FIT FOR THE FUTURE

NHS

Group Clinical Services Plan

2026-2031

Sandwell and West Birmingham NHS Trust
The Dudley Group NHS Foundation Trust

Our patients
Our people
Our population

GROUP CLINICAL SERVICES PLAN **2026-2031**

Document Purpose	To outline a strategic direction of intent for the development, improvement and transformation of clinical services across DGFT and SWBH.
Title	Group Clinical Services Plan 2026-31
Version	Version 2.1 (Final)
Date of report	21st June 2026
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Target Audiences	All clinical service professionals Birmingham Black Country & Solihull ICB Cluster Clinical Services Clinical Directors Managers and Directors Populations of Dudley, Sandwell & West Birmingham Regulators
Cross Reference/s	10 Year Health Plan for England National Policy – GiRFT, NICE Group Strategy 2026-2031 ‘Fit for the Future’ BCPC Clinical Service Transformation Programme
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OUR PEOPLE
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OUR POPULATION
Work together with our partners to improve life chances and health outcomes.

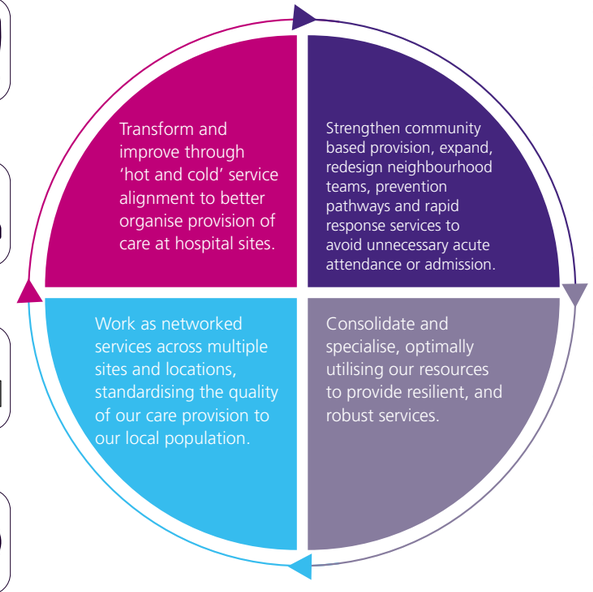
OUR APPROACH AND SERVICES

Maternity & Perinatal Care

Children & Young People

Community & Primary Care Services

Urgent & Emergency Care Services



End of Life Care

Older People Services

Cancer & Specialist Services

Diagnostics & Clinical Services

Planned Care Services

OUR SITES

City Health Campus	Midland Metropolitan University Hospital	Sandwell Health Campus	Corbett Outpatient Centre	Russells Hall Hospital	Guest Outpatient Centre	Community/ Neighbourhood (see page 16 for details)
Planned and specialist care incorporating Birmingham Treatment Centre and the BMEC Centre	Specialist urgent and acute services including maternity and paediatrics	Planned care including outpatient and diagnostic services	Planned care including outpatient and diagnostic services	Specialist urgent and acute services including maternity and paediatrics	Planned care including outpatient and diagnostic services	• Brierley Hill and Stourbridge Health & Social Care Centre • Lyng Centre for Health & Social Care • Family Hubs • Community Midwifery • Community based outpatient clinics offering diagnostics, therapy services and minor procedures

Welcome

Our vision is "*to improve the health and life chances of our populations in Dudley, Sandwell and West Birmingham*". The primary focus of our work is centred on meeting the healthcare needs of our population by providing the best possible care.

How we organise to use public resources in delivering care is becoming increasingly more important especially where demand continues to grow and public expectations remain even higher.

The 10-year health plan for England has set the tone, to which we have responded in establishing our Group Strategy, outlining our intent with a focus on innovation, operational excellence, and sustainable growth (see diagram 1).

Diagram 1 – Our Group Strategic intent.

Our Group Clinical Services Plan is key in supporting delivery of our strategy. This plan provides a clear roadmap for developing, improving, and transforming our clinical services across The Dudley Group NHS Foundation Trust and Sandwell and West Birmingham NHS Trust. The plan aims to achieve better patient outcomes, make more efficient use of resources, and ensure services are responsive to the needs of our community.

Our plan sets out how we will seek to deliver this by:

- A stronger focus on **quality** to improve access, health outcomes, patient experience, and reduce unwarranted variation through 'levelling up' activities such as consistent protocols, integrated care pathways, and standards of care.
- Developing our Group Clinical Services to provide **high quality primary**, **community**, **acute** and **specialist care**, working in partnership across all segments of health, social, and voluntary care, care so that we deliver consistent, high quality care and smoother pathways between services for Our Patients.
- Each service considering how they take a **community first** approach to deliver their services ensuring our services are designed around the needs of our patients, neighbourhoods and communities

I look forward to working diligently with our staff, services, public, patients and wider stakeholders in continually improving our clinical services to meet our population health needs.

Diane Wake
Group Chief Executive

Introduction

We are delighted to introduce our Group Clinical Services Plan through which we aspire to continually improve the quality of our services, as providing outstanding care is a key motivating driver for our colleagues at the forefront of delivering services for our local population.

We have taken the opportunity to engage, reflect, and review our services, to identify key clinical strategic priorities for our nine Clinical themes which support improvement aligned to the direction of travel of our Group Strategy and our delivery vehicle for transformation across the Group through the 'Fit for the Future' programme of work.

We have taken a broad and agile approach which aims to be responsive to new and emerging influences, with an increasing focus on demonstrating how we will lead with prevention, helping people to stay well and reducing avoidable illness.

'Fit for the Future' is our Groups commitment to reshape how we work so that we live within our means whilst protecting what matters most: safe, high-quality care. This includes a clear shift towards stronger community-based care and healthier neighbourhoods, supporting people earlier, closer to home, and in partnership with local services, so we can improve outcomes, reduce avoidable pressure on hospitals, and build more resilient communities for the long term.

Working closely with partners across primary care, local authorities and the voluntary and community sector will be essential and will enable us to be more proactive in identifying risk earlier, tackle the causes of poor health, and seek to address the inequalities that affect our communities.

Our focus will include reducing the risk of the most significant conditions affecting our population, particularly cardiovascular disease, and improving early detection so that illness is identified and treated sooner, before it becomes more complex and costly. This is all outlined within our nine clinical themes.

Our clinical teams thoughts, ambitions and plans are woven into this document – it has been co-produced through engagement across clinical teams and patient groups who have shared their significant knowledge and experience of their services with us. It uses all of this engagement to show we can improve our services for our patients in the future.

We now expect all our clinical teams to come together from both trusts and work as one to build their own service delivery plan based on the principles set out in this document. There will be further opportunities created by our working together and we look forward to seeing the ambition and outputs this provides us.

Each service delivery plan should be developed jointly by the leads and teams from each organisation. We must ensure that our patients and stakeholders have a collaborative voice in this process too. By working together as a Group, we believe we can meet the challenges ahead, improve life chances, and deliver better health outcomes for the population we serve.

We look forward to working with you in partnership to deliver this plan.

Mark Anderson
Group Chief Medical Officer

Mel Roberts
Group Chief Nursing Officer

Our Context…

Emerging environment

In developing our group clinical services plan, we are very mindful of the impact the recent NHS 10-year Health plan (Fit for the future) will have on our environment, such as:

1. **Three 'radical shifts'** – seizing the opportunity to modernise / transform and better organise the provision of service to meet the needs of our patients and local population.
2. **A repositioned operating environment** - which seeks to build a devolved health service, re-orientating the existing architecture (e.g. NHS Regions, NHS ICBs) by shifting "power" and accountability to places, providers and patients.
3. **Quality** – greater focus on improving access, health outcomes and patient experience through improved pathways, protocols and standards of care with an emphasis on promotion and prevention.
4. **Performance and delivery** – better and efficient use of resources to ensure productive service delivery, mindful of meeting constitutional targets which will reflect in performance and regulatory ratings such as CQC, NoF and NHS league tables.
5. **Neighbourhood Health** – giving our communities access to health and care as close to home as possible and only coming into hospital where necessary.

Strategic focus

We seek to optimally use our resources to enable the delivery of our plan through:

a. Strengthen our community-based provision, expanding integrated neighbourhood teams, prevention pathways and rapid response services to avoid unnecessary acute attendance or admission

b. Organising services into our planned care hubs and two acute hospitals to safeguard elective activity from disruptions caused by emergency and trauma care

c. Consolidation and specialisation of services, enabling the skilled workforce to achieve better health outcomes and enhanced service resilience

d. Working as one across multiple sites through the concept of a 'Networked Service Solution', aiming to provide high-quality and standardised care by reducing unwarranted variation

What this will mean for our patients

- They will be supported to have the healthiest start in life.
- They will be helped in preventing deterioration in their health.
- They will be able to access advice and support remotely and quickly, and be seen and treated more quickly.
- They will have fewer emergency admissions and shorter hospital stays.
- Thy will be able to access support at home and on the high street.
- They will have access to new technology, treatments and research.
- They will receive holistic care and prioritise what is important to them
- They will be supported at the end of their life in the environment they choose

Population & demographics

Our key population and demographics are highlighted below.

Aspect	Dudley	Sandwell	Birmingham
Population (2024)	331,930	353,860	263,919
Median Age	41.3 yrs	36.6 yrs	33.7 yrs (very young)
Ethnic Diversity *Source: Census 2021*	White 84.9%, Asian 8.4%, Black 2.5%, Other 4.2%	White 57.2%; Asian 25.8%, Black 8.7%, Other 8.3%	White 48.6%; Asian 31%; Black 11%, Other 9.4%
Deprivation Rank / Profile *Source: IMD 2019*	Deprivation (IMD 2019 – rank of average rank, out of 317 LAs)		
	Dudley: 104 / 317 (mid-range nationally). 11% of Dudley neighbourhoods in most deprived Decile. (26.1%) of children live in absolute poverty	**Sandwell: 8 / 317** (among the most deprived nationally) 20% of Sandwell neighbourhoods in most deprived Decile. (25%) of children live in absolute poverty	**Birmingham: 6 / 317** (among the most deprived nationally) 41% of Birmingham neighbourhoods are in the most deprived Decile. 37.5% of children live in absolute poverty
Home Owner	66.4%	53.7%	52.6%
Adult Unemployment *Source:*	4.4%	6.0%	* 7.2%
Young People (16-17yr olds), Not in Employment, Education or Training (NEET) by local authority 2024/25 academic year Midlands average total: 6.2% England average total: 5.6% *Source: DoE*	2.4% NEET 19.1% Not known **Total 21.5%**	1.9% NEET 0.7% Not known **Total 2.6%**	**3.2% NEET ** 3.2 Not known ** **Total 6.4%**
Health Outcomes **England Life Expectancy** Male: 79.5 Female: 83.3 **Healthy Life Expectancy** Male: 61.5 Female: 61.9 *Source: dept. of Health and Social Care 2021-2023.*	**Life Expectancy (years):** Male: 78.9 Female: 83 **Healthy Life Expectancy** Male: 60.7 (0.8 years less than England average) Female: 60.6 (1.3 years less than England average)	**Life Expectancy (years):** Male: 76.7 Female: 81.2 **Healthy Life Expectancy** Male: 55.5 (6 years less than England average) Female: 54.8 (7.1 years less than England average)	**Life Expectancy (years):** Male: 77.1 Female: 81.2 **Healthy Life Expectancy** Male: 57.6 (3.9 years less than England average) Female: 57.2 (4.7 years less than England average)

*Higher than average (economic challenges noted; no single rate in source). Birmingham city (ONS modelled estimate) had an unemployment rate of about 7.2% (year to Dec 2023)

** Figures for Birmingham local authority as a whole (not split to West Birmingham)

Our Approach

Over the financial year of 25/26, an executive task force led a programme of work, engaging our teams, our Boards, and wider partners to develop our vision in responding to a changing healthcare environment, and the opportunities to better organise the way in which we provide services across our sites.

Our approach to progressing the development of this Clinical Services Plan is summarised below.

Diagram 2 – Phased development approach

Phase 1

Designed & developed our approach

Worked with leaders and engaged services to develop our framework and guiding principles around which our Group Clinical Strategic Plan would be established.

Phase 2

Engaged to obtain input

Pursued engagement activities which enabled input to the development of our clinical service provision.

Phase 3

Review and prioritised

Reviewed what we heard and synthesized to establish key strategic priorities for our clinical services.

Phase 4

Ensured alignment

Ensured good alignment with our Group Strategy, enabling plans, and the strategic direction of our wider system partners.

Our Guiding Principles

Some design principles have emerged through our engagement with leaders and the clinical services, which frame our thinking in the development of priorities across all of our clinical service areas.

Diagram 3 – Our guiding principles

- Responsive to the needs of our patients
- Best use of our estates to deliver high quality care
- Community first, hospital where necessary
- Relentlessly develop and support our people, their skills and our culture
- Tackle inequality, focusing on prevention and population health
- Collaborate with partners delivering collective value, productivity and sustainable services
- Care which improves life chances and health outcomes
- Pursuit and increased use of digital solutions where appropriate
- Transform & improve the way in which we deliver our services through best use of our resources
- Grow our research capability, complemented by increasing our focus on innovation and QI

Our Services

Our Clinical Themes

Both The Dudley Group NHS Foundation Trust and Sandwell & West Birmingham NHS Trust provide a full range of hospital services with some specialist (tertiary) services.

These are provided at multiple sites (see Appendix A) across the geography of Dudley, Sandwell and West Birmingham, whilst also catering for a wider population of neighbouring Integrated Care Systems (ICS's).

This section sets out our vision for our clinical services, organised around nine clinical groupings to which we have mapped our clinical services.

It has been developed and written based on a diverse range of engagement activities (see Appendix B) with detailed input from clinical leaders, service managers, directorates, and Board members, supplemented by an Engagement Workshop which was attended by over 130 delegates and focused public / patient involvement focus groups (see Appendix C for feedback)

We have collated, reviewed and synthesized several hundred ideas to identify practical and attainable priorities to pursue in each clinical service area.

We are cognisant of our changing environment, with successful delivery attainable by working collaboratively with stakeholders and partners across the Dudley, Sandwell and West Birmingham geography.

- Maternity & Perinatal Care
- Urgent & Emergency Care Services
- Cancer & Specialist Services
- Children & Young People
- Planned Care Services
- Older People Services
- Community & Primary Care Services
- Diagnostics & Clinical Services
- End of Life Care

GROUP CLINICAL SERVICES PLAN **2026-2031**

Maternity & Perinatal Care

Where are we now…

Our Perinatal care services are characterised by some of the following:

- Services delivered across acute and community settings, with teams operating from multiple locations across the boroughs.
- Level 2 neonatal care is provided across the Group, alongside increasingly integrated community, health visiting and local authority provision, supporting more joined-up, place-based care.
- The introduction of the Improving Together programme has established a consistent, Group-wide framework for improvement, particularly in reducing perinatal mortality
- Workforce growth has been a key enabler, with an increase of 40 WTE midwives across the Group during the year, the majority newly qualified, improving capacity across services.
- Co-production and engagement have strengthened through closer working with service users, faith groups and community organisations, improving responsiveness to population need and informing key improvements, including translation and interpretation services to address inequalities.

Where do we want to be…

Looking ahead we aspire to:

- Deliver consistently safe, high-quality and compassionate perinatal care across all services, ensuring every family receives equitable, personalised care and an excellent experience, regardless of where they access care.
- Achieve outcomes that are consistently better than the national average, with sustained reductions in stillbirth, neonatal mortality and overall perinatal mortality.
- Care will be delivered through well-coordinated, responsive pathways, where women are seen, assessed and treated without delay, and where continuity of carer supports early identification and management of risk.
- Embed a strong, shared culture of continuous improvement will underpin delivery, where learning from incidents, reviews and service user feedback is consistently translated into practice.
- Ensure services are more aligned and collaborative, with greater consistency in clinical practice, pathways and standards, while maintaining the strengths of place-based delivery.

How will we get there…

Improving safety and quality of care

We will ensure that safety is consistently prioritised across all settings. Data will be used proactively to identify variation, monitor outcomes and drive improvement. Learning from incidents, reviews and feedback will be translated into demonstrable changes in practice, supporting consistently high standards of care and improved outcomes.

Optimising pathways and flow

We will streamline perinatal pathways, including triage and induction of labour, to improve the timeliness, coordination and predictability of care. To reduce delays, support better clinical decision-making and improve both safety and experience. A focus on flow across the system will ensure women receive the right care, in the right place, at the right time.

Reducing perinatal mortality

We will work in partnership with local communities, public health and system partners to deliver equitable, accessible services that are designed around the needs of our population. This will support earlier identification of risk, improved engagement with underserved groups, and a sustained reduction in perinatal mortality, with a clear focus on narrowing inequalities in outcomes.

Digital alignment and information sharing

We will align electronic patient record systems across services to improve the sharing of information, reduce fragmentation of care, and support safer, more coordinated pathways. This will enable clinicians to access timely, accurate information, improving both clinical decision-making and the experience of care for women and families.

Embedding continuous improvement

We will embed quality improvement processes across perinatal services to ensure learning is consistently translated into practice. This will include using data, incident reviews and service user feedback to drive improvement, reducing the risk of poor maternal and perinatal outcomes and supporting a culture of continuous learning and accountability.

Children & Young People

Where are we now…

Our services for Children & Young People are characterised by some of the following:

- We have committed, innovative teams delivering strong child-centred care, with positive examples of acute-community collaboration and effective virtual working during COVID.
- Some services remain fragmented across Trusts, with duplication, inconsistent pathways, outdated booking systems contributing to DNAs, variations in referral thresholds, and age criteria leading to inefficiencies and inequity.
- Insufficient shared data, digital integration, and structured cross-Trust clinical collaboration, alongside gaps in community, social care, and liaison roles that could prevent escalation to acute care.
- Without change, a greater risk of increasing fragility, digital exclusion, reactive service models, and disengagement from young people who expect authenticity, clarity, and meaningful involvement.

Where do we want to be…

Looking ahead we aspire to:

- We will build a truly child- and family-centred CYP model that is transparent, equitable, digitally inclusive, and grounded in authentic engagement and co-production.
- Care will be designed around the patient journey rather than organisational boundaries, with standardised age ranges, seamless transitions, consistent referral guidance, and clear communication about what services offer and why changes occur.
- We will let go of rigid hospital-centric delivery, unnecessary variation, and over-medicalised models, instead growing community- and school-aligned outreach, virtual-first pathways where appropriate, stronger liaison roles, joint clinical guidance, research capability, and integrated data platforms.
- We will preserve quality and professional leadership while actively avoiding fragmentation, over-centralisation, change fatigue, or inequality widening.

How will we get there…

Improve access to services

By 2028 we will have embedded a more flexible approach, to proactively engaging with families to agree suitable appointment times and organise our services to suit the needs of families.

Standardise referral criteria

By 2028 we will have reviewed our current pathways, standardise referral criteria, increase advice and guidance to primary care, reducing unwarranted variation, and build clinical collaboration across clinical teams.

Shift services into the community

By 2031 We will have expanded the use of virtual consultations, deliver more care pathways in community locations and within our Neighbourhoods which are accessible to families., and ensure that attendance in acute hospitals is focused for only those that genuinely require it.

Vulnerable children

We will work with partners (incl. social care, public health, education, faith and volunteer organisations) to improve pathways for our most vulnerable children and families to improve life chances

Promoting education & prevention

We will support our local communities with education to improve understanding of preventative programmes such as immunisation and screening, working in partnership with local faith leaders, the voluntary sector, education, public health and primary care amongst others.

Community & Primary Care Services

Where are we now…

Our Community & Primary Care Services are characterised by some of the following:

- We have a well-established community footprint, committed multidisciplinary teams, strong clinical leadership, and pathways that successfully keep patients closer to home. There are examples of good links between acute and community services, increasing use of PIFU and risk stratification approaches, and a clear focus on supporting patients outside of hospital settings in their local neighbourhoods.
- Our strengths are not yet consistently realised as a single, coherent system. There remains duplication of work, organisational and financial barriers, inequity of access, and fragmentation between services. Digital systems remain partially connected, outcome measurement is inconsistent, and activity-based metrics still dominate.
- There is also concern about the inappropriate shift of work between sectors, historic silo working, and workforce pressures. As a result, our delivery of patient care is not yet operating as an integrated, outcomes-focused model across the wider health and care system.

Where do we want to be…

Looking ahead we aspire to:

- Integrated Neighbourhood Teams delivering coordinated, patient centred, multidisciplinary care tailored to meet the needs of the local community using population health data. Care will be built around shared decision-making, supported by a culture of respect and open communication across professions and organisations.
- Pathways will be simpler to navigate, with clear points of access and reduced duplication, ensuring that patients receive the right support in the right place first time.
- Home First approach where our intermediate care, virtual wards and urgent community response services prevent hospital admissions and enable rapid, safe discharge back into the community.

GROUP CLINICAL SERVICES PLAN **2026-2031**

How will we get there…

Integrate and strengthen community-first pathways

We will develop universal neighbourhood-based service models, embedding system thinking and collective accountability, ensuring an appropriate shift of care and resources from acute settings where clinically appropriate by 2031.

Connect systems and accelerate digital integration

We will ensure appropriate data flow across organisational boundaries, prioritising AI-enabled digital integration with alignment of information systems and digital platforms (e.g. NHS App) to improve the patient journey and experience.

Shift from activity to clinical value and patient outcomes

By 2028 we will have a set of outcome measures for primary and community care aligned to quality, impact, and patient-reported experience outcomes.

Remove Duplication

We will work with partners (incl. social care, public health, education, faith and volunteer organisations) to improve pathways for our most vulnerable children and families to improve life chances

Urgent & Emergency Care Services

Where are we now…

Our Urgent & Emergency Care Services are characterised by some of the following:

- Two acute hospitals delivering Emergency Department Care with Urgent Treatment Centres (UTC) on site. The Emergency Departments serve a wider and increasingly frail population with the departments increasingly being used as a default position for patients resulting in increasing pressure on emergency care delivery.
- There are no consistent or documented criteria to admit from ED.
- Both Trusts have Same Day Emergency Care (SDEC) in multiple pathways including frailty, medical, surgical, paediatric and gynae.
- There is a growing focus on admission avoidance from those emergency portal areas and reducing Length of Stay (LOS) by focussing on left shift to community and appropriate exit strategies for patients.
- Improvement on clinical engagement across all divisions to provide updated pathways within Directory of Service that support admission avoidance and attendance avoidance with clear access from Single point of Access and Care Navigation Centre's.

Where do we want to be…

Looking ahead we aspire to:

- Full adoption of right place first time for all patients with Emergency Department being place for "life or limb threatening" emergencies only and all other pathways supporting delivery of care within the community settings such as long-term conditions, urgent community response, urgent treatment centres.
- UTC and SDEC pathways will be fully established with consistent opening times and pathways with direct access to the care navigation centre. Patients will have clear access to virtual wards, hot clinics and diagnostics from these areas to prevent admission into an acute bed where appropriate.
- The use of digital tools such as e-triage/streaming will be fully embedded across the Group to support clinical decision making and remove duplication and admin processes freeing up clinical time to support clinical delivery.
- Pathways will be re-designed to support left shift into community where ongoing treatment by specialised teams for rehabilitation and long-term conditions will provide care to prevent further admissions and reduce LOS.

How will we get there…

Population health management

We will enable new solutions to identify and assess deteriorating patients early in the community to optimise interventions and prevent admissions e.g. individualised care plans.

Alternate pathways of care

We will continue work with multidisciplinary partners (including pharmacists, optometrists, dentists, social care etc) to access the '*right care, at the right time, and in the right place*'.

Streamlining UEC pathways

By 2027 we will have improved screening and triage processes between the initial patient attendance and required care e.g. Same Day Emergency Care (SDEC), frailty, virtual wards, urgent treatment centre.

Single point of access

By 2028 we will simplify pathways to allow partners to access the right service for their condition. To enable this, we will optimise and develop the 'care navigation centre' as the initial contact point.

Admission avoidance

We will continue to work in partnership with primary care, community and neighbourhood teams to care for patients at their place of residence and reduce variations in care.

Mental health service provision

We will continue work with our partners who support all ages of patients with mental health problems to have a more streamlined journey and improved patient experience by 2028.

Planned Care Services

Where are we now…

Our Planned Care Services are characterised by some of the following:

- We have begun to better organise our planned care services to make best use of our resources (buildings, money, materials and workforce).
- We have established an elective hub to manage planned care in a timelier manner, whilst also creating a diagnostic hub in parallel to supporting improvements in clinical effectiveness by OPD pathway redesign and an increase in virtual appointments versus face-to-face.
- We are pursuing a total redesign of outpatient care centred around the needs of patients i.e. where, when and who best to deliver, through a collaborative and transformative approach.
- We have increased efficiency, reduced manual effort, and built a more agile, resilient organisation aligned with our strategic priorities by modernising systems and embedding digital tools into everyday work.
- We are leveraging our diagnostic hub of digital systems that focuses on right patient, right place to transform our patient services.

Where do we want to be…

Looking ahead we aspire to:

- Separate essential hospital-based services from planned care services (including out-patient care) which can be provided safely in a local community setting – "right care, right place, right time".
- Work with partners to support prevention and promotion activities in the community, enhancing the patient journey and experience.
- To deliver the highest quality of care consistent with national benchmarks (e.g. GiRFT) attaining and exceeding upper quartile performance where possible.
- Advice & guidance implemented in 10 key areas – Cardiology, GI & Liver, T&O, Gynaecology, General Surgery, ENT, Paediatrics, Pain management, Urology, Clinical Immunology
- We will be establishing an Orthopaedic Hub to enable specialist and outpatient care for our patients decreasing wating times Establish improved data flows between service and organisational interfaces, enabling better management of the patient through their journey from referral, through booking, delivery of treatment, and recovery.

GROUP CLINICAL SERVICES PLAN **2026-2031**

How will we get there…

Models of care

We will better organise to deliver emergency and planned care services separately, including Ophthalmology, elective hub at Sandwell health campus e.g. out-patients, CDC by 2031

Prevent hospital attendance

By 2031 we will implement the right technology to reduce the need for patients to attend hospital to access healthcare.

Patient experience

We will continue to work with our partners to improve our communication processes and pathways to ensure timely access to planned care appointments and reduce DNA's and waiting times.

Health on the high street

We will explore new models of care which will allow care to be accessed closer to home where appropriate and safe to do so.

Transformation

We will transform pathways to improve access, outcomes and productivity., ensuring the right care is delivered in the right place at the right time – reducing variation, strengthening clinical sustainability and driving long term financial resilience across the system.

Advice & guidance

We will deliver by 2031 clearer end-to-end pathways that operate seamlessly across organisations and place boundaries, strengthening the primary / secondary care interface through better advice and guidance.

Diagnostics & Clinical Support Services

Where are we now…

Our Diagnostic & Clinical Support Services are characterised by some of the following:

- We have strong clinical expertise, innovative practice, and a committed workforce delivering high-quality care every day. Medicines services, AHP and advanced practitioner roles, ward-based pharmacy, digital optimisation, and virtual ward models are already adding real value to patients and staff, enabling safer care, improved flow, efficient discharge, and better clinical outcomes.
- Our challenges remain the persistent fragmentation and variation in service delivery, duplicated policies, and a lack of systemwide integration which impact of health outcomes. Operational pressures are often met with reactive rather than planned responses, digital systems work in silos, and clinical support services are not consistently embedded in decision-making or early business case development. Workforce expectations are stretching people and affecting sustainability wide integration continue to limit potential.

Where do we want to be…

Looking ahead we aspire to:

- Become a seamlessly integrated system where pharmacy, AHPs, advanced practitioners, and clinical teams are embedded as equal partners in the design and delivery of patient care. Our future model will be built on strong governance, medicines optimisation, aseptic services and expert prescribing, supported by modern digital tools, automation, and artificial intelligence.
- We will grow a multidisciplinary workforce with the right skill mix, supported by apprenticeships, technical roles, and expanded advanced practice teams across all areas.
- A system that is digitally enabled, operationally integrated, workforce ready, and clinically excellent, providing expert support that improves patient outcomes and delivers a consistently high-quality care experience across every site, specialty, and setting ready, and clinically excellent. Our future requires integrated technology, shared pathways, community-first models, and expanded virtual ward capacity that reduces conveyance, improves flow, and strengthens care closer to home.

How will we get there…

Aseptic services

We will work in partnership to deliver a pharmacy aseptics service solution delivering medications in a timely manner to the population of Black Country.

Build a unified system wide diagnostics operating model

We will create a single, coordinated diagnostics function across acute, community, and primary care by strengthening system partnerships, reducing duplication, standardising referral management and governance, and better organise diagnostics care to improve productivity, expanding one-stop clinics, and plan early for increases in screening demand.

Modernise diagnostics care

We will accelerate digital interoperability, reduce and seek to eliminate paper referrals, and adopt AI and automation to streamline reporting, clinical decision making, and patient pathway flow.

Optimising Clinical Support Services

We will prioritise integration across the Trust and care boundaries to maximise clinical support services (e.g. pharmacy, AHPs, healthcare scientists etc) to improve patient pathways and enable access to early consultations and treatment resulting in improved health outcomes.

Cancer & Specialist Services

Where are we now…

Our Cancer & Specialist Services are best characterised by some of the following:

- We serve a large and diverse population with a robust range of screening, diagnostics, treatment and ongoing management of care to patients with suspected or confirmed cancer, supported by a range of highly specialised surgical and medical services.
- We provide rapid access diagnostics, oncology services (including chemotherapy), specialist cancer surgery such as gynae oncology, renal cancer surgery, skin, haematology, head & neck, colorectal, breast surgery and reconstruction, colorectal, hepatobiliary pathways, and vascular surgery.
- Our specialist services such as clinical genetics, haematology, HIV, immunology and complex reconstructive surgery are delivered across acute hospital sites and specialist centres, dialysis is delivered through satellite centres, and community pathways such as lung-screening our provided in our Community Diagnostic Centre (CDC)

Where do we want to be…

Looking ahead we aspire to:

- Establish a Black Country Oncology service that meets the needs of our local population, with a shared ambition to reduce delays in patient pathways, improve access to treatment and enhance overall patient experience and outcomes.
- We will drive improvements and transformation across key specialist areas such as oncology, specialist ophthalmology and vascular services amongst others.
- We will strengthen integration across IT systems by bring our services together, optimise existing infrastructure, and ensure we are consistently working towards meeting all national cancer standards. This unified approach will enable us to deliver more efficient, high quality care.
- We will expand our immunology service, provide enhanced laboratory provision, and work collaboratively across primary and secondary care. Access to specialist genetics services will further ensure that patients benefit from personalised, evidence based cancer care.

GROUP CLINICAL SERVICES PLAN **2026-2031**

How will we get there…

Access & early diagnosis

We will deliver a Community Diagnostic Centre (CDC) in Sandwell and expand the CDC provision at Corbett / Merry Hill to increase capacity, improving access for our local population by 2031.

Black Country Oncology Service

Establish a comprehensive oncology service for the Black Country population that delivers timely, specialist-led cancer care, ensuring patients receive coordinated and compassionate cancer care that meets the needs of our population now and in the future by 2031.

Supporting diagnosis using AI technology

By 2031 we will introduce AI to support a reduction in waiting times for cancer patients, freeing up the time of the specialist workforce so they can focus on providing patient care and improve life chances. This will enable patients to commence earlier cancer treatment and support peoples choices about how they access care, keep patients, their families and carers connected, in control, whilst supporting care in the home setting.

Improving patient pathways

Year on year we will strengthen our partnerships and communication channels with primary care by developing a coordinated approach to cancer & specialist referrals, ensuring that patients are directed to the right pathways at the right time. We will work closely with public health, primary & community care to improve the quality and consistency of referrals, reducing unnecessary diagnostic activity for non-cancer patients and ensuring rapid-access pathways are used appropriately used.

Older People Services

Where are we now…

Our Older People Services are characterised by some of the following:

- A growing and increasingly frail ageing population, with rising levels of multimorbidity, social isolation and clinical complexity continuing to drive demand across urgent, acute, primary and community services.
- We have established acute and community frailty pathways for our moderate to severe patients with enhanced support with our growing community capability and system partner to support more of our residents in the community and prevent readmission with the provision of step down and home-based support.
- We have developed a strong and evolving frailty models, including front-door frailty services and a well-developed frailty virtual wards. Service provision remains variable outside core hours, with limited seven-day working in some areas, and pathways can still be fragmented.
- We have established a digital focus, including an innovative electronic Comprehensive Geriatric Assessment (CGA) tool and routine electronic Clinical Frailty Scale (CFS) scoring. Further work is needed to fully embed their use and strengthen early identification and intervention to help delay the onset and progression of frailty.

Where do we want to be…

Looking ahead we aspire to:

- Deliver a consistently high-quality, person-centred model of care for older people, with frailty embedded as a core organising principle across all pathways.
- Care to be increasingly delivered through community-based integrated medical and social support frailty hub models, providing coordinated multidisciplinary support, early intervention and personalised care plans that enhance advance care planning and support independence at home.
- A shared system infrastructure, including digital frailty registers and coordinated care planning, to support earlier identification, risk stratification and a more anticipatory and population health based preventative approach to frailty care.
- Neighbourhood teams working across health, social care and the voluntary sector to deliver coordinated, holistic support that promotes reablement, functional recovery and independence, with care focused on what matters most to each individual.

GROUP CLINICAL SERVICES PLAN **2026-2031**

How will we get there…

Establish a community first model of care

We will progressively rebalance care delivery toward community settings to support independence, reduce avoidable hospital utilisation and improve patient experience. Strengthening intermediate care, 'home first' approaches, virtual wards, and neighbourhood multidisciplinary teams will be critical to managing rising demand associated with frailty, multimorbidity and functional decline.

Design the system around 'frailty' and anticipatory care

Position frailty as a central organising principle for Long-Term Conditions and End-of-Life pathways. Earlier identification of deterioration, shared frailty registers, proactive planning and coordinated multidisciplinary intervention will support safer crisis management while reducing emergency attendance. Embedding anticipatory approaches by 2028, including advanced care planning and improved dementia pathways will be essential to delivering more personalised and continuous care.

Transitions of care

We will continue to target improvements needed for patients with dementia, those nearing end of life, and care home residents, where fragmented transitions often drive deterioration or readmission by 2031.

Target equity through deliberate service design

We will respond to the pronounced inequalities experienced across the Black Country. Service design will consider deprivation, cultural diversity, digital exclusion, and access barriers to ensure older people receive equitable care regardless of location or background by 2031.

End of Life Care

Where are we now…

Across Dudley, Sandwell and West Birmingham, End of Life Care is delivered by multidisciplinary teams working across hospital, community and primary care settings, supported by specialist palliative care services in all care settings. There are strong local foundations on which to build, with the Connected Palliative Care model in Sandwell and West Birmingham, providing specialist support across settings alongside virtual ward and end of life care delivery and coordination functions. In Dudley, specialist palliative care is complemented by a broader generalist model, strengthened through Gold Standards Framework implementation across generalist services.

However, delivery remains inconsistent across the Group. Information sharing and care planning are variable, interfaces between services are fragmented, and roles across organisational and place boundaries are not always clear. Workforce pressures, inequities in access, and late recognition of people approaching the end of life contribute to avoidable escalation into hospital, delayed discharge and care that is not always aligned with patient wishes.

Where do we want to be…

Looking ahead, we aspire to deliver End of Life Care that is earlier, better coordinated and increasingly community based, aligned to the Group's Community First ambition.

We want:

- Earlier identification of people approaching the end of life, with proactive and shared care planning.
- More people supported to receive care, and where possible to die, in their place of choice when clinically appropriate.
- Consistent, dignified and compassionate care across hospital, community and primary care.
- Reduced avoidable hospital admissions, prolonged stays and delayed discharges at the end of life.
- Generalist teams to be better supported through specialist expertise, education and quality frameworks, including continued use of accredited pathways and frameworks and accreditation.

How will we get there…

Integrate care to reduce fragmentation

We will strengthen interfaces seamlessly across organisational and place boundaries, strengthening primary–secondary interfaces and admission avoidance services.

Strengthen place-based partnership delivery

We will build shared ownership of outcomes with health, social care, hospices and voluntary organisations to support care closer to home.

Improve identification, planning and standards of care

We will through earlier recognition, advance care planning and individualised care through local delivery models. In Dudley this will continue through Gold Standards Framework implementation, accreditation and re-accreditation as part of the agreed trust strategy.

Improve digital visibility and workforce capability

We will enhance visibility of care plans across settings and invest in training and shared learning to reduce variation and improve staff confidence by 2031.

GROUP CLINICAL SERVICES PLAN **2026-2031**

Our focus on Quality

Our focus on improvement and transformation across our clinical services is supported and complemented by a range of quality enablers which are being progressed in parallel, a summary of which is outlined as follows.

Accreditations

We aspire to ensure that the services we provide are of the highest quality, pursuing where appropriate accreditations such as Elective hub accreditation through the national GiRFT team, surgical, diagnostic or anaesthesia through appropriate Royal Colleges and national governing bodies.

We will continue to ensure that we remain vigilant with respect to service quality requirements, retaining all current accreditations, and pursuing new requirements as and when they are published

Care Quality Commission (CQC)

Our current positions for The Dudley Group NHS Foundation Trust and Sandwell & West Birmingham NHS Trust are outlined below.

Table 1 – Current CQC ratings for DGFT

Safe	Effective	Caring	Responsive	Well-led	Overall
Inadequate (May 2019)	Good (May 2019)	Good (May 2019)	Requires Improvement (May 2019)	Requires Improvement (May 2019)	Requires Improvement (May 2019)

Table 2 – Current CQC ratings for SWBH

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement (Feb 2026)	Requires Improvement (Feb 2026)	Outstanding (Feb 2026)	Requires Improvement (Feb 2026)	Good (Feb 2026)	Requires Improvement (Feb 2026)

The Group has a vison to achieve **Outstanding** ratings across all domains at both Trusts, an ambition which this clinical services plan will support and enable, and we continue to work on this collectively across the Black Country undertaking self-assessments, sharing learning, best practice and sharing queries, intelligence and reports.

Key Quality Indicators

As a Group we want to see our key quality metrics improve in the following areas:

- Patient Experience responses and Outcomes
- Waiting Times
- Pals & Complaints
- Staff Survey results
- National Oversight Quality Indicators
- Absence
- CQC ratings
- Response times

Getting it Right First Time (GiRFT)

Our clinical service plans will use Getting It Right First Time (GIRFT) and national clinical audits as core levers to reduce unwarranted variation and improve outcomes. GIRFT data provides specialty-level insights on performance, productivity, and patient outcomes, enabling services to benchmark against peers and identify opportunities for pathway redesign. National audits complement this by offering robust, standardised measures of quality and safety across key conditions and procedures.

Together, these sources inform evidence-based standards, support targeted quality improvement programmes, and can guide resource allocation.

Our plans will use these data sources to inform our clinical leaders to translate findings into practice. We will prioritise transparency, ensuring that best practice is disseminated and sustained. Services across our group can reduce variation and waste, to improve patient outcomes. Ultimately, aligning GIRFT and audit intelligence with local priorities will drive consistent, high-quality, and patient-centred care across our organisations

Allied Health Professionals

The AHP Strategy for England: AHPs Deliver sets out a clear, nationally aligned framework for how AHPs maximise their impact across prevention, treatment and recovery - focusing on improving outcomes, productivity and patient experience through evidence-based, person-centred care.

AHPs Deliver highlights how AHPs are central to delivering sustainable, high-quality care and rehabilitation across both organisations by supporting clinical transformation, workforce development and improved outcomes for the populations we serve.

This strategy provides a strong foundation for our Group, aligning directly with the three shifts of the NHS 10-Year Plan, translating national AHP priorities into locally meaningful action across acute, community, primary care and specialist services.

Together we will work with our fellow clinical, medical and management professionals to supports delivery across key clinical areas including urgent and emergency care, frailty, elective recovery, long-term conditions, mental health, rehabilitation and admission avoidance - by embedding AHP leadership in pathway redesign and multidisciplinary working, making best use of resources.

Nursing

The professional strategy for Nursing & Midwifery in England represents a defining moment for our professions – a collective opportunity to shape the next era of nursing and midwifery practice, education, research and leadership.

Nurses, midwives and nursing associates are at the heart of every community. The national strategy sets out a long-term vision for our professions, recognising our vital role in transforming health and care to meet the needs of our changing population, supporting the health service to reform, including elective care and reducing waiting lists, and improving the health of our nation, now and for the future.

From career development to flexible opportunities and wellbeing – our national nursing strategy also sets out how we will better support colleagues throughout their careers and ensure that nursing and midwifery are modern careers of choice for more people.

We will seek to maximise the opportunities for the nursing profession through the priorities that we pursue in our Group Clinical Services Plan.

Medical

We will continue to support our doctors to deliver a clear, future-focused strategy centred on excellence, innovation, and leadership. We will recruit based on the highest standards, attracting individuals who demonstrate clinical expertise, compassion, and a commitment to continuous improvement. Once in post, we will support medics to innovate and embrace new technology, creating an environment where digital tools, research, and new models of care are actively encouraged and safely implemented.

We will prioritise education by training the next generation of doctors through high-quality placements, mentorship, and protected learning time. Our approach will ensure trainees feel supported, valued, and equipped for modern clinical practice.

Alongside this, we will actively develop our clinical leaders, offering structured leadership programmes, coaching, and opportunities to influence service design. By investing in our workforce at every stage, we will build a resilient, skilled, and forward-thinking medical community.

Quality & Safety

Our quality and safety priorities will focus on delivering safe, effective, and high-quality compassionate care while continuously improving patient outcomes and experience across all services. Central to this is strengthening our focus on fundamentals of care, partnership working with system partners, communities, and patients to support integrated care and a community-first approach, reducing unnecessary hospital admissions and supporting care closer to home.

Specific focus will remain on perinatal quality and safety, improving the prevention and management of the deteriorating patient, reliable incident reporting, learning from harm, and implementation of evidence-based improvement initiatives. Enhancing patient experience will remain a core priority, with care designed around patient needs, dignity, and involvement in decision-making.

Partnerships

Both Trusts recognise the importance of working in partnership across multiple footprints with a diverse range of stakeholders to provide high quality care to our residents.

At a neighbourhood level we work through our local teams, community and voluntary groups to ensure we hear from a wide range of voices engaging our communities in addressing the inequalities they face.

This is complemented by working at a place-based footprint with wider health and care partners, such as councils, housing, mental health and primary care. Through Dudley Health and Care Partnership, Sandwell Health and Care Partnership and West Birmingham Locality Partnership we are reducing the barriers between organisations by planning our services together, in an integrated way.

And finally, we remain committed to our strategic and system wide clinical and service partnerships which include:

- The Black Country Pathology Service (BCPS) which provides a robust and resilient pathology service to the Black Country providers and is amongst the best performing pathology partnerships across the country; and
- The Black Country Provider Collaborative (BCPC), a nationally recognised partnership of four Acute & Community Trusts in the Black Country focused on working as one across multiple site to deliver better, faster and safer care to our population, through standards, care pathways and new models of care.

Research, Development & Innovation

The Group is committed to working with partners across the Black Country to not only sustain but grow our clinical and academic research, development and innovation presence and portfolio.

We recognise that this is critical for a number of reasons such as:

- Better access for our patients to emerging medicines through clinical trials, regardless of which organisation they are treated at
- The opportunity to use our populations diversity and deprivation profile to drive inclusive trials and population health research
- The opportunity to pursue research income and grants competing at scale for commercial trials, NIHR funding and academic partnerships

Through a programme of transformation, we are seeking to consolidate our focus in these areas which will drive benefits in resilience, productivity and performance, whilst practically streamlining approval and administration processes.

We will continue to work with our clinical teams and diverse range of external partners to ensure that we are conscientious, proactive and diligent in contributing to the regional economic position whilst pursuing clinical excellence to deliver best care to our patient population through innovation.

Enabling Plans

Supporting the delivery of this Group Clinical Services Plan are a range of enabling plans. A brief summary is provided below.

- **Digital, Data and Technology (DDaT)** – our plan to support the shift from analogue to digital by converging our hard and software digital platforms and make best use of our resources; better use of artificial intelligence to enhance care and operations; and embed digital transformation as a driver of better outcomes, efficiency and sustainability across the group.
- **Estates & Facilities** – driving a programme of work that seeks to optimally use future capital investment strategically, as a catalyst for clinical excellence and transform the way in which we deliver care for our population.
- **Green plan** – recognising that climate change is a major public health challenge, we are committed to contributing our part in reducing our carbon foot-print working in partnership through collective action. The way in which we develop and establish future service models will be critical in supporting the delivery of our Green plan commitments.
- **People plan** – committed to nurturing a safe, compassionate and inclusive culture focussed on retention, wellbeing and engagement, strengthening leadership and management capability, and deploying our workforce in ways that support service transformation, productivity improvement and financial sustainability.
- **Our People** and Organisation Development services will increasingly operate through coordinated Group leadership and governance, reducing duplication, eliminating unwarranted variation and delivering consistent standards, while remaining responsive to Place-based needs across Dudley, Sandwell and West Birmingham.
- **'Fit for the Future'** – The Group has established the 'Fit for the Future' programme which is a group-wide, multi-year transformation programme designed to deliver the significant changes required to secure a sustainable future across Dudley, Sandwell and West Birmingham.

Programmes have been defined to deliver these ambitions, aligned to our long-term strategic priorities, which are:

- Community Rehabilitation and Reablement.
- Establishment of Integrated Neighbourhood teams.
- Dudley & Sandwell Joint Care Navigation Centre, Orthopaedics,
- Ophthalmology
- Sandwell CDC

The programme will run for three years until March 2029.

Next Steps

To ensure we remain a high performing provider of quality services across the Dudley, Sandwell and West Birmingham geography, we will strive to use the resources available to develop, improve and transform our services in line with the aspirations outlined in this document.

In driving delivery, we will:

- Continue to engage with services, professions and wider stakeholders to ensure we have captured an appropriate level and range of attainable aspirations that improve our services, consistent with local health need
- Ensure that aspirations are aligned with the overall Organisational Strategy and its supporting delivery vehicles
- Work with all Trust services to develop detailed phased annual plans that support delivery of our identified aspirations
- Ensure we support our services to drive delivery in their attainment, developing clear measures of success
- Work with external partners and stakeholders to manage the service change and transformation

We look forward to working with our staff, services, patients, and wider stakeholders in developing and transforming our clinical services to deliver better, faster, and safer care for our resident population and beyond.

Glossary

Acronym	Definition
ACP	Advanced Care Practitioner
AHP	Allied Health Professionals
AI	Artificial Intelligence
BAME	Black, Asian, and Minority Ethnics
BC	Black Country
BCPC	Black Country Provider Collaborative
BSOL	Birmingham and Solihull
CDC	Community Diagnostic Centres
CEO	Chief Executive Officer
CMO	Chief Medical Officer
CNO	Chief Nursing Officer
COO	Chief Operating Officer
CQC	Care Quality Commission
CYP	Children & Young People
DDaT	Data, Digital & Technology
DGFT	The Dudley Group NHS Foundation Trust
DNA	Did Not Attend
EPR	Electronic Patient Record
ESR	Electronic Staff Record
FT	Foundation Trust
GIRFT	Getting It Right First Time
GP	General Practitioner

Acronym	Definition
HIV	Human Immunodeficiency Virus
ICB	Integrated Care Board
ICS	Integrated Care System
LoS	Length of Stay
MDT	Multi-Disciplinary Team
MMUH	Midlands Metropolitan University Hospital
NHS	National Health Service
NHSE	NHS England
NIHR	National Institute for Health and Care Research
NOF	NHS Oversight Framework
OPD	Out-Patient Department
PIFU	Patient Initiated Follow Up
POC	Point of Care
PROM	Patient Reported Outcome Measure
QI	Quality Improvement
RAAC	Reinforced Autoclaved Aerated Concrete
SDEC	Same Day Emergency Care
SPOA	Single Point Of Access
SWBH	Sandwell and West Birmingham Hospitals NHS Trust

Appendix A – Our Clinical Services

An overview of Group wide services by site is provided below.

The Dudley Group NHS Foundation Trust

Russells Hall Hospital (RHH)

638-bed acute site providing emergency, secondary and tertiary services including emergency department, maternity, critical care, in-patient wards, theatres and outpatient clinics.

Guest Outpatient Centre

Outpatient clinics and diagnostics.

Corbett Outpatient Centre

Delivers outpatient appointments, diagnostics and day-case services.

Community Health Centres

Brierley Hill and Stourbridge Health and Social Care Centres.5 Family Hubs/ Community Midwifery, 2 satellite dialysis centres. Community-based outpatient clinics offering diagnostics, therapy services and minor procedures.

Merry Hill Health Hub

Community health hub in retail setting. Outpatient clinics and blood tests.

Primary Care

Chapel Street Medical Centre; High Oak Surgery. Provides general practice services.

Sandwell & West Birmingham NHS Trust

Midland Metropolitan University Hospital (MMUH)

736-bed acute hospital providing emergency, maternity, critical care, surgery, diagnostics, in-patient wards and theatres.

Sandwell Health Campus

Community-facing urgent and planned care site. Provides urgent care, outpatient clinics, therapies, diagnostics and primary care.

City Health Campus

Planned care and specialist ophthalmology hub. Brings together BMEC (specialist eye surgery, emergency eye care and diagnostics) and the Birmingham Treatment Centre (day surgery, endoscopy, imaging, diagnostics and a wide range of outpatient services).

Rowley Regis Hospital

Community hospital and rehabilitation Centre. Provides inpatient rehabilitation, intermediate care, outpatient clinics and therapy services, supporting recovery and step-down care.

Lyng Centre for Health & Social Care

Integrated health and social care hub. Delivers primary care, outpatient clinics, therapy services and wellbeing support.

Leasowes Intermediate Care Centre

Specialist intermediate care facility. Offers rehabilitation, re-ablement and step-down care.

Primary Care

Primary care network. Delivers general practice services and primary care support.

Appendix B – Group Clinical Strategy Development & Engagement Plan

Date	Organisation	Name of meeting	Approach	Who	Expected outcome
18/11/25	Group	Executive Directors	Face to Face	Chief Strategy Officer	Presentation of outline structure of document
21/11/25	Group	Clinical Strategy Task Group	Teams	SRO	Validation of draft document content by COOs, CMOs and CNOs
28/11/25	Group	Infrastructure Committee	Face to Face	Chief Strategy Officer	Presentation of outline structure of document
4/12/25	Group	Clinical Strategy Task Group	Teams	SRO	Validation of draft document content by COOs, CMOs and CNOs
9/12/25 8.30am	DGFT	Medical Director senior team / Chief of service	Teams	SRO	Socialisation amongst senior medical leaders in the trust
11/12/25 8.00am	DGFT	Senior nursing leadership	Face to Face	SRO	Socialisation amongst senior nursing leaders in the trust
15/12/25	SWBT	SWBT Integration Committee	Face to Face	Chief Strategy Officer	Socialisation of concept, approach and a progress update
16/12/25	SWBH	Clinical Directors/Clinical Senior Leaders = CMO and Clinical DD Team Meeting is held monthly on 3rd Tuesday of the month	Teams	SRO	Socialisation of concept, approach and a progress update
19/12/25 2.00pm	SWBH	Medical Director Senior Team = CMO & Deputy CMO Team Meeting is held monthly on 3rd Friday of the month at 12:30	Teams	SRO	Socialisation of concept, approach and a progress update
23/12/25	DGFT	Quality Committee	Teams	SRO	Review of draft
14/1/26	SWB	Private Trust Board	Face to Face	CMO's and CNO	Approval of draft as part of approval of medium-term plan
15/1/26	DGFT	Private Trust Board	Face to Face	CMO's and CNO's	Approval of draft as part of approval of medium-term plan
20/1/26 2.00pm	SWBH	Clinical Directors/Clinical Senior Leaders = CMO and Clinical DD Team Meeting is held monthly on 3rd Tuesday of the month	Teams	SRO	
21/1/26	DGFT	Clinical leaders development session	Teams	SRO	Attendance from medical, nursing and AHP leaders
27/1/26	DGFT	Quality Committee	Teams	SRO	Review of draft
28/1/26	DGFT	Integration Committee	Face to Face	Chief of Integration	Review of draft
29/1/26	Group	Finance & Productivity Committee	Teams	SRO	Review of draft
26/2/26	DGFT	CD/CSL away morning	Face to Face	SRO	Face-to-face session planned to include discussion about clinical strategy
26/2/26	SWB	Integration Committee	Face to Face	Chief Operating Officer	Review of draft
11/3/26	SWB	Private Trust Board	Face to Face	CMO's and CNO's	Review of first draft document
12/3/26	DGFT	Private Trust Board	Face to Face	CMO's and CNO's	Review of first draft document
02/04/26	Group	Clinical Services Plan – Task & Finish Group	Teams	SRO	Review of second draft document
w/c 20/04/26	Group	Clinical Services Plan – Task & Finish Group	Teams	SRO	Review of third draft of document prior to submission for Executive Directors
30/04/26	Group	Service & Stakeholder Engagement	Via Task Group	All	To share a penultimate draft for final engagement over a 1 month period
05/05/26	Group	Executive Directors	Face to Face	CMO's and CNO's	Review of third draft by Executive Directors prior to submission for Board review
20/05/26	Group	Private Group Board	Face to Face	CMO's and CNO's	An opportunity for the Group Board to review the current iteration of the draft Clinical Services Plan
w/c 25/05/26	Group	All appropriate sub-committees	Face to Face	Various	An opportunity for key Group sub-committees to review in detail the draft Clinical Services Plan
15/06/26	Group	Clinical Services Plan - Task & Finish Group	Teams	SRO	Review of final draft prior to sending to Medical Illustration
22/06/26	Group	Medical Illustration	N/A	SRO	Final narrative to Medical Illustration.
22/07/26	Group	Public Board	Face to Face	Group CMO & CNO	Formal sign off of Final Draft

GROUP CLINICAL SERVICES PLAN **2026-2031**

Appendix C – Patient & Public Feedback

FIT FOR THE FUTURE

Your views, shaping the future.

Here is what you told us from our online and face to face workshop sessions.

NHS

People support the idea of providing more care closer to home. However, they want clearer plans, better joined-up working, and real action - not just changes to structures.

Below is a summary of the key messages.

1. The Role of GP Practices

People were unsure how local GP practices fit into the new plans.

- GP practices need to be central to community care, not an afterthought.
- Surgery staff and wider Primary Care teams can help reduce pressure on hospitals.
- It needs to be clearer how GP practices will work with hospitals and community services.

What's needed:
A plan for the role that GPs play in the future NHS plans.

2. Services Feel Fragmented

Many people said services do not always work well together.

Examples included:

- Delays when patients live in one area but are treated in another.
- Health and social care not always aligned.
- Confusion about who is responsible for what.

What's needed:
Better coordination between hospitals, GPs, councils, social care and voluntary organisations.

3. Too Much Focus on Crisis, Not Enough on Prevention

People felt the system reacts to problems rather than preventing them.

- Prevention is talked about, but not always funded.
- Voluntary and community groups play a key role but need stable support.
- Community hubs and local buildings could be used more for health support.

What's needed:
Real commitment in prevention and community services.

4. Social Care, Carers and Dementia Support

People want health and social care to work more closely together.

- Carers and adult social care should be involved earlier.
- There were concerns about dementia services and a lack of updates.

What's needed:
Better joined-up planning between NHS services, social care and carers.

5. Sharing Information Between Services

People asked about progress on a shared care record.

- There are concerns about legal and technical barriers.
- There needs to be clearer leadership and updates.

What's needed:
Transparency about progress and better information sharing between services.

6. Access Barriers

Digital Access

- Not everyone is confident using online systems.
- Older people and visually impaired residents may need extra support.

Travel and Buildings

- Public transport can be difficult.
- Some buildings are hard to navigate.
- Travelling to unfamiliar places causes anxiety.

Enable Information

- Support and communication is accessible for all, whether blind/vision loss, deaf/hearing loss, deafblind, easy read or a different language for example.

What's needed:
Support people who are not online through accessible transport and buildings, introduce a patient health passport so individual needs and preferences are always met, and improve staff awareness of the Accessible Information Standard and available support.

7. Understanding Urgent Care

People are confused about urgent care routes.

- There is a belief that NHS 111 often sends people to A&E.
- People would like clearer explanations about how the system works.

What's needed:
Clear, simple information about urgent care options.

8. Community Voice

People want:

- More local, face-to-face meetings.
- Updates on previous discussions.
- Engagement that leads to real change.

There is frustration about being asked the same questions without seeing progress.

What's needed:
Ongoing local engagement with clear feedback on what has changed.

Overall

People support care closer to home. However, for it to work, they want:

- ☑ Clearer communication
- ☑ Real investment in prevention
- ☑ Visible action following feedback
- ☑ Better joined-up services
- ☑ Improved accessibility

We are committed to continuing the conversation with you and ensuring your voices are heard and listened to. If you would like to stay in touch and join our mailing lists and see our previous engagement, then we would love to hear from you.

For Dudley, please visit our website: Involvement at Dudley Group – The Dudley Group NHS Foundation Trust

For Sandwell and West Birmingham, please visit our website: Engagement events and activities (public, patients and community) | Sandwell and West Birmingham NHS Trust

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FIT FOR THE FUTURE

Sandwell and West Birmingham NHS Trust
The Dudley Group NHS Foundation Trust

Our patients
Our people
Our population

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