

2018/19 Operational Plan Update

April 2018



Agenda Item No: 8.1

Trust Board Report

Meeting Date:	27 April 2018
Title:	2018/19 Operational Plan Update
Executive Summary:	This report details the planning requirements expected as part of the 2018/19 planning round. Included within this report is the refreshed narrative report that details the progress the Trust is making against the key requirements, and expectations identified by NHSI/NHSE in the planning guidance issued for 2018/19
Action Requested:	Approve
For the attention of the Board	
Assure	To alert Trust Board to the Operational Plan for 2018/19
Author + Contact Details:	Tel 01902 694366 Email simon.evans8@nhs.net
Links to Trust Strategic Objectives	<ol style="list-style-type: none"> 1. Create a culture of compassion, safety and quality 2. Proactively seek opportunities to develop our services 3. To have an effective and well integrated local health and care system that operates efficiently 4. Attract, retain and develop our staff, and improve employee engagement 5. Maintain financial health – Appropriate investment to patient services 6. Be in the top 25% of all key performance indicators
Resource Implications:	<p>Revenue: None</p> <p>Capital: None</p> <p>Workforce: None</p> <p>Funding Source: None</p>

CQC Domains	<p>Effective: Care, treatment and support achieves good outcomes, helping people maintain quality of life and is based on the best available evidence</p> <p>Caring: Staff involve and treat everyone with compassion, kindness, dignity and respect</p> <p>Responsive: Services are organised so that they meet people's needs</p> <p>Well-led: The leadership, management and governance of the organisation make sure it's providing high-quality care that's based around individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture</p>
Equality and Diversity Impact	Not applicable
Risks: BAF/ TRR	Not applicable
Risk: Appetite	Not applicable
Public or Private:	Public
Other formal bodies involved:	TMC
References	Not applicable
NHS Constitution:	<p>In determining this matter, the Board should have regard to the Core principles contained in the Constitution of:</p> <ul style="list-style-type: none"> • Equality of treatment and access to services • High standards of excellence and professionalism • Service user preferences • Cross community working • Best Value • Accountability through local influence and scrutiny

Report Details	
1	<p>The 'Refreshing NHS Plans for 2018/2019' guidance was published on 2 February 2018 and detailed the specific planning requirements required.</p> <p>As 2018/19 is the second year of a two year planning and contractual round there has been no requirement to produce a new operational plan. The requirements for this year are as follows:</p> <ul style="list-style-type: none"> • An activity plan (excel spreadsheet) • A workforce plan (excel spreadsheet) • A financial plan (excel spreadsheet) • A triangulation tool (excel spreadsheet) • A narrative summary highlighting material changes to 2 year plan narrative previously submitted and update on the planning requirements <p>All spreadsheets need to be uploaded by 30th April and the Trust Board are required to sign off the planning update for 2018/19.</p> <p>The financial position, including the workforce expectations have previously been presented to Board as part of the financial plan for 2018/19.</p>

Appendices	
1	Narrative Plan



The Royal Wolverhampton
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2018 Operational Plan Update



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1. Activity Planning

The base point for activity planning for 2018/19 is the outturn position for 2017/18.

The release of the national “Refreshing NHS Plans for 2018/19”, describing how the additional £1.6bn is to be distributed, has resulted in the activity plans being re-calculated. The host CCG has produced a revised offer based on month 8 forecast outturn plus the national activity planning assumptions they have been sent by NHSE. This produces a set level of activity that the CCGs will commission. Any QiPP schemes identified are deemed to be within this level of activity. We agreed a financial envelope with the Commissioners on the 23rd March which includes growth. Trust has now modelled where this additional growth activity could be allocated across each of the PODs and groups.

We have a structured process in place in order to arrive at a position where each service has an activity plan they believe is deliverable. This includes a round of internal meetings with each of the service leads to discuss and model the expected activity assumptions for the upcoming year. These comprehensive discussions ensure that each service has the opportunity to review the expectations required and comment on their ability to provide the necessary capacity to meet the forecast. The head of each specialty meets individually with a representative from Trusts' Information and Finance functions, in order to review each line of activity within the proposal. Using trend demand data and capacity information and taking into account a range of other factors such as staffing levels and referral patterns, they jointly assess the activity expectations for 2018/19 and the feasibility of delivery within the service. Following the decision taken by the CCG to commission the national planning assumptions, we have held further series of discussions with all operational Divisions to discuss the potential for delivering the required activity levels. In the most part this has concluded that the activity plans are acceptable. However, there are certain key specialities that have identified workforce pressures and do not believe the activity levels, based on outturn and additional assumptions, are deliverable. This includes General Surgery and Urology. The Trust is aware of this and whilst we have committed to an overall activity figure, we will need to identify in year where the additional activity will be delivered.

Access Standards

Emergency Care

We will work with commissioners to implement the integrated urgent care strategy. This will focus on ensuring sufficient capacity is available in the system through:

- identification of additional beds, where necessary
- reductions in delayed transfers of care (DTOCs) target of 3.5%
- reductions in average length of stay, including a focus on stranded and super stranded patient metrics

The target for our A&E performance in 2018/19 reflects the national planning requirements which are to demonstrate the following:

- Quarter 1 >90%
- Quarter 2 >90%
- Quarter 3 >90%
- Quarter 4 95%

However, as we have accepted the control total which includes access to the PSF fund, we are aware that funding for the access standards element will be based on the assumption that performance is better than in the equivalent quarter in 2017/18 and at 95% for March 2019.

Referral to Treatment Times

The commissioner has planned for activity levels in line with national planning guidance. This will deliver an improvement in the RTT performance. The 2018/19 plan is to ensure that the overall number of patients waiting on an incomplete pathway will be no higher in March 2019 than in March 2018. Our activity plan has identified a 20% reduction in the overall backlog and we remain committed to achieving the RTT access standard. The plan to deliver a significant reduction in the overall backlog means that the average waiting times for ALL patients will be reduced. We recognise that this is a significant reduction and have developed a plan for each speciality that enables us to deliver this. This includes a forecast by month for each area, training plan for administrative staff and the development of improved performance reports.

We will also commit to having zero 52 week waiters across the year.

Cancer 62 day

We currently have a Cancer recovery plan in place, along with an improvement trajectory, that is monitored monthly by the CCG and with oversight from both NHSE and NHSI. This is a comprehensive plan that covers all areas including diagnostic support. Growth in demand has seen increased pressure on a number of specialities; this has led to capacity issues for Breast and Urology. We are exploring options to enhance capacity so that the cancer standard can be delivered within 2018/19.

We have successfully managed to reduce the diagnostic reporting backlog in 2017/18 and plan to deliver cancer performance that is equivalent to our peers in 2018/19.

Following on from the work we did with the Cancer Alliance in 2017/18, we intend to work with the Cancer Intensive Support Team (IST) during the year to identify potential areas for improvement.

Diagnostics

The Trust maintains its commitment to delivering the diagnostic standard across 2018/19.

2. Quality Planning

For 2018/19 our quality priorities remain unchanged and we will continue to work towards the objectives set out in our 2017-2019 Operational Plan.

Progress within 2017/18 and Developments in 2018/19:

Seven Day Services

As one of twenty-six early implementer sites RWT committed to achieving the four priority standards by end of March 2017:

- All patients admitted as an emergency to be reviewed by an appropriate consultant within 14 hours of admission
- All patients to be reviewed daily via a consultant delivered ward round and those who meet level 2 and 3 ICU criteria to be seen twice daily.
- Seven day access to consultant directed and reported diagnostics
- Twenty-four hour access to consultant directed interventions e.g. endoscopy, emergency surgery etc.

As shown by the national audit in both April 2017 and September 2017 we have met these targets by the set date and have continued to meet these throughout 2017/18.

Further work is now on-going to ensure that a further 6 standards are met. These include liaison with Mental Health and Local Authority agencies.

The next stage in the programme plan for 2018/19 will be to embed and maintain compliance and to work with community and support services so that they too are providing full 7 day services where essential.

Staffing

Following review of the national pilot for Nursing Associates the Trust has commissioned a further 14 associates to commence in late March 2018. Apprenticeships continue to be supported and we await evaluation of year 1 of Nursing Apprenticeship degree.

In addition to this, a number of skill mix reviews have been completed, rostering performance metrics are reviewed, monitored and improvements have been noted, this work will continue in 2018/19.

Better Births

RWT is working collaboratively with Maternity Units and Commissioners within the Black County STP as part of the Local Maternity Systems (LMS's) to develop and implement a local vision for improved services that are outcomes based on the principals outlined in Better Births. The Head of Midwifery is presently undertaking a review of Community Midwifery services to inform future service model for RWT re: Continuity of Carer. We have also had a Birth Plus review in order to get assurance on the safe levels of staffing required to manage predicted demand. Details of this review will be available in early 2018/19 and will inform our future planning.

The Trust joined the collaborative in March 2017 as one of 45 Trusts involved in the first wave 2017/18. The focus is aimed at quality improvement and provides structured support for teams to develop plans for measurable improvements. The Trust has had their improvement project approved by NHSI and are working towards implementation.

Improving the quality of mortality review and SI investigation and subsequent learning and action

The Trust has adopted a revised Learning from Death policy aligned with the national guidance released in 2017. The evidence-based methodology developed by the Royal College of Physicians for reviewing deaths, the Structured Judgement Review (SJR), was adopted by the Trust and was implemented in June 2017 as a pilot in 9 specialties. Full trust-wide rollout took place in August 2017.

Around 65% of adult inpatient deaths at the Trust had an initial mortality review by the end of December and following the rollout of the evidence based approach, 40% had a review using the SJR methodology.

A proposal has been discussed for the Trust to adopt a Medical Examiner role. The details of the proposal are currently being considered through the Mortality Review Group. It is likely that if this model is adopted the process for undertaking stage one reviews will change. It is envisaged that this model will allow specialties to undertake more in depth reviews therefore facilitating better learning opportunities.

Plans to improve mortality outlier position

Internal and external audits have shown that the higher than expected standardised mortality rates for the Trust were due to data variation, predominantly from the last quarter of 2015-16. Actions were put in place to ensure data for inpatients activity reflected the patients' case mix as accurately as possible. The focus of the action plan is on the accurate recording and coding of the primary diagnosis and comorbidities on the admission episode, this can lead to more accurate production of the standardised mortality rates.

Changes were made to clerking documentation to improve the clarity of recorded primary diagnoses and comorbidities on admission to hospital, thus aiding richer coding. The existing process meant that multiple, short finished consultants episodes generated on admission to the Acute Medical Unit (AMU) made it more likely that the first and second episode of care would have a non-specific diagnosis recorded and coded. This has been addressed and from April 2018 all admissions to the AMU are recorded as one episode until the patient is either discharged or moved to a different specialty.

The Clinical Coding Department is promoting education regarding coding rules and the importance of clear and comprehensive clinical documentation to medical staff.

Falls

Falls prevention is a key work stream in the Trust that has clear objectives outlined in the quality, safety and patient experience strategy. This work is aimed at a continuing reduction in falls, particularly those with harm.

Falls prevention work undertaken as part of the National Collaborative has now been rolled out across the Trust and a sustained reduction can be noted. Details of this work continue to be monitored at relevant Board sub-committees as well as the Trust Board via the Integrated Quality and Performance Report.

Sepsis

The Trust is committed to raising the awareness and timely intervention for patients with Sepsis across the organisation; as part of the Trust's audit programme, our sepsis audits provide data around the compliance of intervention to assist in the improvement of sepsis diagnosis and treatment. Sepsis leads have been appointed, Sepsis Audits for ED are ongoing and outcomes monitored via the Trusts governance processes. The Trust has implemented the Sepsis 6

pathway and is scoping audit methodology for inpatient areas.

Plans to deliver the national IPC programme

RWT will work collaboratively with commissioners to reduce the impact of healthcare associated infection. The Clostridium difficile infection objective for the Trust in 2018/19 is 35. In 2017/18 RWT recorded 28 toxin positive cases against a target of 45. The Trust continues to review each case with a view to understand the reasons and in order to sustain performance. Results of the 2 MRSA bacteraemia RCA's in 2018 have been shared in the organisation and learning from these cases has been implemented. Having previously undergone several periods of more than 900 days between cases, zero cases are expected in 2018, monitoring and reducing MSSA bacteraemia cases is key to achieving this.

Gram negative bacteraemia reduction is to be explored predominantly through continued improvement of urinary catheter usage. The reduction of device-related bacteraemia will remain a priority. A reduction in E. Coli bacteraemia achieved in 2017 requires full investigation to identify sustainable actions. Finally, a contract with Wolverhampton City Council Public Health Department to maintain outbreak education and management and a sustainable plan with Wolverhampton CCG for flu prophylaxis and management of contacts in care homes has been agreed to lessen the impact of norovirus and flu in winter 2018/19.

Pressure Injuries

The Trust is involved in the first phase of the NHSI pressure ulcer collaborative. For 2017/18 we have seen a reduction in incidents per 1000 bed days.

All current pathways and formulary changes have been approved by the medicines management group and await final sign off by area Prescribing group for use in the CCG and care homes.

Patient Experience

Patient experience is a fundamental cornerstone of quality within the organisation. Patient experience data continues to be triangulated alongside other metrics to provide a 360 degree view of quality and performance.

National Surveys for Inpatients, ED, Children and Young People and Maternity have all concluded with reports received. Action plans have been implemented to address lower performing elements and are monitored through the Trusts governance processes. Our newly devised Council of Members will be undertaking snapshot audits to ensure the action plans are addressing issues as intended.

Development of QI capability and capacity to sustain change

QI methodology is currently used in the organisation supporting various programmes of work including: National Collaborates around Falls, Nutrition, PI and IP. Further Collaborates are being considered as part of the NHSI offer, e.g. frailty and end of life. A QI hub is currently being scoped, with a supporting strategy to be developed. This is aimed at being available via nursing routes in the first instance and being extended Trust wide once piloted.

Service changes that may impact on quality

There are currently no quality issues identified with service changes that are currently in process. All proposed service changes are reviewed following the development of a PID and undertake a full quality impact assessment to consider: patient safety, clinical effectiveness, patient experience. This will continue to be monitored in-year as new changes are considered and the impact of existing changes i.e. stroke reconfiguration are completed.



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3. Workforce Planning

The Trust has an established governance process for aligning workforce planning methodology with the strategic aims, financial plans, service objectives and an integrated operational plan.

The governance process has been reviewed and is robust. The plan is assured at each organisational level including pre-board at the multi-disciplinary Workforce and Organisational Development Committee (WODC) with Non-Executive Director and Executive Director leadership. The HR Executive report provides Board assurance for the system-wide workforce issues.

At operational level, the workforce, finance and contracting and performance functions work across the Trust to triangulate the data provided via the 'Technical Workforce Plan Return' to ensure workforce levels are safe, efficient, sufficient and affordable. The baseline for this is safe-staffing levels and skill mix requirements.

In addition, the efficiency and effectiveness of the workforce mix i.e. balance between permanent, fixed-term and temporary workforce including bank, agency and locum use, is subject to the Financial Recovery Board (FRB). This group reviews efficiency and effectiveness measures to provide assurance to the Board on CIP delivery and optimum use of resourcing in line with Carter outcomes. For workforce, there are two key lines of enquiry:

Use of locum and agency resource, particularly for medical workforce

The Trust achieved the target for the agency cap reduction in 2017/18 and we continue to make good progress in relation to the reduction of locum and agency resource. This continues to be monitored through the Trust's Workforce Programme Group.

The Trust is part of a regional collaboration to standardise locum rates for medical staff; in addition work is underway in relation to collaborative bank set ups.

A number of activities support this; including ongoing recruitment to the Clinical Fellowship Programme within the Trust (85 in post), continued review of locum use, conversion of resource to bank where possible and service re-design for longer term impact.

Effective use of permanent resource

The Trust is in the process of implementing the establishment control functionality in ESR, working jointly with Finance; this will allow for more accurate and timely vacancy management and other related reporting. A steering group has been established with a range of key stakeholders and work streams being monitored utilising a formal project management approach.

Dialogue with all partners across the Health System has commenced through both the STP work and the annual contracting round. This will inform the workforce requirements as we plan for the next two years and will be factored into future plans as more detail becomes available over the coming months.

The Board Assurance framework continues to highlight Workforce as the main Trust risk. This risk is reviewed at Finance and Performance Committee every month in light of changing legislation and with a view to mitigating the impact of the risk on patient care.

4. Financial Planning

Context

The Trust has a strong financial track-record and has over many years pursued a strategy of delivering surpluses in order to generate cash to support a capital programme which has seen significant investment in buildings and equipment.

However, like many other NHS providers the financial position over the last two years has deteriorated and in 2017/18 the Trust delivered pre-PSF deficit of £4.4m which was £6m adverse to the control total. The Trust accepted the control total in 2017/18 and applied a stretch CIP of £7m to a programme that at £20m was already considered ambitious. Whilst the CIP programme has delivered £24.9m, it should be noted that £18.7m was non-recurrent.

In planning for 2018/19, the Trust has set a plan which again delivers the control total. However, the CIP challenge that has been agreed by the Trust Board at £25m is a significant increase to that delivered in 2017/18. In accepting the control total the Trust has then applied a vacancy factor of £9.8m.

The Trust Board are conscious of the consequence of not accepting the control total; in terms of the impact on cash, the exposure to contractual penalties and the sanctions under the single oversight framework. Therefore, whilst the Trust has accepted the control total, this has been done in recognition of the fact that the plan contains an element of risk. This narrative sets out the key components of the plan, the main risks and the current status of the CIP programme.

High Level Plan and 2017/18 FOT Bridge

The Trust's financial plan for 2018/19 (excluding PSF funding) is as follows:

	£'000
Income from patient care	473,339
Other operating income, excluding PSF funding	74,011
Operating expenditure – Pay	(334,163)
Operating expenditure - Non Pay	(198,068)
Non-operating items	(12,924)
Control total change reserve	(2,498)
Surplus/ (deficit) before PSF funding	(303)
Technical adjustment to calculation vs. control total	97
Planned performance against control total	(206)
PSF funding planned - control total achieved	11,415
Planned surplus	11,209

The bridge from the 2017/18 forecast outturn* is set out in the table below:

	£'000
2017/18 forecast deficit excluding PSF funding	(4,353)
Adjustments carried forward from 2017/18:	
Non-recurrent income from patient care 2017/18	(3,186)
Non-recurrent cost improvement savings 2017/18	(8,008)
Non-recurrent underspends in 2017/18	(8,223)
Full year effect of 2017/18 developments in 2018/19	(1,775)
Exiting underlying 2017/18 surplus/ (deficit)	(25,545)
Cost pressures in 2018/19:	
Inflation	(9,784)
Service developments – shown net of growth in income	(7,219)
New cost pressures	(1,313)
Non-inflationary drugs growth	(1,434)
Increase in depreciation and PDC dividend	(1,384)
Increase in interest payable	(273)
Offset by:	
Slippage on business cases and cost pressures	2,500
Growth in income (including service developments)	11,843
Cost improvement plan - recurrent	10,000
Cost improvement plan - non-recurrent	10,000
Cost improvement plan – stretch/ temporary staffing	5,000
Trust wide vacancy factor	9,804
Control total change reserve	(2,498)
Surplus/ (deficit) excluding PSF funding	(303)

**NB non-recurrent adjustments have not been updated to reflect 2017/18 outturn*

Risks to Delivery

- The Trust has a significant level of activity growth in the plan as a result of 2018/19 commissioner allocations and the activity levels that this funding is designed to secure. It will be a challenge to deliver this activity at an acceptable marginal rate. The Trust has phased the additional activity growth from July onwards and is currently working through the process of identifying, costing and securing the capacity required. The financial risk is in the region of £1 - 4m.
- An income budget for £6m transitional support for MSFT has been included. This is a red line for the Trust and if this is not funded then the control total would need to be reduced by £6m in order for the Trust to continue with acceptance.
- There are risks on the pay award nationally that are not fully known.
- The financial model includes £25m CIP and a vacancy factor of £9.8m. The overall programme is higher than has historically been achieved and is therefore a risk.
- £2.5m of the recurrent CIP is income generation through theatre efficiency and outpatient productivity. This is a risk given the activity levels that have been commissioned.

5. 2018/19 Cost Improvement Plan

The Trust has assessed the maximum achievable Cost Improvement Programme target for 2018/19 as £25m (£15m recurrent and £10m non-recurrent). This is 4.6% of planned turnover and 4.7% of planned operating expenditure.

The Trust has added to this a vacancy factor of £11.2m taking the programme to 6.4% of planned turnover and 6.5% of planned operating expenditure. £9.8m of the vacancy factor is shown in the bridge above and £1.4m has been allocated against recurrent CIP

The Trust has a track record of achieving significant non-recurrent CIP in recent years and so it is reasonable to assume a similar level of non-recurrent CIP for 2018/19. The delivery of non-recurrent CIP in 2017/18 was £9.9m pay (aligning to the vacancy factor) and £8.8m of non-pay and income (aligning to the NR CIP).

To date the Trust has identified £7.3m of recurrent CIP and has revised the Service Redesign structure for 2018/19 as follows:

- Clinical Excellence
- Division One – Surgical
- Division Two – Medical
- Division Three – Primary Care/ Community/ Pharmacy
- Enabler Programmes – Corporate, Workforce, Estates & Facilities
- System Wide Programmes – West Park Review, Aseptic Review and Pathology

Each Trust Executive has responsibility for a Programme to demonstrate how the Trust holds itself to account to work with the relevant operational and clinical staff to identify and deliver transformation change.

Clinical Excellence Programme – Lead: Medical Director and Deputy Medical Director

The Programme focuses on the following clinical initiatives:

- Getting It Right First Time (GIRFT)
- Model Hospital (MH)
- NHS Improvement – Deep Dive - Job Planning

The Deputy Medical Director is the Clinical Lead for this Programme and has established a Clinical Excellence Oversight Group which meets monthly to review all Trust specialties on a rolling programme. The purpose of each review is to bring together all of the GIRFT Action Plans, MH opportunities and Job Plan performance and identify opportunities for improvement. The Trust has engaged with NHS Improvement to take part in a Job Planning Deep Dive with nine other Trusts.

The Service Redesign Team support this by meeting the specialties separately to review GIRFT progress, warranted and unwarranted MH variations and job plan status. All meetings are attended by Clinical Directors, Matrons, Group Managers and Directorate Managers and used to agree action plans to improve clinical productivity and efficiency to count towards the Trust Transformation Plan.

Division One – Lead: Chief Operating Officer and Deputy Chief Operating Officer – Division One

The Division One programme focuses on clinical and productivity improvements in surgical specialties, including Day Case opportunities. It also oversees the Operating Theatres Efficiency Programme Group (OTEG) which is attended by clinicians and operational staff and focuses on:

- Pre-Operative Assessment Service
- Theatre Management System
- Theatre Scheduling

Division Two – Lead: Chief Operating Officer and Deputy Chief Operating Officer – Division Two

The Division Two programme focuses on clinical and productivity improvements in medical specialties, including Length of Stay opportunities. It also oversees the Outpatients Efficiency Programme Group (OEG) which is attended by clinicians and operational staff and focuses on:

- DNAs
- Slot Utilisation
- Clinic Utilisation
- Demand Management

Division Three – Lead: Chief Operating Officer and Deputy Chief Operating Officer – Division Three

Division Three has recently been created and will have its own Programme to focus on the following areas:

- Primary Care
- Community
- Pharmacy – Drug Waste, Generic Drug Switches, Biosimilars

Enabler Programmes – Lead: Director of Finance/ Chief Nurse

The Enabler Programme will focus on the following areas to improve efficiency and productivity:

- Corporate – Procurement, Finance, HR, Corporate Functions, Tele-tracking
- Estates and Facilities
- Workforce – Agency, Bank and E-Rostering, Vacancy Controls, Locums

System Wide Programmes – Lead: Director of Strategic, Planning and Performance

The System Programmes will focus on the following areas to improve efficiency and productivity:

- West Park Review
- Aseptic
- Pathology

6. STP Developments and Partnership Working

The key STP transformation programmes that were identified in last year's plan remain for this year:

Place-Based Models of Care

To be implemented for each community that deliver improved access to local services for the whole population, greater continuity of care for those with on-going conditions, and more coordinated care for those with the most complex needs.

Extended collaboration between Service Providers

To create, through extended collaboration between Service Providers, a coordinated system of care across the Black Country and West Birmingham to improve quality and to deliver efficiencies on a scale not accessible to individual organisations.

Maternal and Infant Health

To take coordinated action to address the particular challenges faced by our population in terms of maternal and infant health, and to create a single Black Country and West Birmingham maternity plan that inter-relates with Birmingham and Solihull where necessary

Key enablers

These have been identified and agreed as it is believed that the key enablers that will enable us to achieve significant workforce efficiency and transformation, to deliver the digital infrastructure required for modern patient-centred services, to rationalise public sector estate utilisation, and to streamline commissioning functions.

RWT also plays an active part and is potentially impacted by proposals in the Staffordshire STP. The key components of the Staffordshire STP in which RWT has a part to play are:

- Effective and efficient primary care- RWT will work with CCGs and others to test the appetite for the extension of our VI model into the Cannock area
- Effective and efficient planned care- We play an active part in the planned care work stream which is developing simplified and standardised pathways, initially in Ophthalmology, Orthopaedics and Endoscopy, and we will support the modelling of activity and capacity in Staffordshire.

We will also maximise the use and efficiency of Cannock Hospital for planned care for residents of both Wolverhampton and Staffordshire, as well as to develop Cannock as a resource for enhanced primary and community care in the south of Staffordshire. For example, our capital programme outlines investment to increase outpatient capacity at Cannock and to enhance GP premises within the hospital, if required

The Operational Plan supports the Black Country STP ambitions in the following key areas:

Local place based models of care

Our VI project has already increased the availability of GP appointment time through additional practice opening hours. The aims of this project are to:

- Reduce demand for secondary care
- Improve recruitment and retention in General Practice
- Improve patient satisfaction with Primary Care
- Better integrate Primary, Community Acute Mental Health and Social Care

We now cover some 70,000 patients, we have won an APMS contract and we have recruited our first practice in Staffordshire.

We are working with other providers to develop extended care collaboration for example working with other providers to provide shared and sustainable Urology and dermatology services. We have reached agreement to provide acute and hyper acute stroke services for Walsall patients. We are also working with UHB to resolve Sandwell and West Birmingham Gynaecological oncology service issues.

We have further developed our plans for a Black Country Pathology service with all four Boards approving a final business case. We are recruiting clinical and operational leads and have submitted a bid for capital funds through the Black Country STP

We are working with other Trusts as part of the LMS to develop a standardised approach to maternal and new-born care and to resolve system wide capacity issues. We plan to use the development of specialised commissioning arrangements (RWT is the only tier 2 provider in the Black Country) to create an opportunity to progress the functioning of the neonatal network to improve the safe management of new-borns and to improve the way in which capacity is used.

We continue to work with Black Country partners to develop the local digital road map and estates strategy. We have made some progress in the development of shared back office services including shared bank arrangements.

For both the Black Country and Staffordshire STPs, providers and commissioners need to deliver the CIP and QIPP schemes. We have increased the resource for transformation/service redesign and will continue to review our capacity and capability to deliver a very challenging CIP programme. We understand Wolverhampton may be a pilot area for testing a shared approach to QIPP and CIP delivery and welcome this initiative