are on track to meet the Spearhead target. Arrangements for leadership, coordination, planning and delivery of CVD programmes are clear, straightforward, comprehensive and effective. Delivery of stroke services appears to be truly integrated on a multidisciplinary and multisectoral basis. Well structured and organised Dysrhythmia service. Well established arrangements to manage Heart attack and 'Hyperacute' stroke, and no apparent local inequalities in access; stroke thrombolysis rates above the national average. Exemplary arrangements for PPI. 	<ul style="list-style-type: none"> Primary Care appears to be the area offering the greatest potential for improvements, through: <ul style="list-style-type: none"> Exploring mechanisms to bring more system in to support and performance manage practices regarding the management of BP and cholesterol in people on CHD registers, and blood sugar, BP and cholesterol management for those with diabetes. Audit practices to examine the variability in detection and management of atrial fibrillation and referral of possible TIA. Review all-age CVD mortality rates to ensure over 75 mortality is being addressed so as to contribute to life expectancy targets. HINST can signpost Walsall to those PCTs which have had some success in addressing the problem of patients who do not attend for assessment following invitation. Use Mosaic or other social marketing segmentation software to audit which major local groupings are actually represented in Patient and Public Involvement arrangements. Ensure there is a clinical lead with dedicated and costed time working to the CVD LIT. Ensure that the Local Authority is represented on the LIT and the Stroke Strategic Group
Cancer	Cancer services across the patch	2008-2009	<ul style="list-style-type: none"> Library of information and intelligence about cancer services, organisations, policies and guidance to help LIT set priorities and direction. Full partner in Pan Birmingham Cancer Network, influencing network priorities and benefiting from the networks excellent information and other resources. Acute Trust committed to improving access to cancer services and improving their screening services. Commitment of the local health economy evident in the turnout at the cancer workshop. Cancer LIT enthusiastic and engaged, with full and active participation from key organisations and individuals. Strong relationship between organisations at strategic level. Many examples of effective practice, including evaluations of effectiveness. Cancer Reform Strategy targets up to date 	<ul style="list-style-type: none"> The LIT should develop a higher profile and voice within Walsall, exercising leadership, setting direction and prioritising goals. Review the library of intelligence and guidance material to agree the key messages in each resource. Undertake a Walsall Cancer Equity Audit. (Much of the information needed is already collated). Use the intelligence and messages distilled by the LIT and findings of the Cancer Equity Audit to encourage public engagement and ownership of the cancer inequalities agenda. Increase the reporting of success and celebration of achievement. Systemise the dissemination of examples of good practice on cancer early detection, awareness and prevention. Ensure there is regular performance reporting of internal PCT inequalities and progress in tackling them, to strategic partners, boards, and the public. Develop greater partnership working of individuals and teams at operational and tactical level, to complement the excellent engagement at strategic level. In particular, this engagement must include general practitioners. Attendees of the HINST visit cancer workshop on September 8th and other appropriate key players should continue the positive problem solving discussion started at the workshop.

Examples of initiatives over the past few years cont.

	Overview	Year	What is working	Challenges/opportunities for change
COPD	<p>Fully established COPD Management team consisting of Community, Primary and Secondary Care components. Provides community based support for COPD exacerbated patients</p> <ul style="list-style-type: none"> Home based visits to help educate and support patients around management of COPD and exacerbation Consultant led community based clinics helping to more accurately diagnose COPD exacerbations determining the need for secondary care intervention 	2009	<ul style="list-style-type: none"> No increase in admissions for non-elective COPD exacerbations (when comparing most recent time period April to July 2009 vs (2008) Referrals into the service have increased Over 900 patient contacts (April to September 2009) 	<ul style="list-style-type: none"> Diagnostics capabilities for clinics are required. Currently clinics are limited in terms of diagnostics that can be undertaken to accurately indicate a patient's condition Better engagement of GPs for service improvement Agreement on referral criteria into secondary care is needed to better support the care pathway
Infant and Perinatal Mortality Programme	<ul style="list-style-type: none"> UNICEF baby friendly stage I achieved in May 2009 Halted obesity in mothers with BMI above 35. 100 mothers recruited by December 2009 Increased Breastfeeding in teenage mother to 69% at initiation and 36% at 6 weeks. A reduction in smoking in teenage mothers 20% during pregnancy 405 by 36 weeks. Increased work in Children's centres. Breastfeeding awareness across PHSE sessions Effective BME shared leadership programme engaging hard to reach communities 3.5 WTE peer support workers in place to target breast feeding uptake. Perinatal data in place to enable us to target the most vulnerable communities 	Ongoing	<p>Booking Rates improved to 82% - Pregnant smokers quit rates up from 9.3% to 11.9% - Detection of IUGR increase from 33.3% to 38.8%</p> <ul style="list-style-type: none"> Infant mortality is clearly a local priority. The Infant Mortality Steering Group has a wide membership across local partners and is well placed to drive forward action. Excellent analysis of infant mortality trends based on a review of infant deaths from 2001-2006. Well established local teenage pregnancy strategy. A willingness to adopt innovative practice and pilot new programmes, such as the Family Nurse Partnership; the BME - Shared Leadership Scheme; recruitment of paid peer support workers to increase breastfeeding rates. 	<p>Challenges remain to achieve 55% reduction</p> <ul style="list-style-type: none"> Build on the existing good work and translate the strategy and action plan into systematic delivery that meets the needs of all pregnant women and others. Undertake further analysis of the action plan interventions in order to quantify the necessary scale and reach of these interventions if they are to have an impact on mortality rates. This would build on the analysis undertaken as part of the review of infant deaths from 2001-06 and the further analysis should be reflected in the targets and trajectories within the IM action plan. Undertake equity audits to obtain a clearer picture of the characteristics of those not currently accessing services appropriately. This would inform targeting of resources. Audit current care pathways and referrals to specialist services to ensure the needs of all vulnerable mothers are met. Undertake more training and interventions aimed at improving maternal nutrition before, during and after pregnancy. Develop a more systematic approach within primary care on improving pre-conceptual care e.g. increasing the use of folic acid. Routinely share the Acute Trust data (sent to the PI) with the Public Health Intelligence Team to facilitate more real time performance monitoring. Share data currently provided by the Acute Trust to the regional Perinatal Institute routinely with the Public Health Intelligence Team to permit more real time performance monitoring

Examples of initiatives over the past few years cont.

	Overview	Year	What is working	Challenges/opportunities for change
Teenage Pregnancy	<ul style="list-style-type: none"> • Maternity Services • Family Nurse Partnership Project • Childhood IMS Programme • Smoking • Re-design of sexual health services: Hub and spoke model • Commence phased Implementation of 'You're Welcome Quality Criteria' (improving services for young people) • Further commitment to delivering the teens and toddler preventative programme • Expansion of the FREE Condom distribution scheme • Successful local PSHE certification programme for Nurses and Teachers • SRE audit (13,000 pupils engaged) • Under 16 pregnancy research undertaken locally, supported by GOWM 	2009	<ul style="list-style-type: none"> • Walsall second biggest reduction in the region • Improved Booking Rates • Improved Continuity of care • Acute achieved CNST Level 3 and baby friendly • Breastfeeding Services - Café Au Lait Nominated for Prize • Support programme for young vulnerable families. Early evidence suggests increased breastfeeding rates and smoking cessation • Walsall exceeds the minimum target in all areas • Uptake improving • Dedicated Service for all pregnant teenagers via the Teenage Pregnancy Team • Increased quitters (Piloting a new smoking tariff in pregnancy) • UNICEF – Baby friendly Acute • PCT/WCH Stage 1 of Community Award • NST Reviewers identified Walsall as an innovator • Teens and Toddler Programme success rate, 90% of pupils participating gained a national award • Development of local SRE resources, with national recognition. • Increased numbers of teenage parents accessing Care to Learn funds, to return to education/training (prevention of 2nd unintended pregnancies) 	<p>Uptake of MMR and BCG of neonates</p> <ul style="list-style-type: none"> • Workforce issues due to backlog • Investment not proportionate to prevalence of BME women • Ensure that the re-design of sexual health services meets the needs of young people • Undertake local social marketing exercise to raise awareness of sexual health services • Build on existing good work in relation to existing SRE resources and raise awareness • Consider workforce needs in respect of skills/competencies for front line staff around the TP prevention agenda • Engage with General Practitioners and seek their support/commitment to fully implement 'You're Welcome' by 2012 • Consider how to ensure that TP prevention, via early identification of those at risk is embedded into IYPSS (Integrated Young People's Support Services)

Declaration of Board Approval

We have established a vision and set of values for the organisation alongside a series of aims, goals and initiatives that will allow us to translate our goals into actions that can achieve changes in health in our population. We believe that ultimately our initiatives together with our enabling and supporting services related to our business will deliver the outcomes we have identified for each of our programmes. We have developed this strategic agenda by engaging our key stakeholders, working with partners and drawing on existing evidence and experience to identify the interventions that would have most impact and essentially we are beginning our transition to the Integrated Care Economy.

The Joint Strategic Needs Assessment 2008 and National Data Sets

Existing Walsall strategic documents 5 Year Strategy 2008 –2014 Towards a Healthier Walsall

Local Health Economy Vision and Plan

Local Development Plan

Views of our patients, local people, carers, clinicians and partners sourced from:

Findings from Public Consultation on Strategic documents and Pathway Initiatives

MyNHS Walsall

Active involvement of clinicians in Planning Committees

Annual Patient Surveys

IPSOS MORI Poll

Key NHS Strategic documents:

High Quality Care for All

NHS Next Review: Final Report 2008

Investing for Health: A strategic framework for NHS West Midlands 2007

Investing for Health Step 2: NHS West Midlands 2008

The tiered model of care shown is designed to summarise how we intend the services we commission to deliver our vision, aims and goals. Services will actually be commissioned to work across tiers based on programmes and designed to deliver a personalised service. The model of care can be explained as follows:

Level 1 Promotion of Health and Wellbeing

This will encompass joint working with partners to ensure that housing education and the other wider determinants of health are addressed effectively.

It is also aimed at delivering the Staying Healthy Programme initiatives which will include:

- A range of approaches to promote health messages and a range of activities and facilities to support health lifestyle choices.
- Improved information services used by the community.
- Continued impact of health trainers and increased impact from primary care team advisors.
- Dedicated services to support smoking cessation, increase exercise and reduce weight.

Specialist services for patients with high levels of risk or illness e.g. obesity, COPD, to adopt health lifestyles.

Level 2 Self Care

Identified separately, this tier emphasises the strategic intent to develop a wide range of

services to help people manage their own long term conditions. Building upon the Expert Patient Programmes we will widen our approach to include disease specific and other patient focused approaches.

Creation of Walsall's Own Health and increased access to Telehealth will further extend the impact across a number of Long Term Conditions programme and services.

Level 3 Universal Primary care and Community Services

We are looking to further develop this tier with a continuing shift of activity from secondary care (Tiers 4/5) to primary care. We will further increase choice for both primary and community services.

We intend to maximise the impact of other primary care contractor services through redesigned care pathways and new innovation in service delivery in the community.

Level 4 Specialist Community Services

We will develop services that ensure safe shift from secondary care to deliver care closer to home, good clinical outcomes and best possible patient experience. They will include:

- Primary Care led Urgent Care Centre
- Specialist Palliative Care Model within the end of Life Care Programme
- Specialist Community services for COPD, Heart Failure, Diabetes and other long term conditions

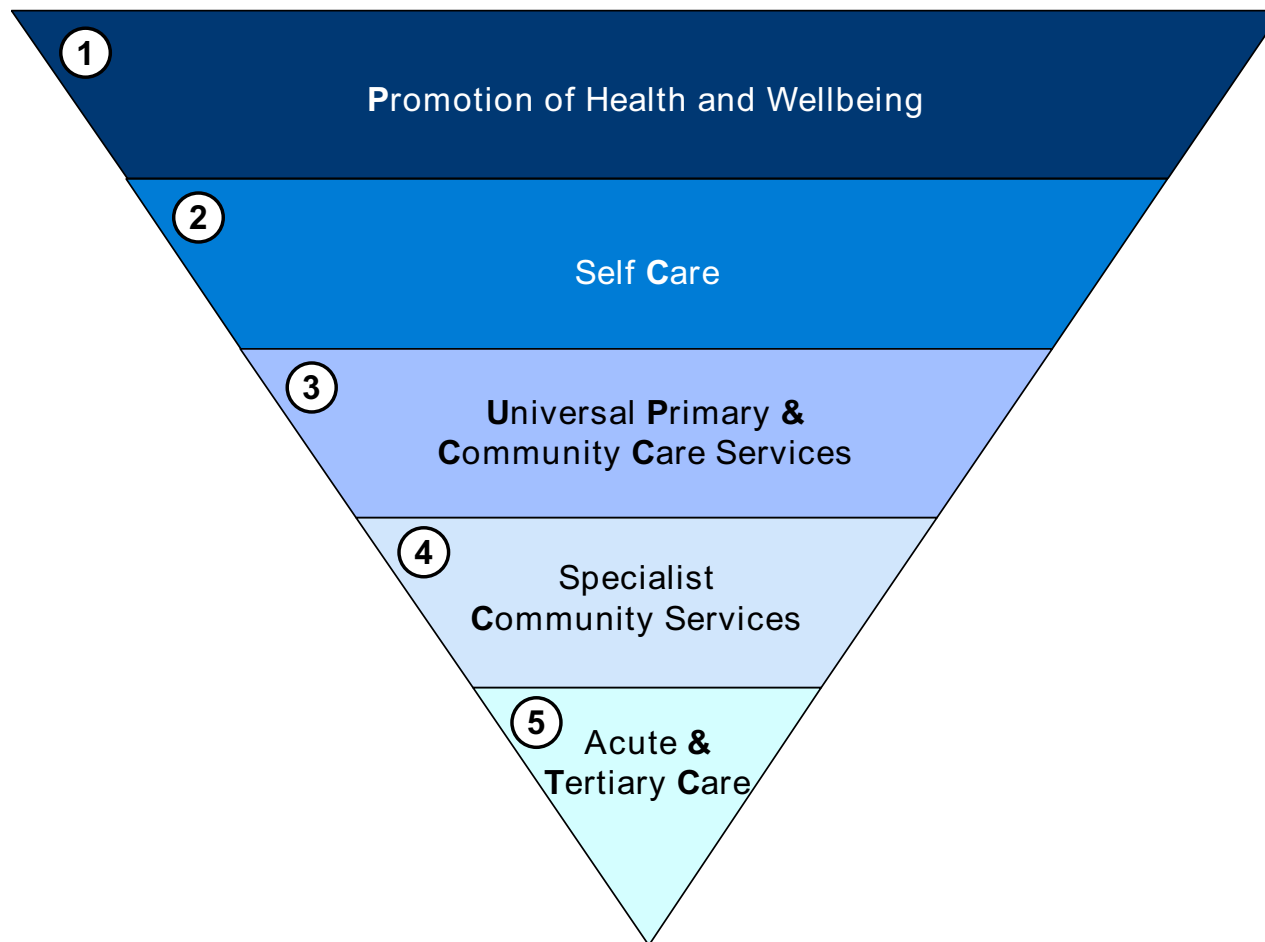
- Community based diagnostics and clinical assessment services
- Extension of the existing Minor surgery services
- Community Chemotherapy services
- Specialist Acute and Tertiary services

These district general hospital services will be provided predominantly by our local acute provider, although we will be increasingly supporting the ability of patients to choose a hospital at the point of referral.

Level 5

The services included within this tier include those that need to be provided specifically in a hospital setting because of the degree of specialisation of the medical input or the diagnostic elements. We are clear that these services need to be used only when necessary and as part of agreed care pathways ensuring effective management of resources and improved experience for patients.

Tiered Care Model

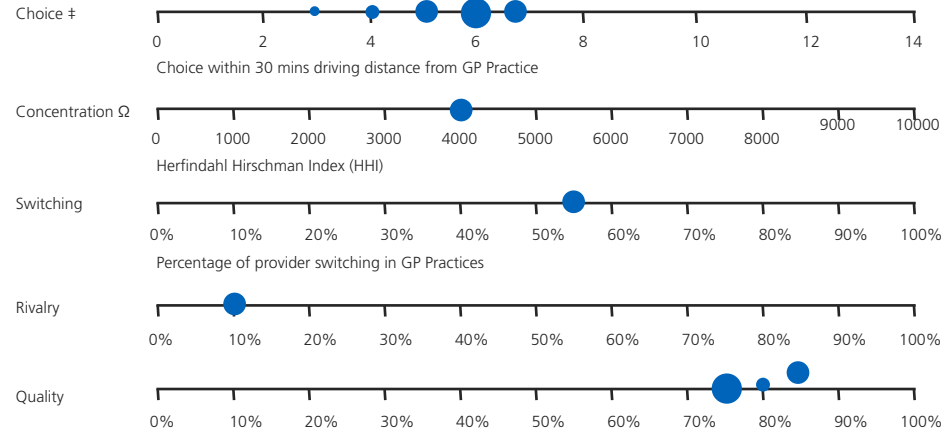


Appendix C: Example of Market Analysis

- Under 30 minutes
- 30-39 minutes
- 40-49 minutes
- 50-59 minutes
- 60 minutes and over



Competition Dashboard



Comments

All 63 practices can reach Little Aston within 28 mins, New Cross Hospital within 31 mins and Cannock Hospital within 32 mins.

From the CBSA download we can identify 13 Reconstruction procedures have taken place in 4 different Hospital Trusts. With a further estimate 16 done at Little Aston.

The Switching percentage show the effect of moving all the procedures away from Little Aston to another provider.

Rivalry shows the position of the sector of all possible providers. The figure of 11% is represented by 10 NHS commissioned services and 1 Private Provider uncommissioned service.

Quality is measured from the results of Peer Review and Patient Surveys at each Hospital. An average of Peer Review Overall %, Peer Review Patient Experience % and Patient Satisfaction % was taken. []

‡ - Timings used from Google Maps from GP Practice to Hospital, using their postcodes as start and finish destinations. The journeys do not include the use of Toll Roads.

Ω - The HHI range shows a score of 10000 for a monopoly and 0 for a heavily populated sector.

[] - It is noted that the full Quality measure for The Royal Wolverhampton could not be identified in the above analysis.

Market Management Levers

Ernst & Young - Understanding health care markets: A PCT guide to market analysis and market management

Lever type	Lever Sub Category	Lever
Demand Side	Demand shaping and education Provision of information Consumer engagement	<ul style="list-style-type: none"> - Activities by PBC/PCT to influence careseeking behaviours by patients - Making available comparative data on providers to inform patient choice - Formal dialogue with patients to inform development of new market options (such as new care pathways) - Use of patient 'voice' within providers (e.g. members of FT)
Supply Side	Market creation (with or without incentives) Market development (with or without incentives) Market exit Provider management	<ul style="list-style-type: none"> - Stimulating competition where monopoly exists - Introducing a greater range of providers in existing markets - Concentrating markets where there is fragmented supply - Decommissioning existing providers (and potentially re-commissioning) replacements - Altering key performance indicators and other quality drivers in contracts
Regulation	Licensing De-licensing Regulatory influence	<ul style="list-style-type: none"> - PCT requiring additional licensing requirements as community services markets are established - Removal of licenses granted by PCTs - Provision of information to formal licensing authorities

Providers	Site	Current/Potential	Sector	Market Share
The Royal Wolverhampton Hospitals NHS Trust	● New Cross	Current	NHS	3%
Sandwell and West Birmingham Hospitals NHS Trust	● City Hospital	Current	NHS	28%
Mid Staffordshire NHS Foundation Trust	● Cannock	Current	NHS	3%
The Dudley Group of Hospitals NHS foundation Trust	● Russell Hall	Current	NHS	
Heart of England NHS Foundation trust	● Heartlands	Current	NHS	
University Hospital Birmingham NHS Foundation trust	● Selly Oak	Current	NHS	10%
University Hospitals Coventry and Warwickshire NHS Trust	● Walsgrave	Current	NHS	
University Hospital of North Staffordshire NHS Trust	● North Staffs	Current	NHS	
	● Alexandra	Current	NHS	
Worcestershire Acute Hospitals NHS Trust	● Worcestershire	Current	NHS	
	● Kidderminster	Current	NHS	
	● Stratford	Current	NHS	
South Warwickshire General Hospitals NHS Trust	● Warwick	Current	NHS	
Spire Little Aston	● Little Aston	Current	Private	55%

Are provider services comparable?

Can patients assess quality of the service and make informed choice?

Would patients value greater choice?

Are there any substitutes or technologies that would threaten or assist providers?

Mixture of procedure within Mastectomy and as a secondary procedure

Yes

Yes

Not currently

Appendix D: Programme Scorecard

Darzi Pathway		Planned Care				
Programme Budget		Walsall Spend	Comparator Grp Average	Distance		
2007/2008 *		Spend per 100,000 pop	36.15	38.9	-2.75	
JSNA commentary		Cancer prevalence rates and trends- bowel, lung, breast, prostate Musculoskeletal – Long term limiting illness and orthopaedic admission rates Dermatology – Variation in outpatient referral rates (opportunities for providing services more locally) Chemotherapy – Patient engagement and choice (ref: Chemotherapy needs assessment)				
Key Strategic Objectives & WCC Outcomes†		Self Reported Experience re: Respect and Dignity	Joint Lead Programme			
		Life Expectancy	Contributor Programme			
		Health Inequality	Contributor Programme			
Theme	Indicators	Target ¹	Achievement ²	Gap ³	Y1 National Rank ⁴	
Outcome Metrics†	▼ Reduce cancer mortality rate by at least 20% by 2010 (equivalent to 108.9 deaths per 100 000 by 2010)	≤ 114.4	125.5	R	R	62/152 ⁵
	▼ Breast Cancer - screening for women aged 53 to 70 years (VSA09)	≥ 90%	86.8%	R	A	97/152
	▼ Proportion of women aged 25-49 who have received cervical screening	≥ 80%	71.7% ⁵	R	R	93/152
	▼ Proportion of women aged 50-64 who have received cervical screening	≥ 80%	78.5% ⁵	A	A	107/152
	▼ Percentage of patients first seen by a specialist within two weeks when urgently referred	≥ 93% ³	94.1% ³	G	G	24/152
	▼ Proportion of patients waiting no more than 31 days for cancer treatment	≥ 96%	98.3% ³	G	G	38/152 (WM=98.5% ¹)
	▼ Percentage of patients receiving their first definitive treatment for cancer within two months of urgent referral for suspected cancer	TBC	81.3%	R	R	12/152(WM=93.8% ¹)
	▼18-week RTT (% pathways completed within 18 weeks) - Admitted Patients	≥ 90%	93.1%	G	G	3/152(WM=94.1% ¹)
	▼ 18-week RTT (% pathways completed within 18 weeks) - Non-Admitted Patients	≥ 95%	97.8%	G	G	16/152 (WM =97.7% ¹)
	Key Performance Indicators ¹	NP- 18-week RTT - number of specialities that fail standards (excluding Trauma & Orthopaedics) (admitted and non-admitted)	0	0	G	G
NP- 18-week RTT - number of standards failures in Trauma & Orthopaedics (admitted and non-admitted)		0	2	R	A	
NP- Direct access to audiology patients treated within 18 weeks		≥ 95%	98.90%	G	G	WM=99.8% (Oct) ¹
NP- Patients waiting >6 weeks for MRI or CT scans (all providers)		0	1	G	G	n/a
NP- Patients waiting >6 weeks for other diagnostics (all providers)		0	25	R	A	
EC- Choose and Book - % GP appointments booked		≥ 90%	54%	R	R	WM=52%
31 days from urgent GP referral to first treatment for acute leukaemia, testicular and children's cancers (existing)		≥ 85%	100%	G	G	WM = 98.6 %
31 Day subsequent treatment - drug (new target)		≥ 98%	100%	G	G	WM = 99.4%
31 Day subsequent treatment - surgery (new target)		≥ 94%	96.6% ³	G	G	WM = 97.8%
31 Day subsequent treatment - radiotherapy & other (new target)		≥ 94%	100%	G	G	WM = 94.5%
Patient Feedback (LHE Evaluation) ²	EC- All cancers – maximum 62 day waiting time (existing)	≥ 85%	85.3%	G	G	WM = 84.7%
	62 day referral to treatment screening program (new target)	≥ 90%	93.8%	G	G	WM = 95.8%
	2 week wait urgent GP referral suspected cancer (existing)	≥ 93%	94.1% ³	G	G	WM = 94.9%
	2 week wait urgent GP referral breast symptoms (new target)	≥ 93%	89.5% ³	R	R	WM = 48.2%
	▲ A general lack of awareness about choice					
	▲ Quality of care ; waiting time; accessible and convenience					
	▲ Promotion of the public transport services to the Manor -costs					
	▲ Performance management - quality of services					
	▲ Communication issues - information transfer; skills training.					
	Quality Scorecard ³	Outpatient cancellation/ postponements by WHT	11%	13.41%	R	R
Provider failure to ensure that 'sufficient appointment slots are made available on Choose and Book system		≥ 90%	93%	G	G	
Provider cancellation of Elective Care operation for non-clinical reasons either before or after patient admission		0.80%	0.54%	G	G	
Discharge summaries to comply with locally determined minimum data set and be received within the timescales as set out in clause 18.3		98%	93.48%	R	R	n/a
2 weeks maximum wait for rapid access chest pain clinic		100%	100%	G	G	
2 weeks maximum wait for urgent referrals from GP with any breast symptom (except suspected cancer) to first outpatient appointment		≥ 93%	89%	R	R	
All chargeable activity to identify GP and Patient		≥ 90%	96.80%	G	G	
Number of delayed transfers of care per 100,000 population (aged 18 and over) ⁶		≤ 11.75%	10.01%(2008/09)		G	
2 weeks maximum wait for urgent suspected cancer referrals from GP or dentist to first outpatient appointment ³		≥ 93%	94%	G	G	This should be aligned to Primary Care Contracting
Access						
Contracted Activity	GP referrals to acute providers	< 36,159	37,927	A	A	
	Extended opening hours for GP practices	≥ 51%	88.0%	G	G	
		Activity ⁷	Finance ⁸	Activity ⁶	Finance ⁸	
Prevention	Inpatient Spells	26,801.00	£36,700,829	718,776	£48,634,624	n/a
	Outpatient Attendances	131,413.16	£12,348,249	175,319.00	£13,647,336	n/a
	WHNHST Income 2008/09 ⁷	n/a	£42,851,333	n/a	n/a	n/a
Key Performance Indicators ¹	NP- Chlamydia screening - % of 15-24 year olds screened or tested for Chlamydia	≥ 25%	11.30%	R	R	n/a
	Number of patient receiving NHS primary dental services located within the PCT area within a 24 month period	≥ 141,682	132,737	R	A	This should be aligned to Primary Care Contracting

N.B.	† WCC Assurance Handbook Year Two 2009/10-2010/11		
	• Programme Budget National Comparisons 2007/08		
	• WCC Targets		
	NP/EC/WM National Priority or Existing Commitment / West Midlands		
	• All figures are classified from the annual plans for apc and op activity split as agreed for NHS Walsall with the Manor 09/10.		
	• Final PBC Pbr/Non-Pbr IP/OP Report 2008/09, CBSA		
	▲ Key points		
	1 NHS Walsall Performance Scorecard 2009/2010		
	2 LHE Evaluation (August 2008) v3		
	3 Walsall Manor Hospital Clinical Quality and Key Performance Review Monthly Report 2009/2010		
	4 Walsall Community Health Performance Indicators Report Monthly Report 2009/2010		
	5 Cervical Screening Programme 2008/09 Report		
	6 Vital Signs Performance Review 2008/09, NHS Walsall		
	7 WCH Budget data 2008/2009		
8 NHS Walsall WCC Benchmark - Year One			
9 Walsall NHS Health Improvement Monitoring Report Quarter 2 2009/10			
n/a No data available, needs to take initiatives			