NHS
University Hospitals Birmingham
NHS Foundation Trust

Our strategy to build healthier lives

1. PURPOSE OF THIS DOCUMENT

University Hospitals Birmingham (UHB) has entered a new strategic phase. We have become an even larger and more complex organisation after our recent merger by acquisition. We are playing a leading role in local health system reform through the Sustainability and Transformation Partnership (STP), while the external environment is becoming even more challenging. For all of these reasons, we need to update and renew our Trust strategy.

This document is intended to engage with staff and leaders throughout our organisation on the overall strategy and to guide detailed plans for the next phase in our journey. It is to be shared with our governors, system partners and key stakeholders, including patients and the public. Section 2 explains briefly what has served us well up to now but why we also need to change for the future. Section 3 explores the changing environment in a little more depth. Section 4 describes where we have come from and where we are going as an organisation. Section 5 sets out what those contextual changes mean for us and what we need to do in practical terms in the months and years ahead. The strategy is intended to guide planning and prioritisation at corporate, divisional, specialty and team levels across our Trust, so that we are all working together within a unified strategic framework.

2. CONTINUITY AND CHANGE

Over the last decade and more, UHB has earned its reputation as a successful, leading organisation. That success can be seen in many ways; in the commitment and expertise of our thousands of staff; in the vote of confidence that was our recent merger to form one of the largest hospital trusts in the NHS; in our leading-edge research, innovation, technology and specialised services; in our ability to meet targets in the face of relentless demand; and in the financial discipline we have maintained through the most challenging of times. We are justifiably proud of all of those achievements.

But, ultimately, they are only enablers of our core purpose. The marker of success we care about more than any other has been the high quality of acute and specialised healthcare we provide to the hundreds of thousands of patients we treat every year. That is our individual and collective purpose. It's who we are and what we do. It is why we all came into healthcare as a profession. Time and again, through patient and visitor feedback, we hear people say 'this is where I want to be, or where I would want my family to be, if/when we are sick'. Over the years, we have provided safety, healing and comfort in times of need.

Nevertheless, in so many ways, the environment in which we operate is changing profoundly. Most obviously, our recent merger means we are now one of the largest and most complex hospital groups in the NHS. The external environment is also changing radically and rapidly. The pressures of our ageing society, chronic diseases and cost growth mean that health systems, as they are currently set up, are not financially sustainable for the long-term. We cannot insulate ourselves from these big societal changes; instead we must forecast, embrace and lead change.

We are NHS people. It would be inconsistent with our values to preside over gradual decline and degradation of NHS services, which is predictable based on current evidence and trends. We are committed to making high quality healthcare, which is free to everyone at the point of use, sustainable now and for future generations.

The challenge for us in the period ahead is to find the right balance between continuity and change. We need to stay true to the values, behaviours and methods that have made us successful in delivering high quality care in the early part of the 21st Century. Our values have been updated slightly following the merger, but essentially represent continuity with who we are individually and collectively. We are collaborative, honest, accountable, innovative and respectful. Through the major changes ahead, we must hold on to our values, behaviours and methods, so that we do not lose our way or our identity.

However, we also need to be leaders in the city and the region in fundamental changes to the model of healthcare delivery for the next part of the century. That model in our city, our country, indeed in much of the developed world, now looks increasingly outdated and is creaking at the seams. We see this in our daily work, with our four Emergency Departments under intense pressure from around 1,200 attendances each day, bed occupancy now commonly reaching 99%, delays or cancellation of elective care, and staff feeling under unreasonable pressure. The fear of unsustainability is not just in the distance; something for the next group of staff and leaders to deal with. We have reached, or even exceeded, the limits of our capacity now. Unless we can find ways, with our system partners and with the public, to slow the rise in demand for healthcare services, we will be completely overwhelmed sooner or later. We would no longer be able to provide our patients with the best in care, and that is something we will not accept.

The demographic and epidemiological trends of ageing and chronic disease are well set and are not going away, so the health and care system needs to change to meet these challenges. We need to help more people stay healthier for longer, so that we begin to moderate the inexorable rise in demand for clinical services. We also need to reorganise the supply of healthcare so that people with less acute or specialised needs can be cared for in appropriate settings outside hospitals. That would allow our acute and tertiary hospitals to concentrate on caring for those patients who are seriously unwell and in need of the specialised care that we are best placed to provide.

We have all known this for some time, yet the operating model of healthcare remains largely the same, with the default being hospitalisation. The time has come for strategic changes and we must use our skills and experience to play a leadership role. The STP provides a vehicle for us to do so.

That is why as UHB, post merger, we have renewed our vision from providing the 'best in care' to 'building healthier lives', which was already the vision statement of Heartlands, Good Hope and Solihull. This is not simply a re-branding exercise; it is a fundamentally important change in our outlook and is intended to signal a strategic pivot in how we operate within the health and care system. We are no less committed to providing high quality care for the patients who come through our doors because that remains part of our core purpose. But we must be increasingly concerned with the mental and physical health of our population before and after they come through our doors.

To truly embody our vision, we need to harness our potential as an anchor institution and a leading employer in the region, as well as a major healthcare provider. We must look beyond the boundaries of our walls to consider how we can work within the wider health and care system, and with other public services, to promote health and well being, prevent illness and to help people get back on their feet as soon as possible after an acute episode.

3. CHANGING STRATEGIC CONTEXT

The scale of change we face is huge and can feel almost bewildering. Some of it is due to major and long-term changes in the structure of the population and the prevalence of diseases. Some is due to scientific and technological change in the digital era. Some is due to the ongoing impact of the Global Financial Crisis that struck last decade and which has continued to dominate political and fiscal decisions in this decade. Let us explore those issues a little more.

3.1 Our ageing society

People are living longer, which is a great success, but it means we need a health and care system that helps more people to live well and independently in later life, and meets their varied care needs. In a generation, the number of people in Birmingham over 65 years of age will increase by a third, the number over 85 will double, and those over 100 will treble. On average, the healthcare costs of someone over 85 years of age are eight times greater than someone of working age. There will be many more people living with dementia, loneliness, musculoskeletal problems and frailty. Too frequently the default position for the care of older people is for them to be admitted to an acute hospital, where they may get stuck due to delays in discharge. The longer they stay in hospital, the less chance there is of them getting back to mobility and independence at home or in the community. This is both a worse experience for people in later life and unsustainably costly for the health and care system.

3.2 The shifting burden of disease

In the UK and the whole of the developed world, the last century has seen a major shift from death and illness being caused mainly by infectious diseases to non-infectious diseases, such as cancer, heart disease, diabetes, dementia and mental illness. This reduces somewhat the risk of sudden, catastrophic illness. The treatment of that kind of acute, episodic care, and the associated risk of impoverishment, was why the NHS was founded 70 years ago 'in place of fear' (in Nye Bevan's phrase). However, it is now far more common for people to live more years with chronic, complex and expensive care needs. For instance, the number of people living with cancer and dementia is expected to double in a generation. That type of care can be ongoing and expensive, not just episodic and curable by a single course of treatment. Much chronic disease can be managed by patients themselves (with professional support), general practitioners or community professionals, so that hospitals can be focused on acute and specialised needs. For example, we see many thousands of stable patients as follow-up outpatients who probably do not need to come to hospital in an age of remote monitoring, video communication and informed self-care.

3.3 An unequal society

Like many other parts of the country, Birmingham, Solihull and South Staffordshire contains shocking inequalities in health and wealth. In Birmingham, 440,000 people live in the 10% of most deprived areas in England, which accounts for some very poor health outcomes. There is a nine-year gap in the life expectancy of the most and least advantaged in the city. On average, people in Birmingham live five fewer years in good health than the population of England as a whole. Solihull is more affluent than the national average but also has sharp contrasts in health and wealth across the borough. In the most northerly part of the borough that is served principally by Heartlands Hospital, health outcomes and life expectancy are as low as in the most disadvantaged areas of neighbouring East Birmingham. Health inequalities are not just an issue for public health, or someone else, they are a major issue for our hospitals and the patients for whom we care. We have an important role to play in tackling these inequalities as a provider of healthcare, as a large employer and as a driver of local economic growth.

3.4 Science, technology and innovation

The UK has a long and proud tradition of scientific and medical discovery. This country pioneered vaccines, test tube babies, organ transplants (for which UHB is now one of the leading centres in Europe), minimally invasive surgery and genomic medicine. Whilst this has vastly improved our ability to prevent and treat illness, and to create and extend lives, technology in healthcare has generally driven cost growth. However, digital technologies hold the possibility of significant productivity improvements, rather than simply adding to the costs of healthcare. The pace of technological change is incredible. Just over a decade ago, we first saw the iphone. Now 90% of the adult population of Birmingham owns a smartphone of some type. Artificial intelligence, autonomous vehicles, crypto-currencies and drone deliveries seemed like works of science fiction when the new QE hospital opened its doors, or when Good Hope merged with Heartlands and Solihull hospitals, not so long ago. The pace of technological change will only increase in the next decade. Birmingham aims to be a leader of innovation, technology and economic growth in the digital era, as it was in the industrial age.

3.5 Financial and workforce pressures

Over the 70-year life span of the NHS, average real terms funding growth has been just under 4% per annum, although it has fluctuated markedly from year to year. In the first decade of this century, when the economy was growing healthily, this surged to an average of over 6% p.a. But in the second decade, after the fallout from the Global Financial Crisis, it slowed sharply to just over 1%

p.a. Perhaps counter-intuitively, the contraction of budgets has been proportionally most severe in social care, followed by public health, general practice and community and mental health. That has had the effect of restricting access to care and support out of hospital and further increasing attendance and admission at our already pressurised hospitals.

The future funding environment is expected to be better than the current decade of austerity, but still slightly below the long-term average growth in NHS spending. To coincide with the 70th anniversary, the Government announced that NHS revenue spending will increase by an average of 3.4% in real terms for the next five years.

This increase will be most welcome, of course, but it is slightly below the long-run average of 3.7% p.a. and it does not include other health related budgets such as public health and training and education, or capital investment. A significant proportion of the increased budget will need to go into making good current shortfalls, such as staff pay, lengthening waiting lists, restricted access to new drugs and technologies, eliminating the structural provider sector deficit and the backlog in urgent capital investment in buildings.

Even though political priorities are being revisited, the NHS cannot expect the kind of funding environment we enjoyed in the 2000s because the economy is not in anything like the same shape. GDP growth is projected to be relatively weak at between 1% and 2% over the next five years, even assuming a better case economic scenario for the Brexit settlement. The NHS also needs to be concerned closely with the forthcoming proposals for the reform of adult social care because, without movement on that, much of the funding growth for health services will go to supporting our chronically under-resourced social care partners.

If we stand back from the near-term political and economic cycles to take a longer-term view, we can see that spending on healthcare in developed countries rises on average two percentage points above GDP growth per annum over the long term. If this trend were allowed to continue indefinitely, it would mean spending on healthcare would eventually crowd out all other areas of public spending, and that is clearly unsustainable.

Alongside these financial pressures, a key constraint in our ability to increase capacity is the availability of clinical staff. The NHS currently has over 100,000 vacancies, with over 1 in 9 nursing positions and 1 in 11 medical positions vacant. The context for national and international recruitment continues to look challenging in the short to medium term, which means we will need to be innovative in how we address our workforce challenges.

3.6 A changing paradigm for healthcare delivery

In spite of the shifting burden of disease, the model for healthcare has tended to default to hospitalisation, for the treatment of chronic diseases as well as for acute and specialised care. National policies and payment systems have encouraged quasi-commercial competition and the pursuit of 'market share' between hospitals. Whether or not that was the optimal model of healthcare, it was affordable and relatively successful in a period of significant funding growth.

Over the last 15 years, the model of healthcare has relied on (i) there being enough hospital capacity to absorb fast growing demand and bring down or maintain waiting times (ii) the workforce being available to staff that capacity and (iii) payment systems to adequately fund that capacity and those staff. All of those things have been running out of road for several years.

Our hospitals are now often operating at 99% occupancy; well above recommended levels. Waiting times are increasing for planned and non-elective care. We have vacancy rates across many specialties and staff groups because there is a major national shortfall in healthcare workers. The tariff payments have been so deflated that they no longer cover the costs of much emergency and specialised activity, even when delivered efficiently. We do have some exciting new buildings in the pipeline after 2020; namely the ACAD facility at Heartlands Hospital and the Specialist Hospital Facility on the Edgbaston site. However, there is limited space, capital investment or staff available for further expansion at any of our sites.

Despite long-term, societal changes in demography, epidemiology and technology, and the fiscal shock of the world financial crisis, local health systems, including our own, have not fundamentally changed their model of delivery. It has not been made easy by cyclical reorganisation of the NHS. Nor has it been easy for health systems to invest in preventative and community based care to address the challenges of the patients of tomorrow when today's acutely ill patients are queuing up to get into hospitals. Nevertheless, the received wisdom within the NHS has now clearly moved away from competition for market share and towards collaborative, managed systems. We must take a collaborative leadership role in the local health and care system to start to shift towards a more preventative and stratified model of care delivery, to moderate the growth in demand for acute services and to focus our efforts on the acute and specialised care that our hospitals are best placed to deliver safely and effectively for the local and regional population.

4. OUR STRATEGIC JOURNEY

We can think of our strategic journey in three broad phases, which helps to put into context where we have come from and where we are going. These phases are not entirely sequential or discrete. We need to manage them in parallel. The challenge is to continue to provide high quality care for our patients, deliver the multiple benefits of the merger, and to design a fundamentally different health system for the future. The three phases can be described simply as:

- **Excellence as a hospital**
- **Excellence as a group of hospitals**
- **Excellence as a healthcare system**

4.1 The journey so far: excellence as a hospital

For well over a decade, UHB has been on a successful journey of continuous quality improvement in patient care. This is never-ending because the pursuit of improvement and excellence is a moving target. The basis of our approach is a relentless focus on the reduction and elimination of actual or potential harm.

UHB has developed, and continues to refine, its own quality improvement methodology. It was informed originally by the approach to eliminating errors in high quality car manufacturing but has been adapted and tailored to the clinical setting of the NHS. It has led to dramatic improvements in patient care, staff satisfaction and efficient use of resources.

The approach is crucially enabled by our home-grown Patient Information and Communication System (PICS), which allows real-time monitoring of patient care and clinical activity at Queen Elizabeth Hospital Birmingham (QEHB). It supports clinicians and managers to accurately identify and tackle unwarranted variation. With this comprehensive and intuitive clinical information system, our experienced and stable leadership team emphasises 'appropriate accountability' for quality, performance and professional standards.

As a result of the journey so far, UHB has become one of the highest quality, most efficient and well regarded hospitals in the UK and internationally. Our operating model encouraged growth, particularly in specialised services. Our vision to deliver the best in care described the pursuit of excellence as a specialised hospital and the commitment to high quality care for all of the patients who came through our hospital doors.

4.2 The next stage of the journey: excellence as a group of hospitals

We have now formally embarked on the next phase of our strategic journey, which brings together QEHB, Heartlands, Good Hope and Solihull hospitals, with their community services, to form the new UHB. We have become one of the largest and most complex provider trusts in England.

Whilst the NHS is made up of hundreds of separate organisations, we recognise that they must operate inter-dependently as a system. The social contract between the population and the NHS, and the expectations of patients for their experience of care, do not recognise organisational boundaries and borders within that system. A patient in one part of the city should be able to expect the same high quality care as a patient in another part of the city, or indeed of the country.

However, the quality of care across different hospitals in Birmingham has been variable up to now, as it has been across hospitals around the country. The next stage of our journey is to raise continuously and consistently the standards of patient care and efficiency across a broader base within the city.

In the phase before the formal merger, we had already delivered substantial benefits of working closely together in terms of improved clinical governance, delivery of targets, financial savings and organisational alignment. Uniquely, the Competition and Markets Authority approved our proposed merger at the first stage of consideration on the basis of the expected patient benefits. Completing the merger gives us the firm platform to push forward the benefits of working across a larger organisation and population.

The multiple opportunities include: two-way spread of best practice as we learn from each other; a single digital platform and patient record for our hospitals, with the associated clinical and research benefits; attracting the highest calibre staff and providing them with a greater breadth of training and career experience; managing clinical pathways more seamlessly across sites, with the right balance of centralising the most specialised care and delivering less specialised care locally to our diverse communities; and driving economies of scale in purchasing power and back office services.

The history of mergers in the NHS and elsewhere tells us that there is a significant risk that the merging parties do not fully integrate, and therefore fail to deliver those benefits. We must not make this mistake. On 1 April 2018, we became one organisation. QEHB and HGS (Heartlands, Good Hope and Solihull hospitals) are identified temporarily as management units only, but they are no longer separate entities and must develop a single culture and approach. We must work hard to ensure that all of our staff feel part of one organisation, with one set of values, consistent standards and working practices and, crucially, that patients experience the same high standards of care wherever they enter our system.

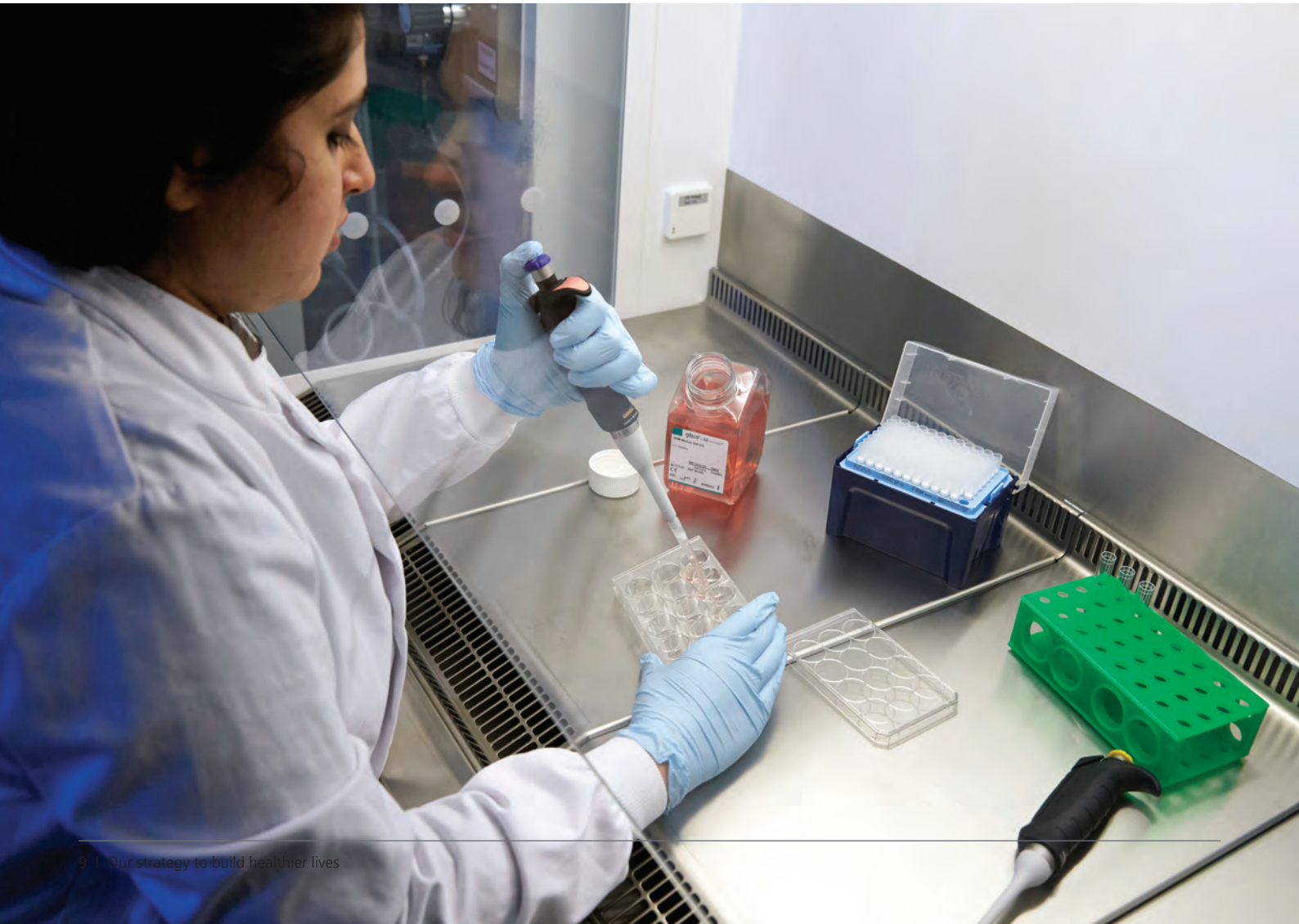
4.3 Our aspiration for the future: excellence as a healthcare system

Whilst there is much hard work still to do in the years ahead to deliver the benefits of the merger, now the third phase of the journey is already coming into sharper focus. Reshaping our hospital capacity to be more equitable, efficient and of a consistently high standard is a major strategic challenge, but will not on its own slow the growth in demand for acute healthcare services in the face of demographic and epidemiological pressures.

We need to design a more preventative health system that can slow the rising demand for healthcare services, and to better organise the supply of health and care services to treat patients in the most appropriate settings, rather than defaulting to hospitalisation when that is not clinically necessary. We can only start to do that by becoming more outward looking and working collaboratively with our partners in the wider health and social care system, and beyond. The key vehicle for us to do this is the Birmingham and Solihull STP, in which we are taking a leading role.

The STP had a stuttering start in 2016, but is now much better placed to drive real change. We are seeing far greater alignment than ever before between the NHS and local government partners. We have a new, shared vision and strategy, to which we are all committed. It seeks to organise care primarily around the mental and physical health needs of our population, at their different stages of life, rather than around organisational boundaries. This is a fundamental difference to how healthcare is organised today, and achieving it will be a journey of several years.

What does this mean for UHB? We will continue to be an excellent healthcare organisation, caring for patients' acute and specialised needs when they come through our multiple hospital doors. But we will also play a much more collaborative role with our partners as we seek to become an excellent health and care system. Together we will be concerned increasingly with supporting people to achieve good health and well-being, the diagnosis of ill health as early as possible, and caring for people's needs in the most appropriate setting, whether that is low acuity care close to home or digitally, or the most specialised and complex care in hospital.



5. TURNING STRATEGIC INTENTION INTO PRACTICAL ACTION

Up to this point, this document has taken a rather 'helicopter view' of the challenges we face and what we are trying to achieve together. It is essential that we also have in place tangible plans and actions, with KPIs, timescales and budgeted resources, to turn strategic ambition into practical change.

The next section is intended to guide our whole organisation, its divisions, specialties, departments and staff in what we want to do in the period ahead. It is not a detailed check-list or intended to micro-manage services. We are too large and complex as a multi-site trust to try to manage everything centrally, and we have great depth of talent, experience and leadership throughout the organisation so that our people will take responsibility at every level.

But we do need unity of purpose and strategic coherence so that we are all pulling in the same direction and so that the sum of our plans and actions delivers the intentions laid out in this document. It is intended that leaders and staff at all levels and sites of UHB should use this as a framework to guide their plans for quality improvement, performance and activity, investment, income generation and CIPs. It is crucially important, in all of our planning, actions and behaviours, that we work as a single, unified organisation, within a more collaborative health system.

5.1 Standardisation of high quality care

We will continue our relentless focus on providing the very best acute and specialised care. The guiding principle is that patients should be able to expect the same high standard of care, for a comparable treatment or care process, wherever they are provided in our hospital or community sites, virtually or at home. In some cases, there are clear national targets or accreditation standards for which sites, services and the whole Trust are accountable but, in other cases, local standards are required. This priority will be crucial in helping us tackle health inequalities across Birmingham, Solihull and South Staffordshire.

Clinical teams should measure their processes and outcomes (including patient-reported outcomes where available) and benchmark them against best practice as part of their clinical audit and performance review. The same measures should be used for comparable services across all sites and agreed between the relevant clinical and professional leads. This will require some adjustment and convergence because we have not always measured things in a consistent way across sites and services. However, it will be necessary for standardisation, accountability and a consistent approach to quality improvement. Clinical and professional standards, policies and practices should be standardised across all sites. Unless there is a good reason in a particular service (e.g. a different patient population profile), there should be 'one UHB way of doing things' for the same service or care process. Where these are not currently aligned, standardisation should be on the basis of 'levelling up to the best', rather than 'meeting in the middle'. Whilst we recognise that in practice there will need to be discussion and debate about what constitutes 'best', we must be able to take a shared UHB view in the end.

In some cases, following the principle of 'levelling up' will require a phased approach, where progress is dependent on capacity, workforce, finance or other finite resources. The timescale for phased convergence, as soon as practicable, should be agreed with the Chief Operating Officers and the Medical Director or Chief Nurse, as appropriate.

5.2 Clinical service planning across sites

The case for change to support the merger selected a small number of specialties to demonstrate the potential benefits (and did so successfully). We now need to go through all clinical services, with joint leadership from divisions, to deliver the benefits of working as a single organisation. This work will be overseen by the Strategic Operations Steering Group (SOSG), which will be responsible for prioritisation, because we cannot do everything at once. We will start with those services where there is the most pressing case for action, for example where there are potential risks for patient safety, different standards of service, quality or patient experience, significant staffing gaps, or a need for consolidation to ensure sustainability. We will also seek out 'quick wins' where relatively straightforward changes can deliver rapid improvements.

Whilst this will lead to some service changes, we are clear on the following fixed points:

- Patients will receive the same high standard of care wherever they access our services
- Standards will be levelled up, not to the average or below
- We will not close any of our Emergency Departments
- We will not close any of our four hospital sites (we will retain their unique brands, each of which is important to our patients and communities)
- We will not reduce the number of hospital beds we provide
- We will not reduce the number of clinical staff we employ

Where service redesign may be necessary, we will consider potential legal requirements and best practice for consultation with stakeholders and the public, although many service developments will not require formal consultation. If in doubt, specialties and divisions should seek advice from SOSG.


Deputy Associate
Director of Nursing

Cross-site planning is no longer an additional project and it must now become our normal way of working. There will be increasing convergence of divisional planning and management across QEHB and HGS.

Before long there will be a single clinical service plan for each specialty covering all relevant sites. Specialties are likely to be organised in one of three main ways:

- **Anchored in each acute site –** certain specialties, such as emergency medicine and acute medicine, amongst others, will always be principally linked to the site-based flow of acute attendances and admissions. The operational management of such specialties will require strong site-based leadership. Cross-site working will focus on strategic service planning, uniform standards and protocols, joint workforce planning and recruitment, and peer support and constructive challenge.

- **Specialist networks –** in some cases the largest or most specialised element of a service is provided on one site but other inpatient, outpatient or community services are provided across sites. In such cases, specialty planning should normally be led by the largest/most specialised site, but with full and due regard for the needs of patients and staff across the specialist network, e.g. giving due weighting to local patient access, staff training and development, and investment decisions across the network.

- **Multi-site, flexible delivery –** certain specialties have a particularly high proportion of their activity as day cases or outpatients, much of which does not necessarily need to be anchored to a particular acute or community site. In these cases, it is important that specialty planning takes a whole service view, as it is likely that some activity may move between sites or be delivered in other, non-acute settings in the future.

For certain specialties, e.g. orthopaedics, obstetrics and gynaecology, and paediatrics, the principle of clinical service planning across sites will be extended increasingly with our STP partners at the Royal Orthopaedic Hospital (ROH) and Birmingham Women's and Children's (BWC). Some clinical support services, such as pathology, will be run on a shared basis with other acute providers, led by UHB.

The coordination of work with BWC and the ROH will be supported by the development of an emerging 'Birmingham Hospitals Alliance' (see box opposite).

5.3 Digital and technological transformation

Ten years ago, we had the foresight to develop PICS and we reap the clinical, financial and research benefits today as an NHS Global Digital Exemplar. As well as extending our existing systems and capabilities to all of our sites and services, we now need to be bold and far-sighted in order to predict, develop and commit to the leading health technologies for the next ten years and beyond. The demographic and epidemiological trends described above will overwhelm the health service unless we can find ways to transform models of healthcare to be radically more effective and efficient. New technologies are the key and we are as well positioned as anywhere in the NHS to lead the way.

In the first instance, Oceano PAS, PICS and Clinical Portal will be rolled out to the sites of HGS (and other hospitals in the city), as soon as practicable based on the infrastructure at each site. Among other things, this will mean we have a single hospital patient record across Birmingham and Solihull for the first time and that many more patients will be able access their records securely online through myhealth, a secure patient portal developed by UHB.

We are far more ambitious in the medium and longer term. We will be at the forefront of developing and adopting new and emerging technologies, including the technology to enable video consultations which can potentially take large numbers of outpatients from the physical clinic to the virtual clinic. We will also make a major commitment to emerging AI diagnostics and analytics. As the national health test bed for 5G, we seek to aim to be a hub for the development of new health technologies and their application in clinical practice.

Much of this agenda will be the responsibility of the IT and informatics teams. However, they will require the support and cooperation of the wider organisation. Clinical and non-clinical teams should aim to adopt a 'digital first' approach, including software process automation where it can increase efficiency, consistency, quality and the patient and staff experience.

The Birmingham Hospitals Alliance (BHA)

The BHA will bring together the three acute and specialised providers in the Birmingham and Solihull STP (University Hospitals Birmingham, Birmingham Women's and Children's and the Royal Orthopaedic Hospital) to work collaboratively on a range of clinical and non-clinical projects.

The Alliance will not require further organisational change but instead will provide a forum for the organisations to work closely together to standardise care pathways and improve outcomes, plan services most efficiently and deliver economies of scale.

The Alliance will have robust governance arrangements, supported by a Memorandum of Understanding. Decisions taken by the BHA will still need to be ratified by the individual organisations involved.

Early priorities for Alliance are: back office services, procurement, capital estates planning, communications, clinical information systems and clinical services delivered across multiple sites, including orthopaedics and maternity.

We have recently upgraded our online security management software to Sophos and will keep under regular review our cyber security systems to ensure they remain up to date and support business continuity. All staff should be aware that we are regularly attacked by malware, whether generalised, such as in the case of Wannacry, or more targeted attacks. Protection against these threats may not always be visible to staff, but is a vital and continual part of our efforts to safeguard clinical care. The work to protect our systems will be led by the corporate IT team but requires all users of IT in the Trust to conform with agreed practices and protocols at all times so that our cyber security is not compromised.

5.4 Making best use of resources

Delivering high-quality care means using our resources as efficiently as possible to provide the best outcomes for patients. This needs to apply in our approach to the way we manage our estates, assets, workforce and the way we buy our goods and services.

Most of our estate is occupied well above recommended levels, all year round. The quality of the estate is highly variable across our sites. The greatest need for catch-up investment is at Heartlands Hospital, where ACAD and the subsequent stages of redevelopment, will be our largest and highest priority investment up to 2020 and beyond. The QEHB site will also benefit from the Specialised Hospital Facility from 2021, which will provide 72 NHS beds as well as private care.

We aim to focus the QEHB campus on its portfolio of tertiary services along with general acute services for the surrounding population. It will always have a significant workload associated with the acute medical and surgical take through ED. In order to create space for these clinical services, we will be looking to maximise the proportion of the site used for clinical purposes and to decongest the site of some lower acuity services, outpatients and non-clinical services that could potentially be delivered in community settings, virtually or at home.

Heartlands is the major ED for the East of the city and will continue to provide the large majority of DGH services for the surrounding areas. It will also retain a cohort of tertiary services where it will lead the relevant specialist network. We will significantly upgrade its facilities for ambulatory care and diagnostics with the construction and opening of ACAD. Prioritising this development is an indication of our commitment to bring up the level of care we provide to all patients, in turn tackling inequality of outcomes across the city.

Good Hope will remain the main DGH for Sutton Coldfield and the surrounding area. With its busy Emergency Department, it will to continue to operate the range of services associated with acute medical and surgical flows. The growth in this emergency activity has heavily constrained the amount of elective activity that can be undertaken at Good Hope. Part of the solution will be in decongesting the site, for example, by making use of step-down facilities to reduce DTOCs, and other steps to reduce length of stay and improve productivity. There may also be potential as well to move some elective surgery to other sites.

Whilst Solihull Hospital will continue to provide for the urgent care needs of the local population through its Minor Injuries Unit and Acute Medical Unit, we will also make increasing use of Solihull as a centre for elective and day case surgery, so that fewer electives are cancelled or postponed at our three sites with major Emergency Departments.

We must use our resources as efficiently as possible, so there will be a continuing focus in divisional performance reviews on measures such as average length of stay, day case rates, theatre productivity, Red to Green, procurement, three session days and seven day working and discharge planning. We will draw on the best available national benchmarking data to help us identify further efficiencies in the way we deliver services. There should be no void space or under-utilised space across the sites, unless it is because the costs of capital investment are prohibitive (e.g. for some of the older estate).

In order to create space on all of our over-stretched sites, we will be looking to maximise the proportion of those sites used for specialist, clinical purposes. This will mean thinking carefully about the best model of care for particular services, building on the services we already deliver in the community, virtually or at home. This in turn will help decongest some lower acuity services, outpatients and non-clinical services that could be delivered in different ways..

5.5 Planning and supporting our workforce

We must look to achieve the optimum deployment of our workforce to best meet the needs of our patients and clinical efficiency. As specialty plans come together across sites, we want to see workforce and job planning on the same basis.

There should be more opportunities for rotation between sites so that staff can broaden their experience and skills. We may require some staff to work on more than one site, where that is necessary for their service, although we do not expect individuals to be faced with unreasonable working patterns or job plans.

Recruitment should be carried out with regard to service needs across sites. Whilst we hold to the principle of 'levelling up rather than meeting in the middle', that may take time and where vacancy rates are particularly high, we will expect sites to support each other as a temporary expedient to deliver safe patient care, especially if there is a significant difference in the staffing levels between a similar service at different sites.

HR will prioritise the harmonisation of terms and conditions and roles, as part of embedding the merger, and in consultation with staff side representatives. We will continue to develop a consistent approach to staff banks across all of our sites, and with the other acute providers in the STP. Driving down agency spending will remain a key measure for divisional performance reviews.

In order to improve productivity and to address the workforce shortage in the longer term, clinical and professional leaders should think carefully about how new professional roles can complement their services and fill gaps, and where they can make use of apprenticeships. They should also be open-minded about which tasks currently carried out by people may in the foreseeable future be able to be carried out by increasingly sophisticated machines.

We are proud of our work to support staff health and well being but in the next phase we will redouble our efforts because this will become more important than ever. We will offer an even greater range of physical and mental health support to help staff stay healthy, happy and productive. At service and department level, leaders should understand in detail their staff survey data and have priority plans to act upon the findings. Regular and structured communication and engagement with staff throughout the organisation about all of the issues described in this document remains crucially important.

We will put equality, diversity and inclusion at the heart of our plans to develop the workforce. Investing in the diversity of our workforce, at all levels of the organisation, will help staff fulfil their potential, support us to deliver more inclusive services and improve patient care.

As a major local employer, we will expand across all sites the employment opportunities we offer for apprentices and for local people who have been helped into work through the Learning Hub and similar schemes to support disadvantaged groups. We will model our core value of respect, being open, inclusive and fair in all of our employment practices.

5.6 Working with our partners

In the phase when we were principally concerned with providing the 'best in care', we focused relentlessly on improving the quality of patient care we provided in hospital. Whilst we are no less committed to that goal, we are clear now that we also intend to be more outward looking to our partners in health, social care and the community in order to help build healthier lives, and to narrow the gap in health inequalities and outcomes in the populations we serve.

As one of the largest employers in the region, we have an important role to play as an 'anchor institution' for our population and our staff, helping them to lead happier and healthier lives, by working in partnership with other organisations.

Some of the most common problems we face in providing high quality care can only be solved by working more closely with partners. For instance, we need to work with mental health colleagues to address the issue of acute psychiatric patients being stuck in ED; with other DGHs, community providers and social care to make further progress in reducing delayed transfers of care; and with GP federations to better manage the care of patients with multiple comorbidities who frequently attend hospital as emergencies. Given the inter-dependence between social care and NHS services, crucial partnerships for us will be with our local authority colleagues in Birmingham , Solihull and South Staffordshire, which we will continue to strengthen and further develop.

As an organisation, teams and individuals, we must model our value of collaboration. That is in the best interests of our patients and population. We cannot deliver a collaborative strategy without collaborative behaviours. In addition to the STP, and the hospitals alliance within it, we will model those same behaviours with our many other partners and networks, such as the RCDM, WMAS, NHSE specialised commissioning, the Shelford Group, Birmingham Health Partners, WMAHSN, universities, local government, including social care colleagues, the West Midlands Combined Authority and the third sector, amongst others.

We must work with our partners across the health and care system, centrally and at clinical service level, to understand patients' needs and feedback and to analyse epidemiological data and our own clinical datasets in order to understand in detail the drivers of demand. We should explore how we can affect the demand curve, and how we can organise the supply of care for people in the most appropriate setting e.g. through more preventative care, earlier interventions, shifting lower acuity care out of hospital and more timely and coordinated step-down care. This will mean more people are cared for in primary, community or residential settings (including their own homes), and that our hospitals can focus on the acute and specialised care that we are best placed to provide.

We will welcome divisional/specialty business cases that demonstrate robust planning with STP partners to support the model of healthcare delivery we are seeking. We will facilitate those conversations centrally through the STP where necessary, especially where business cases require income to shift from one organisation to another, or where investment in one place delivers savings elsewhere. Cost improvement programmes that deliver savings for the whole system, whilst maintaining or improving patient care, are what we seek and should prioritise. Simply shifting equal costs from one organisation in the STP to another is of limited value.

5.7 Non-clinical support services

Through the Birmingham Hospitals Alliance, we will take a shared view of how to consolidate back office services for economies of scale. This will include estates planning, procurement, and some HR and IT services. As well as consolidating services for efficiency and scale, we may locate some of these services away from the main hospital buildings where space is better used for clinical services, just as we have done at Five Ways.

As the largest organisation in the Birmingham Hospitals Alliance and the STP, UHB has a leadership role to play. We are already doing that on the development of IT systems. Where non-clinical support services are consolidated between NHS organisations locally, they will most likely come together under our stewardship. It is essential that we discharge this responsibility in the best interests of the system as a whole and our population's health needs, rather than using our scale to look after what may be perceived as narrow organisational interests.

This is true of capital planning as an example. Recent national guidance from NHS England and NHS Improvement has signalled that capital investment plans need to be agreed by STPs in order to access the scarce capital that will be available. Our partners are all fully signed up to the ACAD development at Heartlands being a top priority for the system because of the inadequacy of the current estate there (the Specialist Hospital Facility will be funded through alternative funding sources). Beyond the redevelopment of Heartlands, and other essential capital works, we must recognise that a more preventative model of care to reduce the pressure on our hospitals will also require substantial investment in estates and IT outside hospital.

5.8 Emergency preparedness

QEHB is the adult major trauma centre for the region and Heartlands has the busiest Emergency Department. One of the post-merger priorities is for us to align emergency preparedness and business continuity planning across our sites, and with relevant partners in the NHS and emergency services. The events of 2017 in Manchester and London showed how important it is that we regularly test and review our emergency preparedness as a major regional centre, and this is an example of where it is critically important that we have a unified approach across our merged organisation.

5.9 Research and innovation

One of the areas in which we will continue to pursue a strategy of growth and expansion is in research and innovation. There are clear benefits to our patients from being able to continue to increase their access to the most advanced therapies, diagnostics and devices through clinical trials and other research and innovation activities. We intend to work with our patient and public representatives to ensure that the 'patient voice' influences the work we undertake. Working with NHS, academic, industry and charitable partners, we will support the development of research active clinicians across the full range of professional groups. We will actively seek opportunities to build on and expand our research and innovation infrastructure, for example the NIHR Biomedical Research Centre, West Midlands Genomic Medicine Centre, Midlands and Wales Advanced Therapies Treatment Centre, through competitive bids to research funders in the UK and internationally.

The Government has signalled in its Industrial Strategy that R&D is one of the areas of the economy that will receive greatest investment in the years ahead in order to catch up with comparator countries as a proportion of GDP. This is underpinned by the national and regional life sciences strategies, and we aim to be one of the leading health research centres outside the Golden Triangle in the South East.

We are one of six centres across the UK that has been funded by Health Data Research UK to create a national network to address major healthcare challenges through the use of data science. Building on the strong digital healthcare and research capabilities at UHB and partner universities, we will aim to make particularly rapid progress at the interface between healthcare and computer sciences. We will develop programmes of activities to evaluate the outcomes of integrating data science technologies, for example artificial intelligence and neural language processing, into patient care pathways.

NEXT STEPS

This document, and specifically the guidelines in section 5, will shape the decisions of the Board and at all levels of the organisation in the period ahead, including: the annual planning round and clinical service strategies; activity and financial projections; KPIs to monitor and for periodic performance review; business cases and other investment and resourcing decisions; recruitment and training; allocation of space; data sharing; research priorities; contracts with commissioners; and relationships with partners.

Making this happen will require extensive dialogue right across the organisation and to the community beyond, between specialties on different sites, between clinical and support services, and between service leads, divisions and corporate HQ. We need to know what barriers we can help to remove centrally to support divisions, specialties and departments to deliver their part in the strategy. If we are clear on the overall direction and our own roles within it, we know that everyone will step up and take responsibility for delivery because that is the UHB way.

Building healthier lives