Trust Board
There will be a meeting of the Trust Board on **Thursday 15 July 2021** at 10:00. It will be held virtually and live streamed on You Tube.

Sir David Nicholson
Chair

Agenda			Enclosure	Time
054/21	**Welcome and apologies for absence:**			**10:00**
055/21	**Patient Story**			**10:05**
056/21	**Items of Any Other Business** *To declare any business to be taken under this agenda item*			**10:30**
057/21	**Declarations of Interest** *To declare any interest members may have in connection with the agenda and any further interest(s) acquired since the previous meeting.*			
058/21	**Minutes of the previous meeting** *To approve the Minutes of the meeting held on **10 June 2021** as a true and accurate record*	*For approval*	**Enc A** **Page 3**	**10:30**
059/21	**Action Log**	*For noting*	**Enc B** **Page 12**	**10:35**
060/21	**Chair's Report**	*For noting*	**Enc C1** **Page 14**	**10:40**
061/21	**Chief Executive's Report**	*For noting*	**Enc C2** **Page 15**	**10:45**
Strategy				
062/21	**Annual Plan Priorities** Deputy Director of Strategy and Planning	*For approval*	**Enc D1** **Page 19**	**10:55**
063/21	**End of Life Strategy** Chief Medical Officer	*For approval*	**Enc D2** **Page 31**	**11:05**
Performance				
066/21	**Integrated Performance Report** **Executive Summary/SPC Charts/Infographic** Chief Executive/Executive Directors	*For assurance*	**Enc E** **Page 50**	**11:15**
067/21	**Committee Assurance Reports** Committee Chairs		**Page 139**	
Governance				
068/21	**Safest Staffing Report**	*For assurance*	**Enc F1**	**11:35**

	a) Adult/Nursing **b) Midwifery** Chief Nursing Officer/Director of Midwifery		**Page 145** **Page 151**	
069/21	**Maternity Services - Continuity of Carer Position** Director of Midwifery	*For assurance*	**Enc F2** **Page 158**	**11:50**
070/21	**CNST: Maternity** Director of Midwifery	*For approval*	**Enc F3** **Page 168**	**12:05**
071/21	**KP Sepsis & PMRT WMODN Assurance Report** Director of Midwifery	*For assurance*	**Enc F4** **Page 171**	**12:15**
072/21	**Bewick Review Update** Chief Medical Officer	*For assurance*	**Enc F5** **Page 176**	**12:25**
073/21	**Audit and Assurance Committee Report** Committee Chair	*For assurance*	**Enc F6** **Page 184**	**12:35**
074/21	**Remuneration Committee Report** Committee Chair	*For assurance*	**Enc F7** **Page 186**	**12:40**
075/21	**Any Other Business** *as previously notified*			**12:45**

Close

Date of Next Meeting

The next public Trust Board meeting will be held on 9 September 2021, virtually.

MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON THURSDAY 10 JUNE 2021 AT 10:00 AM HELD VIRTUALLY

Present:

Chair:	Sir David Nicholson	
Board members: (voting)	Waqar Azmi	Non-Executive Director
	Anita Day	Non-Executive Director
	Paula Gardner	Chief Nursing Officer
	Mike Hallissey	Chief Medical Officer
	Matthew Hopkins	Chief Executive
	Dr Simon Murphy	Non-Executive Director
	Robin Snead	Deputy Chief Operating Officer (deputising for Mr Paul Brennan)
	Robert Toole	Chief Finance Officer
Board members: (non-voting)	Richard Haynes	Director of Communications and Engagement
	Colin Horwath	Associate Non-Executive Director
	Vikki Lewis	Chief Digital Officer
	Rebecca O'Connor	Company Secretary
	Richard Oosterom	Associate Non-Executive Director
	Jo Newton	Director of Strategy and Planning
	Tina Ricketts	Director of People and Culture
	Sharon Thompson	Associate Non-Executive Director
In attendance	Simon Adams	Healthwatch
	Elizabeth Brodier	Staff – Item 037/21
	Jackie Edwards	Deputy Chief Nurse
	Justine Jeffrey	Director of Midwifery - Item 047/21 onwards
	Mike McCabe	Staff - Item 037/21
	Anna Sterkx	Staff – Item 037/21
	Keith Wilson	Staff – Item 037/21
Public		Via YouTube
Apologies	Paul Brennan, Bill Tunnicliffe and Dame Julie Moore	

036/21 **WELCOME**

Sir David welcomed everyone to the meeting, including the public viewing via YouTube. In particular welcoming Simon Adams from Healthwatch and the staff members who had joined the meeting.

037/21 **PATIENT STORY**

Sir David welcomed Dr McCabe to the Board to share progress regarding the #callme initiative. He explained how he had received a frosty reaction from the family of a transgender child, when he inadvertently used their non preferred name. This had left him wanting to make change so this does not happen. Thus the #callme initiative is about dignity, respect and putting patients first

The initiative presents a simple solution, #call me is printed on patient stickers and wristbands – the first point of contact when you see a patient. There are limits with

headboards, whereas the wristband follows the patient and is compliant with all regulations.

The impact is centred on putting patients first, respect and delivering compassionate care. There is a bigger impact on some groups, especially the elderly, young, post-operative or those who may be confused.

6150 #callme names were recorded in the first 6 weeks. Of those, 25% had a different #callme to their recorded name. The cost to date has been £150 for some banners. In terms of challenges, Dr McCabe set out how getting the key people involved was initially challenging. We have worked with our suppliers who were initially resistant, but we overcame these issues. Making #callme a mandatory field on Oasis is a next step.

Looking forward, this is not yet embedded. We also need to get WMAS on board as they provide information ahead and this is printed in readiness. Paediatric forum asked for preferred pronouns, so this can be considered and developed in the future. We have showcased the initiative to other Trusts, with 10 having asked us how we implemented this.

Dr McCabe reported that the feedback from the child and mother regarding their case was that this was an “amazingly thoughtful idea”. Ms Sterkx further highlighting the huge backing support of the initiative from the PPI forum.

Ms Sterkx shared the experiences of “Muzzi” a learning disabilities patient, who does not use her formal name. She feels that using her formal name represents a disinterest in her and her care. Muzzi has strong bonds with the staff and this is now a way to make sure we have an inclusive relationship

The story of a Trust staff member was shared, describing their experience at another Trust, which did not have such an initiative. Ms Sterkx read out their story.

My mother was always known as Maria. She was accompanied on every hospital appointment and those staff who knew her always used the name Maria. She was taken into hospital by ambulance; I was called and asked to drop things in, but by the time I got there she had sadly passed. Afterwards, I was able to spend some time with her. The staff spoke really nicely to her “let me make you beautiful Elizabeth”, but as they called her Elizabeth, I realised this was how my mother was referred to in the last day of her life; a name that was unfamiliar. #callme is such a simple idea, but has a huge impact.

Dr McCabe concluded by endorsing #callme as the simplest, cheapest and most impactful idea you will hear this year. He gave thanks to Keith Wilson, Anna Strekx and Lizzy Brodier for their huge support in the initiative.

Sir David noted the personal efforts made by the team, recognising the impact of their persistence and the simplicity of the idea is enormous. He opened up the item to questions:

Dr Murphy asked how are we engaging with West Midlands Ambulance Service (WMAS)? There was broad support from the executive and a number of potential ways to record this information were identified. Mrs Ricketts offered support with awareness raising as part of staff on-boarding. Mr Adams believed this was a great initiative and

Healthwatch would write and share with other local providers and the Local Medical Committee.

Sir David thanked Dr McCabe and the team for bringing this to life, thanking them for their enthusiasm and energy to address this matter. Sir David also contact WMAS chair and CEO and will raise with the wider system.

ACTION it was agreed for:

- **Mrs Gardner to raise with WMAS' Chief Nurse**
- **Mrs Lewis to raise with WMAS' Chief Digital Officer and the Oasis system supplier**
- **Mrs Ricketts to add to the staff on-boarding programme**
- **Sir David to contact WMAS Chair and CEO and raise with the wider system**

038/21 **ANY OTHER BUSINESS**

There were no items of any other business.

039/21 **DECLARATIONS OF INTERESTS**

There were no additional declarations pertinent to the agenda. The full list of declarations of interest is on the Trust's website.

040/21 **MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON 13 MAY 2021**

Minor typographical amendment "correlation".

RESOLVED THAT subject to the above the Minutes of the public meeting held on 13 May 2021 be confirmed as a correct record and signed by the Chair.

041/21 **ACTION SCHEDULE**

Ms O'Connor updated the action log as follows:

021/21 - Dr Murphy noted the patient story from the last Board meeting will be the theme of this year's BAME network conference. Mrs Gardener confirmed thanks has been shared with staff.

All other actions were either closed as per the log, or not due for update at this meeting.

042/21 **CHAIR'S REPORT**

Sir David confirmed there was nothing further to report that was not already referenced within the Chief Executive's report.

043/21 **CHIEF EXECUTIVE'S REPORT**

Mr Hopkins presented his report which was taken as read. The following key points were highlighted:

- Chief Medical Officer recruitment process has led to the recommendation of an appointment and the necessary checks and clearances are in hand, with an announcement to follow in due course.
- The Board noted the excellent response; from 16 applicants, 5 were interviewed with a mix of internal and external candidates. It was very pleasing to see such a strong response.

In response to questions from Mr Oosterom and Dr Murphy, a discussion followed regarding the ongoing pressures within urgent and emergency care, demand for services, primary care and system constraints.

- Discharge constraints were partly linked to reablement capacity. The CCG had funded £3.5m of social care capacity. Currently there is funding of only 70 care packages, so demand is outstripping supply. They need to move quickly to recruit, with the challenge being how quickly capacity can be increased. The reality is one of increased clinical risk to patients in ED, who cannot move out because there are patients waiting discharge.
- There was a reduced level of access to primary care as Covid has constrained attendance and there is backlog of need. There is a push in primary to support 2 hour response and access to community support. There have been a few instances where patients have been told to come directly to ED and we are working with PCNs to address this. However, currently the unmet need is larger than we can manage on either side.
- Pathway 1 historically has had 70 patients per week, the real term increase in demand means this is now circa 130 patients per week, which in turn blocks pathway two. The plan to increase to 90 patients in July, 110 in August and 130 in September. Brokerage to support pathway 1 was a Covid level 5 action; this was put in place on Tuesday this week and we are pushing for this to stay in place until we see some movement.
- The matter will be escalated to ICS if we have done everything operationally that we can. Sir David asked when will the actions we have taken have an effect and what else do we need to do about discharges, noting leadership and working together is at least as important as the resource we put in. Mr Hopkins described the strategic outline case to redesign the reablement resource, which will come through for discussion over the next month and via AOs. There are currently too many handoffs and this will be an example of how we can better organise services align and to integrate care.

RESOLVED THAT: the report be noted.

STRATEGY

044/21 **Communications and Engagement Update**

Mr Haynes presented the report which was taken as read. This was a previously a quarterly report to Board which has been reinstated as we move towards BAU. The following key points were noted:

- Regarding collaborating with system partners, it was confirmed there is a monthly forum of the ICS comms leads; this was one the earliest forums to develop, as it builds on prior winter communications. Mr Haynes is acting as comms lead at Place level; a Place based comms forum is being developed, alongside a broader system forum.
- Dr Murphy queried the temporary relocation of the Garden Suite. Mr Haynes advised we have been clear in public messages, to HOSC and to MPs. The current status is temporary pending a future review of the operating model. If any changes are to be made permanent, the Trust will follow the usual public, patient and stakeholder involvement processes. It was confirmed this would be included in the HOSC induction next week.
- Ms Thompson congratulated the team, noting impressive social media impressions, asking how will we work with hard to reach communities in different ways? Mr

Haynes confirmed the BAME network has a designated comms lead, who is closely involved in planning for their conference and use of social media. Translation is on the agenda of both ICS and Place forums, with to maximise the system resource we have to increase reach into hard to reach groups.

- Regarding diversity of recruitment, Mr Azmi asked what are we learning from 4ward and the future role of advocates? It was outlined how recruitment campaigns are stratified on professional groups, which includes all staff in that area. This is more of a challenge is in cross cutting areas such as apprenticeships. Targeted recruitment is specifically focussed, such as the recent ED recruitment campaign. We use inclusive imaging and wording as we cannot afford to overlook any audience.

ACTION – Mrs Ricketts and Mr Haynes to consider how we target recruitment and update on plans at a future meeting.

The discussion moved onto the 4ward programme and how for any programme to succeed, we need organisational buy in. This is a ground up social movement and it needs a post to link across the organisation and keep the community growing and enthused. The Board supported the need to measure impact going forwards and to learn any lessons from phase one. We do not want to lose traction as we progress, there is opportunity to better reflect the diversity of our workforce and opportunity to give younger people an opportunity to contribute. It was confirmed there is a plan for an interim lead, as phase two is reviewed.

ACTION – People & Culture Committee to discuss 4ward phase 2

RESOLVED THAT: the report be received for assurance

PERFORMANCE

045/21 **Integrated Performance Report**

Mrs Lewis presented the month 1 report. The key points highlighted on the executive summary were noted and discussed. The introduction of a data quality kitemark was welcomed.

Key points included:

- UEC as referenced in the earlier discussion at item 043/21;
- Recovery outpatients – 18 week RTT are at a high
- There have been 2 never events in April
- Sepsis had shown an improvement to level 6 assurance
- Cancer performance is at 96% with focus on two week wait capacity.
- Vacancy rates had increased to 9.3% from 4% as a result of the budget setting process, changes to business cases and cost pressures. A report will come to Finance & Performance Committee (F&P) in due course.

Restoration and Recovery

Mr Snead advised that Board Elective Recovery Fund (ERF) targets were exceeded in April in outpatients and daycases, there being a significant improvement in throughput. Outpatients are to be reviewed in line with social distancing guidance, with the Trust going through a process of environmental risk assessments to maximise space.

The Vanguard is expected mid August to mid December. We intend to use this capacity for daycase activity, which will triple the volume of activity through the facility. Meetings have taken place with the CCG CEO to lobby to see if we can keep the facility longer. A sixth theatre has been bought online at the Alex, with plans for a seventh. Theatres are now working to pre Covid protocols which enables further increases in productivity. There has been a systematic review of the allocation of theatres; they are booked four weeks ahead of schedule and allocation is weighted towards those services with significant backlog, followed by complexity.

Mr Oosterom queried the involvement of the private sector? Mr Snead advised the Trust is still working with Spire and BMI. We are constantly in conversation to maximise the numbers they can provide us with. Sir David noted this is critical as we have too many patients, waiting too long.

Ms Day recognised the good work, challenge and context. For every service not at 100% the list gets bigger. How long will it take us to clear the backlog? Are our system for assessing harm? Is there anything we can do to push the system harder? Mr Snead appreciated the concerns; backlogs are significant and harm reviews are undertaken. We need to continue to push on everything highlighted. We are constricted by social distancing and bed base. In terms of modelling, it is expected to take circa 2/3 years to clear the backlog. 52 week waits had reduced to 6598, with over 70 week waits increased to 1879, but this indicative of the work we are doing. It was noted that as we address the backlog, referrals are increasing and unmet need challenges are even higher in some areas. This will be a key part of annual planning focus in the Board development session.

Finance – ERF

Mr Toole advised overall of a favourable position of £1.2m surplus with a number of caveats, as at month 1. As the Trust achieved 75% ERF target, £560k ERF is arguably payable. Discussions are underway regarding how this is co-ordinated in the event some system providers do not deliver. ERF payments are to the system, not to individual Trusts.

Month 2 is closer to plan. The Trust having achieved 79% against a 75% target, thus potential payment of £400k. June will be a bigger challenge as we had a strong June in 19/20 which is the comparator year, not the preceding months.

RESOLVED THAT: the report be noted for assurance.

046/21 **Committee Assurance Reports**

The following points were highlighted by Committee Chairs:

- F&P: emphasis on annual plan and reduction of waiting list challenges. UEC business case discussed.
- QGC: Dame Julie chaired the meeting; Committee has seen progress on core issues as per the report. Maternity discussed in detail.
- P&C: annual report was key item on last year achievements and plans for next year the progress and milestones over the coming year.

RESOLVED THAT: the Committee reports be noted for assurance.

GOVERNANCE

047/21 **Safest Staffing Report**

a) Adult/Nursing
b) Midwifery

Adult/Nursing
Mrs Gardner presented the nursing element of the report which covered the period to April 2021 and confirmed review of the same had taken place at P&C. Nursing staff continue to be deployed to provide safer staffing levels. Student nurses who had been deployed have now returned to their studies. Mrs Gardner had undertaken a night visit and there will be reviews to ensure equity of HCA on weekend, day and night shifts. International recruitment of nurses from India has been temporarily paused due to concerns around the delta variant.

A discussion followed regard use of bank and agency staff, querying how much of bank and agency hours are as a result of last minute decisions due to safety? Mrs Gardner confirmed there is a staffing meeting ahead of every weekend, however we do have last minute staff not attending. There are systems in place to prevent this, but agencies are failing to attend and short term sickness is an issue. 200 shifts were not covered one weekend resulting in premium agency costs.

ACTION: Mrs Gardner to confirm figures re last minute use of bank and agency die to safety

Midwifery

Ms Jeffrey presented the midwifery element of the report, noting a reduction in the vacancy factor as new starters have joined and the reduction in sickness is continuing into Q1. Multiple options to mitigate risk to ensure safe staffing are considered and we have procured agency where needed, which has well received by midwifery colleagues. We are pursuing the midwifery support programme in postnatal areas, with 18 staff identified. Progress is being made with PIN numbers, once these staff arrive we will have covered all retirements and planned maternity leave.

Sir David welcomed the progress, asking are the staff happier? Ms Jeffrey advised this is mixed, we still have challenges and have to be very proactive regarding rota management, but we are on the right path. The feedback is positive, they feel there is a lot of work to do but that we are going in the right direction.

Mrs Gardner added that her night visit was positive, we want the staff involved in changes as we go forwards. New recruits need to settle and this will take time, however being able to source an agency midwife who has worked in all areas is very positive and staff are seeing this as a step change. We have told staff they will be involved in shaping the continuity of carer rationale as we go forwards; they are pleased we have done this. There had been depleted leadership for some time, this impacted on communications but we have a full suite now, are coming out of covid and team meetings have all been restarted, this all helps bring the messages together. There is a divisional briefing to the team and monthly Q&A, with Ms Jeffrey visiting all areas of the unit each day.

Ms Day welcomed the update reflecting this sounds positive and progress has been made. In prior conversations, there had been reflections that there might be pockets of poor culture, we do not want this it be embedded in new starters. How are we mitigating this? Mrs Gardner advised how we need to make the shift change in attitudes, we are using examples of how the team helps itself, to not have negative

conversations. At the moment we are not hearing the negative conversations we were having before and as activity has been lower, staff have been able to support the newly qualified midwives. We are cautiously optimistic and keeping a very close eye on this.

Mr Hopkins had also dropped in to visit the department. He had a similar experience and speaking to the students they were very positive. He stressed that visible leadership is critical and will make the difference and this is the focus of the divisional leadership team.

RESOLVED THAT: the report be received for assurance.

048/21 **Maternity SI Report**

Ms Jeffrey presented the report which was taken as read. The Board was advised that the clinical details had previously been reviewed and discussed by both Quality Governance Committee and Trust Management Executive.

5 cases met the criteria for reporting, however on review no themes were identified. Prior issues regarding clinical pathways have been changed and implemented. All immediate actions have been completed for all cases – including the specific query raised in relation to case two. The report will go to LMNS to discuss learning and share learning across the system.

Sir David asked as to the approach taken regarding internal learning? Ms Jeffrey confirmed feedback was shared on a one to one basis and information shared via team meetings. There was a number of other mechanisms including a closed private facebook page, email, team meetings, handovers, huddles etc. The governance teams have ordered new boards so information can be posted too. Sir David reflected learning from Sheffield was that teams did not understand the learning. Mrs Jeffrey advised the team meetings and boards will address this and are further strengthened by having the right team in post. However, there is still work to do to make sure messages get to all the team and this is part of the development of the improvement plan.

RESOLVED THAT: the report be received for assurance.

049/21 **Quality Accounts 2020/21**

Mrs Gardner introduced the report which was taken as read. Board is asked to approve the priorities and draft account pending the final comments to be included. The QGC have reviewed the draft in detail and recommended approval. A user friendly summary of the priorities will be developed by the communications team.

Thanks was expressed from the Board to the Quality Hub and Deputy Chief Nurse for the hard work and commitment in preparing the Quality Accounts.

RESOLVED THAT:

- **Reviewed the year-end final results against the Year 3 Quality Priorities set out in the 2019/20 Quality Account, along with the targets for 2021/22.**
- **Noted the progress of the Quality Account draft, and timescales for the compilation and production of the 2020/21 Quality Account in readiness for the publication date of 30 June 2021.**
- **Reviewed and approved the draft Quality Account 2020/21.**

051/21 **Clinical Negligence Scheme for Trusts (CNST) Maternity (Q3 and Q4)**

Ms Jeffrey presented the report which was taken as read. The outstanding evidence will go to TME at the end of June, with submission later that day. The timing is tight, but it means we would be able to submit 10/10.

It was agreed the Chair may take Chair's action on the recommendation of QGC/TME

RESOLVED THAT the evidence submitted against the ten safety actions and accepted the report to demonstrate compliance.

The Chair to take Chair's action to approve final evidence on the recommendation of QGC/TME.

052/21 **Audit and Assurance Committee Report**

Ms Day noted the paper as read, nothing that Committee had met earlier that week. At the latest meeting, Committee had been apprised of data quality exercise and an update was due in two months. Committee had also approved the internal audit plan and undertaken a review of its effectiveness.

RESOLVED THAT the report be received for assurance.

053/21 **ANY OTHER BUSINESS**

There was no further business to transact.

DATE OF NEXT MEETING

The next Public Trust Board meeting will be held virtually on Thursday 15 July 2021 at 10:00am.

The meeting closed at 12:37pm

Signed _____ **Date** _____
Sir David Nicholson, Chair

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

PUBLIC TRUST BOARD ACTION SCHEDULE – JULY 2021

RAG Rating Key:

Completion Status	
	Overdue
	Scheduled for this meeting
	Scheduled beyond date of this meeting
	Action completed

Meeting Date	Agenda Item	Minute Number (Ref)	Action Point	Owner	Agreed Due Date	Revised Due Date	Comments/Update	RAG rating
10.6.21	Patient story	037/21	Mrs Gardner to raise with WMAS' Chief Nurse	PG	July 2021		To be raised at meeting on 15 July 2021.	
10.6.21	Patient story	037/21	Mrs Lewis to raise with WMAS' Chief Digital Officer and the Oasis system supplier	VL	July 2021		The CIO for WMAS has advised this functionality will be part of their new ambulance EPR. Due to roll out soon. We are awaiting clarification of the roll out date. Engagement with the team to find solution in Patient First is in progress along with OASIS, this improved functionality is linked to the latest upgrade.	
10.6.21	Patient story	037/21	Mrs Ricketts to add to the staff on-boarding programme	TR	July 2021		Work is currently in progress to update the staff induction programme.	
10.6.21	Patient story	037/21	Sir David to contact WMAS Chair and CEO and raise with the wider system	DN	July 2021		Matter to be raised at the next system meeting.	

10.6.21	Safer Staffing Report	047/21	Mrs Gardner to confirm figures re last minute use of bank and agency die to safety	PG	July 2021		Due to the timing of data availability, this update will be circulated after the distribution of board papers, but in advance of the next Board meeting.	
10.6.21	Comms Update	044/21	Mrs Ricketts and Mr Haynes to consider how we target recruitment and update on plans at a future meeting.	TR/RH	Sept 2021		Not yet due	
11.3.21	Patient Story: Family Liaison Service	131/20	Development of a business case and interim plan to maintain the service and address any lessons learned specifically in addressing BAME needs	DK	April 2021	Dec 2021	A new Patient Experience Lead Nurse and Sister have been appointed and joined the Trust in April. The Lead Nurse for PE will lead a review of existing resources to embed actions from the feedback and learning from the temporary Family Liaison Service, operationalised during the second wave of the pandemic.	
10.6.21	Comms Update	044/21	People and Culture Committee to discuss 4ward phase 2.	TR/RH	July 2021		Scheduled on July TME and August P&C agendas. Action closed.	

Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	15 July 2021
Paper number	Enc C1

Chair's Report

For approval:	X	For discussion:		For assurance:		To note:	

Accountable Director	Sir David Nicholson Chair		
Presented by	Sir David Nicholson Chair	**Author /s**	Martin Wood Deputy Company Secretary

Alignment to the Trust's strategic objectives (x)							
Best services for local people		Best experience of care and outcomes for our patients		Best use of resources	X	Best people	

Report previously reviewed by		
Committee/Group	Date	Outcome

Recommendations	The Trust Board are requested to ratify the Chair's action undertaken since the last Trust Board meeting in June 2021.

Executive summary	Following the meeting of the Finance and Performance Committee on 30 June 2021, the Chair undertook a Chair's Action in accordance with Section 24.2 of the Trust Standing Orders to approve additional infrastructure expenditure requirements for the DCR Programme. Approval was required to place orders before 1 July 2021 to avoid cost increases and delivery dates not being be guaranteed to meet the programme milestones.

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	*N/A*

Assurance Level (x)	0	1	2	3	4	5	6	7	N/A	X
Financial Risk	*State the full year revenue cost/saving/capital cost, whether a budget already exists, or how it is proposed that the resources will be managed.*									

Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y		N		N/A	X
Are the actions identified starting to or are delivering the desired outcomes?	Y		N			
If no has the action plan been revised/ enhanced	Y		N			
Timescales to achieve next level of assurance						

NHS
Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	15 July 2021
Paper number	Enc C

Chief Executive Officer's Report

For approval:		For discussion:		For assurance:		To note:	X

Accountable Director	Matthew Hopkins Chief Executive Officer		
Presented by	Matthew Hopkins Chief Executive Officer	**Author /s**	Rebecca O'Connor Company Secretary

Alignment to the Trust's strategic objectives (x)							
Best services for local people	X	Best experience of care and outcomes for our patients	X	Best use of resources	X	Best people	X

Report previously reviewed by		
Committee/Group	Date	Outcome

Recommendations	The Trust Board is requested to • Note this report.

Executive summary	This report is to brief the Board on various local and national issues. Items within this report are as follows: • UEC pressures • BAME conference • Covid thank you to staff • The George Cross • AGM • Staff Awards • ICS update • Single Improvement Methodology • Exec to Exec meeting with UHCW

Risk			
Which key red risks does this report address?	N/A	**What BAF risk does this report address?**	N/A

Assurance Level (x)	0		1		2		3		4		5		6		7		N/A	X
Financial Risk	None directly arising as a result of this report.																	

Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y		N		N/A	X
Are the actions identified starting to or are delivering the desired outcomes?	Y		N			
If no has the action plan been revised/ enhanced	Y		N			
Timescales to achieve next level of assurance						

Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	15 July 2021
Paper number	Enc C

Introduction/Background

This report gives members an update on various local, regional and national issues.

Issues and options

Urgent and Emergency Care pressures

The high demand for our emergency and urgent care services that accelerated over Apr-21 has continued throughout May-21. Week on week figures were, again, consistently high for ambulance attendances and walk-ins alike, paediatric attendances and across all categories. This level of demand is unprecedented with attendances at both WRH and ALX rising for the fourth consecutive month and both sites at the highest level in the last 19 months.

EAS performance was impacted by this level of demand with increased numbers of patients breaching the 4 hour urgent and emergency access standard. Ambulance handover delays have increased and close engagement with West Midlands Ambulance Service is underway across the West Midlands region to ensure the safety of patients held on ambulances.

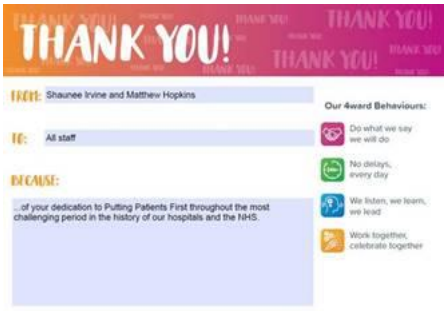
The picture is further compounded by increased discharge delays for patients waiting for packages of care within their own homes or within community hospitals across the county.

Work continues with system partners through the ICS forums to urgently resolve the issues that are adversely impacting on the number of emergency attendances and delayed

1st Anniversary of Ethnic Minority Staff Network

The anniversary on 29th June was marked by an on-line webinar “Lets talk Racism” which was open to colleagues across the Herefordshire and Worcestershire Integrated Care System. With over 240 attendees the webinar included a recap on the key achievements of the network to date, key note speakers on racism, patient stories and staff stories. We heard how colleagues are still subject to inappropriate behaviours and comments by some patients and staff due to their race and the detrimental impact that this has on their wellbeing. Further work is needed to make it clear that this behaviour will not be tolerated within the Trust and indeed in any health and care setting and a charter is being developed in conjunction with colleagues as part of the work we are undertaking for our cultural change journey.

Staff Thank you Day



On 1st July (Thank You Thursday day) and ahead of the national NHS Thank You day on Sunday (July 4), we said our biggest thank you yet to all colleagues, in recognition of their incredible work to Put Patients First over the past 16 months. As a token of our huge appreciation for colleagues dedication and hard work throughout the pandemic we have granted all substantive staff a **Thank You Day** – an extra day’s paid annual leave to be taken before April 2023 to spend as they wish. Staff Side have been passionate in

their discussions with the senior leadership team about how we should recognise the contribution, and often the sacrifices, that everyone has made during the pandemic and we listened carefully, learned from the feedback from colleagues, and are proud to be leading the way in 'doing what we said we would do' and ensuring the health and wellbeing of our people is a priority.

George Cross
As part of the celebrations to mark the NHS' 73rd birthday over the weekend of 3-5 July, Her Majesty the Queen awarded the George Cross to the NHS. The George Cross is the UK's highest civilian gallantry award, equivalent to the military Victoria Cross and is given for acts of the greatest heroism or of the most conspicuous courage in circumstances of extreme danger. The award comes in recognition of 73 years of dedicated service, including the courageous efforts of healthcare workers across the country battling the COVID-19 pandemic. It is only the third time the George Cross has been bestowed collectively in its 81-year history.

Staff Awards
As this report was being written we were making the final preparations for our rescheduled Staff Recognition Awards – a virtual event which was being streamed live on the evening of Friday 9 July to enable colleagues to watch from home or with their teams. For limited numbers of staff (mainly those individuals and teams shortlisted for awards), there was also a chance to join small, socially distanced gatherings taking place at the Alexandra, Kidderminster and Worcestershire Royal on the night. The awards are another chance for us to say thank you to some of our colleagues for their commitment, compassion and courage in the face of the biggest challenge our NHS has ever faced.

AGM
Like the Staff Recognition Awards, our 2021 Annual General Meeting (AGM) on Thursday 8 July was also being held virtually due to continuing COVID-19 related restrictions, providing an opportunity for Board members, system partners and other stakeholders to reflect on the achievements and challenges of financial year 2020/21 and look ahead to our plans for working together to deliver safe, high quality, efficient health care in the post-Covid era.

Integrated Care System (ICS) update
The Health & Care bill has received its first reading in Parliament, enabling the first suite of guidance to be published by NHSEI on June 17th. This outlines the System Design Framework and The Employment Commitment (for CCG staff). All Integrated Care Systems are required to provide a System Development Plan to outline:

• Transition plans for moving from CCGs to ICS NHS Bodies
• Organisational Development activities to support the successful working of the ICS.

The draft plan is due to be received at ICS Executive forum mid-July, with final submissions due by the end of the month.

The first Worcestershire Partnership board (WPB) meets this month with a dual focus on development and delivery at place. Both the Worcestershire Alliance, and A&E Delivery boards have been stood down as part of the transition. Supported by an executive led

transition sub-group, key themes have been identified to define the new operating model. Our Company Secretary is advising on governance arrangements for the transition period, with recommendations to be made to the next Trust Board following the inaugural WPB board meeting.

From this month the trust Homefirst programme will be extended from a trust to a place based focus. Chairing arrangements will be maintained with terms of reference being refreshed in terms of membership, scope and patient involvement in line with its' reframed purpose. This will support greater accountability of all system partners in delivery of urgent and emergency care and associated pathways.

Early discussion has taken place with acute partners at Wye Valley Trust, the SWFT group and University Hospitals Coventry & Warwickshire (UHCW) to identify opportunities for provider collaboration, pending release of further national guidance.

The Trust is actively engaging with a Health and Wellbeing Board governance review which has been launched this month

Single improvement methodology
Following a month of extensive supplier engagement with staff from across the trust, we have now entered the Discovery phase to co-design the benefits realisation framework prior to final board decision.

Executive level discussion
Executive members attended a E meeting with UHCW to share current experiences on operational recovery, and developments within our respective ICS footprints and emergent provider collaborative opportunities.

Recommendations

The Trust Board is requested to

- Note this report.

Appendices - None

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Annual Plan Priorities for 2021/22

For approval:	x	For discussion:		For assurance:		To note:	

Accountable Director	Jo Newton, Director of Strategy & Planning		
Presented by	Lisa Peaty, Deputy Director of Strategy & Planning	**Authors**	Jo Newton, Director of Strategy & Planning Lisa Peaty, Deputy Director of Strategy & Planning

Alignment to the Trust's strategic objectives (x)							
Best services for local people	x	Best experience of care and outcomes for our patients	x	Best use of resources	x	Best people	x

Report previously reviewed by		
Committee/Group	Date	Outcome
TME	23rd June 2021	Comments addressed
CETM	7th July 2021	Minor amendments required (completed)

Recommendations	It is recommended that Trust Board approve: • the Trust's Annual Plan priorities for 2021/22

Executive summary	The purpose of this report is to set out the annual plan priorities for 2021/22. It outlines our refreshed priorities and actions for the year ahead and aims to further improve the quality, safety and sustainability of our services, as well as operational and financial performance. The plan has been developed following a progress review of last year's priorities which were agreed by Board in June 2020, with a refresh in November in light of the disruption to business as usual due to COVID. Reviews of current strategic transformation programmes and of key strategic risks outlined in the board assurance framework have also taken place. The plan builds on our successes in 2020/21 and addresses areas where progress remains challenged. It is set within the context of the developing Herefordshire and Worcestershire Integrated Care System (ICS).

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	*BAF 1, 3, 5, 7, 9, 10, 11, 14, 15, 16*
The annual plan priorities contribute to the mitigation of the risks above. It will continue to be reviewed in light of the continued restoration and recovery and transformation of services in light of the ongoing impact of COVID-19.			

Assurance Level (x)	0		1		2		3		4		5		6		7		N/A	

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											x												

Financial Risk	N/A.										
Action											
Is there an action plan in place to deliver the desired improvement outcomes?	Y		N		N/A	x					
Are the actions identified starting to or are delivering the desired outcomes?	Y		N								
If no has the action plan been revised/ enhanced	Y		N								
Timescales to achieve next level of assurance	End Q2 - progress of delivery of plan										

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Introduction/Background

The trust's annual plan priorities for 2021/22 are set out in Appendix One. The plan has been developed following a review of the 2020/21 plan approved by Trust Board in June 2020, with a refresh in November in light of the disruption to business as usual due to COVID. At that time, the unknown trajectory of the COVID-19 pandemic meant that there was uncertainty about the extent to which the 2020/21 plan was achievable. The revised plan for 2021/22 has been developed following a review of last year's priorities; current strategic transformation programmes and of key strategic risks outlined in the board assurance framework.

Issues and options

The plan set out in Appendix One is ambitious, yet reflects the Trust's key priorities for the year ahead.

The deliverability of the actions and measures outlined in the plan will depend on progress with addressing the backlog of patients as a consequence of COVID-19; requirements of the forthcoming national planning guidance for October 21 – March 22 (described in planning guidance as H2); pressures related to the demand for emergency and urgent care; and the future trajectory of the COVID-19 pandemic. In addition, consideration of pump priming resource to deliver the ambitious agenda has been undertaken. Given the current working environment, it is proposed that the plan will be reviewed on a quarterly basis. The review will also provide an opportunity for ongoing progress in the development of the Herefordshire and Worcestershire ICS to be triangulated with and reflected appropriately in our priorities.

Conclusion

2021/22 will be another challenging year for the Trust, during which we will continue to improve the organisation both operationally and financially. We will continue to work with our partners to support development of the ICS and delivery of the system-wide plan.

Recommendations

It is recommended that Trust Board approve:

- the Trust's Annual Plan priorities for 2021/22

Appendices

Appendix One: Annual Plan 2021/22

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APPENDIX 1

OUR STRATEGIC OBJECTIVES, ONE YEAR GOALS & IMPROVEMENT PRIORITIES IN 2021/22 – JUNE 2021

STRATEGIC OBJECTIVE ONE: *BEST SERVICES FOR LOCAL PEOPLE*			
CLINICAL SERVICES STRATEGY			
Exec Lead	**Refreshed Improvement Priorities 2021/22**	**Exec Lead / Delivery Lead**	**Measured by / by when**
	GOAL 1.0 ICS & CLINICAL SERVICES STRATEGY		
DSP	• Refresh Clinical services strategy in line with MTFP and ICS place	DSP/CFO	CSS refreshed by end Q3
DSP	• Consolidate the role of the Trust as an anchor institution in the ICS ○ Collaboratively develop and implement place-based narrative, vision and operating model ○ Agreed strategy and plan to deliver min 1 provider collaboration ○ Implement the 8 point plan developed by Trust Board to enhance the role of the Trust in the ICS	CEO/DS&P	• Place-based operating model confirmed by Q4 • Provider collaborative MoU and board by end Mar 22 • Achieve milestones set out in 8 point plan
COO	• Develop System wide integrated service models: ○ A. Implement Geriatric Emergency Medicine Service (aligned with 2 hour response model) (ICOPE) ○ B. Integration of Stoke and Neurology services ○ C. Phase 1 (Integration of OCT, Therapies and Re-enablement)	COO / DD Spec Med	• Revised model agreed Q2 implemented by Q3 • Case for change agreed by end Q3 • Develop OBC to FBC by Q3 • Oversight via Homefirst Worcestershire & Place board in line with agreed plan
	Support /develop of new service models for out of hospital care for minimum one long term conditions: diabetes; respiratory (including long-COVID), cardiovascular disease	CMO/DD Spec Med	• Clinical Forum plan developed by end Q2 • Diabetes pathways developed by Q4

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STRATEGIC OBJECTIVE ONE: *BEST SERVICES FOR LOCAL PEOPLE*			
CLINICAL SERVICES STRATEGY			
Exec Lead	**Refreshed Improvement Priorities 2021/22**	**Exec Lead / Delivery Lead**	**Measured by / by when**
COO	○ Review acute input to system model requirement for long COVID ○ Develop a Diabetes plan at PLACE level		• Respiratory pathways developed by Q4
COO	**GOAL 1.1 URGENT AND EMERGENCY CARE**		
	• <u>UEC capital development and implementation of clinical model</u> ○ Deliver UEC build programme ○ Develop and implement UEC clinical model	COO/DD U Care	• Each phase of UEC build delivered in line with plan • Business case for staffing of clinical model approved by end Q4 • Recruitment of staff in line with timescale outlined in business case
COO	• <u>PLACE Homefirst development for urgent and emergency care.</u> ○ Further development of acute medicine speciality and increased capacity and coverage to support acute take ○ Increase in same day emergency care ○ Improvement in assessment unit capacity and flow ○ Extensive internal pathway development to support rapid flow of specialty patients from ED	DS&P/ COO /DD UC/ All DDs	• EAS consistently greater than 85% by July 21 • Audit shows discharge policies are embedded across the system • MFFD patients in acute beds reduced by 50% from March 21 baseline by July 21 • SDEC receives >33% of all attendances (national standard)
COO	**GOAL 1.2 RESET & RECOVERY**		
	• <u>Deliver the ICS reset and recovery system plan to deliver elective care, diagnostic and cancer</u> ○ Restore services to deliver activity in line with H1 annual plan submitted to	COO/DOPs	• Planned activity levels achieved on a monthly basis to secure Elective Recovery Fund • Mobile endoscopy unit commissioned on

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STRATEGIC OBJECTIVE ONE: *BEST SERVICES FOR LOCAL PEOPLE*			
CLINICAL SERVICES STRATEGY			
Exec Lead	**Refreshed Improvement Priorities 2021/22**	**Exec Lead / Delivery Lead**	**Measured by / by when**
COO	NHSE/I Agree and deliver to H2 planning framework following publication ○ Deliver Phase 1 community diagnostic hub for Worcestershire • Implement ME4 / LIMs service		KTC site by End Sept 21 • Agree MoU by end Q1
	○ Delivery of all operational performance standards		• All statutory operational performance standards reach target
	GOAL 1.3 ACUTE AND SPECIALIST PLANNED CARE		
COO	• <u>Deliver surgical reconfiguration programme as part of agreed site strategy</u> ○ Develop and implement site strategy ○ Utilisation of site configuration co-dependency matrix ○ Implement Surgical reconfiguration programme, including theatres productivity	DS&P/COO	• Site Strategy approved by end Nov 21 • Surgical reconfiguration programme delivered in line with milestones in programme plan
DSP	• <u>Deliver strategic capital programmes to support delivery of care</u> ○ Develop business case for theatres development at AGH ○ Develop business case for surgical robot ○ Implement developments associated with ASR	COO/DDs/Dir of Estates	• Theatres business case approved by Apr 22 • Robot business case approved by Dec 21 • Breast Unit developments completed in line with planned milestones • Endoscopy at AGH by end Apr 22 (dependent on ASR case approval)
	• <u>Strategic Partnerships /Provider collaboratives</u> • Joint service model for oncology, urology & head and neck cancer developed with preferred partner • Seek opportunities for joint appointments in oncology and urology	DS&P/CMO COO/ DDs Surgery, SCSD	<u>By end Mar 22:</u> • MOU agreed by Dec 21 • Clinical models agreed by Jan 22

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STRATEGIC OBJECTIVE ONE: *BEST SERVICES FOR LOCAL PEOPLE*			
CLINICAL SERVICES STRATEGY			
Exec Lead	**Refreshed Improvement Priorities 2021/22**	**Exec Lead / Delivery Lead**	**Measured by / by when**
DSP	• Virtual Patient Management (HICs 1-4) ○ Reduction in follow up appointments ○ Increase in virtual outpatient appointments ○ Increase in Advice & Guidance ○ Remote monitoring implemented in selected specialties	COO/DDs (All)	• Increase virtual OP consultations in line with activity plan • Reduce follow up appointments in line with activity plan • Increase A&G in line with plan

STRATEGIC OBJECTIVE TWO: *BEST EXPERIENCE OF CARE AND BEST OUTCOMES FOR OUR PATIENTS*			
QUALITY			
Exec Lead	**Refreshed Improvement Priorities 2020/21**	**Exec Lead / Delivery Lead**	**Measured by**
CNO	**GOAL 2.1 CARE THAT IS SAFE**		
	• Quality & Safety Strategy • Review and update Quality & Safety Strategy	CNO/CMO	• First draft of Quality & Safety Strategy by end Nov 21 • Quality & Safety Strategy approved by end Q3
	• Maternity improvement plan ○ Agree and deliver improvement plan incl Continuity of Carer	CNO	• Plan agreed by Q2 • Plan implemented in line with milestones • Staff survey results back to average by Dec 21

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	• Infection Prevention and Control • Embed our current infection prevention and control policies and practices • Continuously monitor the effectiveness of our enhanced infection control policies and practices in preventing in - hospital transmission of COVID- 19	CNO / Deputy DIPC	• 95% compliance with IPC mandatory training by end Mar 22 • Full compliance with our *Key Standards to Prevent Infection*, i.e. Hand Hygiene 97%, Cleanliness in line with national standards, ongoing care of invasive devices 97% • Business Case proposal to recruit for Infection Prevention Clinical Estates Project Manager by end Feb 22 dependant on acceptance of business case for new capital team structure
	GOAL 2.2 CARE THAT IS EFFECTIVE		
	• Implement clinical standards for seven day hospital services and agreed Internal Professional Standards (IPS) consistent with HomeFirst principles	CMO / DDs	• 95% compliance with the 4 priority clinical standards by end Dec 21 • 100% compliance with IPS by the time UEC development is in place
CNO	**GOAL 2.3 CARE THAT IS A POSITIVE EXPERIENCE FOR PATIENTS AND THEIR CARERS**		
	• Launch and implement real time patient and carer feedback through a focussed "you said….we did" approach utilising FFT/ WREN data at ward and department level	CNO / Head of Patient, Carer and Public Engagement	• Adopted by 100% of all wards/ departments (adults, children, maternity, theatre and outpatients) as measured through ward accreditation programme by Apr 2022 • Evidence of patient involvement in all improvement strategies
CEO	**GOAL 2.4 IMPROVEMENT**		
	• Implement and monitor transformation and action plans associated with GiRFT at system and Trust levels ○ Implement acute elements of system plans for T&O, Ophthalmology,	COO / DSP / Head of Improvt	• Transformation plans for each specialty achieved as planned • Trust-level remedial action plans achieved

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	Gynaecology, Urology, ENT and General Surgery ○ Trust-level GiRFT remedial plan prioritisation, development and delivery		as planned
	• Single Improvement Methodology ○ Preferred Single Improvement Methodology partner identified ○ Business case approved by Board ○ Single Improvement Methodology implementation plan developed in conjunction with preferred partner	CEO/DS&P	• Partner identified by end July 21 • Business case approved Sept 21 • Implementation plan developed and approved end Nov 21 • First value stream completed Jan 22

STRATEGIC OBJECTIVE THREE: *BEST USE OF RESOURCES*			
ENABLERS			
Exec Lead	**Refreshed Improvement Priorities 2020/21**	**Exec Lead / Delivery Lead**	**Measured by**
CDO	**GOAL 3.1 DIGITAL STRATEGY**		
	• Deliver year two of our digital strategy • Re-implementation of PAS • Digital Infrastructure modernisation • Digital care record implementation • Digital innovation programme to support new ways of working • Integrated digital programme, including digital aspirant / unified tech fund	CDO / Deputy CDO/Director of IT	• Reimplementation PAS by end Mar 22 • Progress is in line with capital plan 21/22 • Progress is in line with programme plan • Progress in line with programme plan • In place by end Q3 21/22
CFO	**GOAL 3.2 FINANCE**		
	• Refresh our medium term financial plan linked to the delivery of system wide financial improvement • Reduce reliance on temporary staffing	CFO / Deputy Directors of Finance/	By end Mar 22: • Agency spend is reduced to 6% of total pay • £4m reduction in agency premium • Minimum £8m PEP savings/efficiencies

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	• Further develop the productivity and efficiency programme • Implement Service Line Reporting • Understand the implications of ICS financial frameworks for the Trust	PMO	
COO	**GOAL 3.3 ESTATES**		

	• <u>Estates strategy</u>
	  ○ Develop an estates strategy for more efficient utilisation of Trust sites
	  ○ Refresh Parking Strategy in light of post-COVID ways of working
		COO / Director of Estates and Facilities	• Estates Strategy approved by end Jul 21
			• Reduce the amount of empty and under – utilised space (1.0%) to align more closely with the Model Hospital benchmark values (0.75%) by March 22
			• Parking Strategy approved by end Aug 21

STRATEGIC OBJECTIVE FOUR: *BEST PEOPLE*			
WORKFORCE AND CULTURE			
Exec Lead	**Refreshed Improvement Priorities 2020/21**	**Exec Lead / Delivery Lead**	**Measured by**

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D of P&C	**GOAL 4.1 WORKFORCE**		
	• Organisation development ○ Implement our new clinical division management structure	COO/DDs	• New structure fully in place with supporting leadership development offer by end March 22
D of P&C	• BEST PEOPLE - Strategic workforce plan ○ Introduce new roles and staffing models to support the delivery of our clinical services strategy ○ Deliver opportunities for the enable development of new skills and ways of working ○ Develop one year and three year workforce plan for each of the 42 clinical specialties and each division ○ Implement and review the Location by Vocation pilot	DP&C / COO	By end March 22: • new roles and staffing models implemented in line with workforce transformation plan on a page milestones: ○ Physician Associates, Clinical Fellows, Associate Nurses, Virtual Ward, Hospital @ Night, Skill Mix Reviews (SCSD) • Three year and one year workforce plans in plans in place for all 42 specialties and each division • 10% of staff work remotely for more of the time • Further reduction in substantive vacancies so that the Trust is in line with the national average
D of P&C	• Equality, Diversity and Inclusion (EDI) ○ Refresh the trust's EDI plan ○ Further develop EDI networks for staff ○ Develop a charter which sets out our position on EDI ○ Add an additional strand (dignity, inclusion, compassion and civility) across our 4ward behaviours ○ Refresh the wellbeing strategy to ensure it is fully inclusive	D of P&C	• EDI plan refreshed by October 21 • Double the BAME network membership by Mar 22 (200) • EDI Charter produced by Sept 21 • Additional strand to 4ward behaviours developed and launched by Mar 22 • Wellbeing strategy refreshed by end Dec 21
D of P&C	**GOAL 4.2 CULTURE**		

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	• 4ward ○ Continue to develop our culture and improve staff engagement through 4ward phase 2 – Step Forward ○ Roll out the new NHS People Pulse survey by end July 2021 ○ Using the first People Pulse survey as a benchmark, deliver improvements in rates of participation and feedback by end of March 2022	D of C&E / Lead Advocate	• Increase in number of 4ward advocates by at least 120 (to a total of at least 500) by end Mar 2022 • Internal engagement completed on the next phase of our 4ward programme by the end of Oct 2021 • Improve the Trust's score to average for staff recommending the trust as a place to work by end Mar 22 • Improvement in 2021/22 staff survey scores with 25% of indicators above average for acute trusts by end Mar 22

NB. ***Whilst each goal and improvement priority has an executive lead, the wider executive team will be expected to provide appropriate support in line with our signature behaviours, collective leadership and the guiding principal of never knowingly allowing a colleague to fail.***

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End of Life Care –Strategy

For approval:	X	For discussion:		For assurance:		To note:	

Accountable Director	Mr Graham James, Deputy Chief Medical Officer		
Presented by	Dr Nicola Heron, Consultant in Palliative Medicine	**Author /s**	Dr Nicola Heron, Avril Adams Lead Nurse for Palliative & EOL Care

Alignment to the Trust's strategic objectives (x)							
Best services for local people	x	Best experience of care and outcomes for our patients	x	Best use of resources		Best people	

Report previously reviewed by		
Committee/Group	Date	Outcome
CGG	1/6/21	Approved
QGC	1/7/21	Approved

Recommendations	The board are invited to support the changes to implement the End of Life Care Strategy.

Executive summary	Worcestershire Acute Hospitals NHS Trust is committed to delivering the best possible care and services for our patients, putting them first in everything we do. End of life care was recently identified as an imperative in underpinning clinical strategy for Worcestershire Acute Hospitals NHS Trust. It is estimated that, at any one time, one third of adult inpatients are in their last year of life. In 2019, in Worcestershire 43.3% of adults died in hospital, which is slightly below national figures (44.9%). When our patients are entering the last days, weeks or months of their life we aim to ensure their care, and that of those important to them, is tailored to their specific needs; making care as individual as they are. In the last Care Quality Commission (CQC) inspection for End of Life Care Worcestershire Acute Hospitals Trust (WAHT) was rated as 'Good'. In preparation for the next anticipated CQC inspection, the reports of other organisations that have achieved 'Outstanding' have been reviewed. This review has highlighted a common theme of End of Life Care having senior, Trust-wide leadership in place. This was often achieved and evidenced by an End of Life Care Steering Group. Furthermore, Care at End of Life has been identified as one of the four imperatives in WAHT in the Clinical Services Strategy. End of Life care is one of the 4 new quality indicators in the Quality Priority and Trajectories 2020-21. The Hospital Palliative Care Team has developed a new End of Life Care (EOLC) Strategy with an associated Implementation Plan; these have been

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	reviewed and approved by the recently formed EOLC Steering Group and at the Clinical Governance Group. These documents complement the existing End of Life Care Policy and are based on national guidance and feedback from the National Audit for Care at the End of Life (NACEL).

Risk			
Which key red risks does this report address?	*Ensuring patients at the end of their lives receive high quality care and that those important to them are well supported.*	**What BAF risk does this report address?**	Quality & Safety (4)

Assurance Level (x)	0		1		2		3		4		5		6	x	7		N/A	
Financial Risk	*none*																	

Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y		N		N/A	
Are the actions identified starting to or are delivering the desired outcomes?	Y		N			
If no has the action plan been revised/ enhanced	Y		N			
Timescales to achieve next level of assurance						

Introduction/Background

Worcestershire Acute Hospitals NHS Trust is committed to delivering the best possible care and services for our patients, putting them first in everything we do.

End of life care was recently identified as an imperative in underpinning clinical strategy for Worcestershire Acute Hospitals NHS Trust.

It is estimated that, at any one time, one third of adult inpatients are in their last year of life. In 2019, in Worcestershire 43.3% of adults died in hospital, which is slightly below national figures (44.9%).

When our patients are entering the last days, weeks or months of their life we aim to ensure their care, and that of those important to them, is tailored to their specific needs; making care as individual as they are.

In the last Care Quality Commission (CQC) inspection for End of Life Care Worcestershire Acute Hospitals Trust (WAHT) was rated as 'Good'. In preparation for the next anticipated CQC inspection, the reports of other organisations that have achieved 'Outstanding' have been reviewed.

This review has highlighted a common theme of End of Life Care having senior, Trust-wide leadership in place. This was often achieved and evidenced by an End of Life Care Steering Group. Furthermore, Care at End of Life has been identified as one of the four imperatives in WAHT in the Clinical Services Strategy. End of Life care is one of the 4 new quality indicators in the Quality Priority and Trajectories 2020-21.

The Trust's End of Life Steering Group was established in September 2020 with bi-

monthly meetings being chaired by the Deputy Chief Medical Officer, with support from the Palliative Medicine Consultants.

The End of Life Care Steering group have agreed a 5-year EOLC strategy based on the principles of the National Palliative and End of Life Care Partnership published guidance 'Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020'. It has been confirmed that this framework will be continued beyond 2020. The Strategy is based upon 4 areas of focus to achieve high quality End of Life Care:

- Individualised patient care
- Supporting families and carers
- Supporting and empowering staff
- Communication & Information

Significant progress has already been made in the following areas:

- Staff training & education
- High engagement with the 'Individualised Last Days of Life Care Plan' by ward teams
- Introduction of SUPPORT Programme
- Carers Room at WRH
- EOLC Steering Group providing senior level assurance
- Engagement with STP-led EOLC Network
- Engagement with NACEL

Issues and options

End of Life Care at WAHT was rated 'good' across all domains when last inspected in 2017.

The organisation's results in the last round of NACEL were in line with national averages and in some areas outperformed these (see appendix).

Specific areas for improvement have been identified and an action plan has been generated within the EOLC Strategy. These include:

- An emphasis on staff training to ensure our staff are confident and competent at delivering high quality end of life care
- The ongoing use of EOLC tools, for adult inpatients, such as the Individualised Last Days of Life Care Plan, the AMBER Care Bundle (when a patient's recovery is uncertain), Individualised Care After Death Pathway and ReSPECT.
- Promotion of sensitive conversations to enable patients and their families to be involved in planning their end of life care
- Ensuring those important to patients at the end of their lives are supported both emotionally and practically, including in the post-bereavement period.
- Ensuring a robust governance process is in place to support ongoing improvements in EOLC in the organisation.
- Continue to work closely with partner organisations in the STP to deliver seamless care to our patients in all settings.
- Ongoing engagement with NACEL, which also seeks feedback from bereaved family members & staff

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Conclusion
End of Life Care is a priority area for the Trust. A high proportion of adult inpatients are in the last year of their life, and a significant number will die in hospital. It is therefore essential that staff are empowered to provide high quality, patient centred care, with competence and confidence. The End of Life Care Policy and Strategy defines where improvements need to be made and how these will be achieved.
Recommendations
The board are invited to support the changes to implement the End of Life Care Strategy.
Appendices

1. EOLC Strategy
2. EOLC Strategy Implementation Plan

Putting Patients First

Worcestershire Acute Hospitals NHS Trust

End of Life Care Strategy 2020 -2025

Outlining the approaches for End of Life Care for adult hospital patients

Putting Patients First

Hospital Palliative Care Team

Background:

Worcestershire Acute Hospitals NHS Trust is committed to delivering the best possible care and services for our patients, putting them first in everything we do.

End of life care was recently identified as an imperative in underpinning clinical strategy for Worcestershire Acute Hospitals NHS Trust.

This document outlines the approach to end of life care, and its delivery, for adult patients.

When our patients are entering the last days of their life we aim to ensure their care, and that of those important to them, is tailored to their specific needs; making care as individual as they are.

End of life care is a component of palliative care. At Worcestershire Acute Hospitals NHS Trust we follow NICE (National Institute of Clinical Excellence) in their outline of people who are approaching the end of life as those who are likely to die within 12 months, people with advanced, progressive, incurable conditions and people with life-threatening acute conditions.

Worcestershire Acute Hospitals NHS Trust places emphasis on preventing avoidable deaths but for patients whose condition is, despite the most appropriate medical care, deteriorating towards the end of life we continue to support and care for our patients, and those important to them, through this time.

The National Palliative and End of Life Care Partnership published guidance 'Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020'. This framework, it is anticipated, will be continued beyond 2020. These six ambitions are:

1. **Each person is seen as an individual**
2. **Each person gets fair access to care**
3. **Maximising comfort and wellbeing**
4. **Care is coordinated**
5. **All staff are prepared to care**
6. **Each community is prepared to help**

Worcestershire Acute Hospital NHS Trust structures its approach to End of Life Care around these six ambitions and works collaboratively with community partners and care providers to achieve this.

In addition, Worcestershire Acute Hospitals NHS Trust explicitly structures care of those in the last days of life around the five priorities of care for the dying person from 'One Chance to get it Right' (2014).

RECOGNISE – the possibility that a person may die within the next few days or hours is recognised and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly.

COMMUNICATE – sensitive communication takes places between staff and the dying person and those identified as important to them.

INVOLVE – the dying person, and those identified as important to them, are involved in decisions about their care to the extent that the dying person wants.

SUPPORT – the needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible.

PLAN & DO – an individual plan of care, which includes consideration of food and drink, symptom control and psychological, social and spiritual support, is agreed, coordinated and delivered with compassion.

Our Vision

Worcestershire Acute Hospitals NHS Trust is committed to the delivery of high quality, supportive, coordinated, individualised care for patients, and those important to them, at the end of life.

We believe, for staff at Worcestershire Acute Hospital NHS Trust, everyone has a role to play in providing and enabling good quality End of Life Care to support patients and those important to them.

At Worcestershire Acute Hospitals NHS Trust we are committed to providing high quality care of dying patients and to continually evaluate and improve our service.

Our vision will be achieved by focusing on the following four areas:

- Individualised patient care
- Supporting families and carers
- Supporting and empowering staff
- Communication & Information

Ambitions 1, 2, 3, 4

Individualised patient care

- Promote the use of advance care planning tools, such as ReSPECT, to help identify patient priorities and preferences.
- Identify patients whose acute hospital admission is associated with an uncertain recovery and offer to engage these patients with the AMBER Care Bundle that allows consideration of preferences of care in the event of deterioration whilst acute treatment continues.
- Identify patients who are approaching the last days of life, ensuring reversible conditions have been considered and treated where appropriate.
- Allow patients who are approaching the last days of life, and those important to them, the opportunity to engage in discussions and plans for their individualised care.
- Ensure the national recommendations of the 'Five Priorities of Care for the Dying Person' are embedded in the Individualised Last Days of Life Care Plans for Adults that are used in the Trust.
- Promote the sensitive exploration of psychological, cultural, social or spiritual needs of dying patients and those important to them and offer appropriate support with these needs.
- Establish a structured approach to the regular assessment of symptoms for the dying person by utilisation of the Palliative Care Symptom Observation Chart.
- Ensure an individualised approach to symptom management including daily review of patients at the end of life.
- Support sensitive conversations with patients and those important to them about practicalities of end of life care in different locations, including at home
- Work collaboratively with partners to enable a clear and rapid discharge process for those patients who wish to return home to die.
- Work collaboratively with community palliative care services to ensure continuity of palliative care on change of care location.
- Continue to offer a seven day a week, face-to-face, specialist palliative care service for hospital inpatients with specialist needs.
- Ensure high quality, sensitive care of the patient after death.

Ambitions 1, 3

Supporting families & carers

- Offer support to those important to the patient, irrespective of their relationship or role, during the last days of life of the patient.
- Identify ways to support those important to the patient including information about financial support, open visiting and hospital parking arrangements.
- Identify ways of improving the support to those important to the patients including developing carers' rooms and carers' comfort packs.
- Ensure bereavement needs are considered and make arrangements for appropriate support to be offered.

Ambitions 4, 5

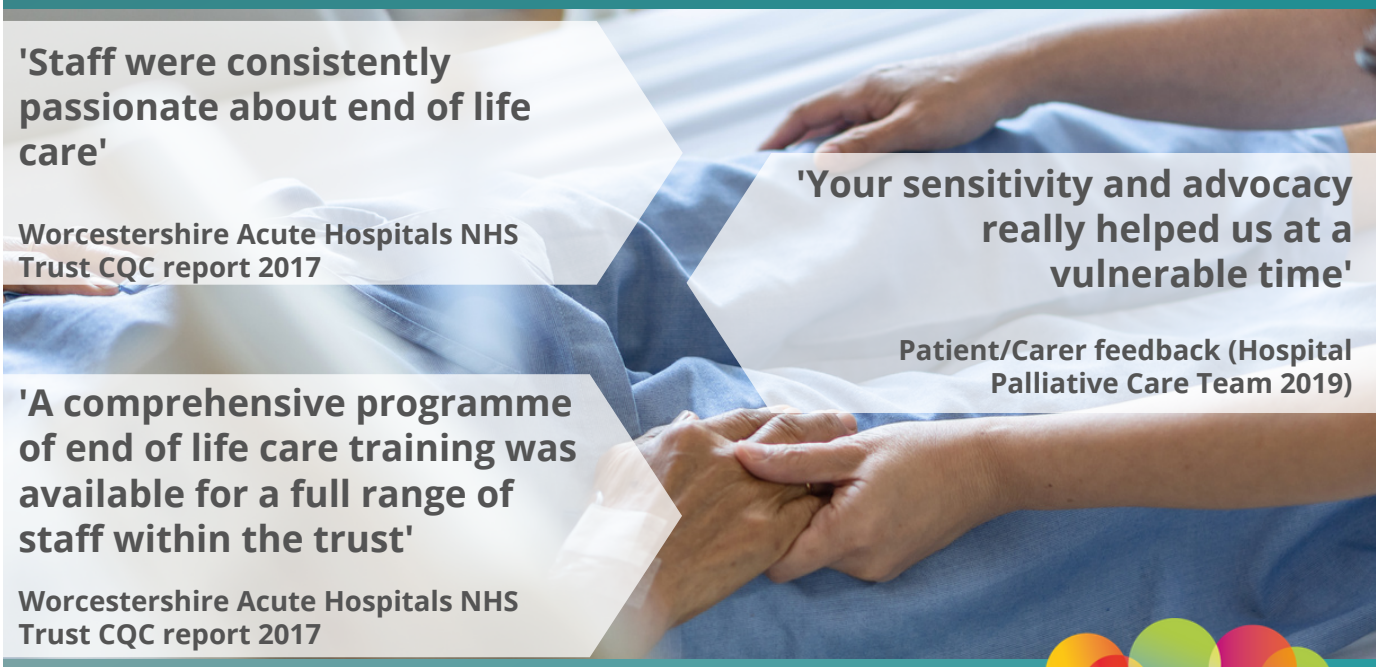
Supporting & empowering staff

- Emphasise that everyone has a role to play in enabling good quality end of life care.
- Ensure leadership for End of Life Care in the Trust is coordinated by an End of Life Steering group that includes Trust board representation.
- Deliver care that is fully compliant with clinical governance processes for end of life issues.
- Actively promote end of life care initiatives and approaches across the Trust by working collaboratively with the Communications team.
- Continue to engage with Trust staff who are involved in delivering front-line end of life care to better understand the current and future needs of the workforce.
- Ongoing development of End of Life Link Workers and ward accreditation schemes in clinical areas to promote and engage staff with end of life care approaches.
- Information resources for staff made available by maintaining an up-to-date Hospital Palliative Care Team Intranet page.
- Offer high quality palliative and end of life care education to all staff, tailoring learning to the bespoke needs and patient groups they care for, utilising face-to-face and e-learning approaches.
- Promotion of end of life care education initiatives, with inclusion in Trust induction and mandatory training.
- Equip medical and nursing staff to offer support to patients and those important to them through the use of communication skills training, such as 'SAGE & THYME'.
- Use reflective practice to support staff caring for dying patients including dissemination of compliments and learning from complaints.
- Ensure all clinical staff are aware of 24/7 access to specialist palliative care advice and support.

Ambitions 4, 6

Communication & Information

- Ongoing use of the Countywide shared palliative care electronic record to promote seamless transitions of care between palliative care services.
- Promotion of clear communication and use of electronic resources to engage with primary care services for patients at the end of life.
- Ongoing engagement in Worcestershire Palliative and End of Life Care Network for peer review and collaborative working with partnership agencies.
- Continue to utilise clinical governance approaches, including local and national audit, to review and disseminate clinical learning for end of life care issues.
- Provide patients and those important to them with written information regarding End of Life Care and Advance Care Planning in an accessible form.
- Promote the use of available technology to aid communication with staff, patients and those important to them when face-to-face visiting is not possible.
- Offer patients and those important to them written summaries of consultations and care plans.
- Regularly review the responses to the VOICES survey of bereaved relatives to ensure families and carers are satisfied with care and follow up on any issues raised.
- Regular engagement with Communications team within the Trust to keep staff up to date with End of Life Care approaches.
- Engage with the public through initiatives such as 'Dying Matters' week.



Indicators of success

- Increase in engagement in Advance Care Planning including the uptake of the AMBER Care Bundle for those with uncertain recovery and ReSPECT;
- Compliance with the use of the Individualised Last Days of Life Care Plan for Adults for those identified as being in the last days of life;
- Constructive participation in local and national end of life audits; 'such as NACEL that allows benchmarking of the service against annually set nationally defined outcome measures
- Positive feedback from patients and those important to them;
- Reduction in end of life care related complaints;
- Engagement and increased uptake of End of life education and training amongst health care professionals.

Future commitment

Worcestershire Acute Hospitals NHS Trust is committed to delivering high quality care for all patients at the end of their lives.

This strategy outlines how we will promote, develop and enhance the current care to further advance this commitment. This strategy is concurrent to the Trust Policy on End of Life Care. As we are committed to ongoing improvement and development, both the strategy and policy will be reviewed in the event of changes to the national End of Life Care guidelines and recommendations that underpin it.

This strategy will be planned for review after five years as part of the palliative care service's engagement with trust governance processes.

References

- National Palliative and End of Life Care Partnership (2015). The Ambitions for Palliative and End of Life Care – A National Framework for local action 2015-2020.
- The Leadership Alliance for the Care of Dying People (2014). One Chance to Get it Right: Improving people's experience of care in the last few days and hours of life.
- Care Quality Commission (2017): Worcestershire Acute Hospitals NHS Trust End of Life Care Quality Report

Putting Patients First

Worcestershire Acute Hospitals NHS Trust

End of Life Care Strategy 2020 -2025

Putting Patients First

Implementation Plan for Worcestershire Acute Hospitals NHS Trust End of Life Care Strategy

Theme 1: Individualised Patient Care					
Strategy goal	**We will do this by:**	**Responsible team:**	**Evidence of current achievement?**	**New action/partially completed**	**Date to be completed by**
Promote the use of advance care planning tools, such as ReSPECT, to help identify patient priorities and preferences.	Training & education Feedback from audits	-HPCT -EOLC team -ACB nurse -ReSPECT lead	Currently in progress Continue with current practice		To be reviewed annually June 2022
Identify patients whose acute hospital admission is associated with an uncertain recovery and offer to engage these patients with the AMBER Care Bundle. This allows consideration of preferences of care in the event of deterioration whilst acute treatment continues.	Training & education Feedback from audits Engagement with countywide initiatives	-ACB nurse -HPCT	ACB in post and working towards wider trust recognition and implementation of AMBER care bundle		To be reviewed annually June 2022
Identify patients who are approaching the last days of life, ensuring reversible conditions have been considered and treated where appropriate.	Training & education	-HPCT -EOLC team	Current trust practice and included in ILDOL care plan.	Scope for early recognition of dying (that is; > 48 hours) to be addressed through education initiatives	To be reviewed annually at NACEL April 2022
Allow patients who are approaching the last days of life, and those important to them, the opportunity to engage in discussions and plans for their individualised care.	Training & education	-HPCT -EOLC team	Current practice as part of ILDoL Care plan Continue with current practice		To be reviewed annually June 2022
Ensure the national recommendations of the	Guideline development	-HPCT	Current practice as part of ILDoL		To be

'Five Priorities of Care for the Dying Person' are embedded in the Individualised Last Days of Life Care Plans for Adults that are used in the Trust.		-EOLC team	Care plan Continue with current practice		reviewed annually June 2022
Promote the sensitive exploration of psychological, cultural, social or spiritual needs of dying patients and those important to them and offer appropriate support with these needs.	Training & education Input from Hospital Palliative Care Team & Hospital chaplaincy service	-HPCT -EOLC team	Currently included in the ILDOL care plan	Scope for better engagement with this aspect of care plan – to be addressed through education	To be reviewed annually June 2022
Establish a structured approach to the regular assessment of symptoms for the dying person by utilisation of the Palliative Care Symptom Observation Chart.		-HPCT -EOLC team	Current practice as part of ILDoL Care plan. Evidence from audit that this is well completed		To be reviewed annually June 2022
Ensure an individualised approach to symptom management including daily review of patients at the end of life.	Training & education Feedback from audits	-HPCT -EOLC team	Current practice as part of ILDoL Care plan.		To be reviewed annually June 2022
Work collaboratively with partners to enable a clear and rapid discharge process for those patients who wish to return home to die.	Multidisciplinary working with AHP's, discharge teams & primary care.	-HPCT -EOLC team - OCT	Rapid process in place	However, frequent changes to process can cause delay. Access to community care variable	To be reviewed annually June 2022
Support sensitive conversations with patients and those important to them about practicalities of end of life care in different locations, including at home.	Training and education	- HPCT	Currently offered by HPCT	Scope for improvement with conversations by ward staff	To be reviewed annually June 2022

Work collaboratively with community palliative care services to ensure continuity of palliative care on change of care location.	Use of shared electronic patient record	-HPCT -EOLC team	Current practice > 5 years in duration	In place	To be reviewed annually June 2022
Offer a seven day a week, face-to-face, specialist palliative care service for hospital inpatients with specialist needs.		-HPCT -EOLC team	Current practice > 5 years in duration	Feb 2014	To be reviewed annually June 2022
Ensure high quality, sensitive care of the patient after death.	Training & education of ward staff & bereavement staff	-HPCT -EOLC team - Mortuary team - Bereavement services	Currently facilitated by care after death pathway	Ongoing role out and training to ward staff	To be reviewed annually June 2022

Theme 2: Supporting Families and Carers					
Strategy goal	**We will do this by:**	**Responsible team:**	**Evidence of current achievement?**	**New action/partially completed**	**Date to be completed by**
Offer support to those important to the patient, irrespective of their relationship or role, during the last days of life of the patient.	Staff support	-HPCT -EOLC team	Evidence of support from VOICES /NACEL and spontaneous carer feedback	Relaunch of VOICES survey/SUPPORT initiative / Carer's room	Sept 2021
Identify ways to support those important to the patient including information about financial support, open visiting and hospital parking arrangements.	SUPPORT programme	-EOLC team -HPCT	Information currently offered by EOLC team/HPCT	SUPPORT initiative will further promote	Sept 2021
Identify ways of improving the support to those important to the patients including developing carers' rooms and carers' comfort packs.	SUPPORT programme	-EOLC team -HPCT	Carers room at Alex in place.	SUPPORT/Peony room (carers room) at WRH	Sept 2021
Ensure bereavement needs are considered	Bereavement service to ensure	-HPCT	Bereavement	Consideration of	To be

and make arrangements for appropriate support to be offered.	written information on support available is provided	-EOLC team - Bereavement services	needs for patients known to HPCT reviewed at MDT	more global assessment of bereavement needs ? to be led by bereavement service	reviewed annually June 2022

Theme 3: Supporting and Empowering Staff					
Strategy goal	**We will do this by:**	**Responsible team:**	**Evidence of current achievement?**	**New action/partially completed**	**Date to be completed by**
Emphasise that everyone has a role to play in enabling good quality end of life care.	Staff training & education On the ward support by HPCT	-HPCT -EOLC team	Current practice	To be continued and emphasised at all opportunities	
Ensure leadership for end of life care in the Trust is coordinated by an End of Life Steering group that includes Trust board representation.		-EOLC steering group chair - HPCT -EOLC team	EOLC Steering Group in place	Continue with regular meetings	Sept 2020
Deliver care that is fully compliant with clinical governance processes for end of life issues.	Overview by EOLC Steering Group	-EOLC steering group chair -HPCT -EOLC team	EOLC Steering Group in place Palliative Care Governance lead in place	Continue with current practice	
Actively promote end of life care initiatives and approaches across the Trust by working collaboratively with the Communications team.	Support from Comms team	-HPCT -EOLC team - Trust comms team	Current practice, involved with ILDOL launch	SUPPORT / Dying Matters promotion	To be reviewed annually June 2022
Continue to engage with Trust staff who are	Staff survey	-HPCT		Staff survey to	To be

involved in delivering front-line end of life care to better understand the current and future needs of the workforce.	Ward based support from EOLC team	-EOLC team		conducted	reviewed annually June 2022
Ongoing development of End of Life Link Workers and ward accreditation schemes in clinical areas to promote and engage staff with end of life care approaches.	EOLC Champions group Ward accreditation	-EOLC team	Link workers in place	Ongoing working in progress for accreditation	To be reviewed annually June 2022
Information resources for staff made available by maintaining an up-to-date Hospital Palliative Care Team Intranet page.		-HPCT -EOLC team	Website on trust intranet		To be reviewed annually June 2022
Offer high quality palliative and end of life care education to all staff, tailoring learning to the bespoke needs and patient groups they care for, utilising face-to-face and e-learning approaches.	EOLC team working with Training & Development team Inclusion in Fundamentals of Care programme	-HPCT -EOLC team - Learning and Development	Current practice, EOLC workshops, ILDOL video on intranet	To continue	To be reviewed annually June 2022
Promotion of end of life care education initiatives, with inclusion in Trust induction and mandatory training.	Inclusion in Fundamentals of Care programme & Trust Induction	-HPCT -EOLC team	Current practice	Recently added to FOC	To be reviewed annually June 2022
Equip medical and nursing staff to offer support to patients and those important to them through the use of communication skills training, such as 'SAGE & THYME'.	Promotion of SAGE & THYME	-HPCT -EOLC team - Learning and development	SAGE & THYME sessions available	To be restart in June 2021	To be reviewed annually June 2022
Use reflective practice to support staff caring for dying patients including dissemination of compliments and learning from complaints.	Introduction of 'Team Time'	Wellbeing team	Compliments and Complaints discussed in HPCT business meeting Record on Datix dashboard	Team Time imitative being explored	To be reviewed annually June 2022

Ensure all clinical staff are aware of 24/7 access to specialist palliative care advice and support.	Team promotion & staff education	-HPCT -EOLC team	On Palliative Care Posters/ intranet mentioned in all teaching	Continue with current approach	To be reviewed annually June 2022

Theme 4: Communication and Information					
Strategy goal	**We will do this by:**	**Responsible team:**	**Evidence of current achievement?**	**New action/partially completed**	**Date to be completed by**
Ongoing use of the Countywide shared palliative care electronic record to promote seamless transitions of care between palliative care services.	Using the record (Systm1)	-HPCT -EOLC team - Digital team if new system launched	Currently in place	To continue	To be reviewed annually June 2022
Promotion of clear communication and use of electronic resources to engage with primary care services for patients at the end of life.	Use of EPaCCS	-HPCT -EOLC team -Digital services team	Currently we have access to system but limited use	Needs to be embedded in daily practice	To be reviewed annually June 2022
Ongoing engagement in Worcestershire Palliative and End of Life Care Network for peer review and collaborative working with partnership agencies.	Participate in Network	-HPCT -EOLC team	Attendance at Network meetings	To continue	In place
Continue to utilise clinical governance approaches, including local and national audit, to review and disseminate clinical learning for end of life care issues.	Participate in NACEL	-HPCT -EOLC team - Clinical and governance lead	Involved in NACEL Annual BOPP	To continue	To be reviewed annually June 2022
Provide patients and those important to them with written information regarding End of Life Care and Advance Care Planning in an accessible form.	Patient/carer information leaflets with information on ReSPECT, AMBER Care Bundle, EOLC	-HPCT -EOLC team - ACB nurse - Ward teams	Macmillan Hub in WAHT	Reinvigoration of information provision required	To be reviewed annually

					June 2022
Promote the use of available technology to aid communication with staff, patients and those important to them when face-to-face visiting is not possible.	Use of iPads	-HPCT -EOLC team - Ward teams - IT teams	Wards have iPads in place		To be reviewed annually June 2022
Offer patients and those important to them written summaries of consultations and care plans.		-HPCT -EOLC team	Included in ILDoL	Encourage use	To be reviewed annually June 2022
Regularly review the responses to the VOICES survey of bereaved relatives to ensure families and carers are satisfied with care and follow up on any issues raised.	VOICES bereavement questionnaire & feedback from audit	-EOLC team - HPCT	VOICES reviewed and presented at HPCT team and directorate governance	To continue	To be reviewed annually June 2022
Regular engagement with Communications team within the Trust to keep staff up to date with End of Life Care approaches.		-HPCT -EOLC team	Current practice	To continue	To be reviewed annually June 2022
Engage with the public through initiatives such as 'Dying Matters' week.	Annual promotional week in May	-HPCT -EOLC team - ACB nurse	Stands in hospital pre-covid for Dying Matters	To be reviewed post COVID	To be reviewed annually June 2022

Reviewed: 19/5/2021

NHS
Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	15th July 2021
Paper number	

Integrated Performance Report – Month 2 2021/22

For approval:		For discussion:		For assurance:	X	To note:	

Accountable Director	Paul Brennan – Chief Operating Officer, Paula Gardner – Chief Nursing Officer, Mike Hallissey – Chief Medical Officer, Tina Rickets – Director of People & Culture, Robert Toole – Chief Finance Officer		
Presented by	Vikki Lewis – Chief Digital Officer	**Author /s**	Steven Price – Senior Performance Manager

Alignment to the Trust's strategic objectives (x)							
Best services for local people	X	Best experience of care and outcomes for our patients	X	Best use of resources	X	Best people	X

Report previously reviewed by		
Committee/Group	Date	Outcome
TME	23rd June 201	Approved
Finance and Performance	30th June 2021	
Quality Governance	1st July 2021	

Recommendations	▪ The Board is asked to note this report for assurance.

Executive summary

Emergency and Urgent care demand including discharge capability

The high demand for our emergency and urgent care services that accelerated over Apr-21 has continued throughout May-21. Week on week figures were, again, consistently high for ambulance attendances and walk-ins alike, paediatric attendances and across all categories. This level of demand is unprecedented with attendances at both WRH and ALX rising for the fourth consecutive month and both sites at the highest level in the last 19 months.

EAS performance was impacted by this level of demand with increased numbers of patients breaching the 4 hours standard. There were 6 12 hour trolley breaches in May and ambulance handovers in excess of 60 minutes increased in May-21 as did the hours spent by patients on our corridors.

Indicator	Apr-19	Apr-21	May-20	May-21	Apr/May 2019	Apr/May 2021	Variance
Type 1 ED Attendances	11,181	12,065	11,528	13,227	22,709	25,292	Up 2583 or 11%
MIU Attendances	5,739	4,003	6,050	4,664	11,789	8,667	Down 3122 or 27%
Ambulance Conveyances	4,586	4,840	4,519	5,122	9,105	9,962	Up 857 or 9%
ED Waits >4 hrs < 12 hrs	1,202	659	1,367	980	2,569	1,639	Down 930 or 37%
12 Hour DTA's	65	0	51	6	116	6	Down 110 or 95%
1 hour Ambulance Handover Delays	496	101	354	273	850	374	Down 476 or 44%
Type 1 4 hr Performance	64.48%	74.95%	65.96%	70.33%	n/a	n/a	n/a

So from the table above you can see ED attendances and ambulance conveyances are increasing yet MIU attendances are reduced; however 4 to 12 hour waits, ambulance 1 hour handover delays, 4 hour type 1 performance and 12 hour DTA's are all improved. We still have a lot to work on to achieve the standards we are aiming for but in the like for like year comparison you can see a real improvement.

The conversion rate of attendance to an inpatient bed has reduced further with both high numbers of minor activity and increased SDEC activity supporting this outcome.

However, the position remains that the flow out of the hospital has deteriorated with significant numbers of patients remaining in acute beds despite no longer needing acute care. Both sites have statistically high numbers of patients who are still on our wards 24 hours after being declared medically fit for discharge and bed days are being lost across simple and pathway discharges, particularly pathway 2 (Discharge to Assess for Rehabilitation/Reablement) and pathway 5 (palliative/ terminal diagnosis) patients.

WRH has shown special cause improvement in discharges before midday in May-21; although both sites still have some way to go to achieve the 33% target, there are wards consistently achieving the target and an increasing number are showing improvement from week to week.

Recovery and restoration of the elective programme including Outpatients and Diagnostics

The final version of the annual planning return, for the first 6 months of 21/22, was submitted by the ICS to NSHEI by the 3rd June deadline. We are now monitoring levels of activity against our H1 plan and targets and the ICS holds a weekly re-set and recovery meeting where an aggregated system view is shared and the Trust is held to account on delivery.

For the second consecutive month, the number of RTT patients waiting over 52 weeks for their first definitive treatment at the end of the month has reduced, from 6,271 to 5,935 (unvalidated), but unfortunately the over 70 week waiters within this cohort has increased from 1,879 to 2,337. The total waiting list has increased again as referrals continue to be made and now stands at 51,336 with the number of patients waiting over 18 weeks at 24,613.

In Apr-21, we achieved the day case and elective inpatient H1 targets and although activity has increased between Apr-21 and May-21 for both, we are marginally below plan by -96 (DC) and -48 (EL) but above the ERF target for both April and May. Consultant-led first outpatient appointments showed no change between Apr-21 and May-21 and the H1 targets were met in both months. When reviewing the contributions of face-to-face and non-face-to-face appointments, the former achieved

target in Apr-21 and May-21 and the latter in Apr-21; currently May-21 is below target by -139 attendances. Consultant-led follow-up outpatient appointments also showed no discernible change between Apr-21 and May-21 although the H1 target was only met in Apr-21. The difference from target in May-21 is being driven by -1,100 fewer non-face-to-face appointments then planned; there is evidence cited by Divisions that there are delays in recording the outcomes of these appointments; as such this position will improve if more appointments are outcomed.

Over 15,000 diagnostic tests were undertaken in May-21 in-line with the peak of phase 3 recovery recorded in Oct-20 and Nov-20. A subset of the DM01 modalities are monitored in the H1 activity plan. For radiology, CT and non-obstetric ultrasound achieved their H1 targets and showed an increase between Apr-21 and May-21, whereas MRI showed no change in activity and didn't achieve the activity targets. For endoscopy, all three modalities showed an increase in activity but only gastroscopy achieved an H1 target which was in Apr-21. Echocardiography is a new addition to our monitoring having not been part of phase 3; this modality has a decrease in activity between Apr-21 and May-21 and didn't achieve the activity targets.

Quality and Safety
Infection Prevention and Control
C. diff and E. coli BSI exceeded their in-month targets although C. diff does remain below the year to date cumulative target. All HCAI targets and trajectories have been set internally for 21-22 with national targets expected to be issued by July 21 which will supersede our local targets.

E. coli BSI is often related to factors outside acute healthcare, and it should be noted that we achieved a 38% reduction in 20-21, performing significantly better that the target of 50. The locally-set target for 21-22 has set an ambitious further 10% reduction on 20-21 performance.

Sepsis
Sepsis 6 screening compliance performance rose in Apr-21 to be above the mean, after three months below it. Revised documentation is being introduced which make the process of identification easier and an update on progress will be provided in October.

Never Events
A further Never Event occurred in May-21 following the 2 reported in Apr-21 and was because an incorrectly inserted NG tube resulted in feed delivery into the lungs. This event is also subject to Serious Incident investigation.

Maternity
The Digital Informatics team concluded their investigation in to the identified data quality issues and have updated the metrics in the IPR to include Apr-21 and May-21 values. Recommendations have been made

to the service on how amendments to the processes that underpin data capture in Badgernet can address these issues e.g. correct recording of antenatal and postnatal only care and non-Trust deliveries. Alongside this, a thorough review of neonatal deaths ratified those identified through data logic.

As well as late fetal losses and stillbirths, any liveborn baby (born at 20^{+0} weeks) who died before 28 completed days after birth is reportable to MBRRACE-UK. However, MBRRACE-UK only publish mortality data for those liveborn babies born at 24^{+0} weeks gestational age[1] and so this is the approach adopted in reporting neonatal deaths in the IPR. No neonatal deaths were reported in Apr-21 and, currently, there are none reported for May-21; however, please note that at the time of writing, 28 completed days for births between the 20th and 31st May has yet to elapse.

People & Culture
Progress with getting the basics right continues this month with improvement in appraisal, mandatory training and job planning compliance, albeit we are still below model hospital average for job planning.

There are a number of workforce challenges that have contributed to the increase in premium staffing costs this month. We have seen an increased in the run rate for non-covid sickness absence (increase of 0.47% this month), the number of staff in post has reduced by 36 WTE and there are 40 more staff on maternity leave when compared to the start of the pandemic. To address this we are focusing on the management of short term sickness absence, increasing the number of domestic recruitment campaigns and the block booking of bank staff.

Our vacancy rate has increased to 10.1% due a further increase in establishment of 16 WTE. The detail behind the increase in establishment since 1st April 2021 will be considered by the Finance & Performance Committee in July 2021.

Our Financial Position

NHSI Financial Framework 21/22
Due to the continuing Covid-19 pandemic, a revised Covid-19 financial framework will be in place for H1 21/22. System funding envelope, comprising adjusted CCG allocations, system top-up and Covid-19 fixed allocation, based on the H2 2020/21 envelopes adjusted for known pressures and policy priorities. Block payment arrangements will remain in place and signed contracts between NHS commissioners and NHS providers are not required for the H1 2021/22 period.

[1] Source: https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/perinatal-surveillance-report-2018/MBRRACE-UK_Perinatal_Surveillance_Report_-_Technical_document.pdf

NHS England and NHS Improvement have nationally calculated CCG and NHS provider organisational plans for the H1 period as a default position for systems and organisations to adopt.

Financial Plan

The 2021/22 operational financial plan for H1 has been developed from a roll forward of the recurrent cost and non-patient income budget from 2019/20 adjusting for an assessment of PEP delivery in 2020/21 and the recurrent impact, identification of cost pressures and an assessment of legacy and approved business cases in 2020/21. We have then overlaid the impacts of additional Covid expenditure (and additional Covid income) and PEP schemes developed by the Divisions. The final step has been to adjust for vacancy factors, activity levels lower than 2019/20 and any slippage in Business cases. Our submission to the system was a £(2.9)m deficit for H1.

Against the H1 operational plan £(2.9)m, in month 2 (May 2021) we report an actual surplus of £0.7m against the plan £(0.8)m deficit. Positive variance of £1.5m.

The combined income position was £1.3m favourable to plan of which £1m was Elective Recovery Fund income recognised in month.

Favourable variances against operating expenses (£0.4m) largely driven by activity and slippage to the overseas nurse recruitment programme.

Adverse variances against employee expenses (£0.3m) of which £0.2m relates to retrospective shifts added to the Medics booking system. This has been escalated to HR.

£8.9m additional System Covid/top up payment was received from Commissioners to cover additional costs of Covid and to fulfil the STP breakeven requirement.

Given the positive variance in YTD across the system (£3.1m), system CFOs have agreed to offset beneficial variances position to the unmitigated system risk in H1 (£6.4m). A further assessment of ERF achievement has been performed following the recent activity submissions. Our H1 revised plan, inclusive of ERF is a £1.1m surplus. Excluding ERF this would be a £(1.1)m deficit.

Cash

At the end of May 2021 the cash balance was £33.5m. The high cash balance is the result of the timing of receipts from the CCG's and NHSE under the current payment arrangement as well as the timing of supplier invoices.

Capital

Capital expenditure for month 2 of financial year 2021/22 is £3.4m, with

NHS
Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	15th July 2021
Paper number	

	the majority relating to spend on projects carried over from the previous financial year. The 2021/22 Capital Plan is £51.69m for the financial year, including IFRIC 12. This is inclusive of the in-year works on the new Urgent and Emergency Care scheme, plus the ASR project subject to Full Business Case national approval. The share of the remaining capital envelope is being prioritised across the work streams to ensure we address regulatory risks, infrastructure backlog and to replace end of life equipment.

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	1,2,3,4,5, 7,8,10, 11, 12 and 13

Assurance Level (x)	0		1		2		3		4	X	5		6		7		N/A	
Financial Risk	*N/A*																	

Action						
Is there an action plan in place to deliver the desired improvement outcomes?	**Y**		**N**		**N/A**	X
Are the actions identified starting to or are delivering the desired outcomes?	**Y**		**N**			
If no has the action plan been revised/ enhanced	**Y**		**N**			
Timescales to achieve next level of assurance						

Recommendations
▪ The Board is asked to note this report for assurance.
Appendices
▪ Trust Board Integrated Performance Report (May-21 data) ▪ WAHT May 2021 in Numbers Infographic ▪ Committee Assurance Statements

Integrated Performance Report

Trust Board

15th July 2021

Best services for local people, Best experience of care and Best outcomes for our patients, Best use of resources, Best people

Summary Performance Tables | Month 2 [May] 2021-22

NHS Worcestershire Acute Hospitals NHS Trust

Performance Metrics		Latest Month	Measure	Target	Performance	Assurance	Mean	Lower process limit	Upper process Limit
EAS	4 Hours (all)	May-21	77.73%	95%			83%	76%	90%
	15-30 minute Amb. Delays	May-21	776	0			963	647	1,278
	30-60 minute Amb. Delays	May-21	303	0			189	9	369
	60+ minutes Amb. Delays	May-21	273	0			104	-56	265
RTT	Incomplete (<18 wks)	May-21	52.01%	92%			74%	69%	78%
	52+ WW	May-21	5,920	0			1032	520	1,544
CANCER	2WW All	May-21	81.20%	93%			85%	72%	97%
	2WW Breast Symptomatic	May-21	5.10%	93%			46%	7%	85%
	62 Day All	May-21	67.19%	85%			71%	58%	83%
	104 day waits	May-21	78	0			50	16	84
	31 Day First Treatment	May-21	98.05%	96%			97%	93%	101%
	31 Day Surgery	May-21	92.30%	94%			88%	65%	110%
	31 Day Drugs	May-21	90.90%	98%			98%	87%	109%
	31 Day Radiotherapy	May-21	96.20%	94%			99%	91%	107%
	62 Day Screening	May-21	68.40%	90%			74%	36%	113%
	62 Day Upgrade	May-21	93.70%	90%			81%	52%	110%
Diagnostics (DM01 only)		May-21	57.26%	99%			78%	67%	89%
STROKE	CT Scan within 60 minutes	Apr-21	34.38%	80%			46%	20%	72%
	Seen in TIA clinic within 24hrs	Apr-21	91.30%	70%			87%	62%	113%
	Direct Admission	Apr-21	39.06%	90%			46%	16%	77%
	90% time on a Stroke Ward	Apr-21	78.13%	80%			76%	62%	91%

Quality and Safety Metrics		Latest Month	Measure	Target	Performance	Assurance	Mean	Lower process limit	Upper process Limit
Infection Prevention	C-Diff	May-21	5	4			4	0	9
	Ecoli	May-21	4	4			5	0	10
	MSSA	May-21	0	0			2	0	6
	MRSA	May-21	0	0			0	0	1
Hospital Acquired Pressure Ulcers: Serious Incidents		May-21	0	-			0	0	2
Falls per 1,000 bed days causing harm		May-21	0.1	0.04			0	0	0
% medicine incidents causing harm		May-21	6.25	11.71			10	2	19
Hand Hygiene	Hand Hygiene Audit Participation	May-21	91.82	100			90	76	103
	Hand Hygiene Compliance to practice	May-21	99.53	98			99	99	100
VTE Assessment Rate		May-21	96.67	95			96	94	98
Sepsis	Sepsis Screening compliance	Apr-21	85.52	95			83	70	96
	Sepsis 6 bundle compliance	Apr-21	50	95			51	23	78
#NOF time to theatre <=36 hrs		May-21	77.19	85			79	61	97
Mortality Reviews completed <=30 days		Nov-20	35.5	-			43	20	67
HSMR 12 month rolling average		Feb-21	98.34	-			105	102	108
Complaints responses <=25 days		May-21	89.74	80			76	42	111
Ice viewed reports	ICE viewed reports [pathology]	Apr-21	95.79	-			96	94	98
	ICE viewed reports [radiology]	Apr-21	82.89	-			85	81	89

Operational Performance

Data Quality Risk Matrix – Operational Performance

Data Set	Includes	Likelihood	Impact	Total Score	Context
Urgent Care	• EAS • EAS Type 1 • Total Time in A&E • Bed Capacity • 30 day re-admission rate • Aggregated patient delay • Conversion Rate • 15 minute time to triage	2	3	6	These metrics have regular scrutiny including at patient level. There are audits completed so are calculations based on metrics further down the list.
Urgent Care Exception	Ambulance Handover	2	2	4	We use WMAS data to report on handovers. This data is audited regularly and although there are on the odd occasion differences of 1 or 2 ambulances these are over the change of midnight.
	12 Hour Trolley Breaches	4	2	8	These are reviewed at patient level daily but we still have a number of patients where DTA times are incorrectly recorded, thus indicating a breach which is then validated off and the patient record amended. This has been an issue for a number of years. **Mitigation:** Identify a new location for the data that keeps erroneously being entered, and refresh the knowledge of the standard operating procedure.
	Specialty Review	4	2	8	There are several issues with this data. Timeliness of data capture, accurate data capture of referrals and in particular missing times of arrival. The issue is the allocation of a responsible person(s) for capturing accurate times. This has been an issue for a number of years. **Mitigation:** No clear mitigation until a deep dive has been reviewed in Home First Board.
	Discharges (including Discharges before midday)	3	3	9	This does not impact the patient. This data quality score impacts the ability for the Trust to manage beds using our clinical systems. Whether a patient has been discharged predominantly is shared verbally as opposed to using the real time data from the patient administration system. Timeliness is impacted by administrative staff not being available (particularly during the evening), complexity with the electronic discharge documentation and system configuration. **Mitigation:** A review of administrative cover to be completed and potential improvements to be made as part of the Digital DCR Programme, but impact may not been seen until implementation.

Data Quality Risk Matrix – Operational Performance

Data Set	Includes	Likelihood	Impact	Total Score	Context
Cancer	• 2WW Referrals • 2WW All • 2WW Breast Symptomatic • 31 Day All • 62 Day All • 62+ day • 104+ day	2	3	6	Cancer Services data has recently been reviewed externally and was rated good. The data is captured in a timely manner and is complete.
RTT	• % Within 18 weeks • 40-52 weeks wait • 52+ weeks wait • RTT Referrals	3	4	12	There are several small issues in RTT waiting list management and reporting. However these collectively have resulted in some patients not being managed effectively; and long waits not being transparent facilitating the potential for harm. **Mitigation:** We have been undertaking a systematic review of reporting which will be accompanied by a training programme to ensure that patients are managed in compliance with RTT rules. This will be in place by the end of June 2021 and after a period of testing it is expected that this score would decrease to no more than 4.There is also a national data quality programme on waiting lists which will support Trusts with planning data quality improvements where needed. This will include NON RTT'
Theatre Utilisation	• % Actual theatre sessions • Day cases on elective sessions (n) • Elective on Elective sessions (n) • Non-elective and Emergencies on elective sessions (n) • % rebooked within 28 days	3	1	3	Although data quality is possible, the impact is more on the performance reporting than a risk to the patient hence the consequence score is a 1.
Theatre Utilisation Exception	• % Cancellation on the day	3	3	9	The cancellation process is quite complex and involves a number of clinical systems for the data to be captured across. This means that data capture issues are possible and the impact on the patient could mean that they are not invited back for Surgery. **Mitigation:** There is a detailed report which highlights potential data quality issues that should be reviewed regularly by operational colleagues.

Data Quality Risk Matrix – Operational Performance

Data Set	Includes	Likelihood	Impact	Total Score	Context
Diagnostics	• Radiology waiting list size • Radiology Activity • Endoscopy waiting list size • Endoscopy Activity	2	3	6	Detailed scrutiny at patient level regularly by the Division. Mitigation : Detailed reporting including potential data quality errors on WREN.
Stroke	• % patients spending 90% of time on stroke unit • % seen in TIA clinic within 24 hours • % Direct admission to stroke ward • % CT Scan within 60 mins	1	3	3	The data is scrutinised heavily by the Division and underwent a significant review within the last 2-3 years so currently there are no known issues. An audit of Stroke will occur again within the next financial year.

Operational Performance Report - Headlines

Operational Performance	Comments
Urgent care and patient flow including Home First Worcestershire	• In May-21, the Trust saw a further increase in the number of patients attending our sites, both via ambulance conveyance and walk-ins with children and young people attendances contributing 24% of the total; there were notable increases in the presentation of respiratory complaints, self-harm and injury to limbs compared to May-19. • 4 hour EAS and ambulance handover show special cause concern for May-21 whilst 12 hour breaches continue to show normal variation; however those metrics are an improved position compared to May-19 despite the increase in attendances. • The pressure remains on both hospital sites to manage bed capacity and patient flow, particularly to discharge patients before midday and support our long length of stay and medically fit for discharge patients to leave the hospital when they no longer need an acute hospital bed. Our wards are showing early signs of being able to achieve the 33% target but lost bed days to non-simple pathways when medically fit remains a contributing factor to hindering patient flow.
Cancer	• Overall cancer referrals in May-21 have remained in line with Apr-21 following the peak in Mar-21 although colorectal and skin have seen their high volumes sustained for a third month. • Cancer two week waiting times have not changed significantly in the last ten months with Breast Services and Skin not to be able to see the majority of their patients within two weeks. • An in-sourcing solution for the Breast backlog has been agreed and a similar option (albeit a different supplier) is being explored to support Skin. • Although still normal variation, cancer two week waits for Breast Symptomatic remains a concern with the majority of patients still not being seen within 14 days. • Cancer 62 day waits is showing normal variation. Performance will not improve to the operational standard whilst we rightly focus on the cohort of patients requiring treatment. • **Long Waits:** The backlog of patients waiting over 62 days has increased to 231 from 211 and although those waiting over 104 days has decreased to 81 it is not at the rate seen in 2020.
RTT	• The RTT waiting list size remains a cause for concern. Although Advice and Guidance and RAS triage will be offsetting some new referrals, our waiting list is growing. RTT simulation modelling shows that if we deliver the activity plan as currently envisaged 52 week plus waits for treatment will decrease but 52 week plus waits for first outpatient referrals will increase. • **Long Waits:** At the end of May-21, the total RTT waiting list increased to 51,005 and the number of patients waiting over 18 weeks to 24,477. The number of waiting over 52 weeks for their treatment has reduced to 5,920 however 2,318 of those patients have been waiting over 70 weeks and the profile of this cohort has changed with 24% of our longest waiters requiring T&O surgery and oral / orthodontic surgery decreasing to 22% from 31% in Apr-21.
Outpatients	• May-21 saw 37,015 outpatient attendances take place (consultant and non-consultant led) which is in-line with the number seen in Apr-21 where the H1 target was achieved; currently May-21 is -589 to target. Comparing to May-19 shows we undertook approximately 73% of historic activity and 32% of May-21 appointments were non-face-to-face whilst in May-19 it was only 3%. • Consultant-led first outpatients attendances were above the H1 targets in Apr-21 and May-21; the follow-up attendances target was achieved in Apr-21 but currently -493 to target in May-21
Theatres	• In Apr-21, we achieved the day case and elective inpatient H1 targets and although activity has increased between Apr-21 and May-21 for both, we are marginally below plan by -96 (DC) and -48 (EL) but above the ERF target for both April and May • Some patients are being rebooked within 28 days following the cancellation of their surgery and although lower numbers of cancellations are happening than pre-pandemic, we are not achieving the standard of rebooking all of them. • The Independent Sector decreased their day case and elective activity from 128 in Apr-21 to just 43 in May-21.
Diagnostics	• Diagnostic testing remains a cause for concern; the process is currently not capable of achieving the 1% target. The proportion waiting under 6 weeks has increased and although activity has increased from Apr-21 to May-21 (to the level seen in phase 3) we did not achieve all the H1 submitted targets. • **Long Waits:** 4,952 patients are waiting over 6 weeks for their diagnostic test and of the total number of breaches, 2,366 have been waiting over 13 weeks and 58% are attributable to DEXA and echocardiography

Operational Performance: Urgent care and patient flow including Home First Worcestershire

2.4 - Complete the implementation of Home First Worcestershire to eradicate corridor care and minimise ambulance handover and admission delays

12 Hour Breaches	Ambulance Handover Delays (Home First Programme metric)			Average Bed Occupancy (midnight)			
	15-30 mins	30-60 mins	60+ mins				
6	871	380	273	WRH	85.85%	ALX	53.88%

What does the data tell us?

- **EAS** - The overall Trust EAS performance which includes KTC and HACW MIUs was 77.73% in May-21, compared to 81.00% in April-21. There was an 11% increase in attendances across all settings.
- **EAS Type 1 -** The EAS performance at WRH decreased by 4.21 percentage points with 652 **more** ED attendances and 540 **more** 4 hour breaches than April-21 (May-21 breaches were 2,844). The ALX EAS decreased by 5.35 percentage points, with 513 **more** attendances and 362 **more** 4 hour breaches (May-21 breaches were 5,341). Total Type 1 attendances across ALX and WRH were 13,227; a **9.6%** increase on the previous month.
- **CYP Attendances**: 24% of all attendances in May-21 were children and young people. Comparing to May-19, the top presenting complaints remained the same i.e. injury to limb; however fever, shortness of breath, noisy breathing and difficulty breathing combined showed a 75% increase and although low numbers, there was a 112% increase in attendances with presentation of self-harm (8 to 17).
- **Ambulance Handovers** - There were 273 x 60 minute ambulance handover delays with breaches at both sites.
- **12 hour trolley breaches –** There were six validated 12 hour trolley breaches in May-21
- **Specialty Review times** – Specialty Review times are now highlighted as a cause for concern with 7 consecutive months below the mean; the target cannot be met.
- **Discharges** – Before 12pm discharges (on non-COVID wards) is showing no significant change however the process will not achieve the target of 33% at either site The number of patients with a length of stay in excess of 21 days decreased from 51 (at 31st March) to 44 with 16 patients being MFFD.
- **Total Time in A&E:** The 95th percentile for patients total time in the Emergency departments has increased from 619 in April-21 to 743 in May-21. This metric remains within normal variation but the process is unlikely to consistently achieve our target of 380 minutes.

What have we been doing?

Clinical Site Management

- Process in place means golden patient's beds identified the day before at 3.30pm will be pulled to the Discharge Lounge early the following morning
- All new SOPs now embedded in the weekend plans
- Discharge lounge moving back to Evergreen; it was previously on Laurel 1 whilst works being completed

Acute Patient Flow

- Divisions providing the number discharges for the next day at the 15:30 bed meetings (patients to have TTOs and discharge letters completed) to help them achieve 33 percent of discharges before midday
- Three times weekly LLOS review for all patients over 17 days on WRH combining the R2G/ SAFER focus with LLOS.

Acute Front Door

- Provided activity from Alex site outlining the increased primary care demand to GP and CCG colleagues to agree action plan for addressing.
- The Acute Physician substantive post advert is currently with RCP for approval and there is an advert out for locum consultants in the interim
- WMAS handover SOP in draft, awaiting approval and inclusion in escalation policy
- Progress Chasers: data from PDSA cycle showed process not yet embedded as intendeds o matron providing an action plan to push this forward.

Frailty

- ED recording CFS Scores – currently 73% recorded for eligible patients
- Development of QI Project to trial Frailty Care Bundle in T&O #NOF Pathway to support a frailty sensitive approach as currently no Ortho-geriatrician support linked to Reconfiguration Programme - Relocation of Inpatient Trauma
- Participation in the NHSEI project to promote identification of those living with severe frailty with PCN's

8

Operational Performance: Urgent care and patient flow including Home First Worcestershire

2.4 - Complete the implementation of Home First Worcestershire to eradicate corridor care and minimise ambulance handover and admission delays

Total time in A&E – 95th percentile (Target – 360 mins)	Overnight Bed Capacity Gap (Target – 0)	30 day re-admission rate (Dec-20)	Aggregated patient delay (APD) (Target – 0)	Discharges as a % of admissions IP only (Target >100%)			
743	37 Beds	3.09%	529	WRH	98.87%	ALX	98.18%

What does the data tell us?

- **Bed Capacity** - Our G&A bed base is 761; with closed wards and unused beds during Apr-21 our average number of G&A beds occupied per day was 570, up from 552 the month before and the average occupancy was 74.48%.
- **The 30 day re-admission rate** shows no significant change since Jun-20; the process limits have widened and this indicates a change during COVID-19 that we have not yet got control of.
- **Aggregated patient delay (total time in department for admitted patients only per 100 patients – above 6 hours) –** this indicator remains at normal variation for April-21 but the process still indicates we cannot achieve the target of zero.
- **Conversion rates** – 3,553 Type 1 patients were admitted in May-21; a Trust conversion rate of 28.51%. The conversion rate at WRH was 29.40% and the ALX was 24.58%. The conversion rate at WRH in April-21 compared to April-20 is 5.37 percentage points lower.
- **15 minute time to triage –** The Trust performance is 88.53%, showing no significant change; the process will not consistently achieve the target of 95% consistently but may be expected to vary between 88% and 97%. It is the same at site level, with no significant change for WRH or ALX.

What are we doing next?

Clinical Site Management

- Discharge Lounge - progress proposals for change of shift pattern once all staff in post
- Reinstate the regular CSM Quality and Governance meetings and report into S&RG regarding site governance issues / learning
- Work with the CSM transformation group to understand route causes of why KPIs are unable to be maintained and identify solutions to address

Acute Patient Flow

- Continue to support ward areas daily in educating and supporting the completion of white boards with all appropriate information
- Surgery have agreed the clinical patient pathways to support CLD for each of their specialities.. Other clinical pathways are to be identified including vascular and head & neck.

Acute Front Door

- Advertise posts in ED at the Alex and take forward campaign ensuring posts advertised with recruitment options cross county
- Recruitment for interim locum Acute Medicine Consultants pending long term recruitment of substantive consultants.
- Progress Chasers: first breach code analysis via audit completed showed low adherence to standards, 2nd audit to be completed now better engagement with the process.

Frailty

- QI Project Standardising the Advanced Clinical Practitioner (ACP) Role in WAHT scoping completed. Decision awaited re governance and links with ICS Academy
- Align GEMS with BGS Silver Book II specifically during the first 72 hours of an urgent care episode

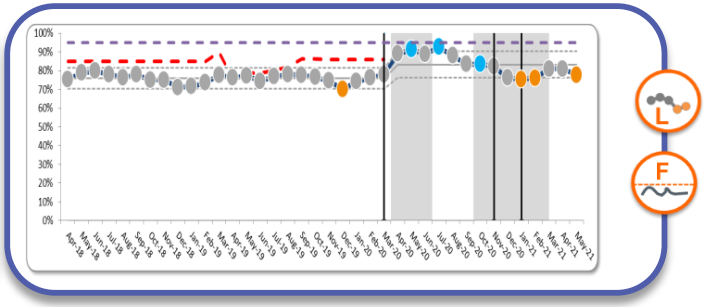
Current Assurance Level: 5 (May-21)	**When expected to move to next level of assurance:** This is dependent on the on-going management of the increase attendances and achieving operational standards.
Previous assurance level: 5 (Apr-21)	**SRO: Paul Brennan**

Month 2 [May] | 2021-22 | Operational Performance: Urgent Care & Patient Flow

Responsible Director: Chief Operating Officer | Validated for May-21 as 17th June 2021

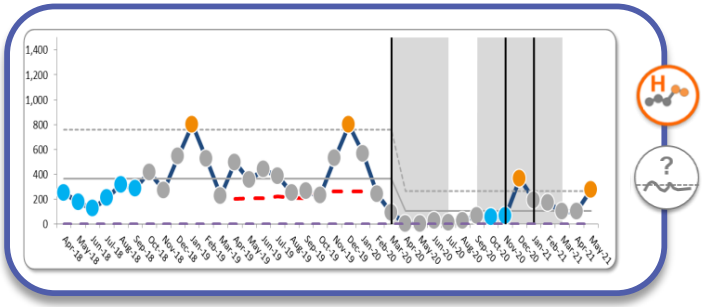
4 Hour EAS (all)

81.00%



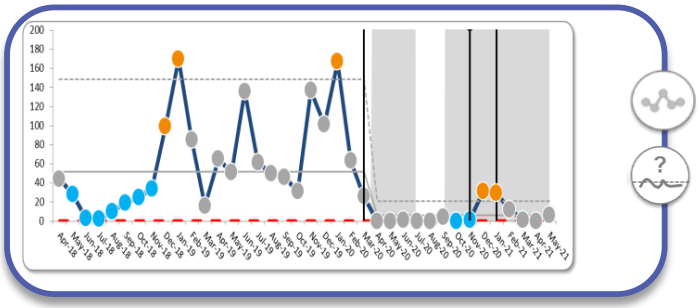
60 minute Ambulance Handover Delays

273



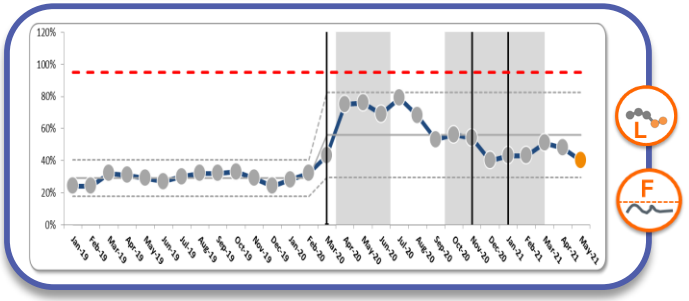
12 Hour Trolley Breaches

6



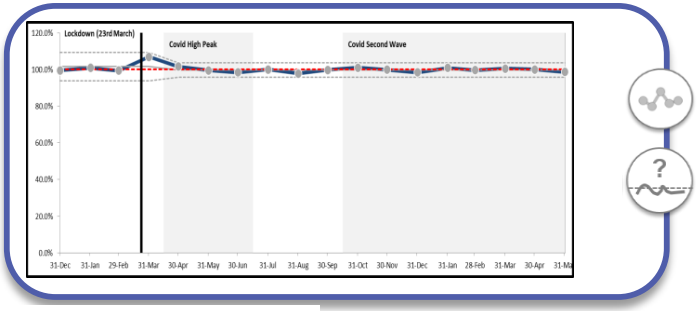
Specialty Review within 1 hour

48%



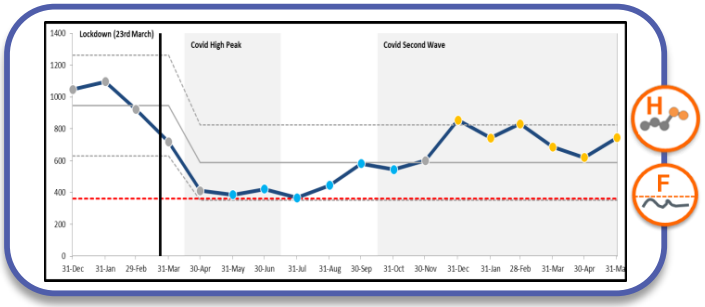
Discharge as a percentage of admissions

98.65%



Total time spent in A&E (95th Percentile)

743



Please note: These SPC charts have been re-based to evidence if any changes in performance, post the initial COVID-19 high peak, are now common or special cause variation.

Key

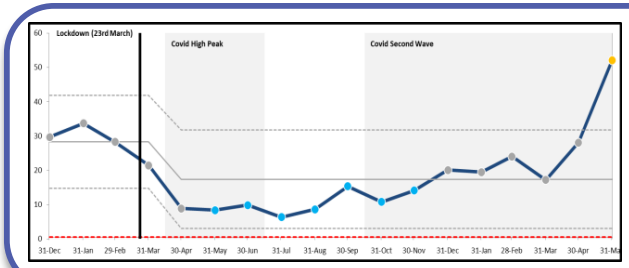
- Internal target
- Operational standard

Month 2 [May] | 2021-22 | Operational Performance: Urgent Care & Patient Flow

Responsible Director: Chief Operating Officer | Validated for May-21 as 17th June 2021

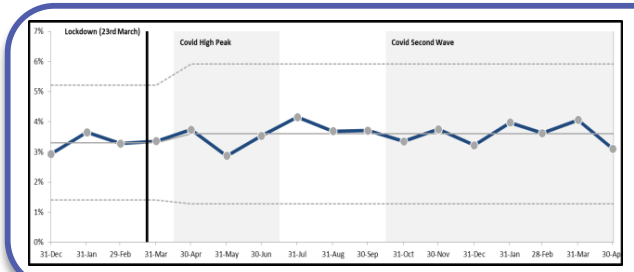
Capacity Gap (Daily avg. excl. EL)

51.58



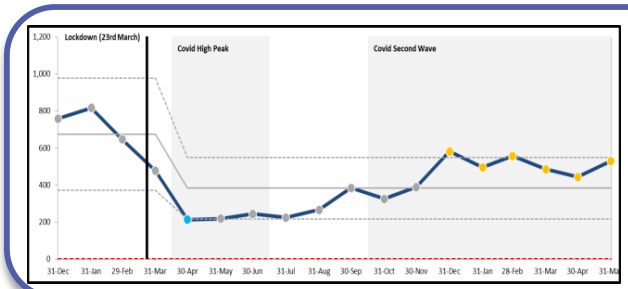
30 day readmission rate for same clinical condition

3.09%



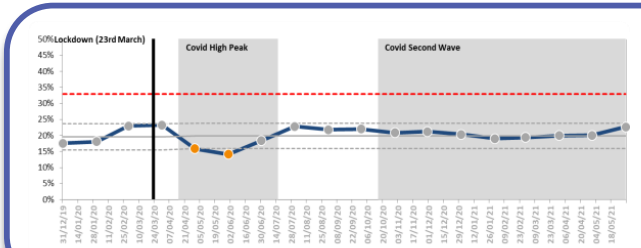
Aggregated Patient Delay (APD)

529



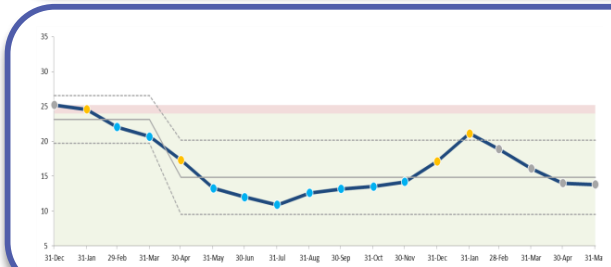
% Discharges before midday (non-COVID wards)

22.71%



Average LOS in hours in AMU – Zone 2 (in hours) (Trust)

13.8



Please note: These SPC charts have been re-based to evidence if any changes in performance, post the initial COVID-19 high peak, are now common or special cause variation.

Key

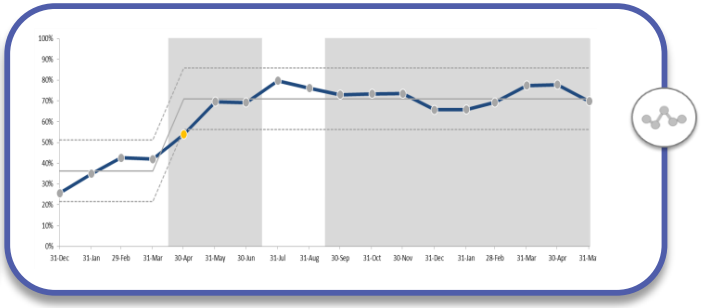
- Internal target
- Operational standard

Month 2 [May] | 2021-22 | Operational Performance: Urgent Care & Patient Flow – New ED Metrics

Responsible Director: Chief Operating Officer | Validated for May-21 as 17th June 2021

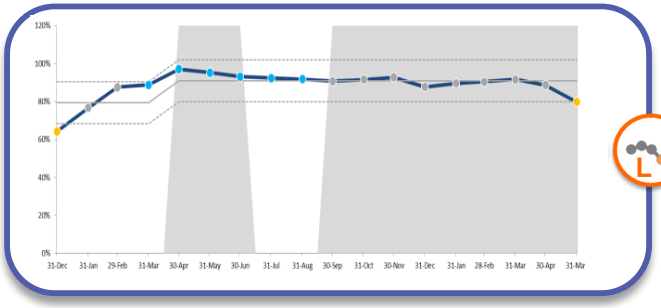
Percentage of Ambulance handover within 15 minutes

69.79%



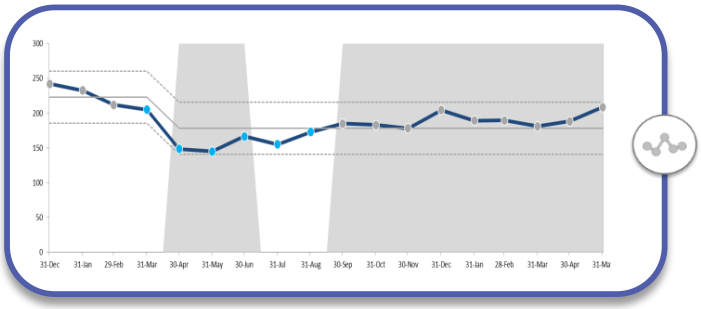
Time to Initial Assessment - % within 15 minutes

79.71%



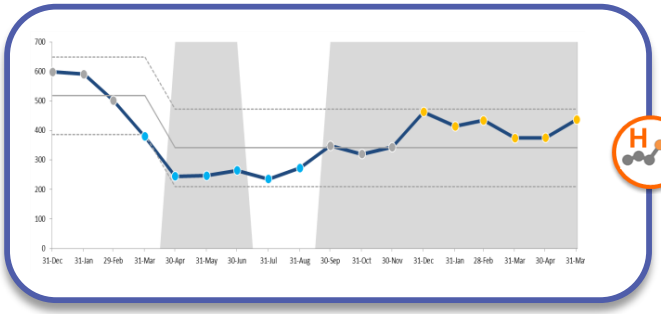
Average time in Dept for Non Admitted Patients

208



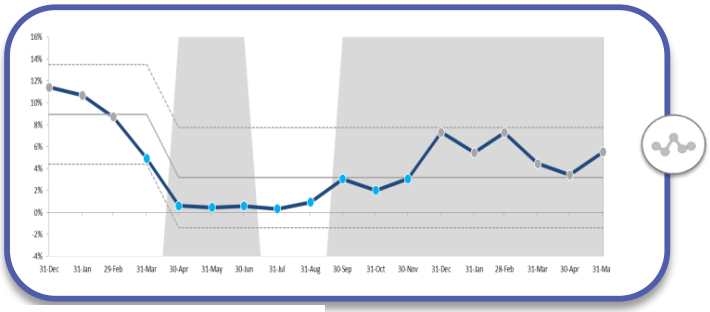
Average time in Dept for Admitted Patients

437



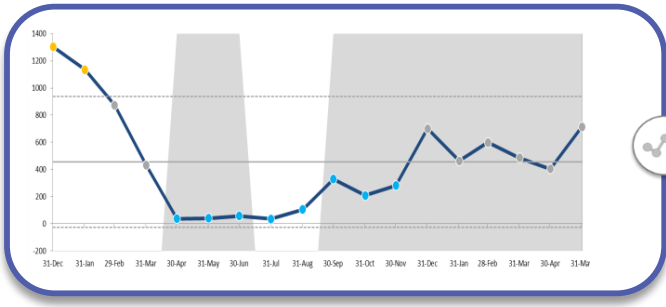
% Patients spending more than 12 hours in A&E

5.50%



Number of Patient spending more than 12 hours in A&E

714



Please note: These SPC charts have been re-based to evidence if any changes in performance, post the initial COVID-19 high peak, are now common or special cause variation.

Key

- Internal target
- Operational standard

Operational Performance: Urgent Care Benchmarking

2.4 - Complete the implementation of Home First Worcestershire to eradicate corridor care and minimise ambulance handover and admission delays

National Benchmarking (May 2021)

EAS (All) -The Trust was one of 12 of 13 West Midlands Trust which saw a decrease in performance between Apr-21 and May-21 This Trust was ranked 8 out of 13; no change from the previous month. The peer group performance ranged from 65.58% to 92.24% with a peer group average of 77.74%; declining from 80.53% the previous month. The England average for May-21 was 83.70% a -1.7% decrease from 85.40% in Apr-21.

EAS (Type 1) - The Trust was one of 12 of 13 West Midlands Trust which saw a decrease in performance between Apr-21 and May-21 This Trust was ranked 8 out of 13; no change from the previous month. The peer group performance ranged from 57.12% to 89.68% with a peer group average of 69.73%; from 73.27% the previous month. The England average for Mar-21 was 76.90% a 7.2% increase from 69.73% in Feb-21.

In May-21, there were 694 patients recorded as spending >12 hours from decision to admit to admission. 6 of these patients were from WAHT; 0.86% of the total.

EAS – % in 4 hours or less (All) – May-21

EAS – % in 4 hours or less (Type 1) – May-21

EAS – % in 4 hours or less (All) – April - 21

EAS – % in 4 hours or less (Type 1) – April-21

WAHT — Operational Standard 95%

Operational Performance: Cancer

2.4 - Ensure timely access to diagnostics and treatment for all urgent cancer care

NHS Worcestershire Acute Hospitals NHS Trust

Cancer Referrals	Patients seen within 14 days (2WW | All Cancers)		Patients seen within 14 days (2WW | Breast Symptomatic)		Patients treated within 31 days		Patients treated within 62 days		Total Cancer PTL	Patients waiting 63 days or more	Of which, patients waiting 104 days or more
2,144	81.20%	2,357 seen	5.10%	98 seen	98.05%	257 treated	67.19%	160 treated	2,715	231	81

What does the data tells us?

- **Referrals:** We received 2,365 referrals in May-21 , this is within a normal range for the Trust. Skin, Gynae and Lower GI are higher than the previous month and after the peak in Mar-21, Breast has returned to fewer than 300 referrals in a month (as seen between May-19 and Aug-20).
- **2WW:** The Trust saw 82 more patients in May-21 than April-21 and 81.20% were within 14 days. The Breast service saw 316 patients but only 7.28% were within 14 days. Of the 403 breaches, 316 (78.4%) were attributable to Breast Services. Across all tumour sites, only 38 2WW breaches were due to patient choice.
- **2WW Breast Symptomatic:** The Trust saw no significant change in patients referred for breast symptoms and the waiting time performance is 5.10%.
- **31 Day:** Of the 257 patients treated in May-21, 252 waited less than 31 days for their first definitive treatment from receiving their diagnosis. Even though the CWT target has been achieved, this metric is showing significant variation as it a run of 7 points below the mean and although the process is still capable of achieving the target it is not consistent.
- **62 Day:** There have been 160 recorded first treatments in May-21 to date and 67.19% within 62 days. This does continue the trend of no significant change in variation since Aug-19 and, currently, the 85% target is not achievable.
- **Cancer PTL:** As at the 31st May there were 2,715 patients on our PTL with 146 having been diagnosed and 1,502 still suspected. The remaining 1,078 patients were between 0-14 days.
- **Backlog:** Of the 2,715 patients, the number waiting 62+ days for their diagnosis and, if necessary, treatment increased from 211 in April-21 to 231 in May-21; of that cohort, the number of patients waiting 104 days or more is 81, 26 diagnosed and 55 suspected; this metric cannot currently meet the target of zero.
- **Conversion rates:** In 2019/20 the Trust's conversion rate from referral to positive diagnosis was 9.25% across all specialties. In 2020/21 our conversion rate is 11.07%.

What have we been doing?

- Breast and Skin continued to drive the 2ww underperformance in May 2021 with capacity related challenges for both.
- Breast now have an approved plan to eradicate the backlog via the use of Your Medical Services to reduce the current polling of 21 days to 7 days with additional clinics over 4 weekends during July and August 2021, whilst Skin are looking for a similar resolution via the use of Medinet.
- Concerns have been raised regarding the timely availability of some diagnostic tests, most notably MRI and Endoscopy, these have been escalated to SCSD divisional management for resolution / recovery.
- 31 day first treatment performance continues to improve and subject to final validation should see us having achieved the target two months running.
- The 62 day underperformance continues to be driven by most specialties with the current exceptions of Gynaecology, Haematology and Skin, with this due to a combination of delays to the 2ww or diagnostic pathways or delays to delivering treatments (surgery) or both.
- It should be noted however that a number of specialties have improved their 62 day performance in April 2021 mostly notably Breast, Colorectal and Upper GI.

What are we doing next?

- Continuing to monitor 2ww referral levels which remained consistent with the previous month during May dropped overall but remained very high for both Colorectal and Skin for the third month in a row. Also monitoring the conversion rates by specialty as an early warning for the 31 day and 62 day standards, but to-date these ratios are holding.
- Continued expansion of the use of the ALX for cancer treatment and the recommencement of the more wider piece of work (paused during the pandemic) concerning surgical reconfiguration.
- Prioritisation of available theatre lists / elective beds now established via the Restoration Group who allocate capacity on a service (backlog) priority as opposed to individual patient basis going forwards.
- Reinstatement of key Performance Management Group (PMG) meeting with focus on producing meaningful Remedial Actions Plans (RAPs) by speciality for recovery of the cancer performance standards.
- Work continues on the operational plan for the next 12 months in line with National guidance.

Current Assurance Levels (May-21)	Previous Assurance Levels (Apr-21)
2WW – Level 5	2WW - Level 5
31 Day Treatment - Level 5	31 Day Treatment - Level 5
62 Day Referral to Treatment – Level 5	62 Day Referral to Treatment - Level 4

When expected to move to next levels of assurance: when we are consistently meeting the operational standards of cancer waiting times and the backlog of patients waiting for diagnosis / treatment starts to decrease

SRO: Paul Brennan

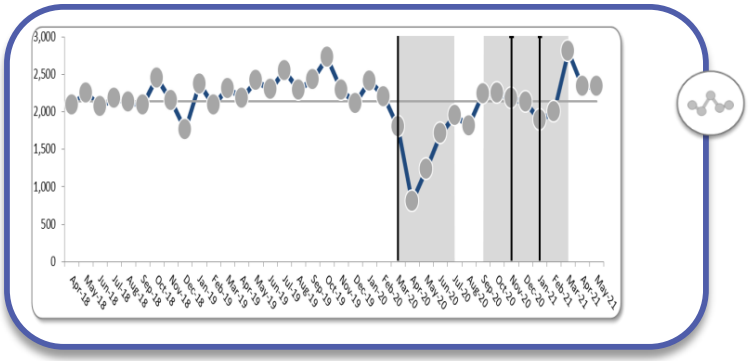
Month 2 [May] | 2021-22 | Operational Performance: Cancer

Responsible Director: Chief Operating Officer | Unvalidated for May-21 as 17th June 2021

NHS Worcestershire Acute Hospitals NHS Trust

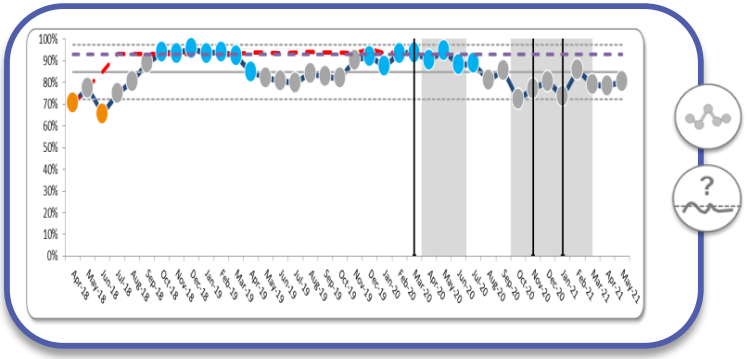
2WW Referrals

2,365



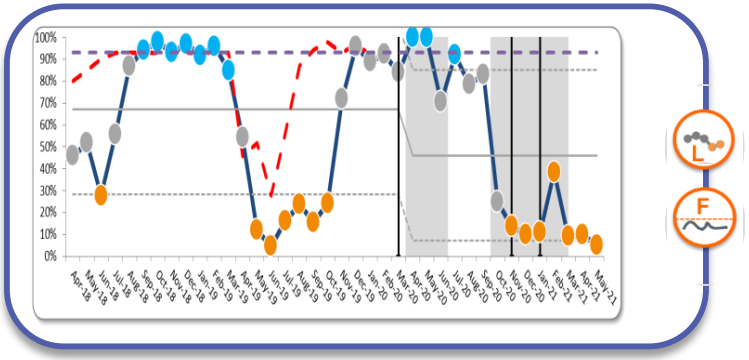
Cancer 2WW All

81.20%



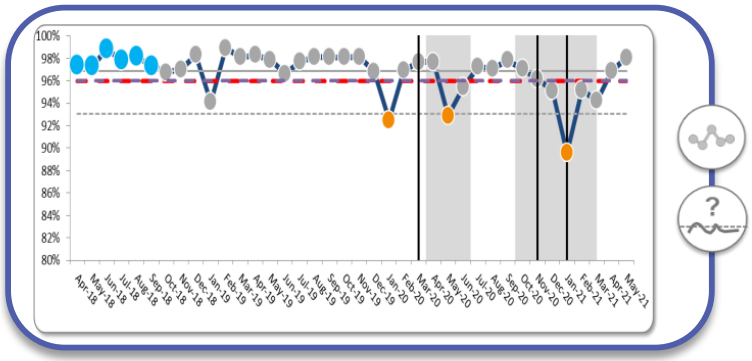
Cancer 2WW Breast Symptomatic

5.10%



Cancer 31 Day All

98.05%



Key

- Internal target
- Operational standard

Lockdown Period

COVID Wave

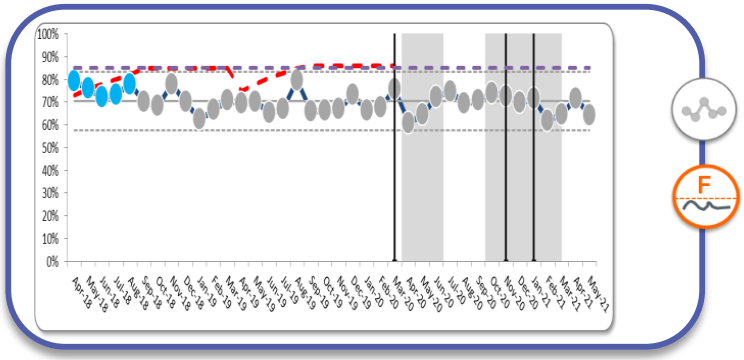
Please note: The **2WW Breast Symptomatic** SPC chart has been re-based to evidence if any changes in performance, post the initial COVID-19 high peak, are now common or special cause variation.

Month 2 [May] | 2021-22 | Operational Performance: Cancer

Responsible Director: Chief Operating Officer | Unvalidated for May-21 as 17th June 2021

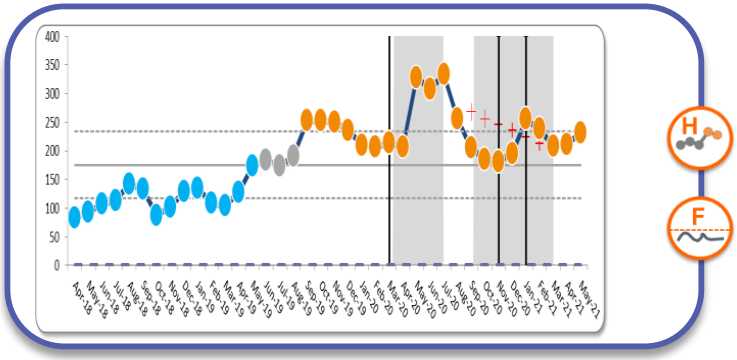
Cancer 62 Day All

67.19%



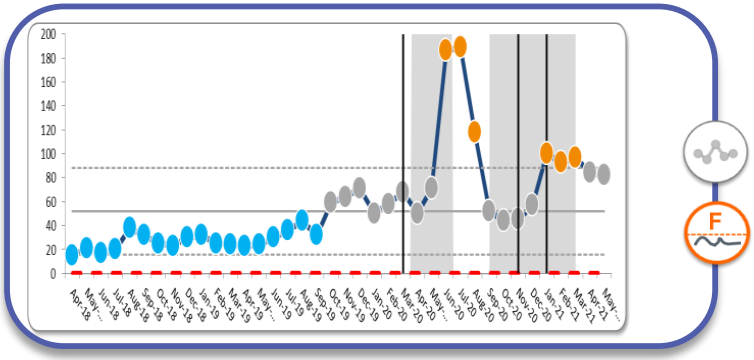
Backlog Patients waiting 63 days or more

231

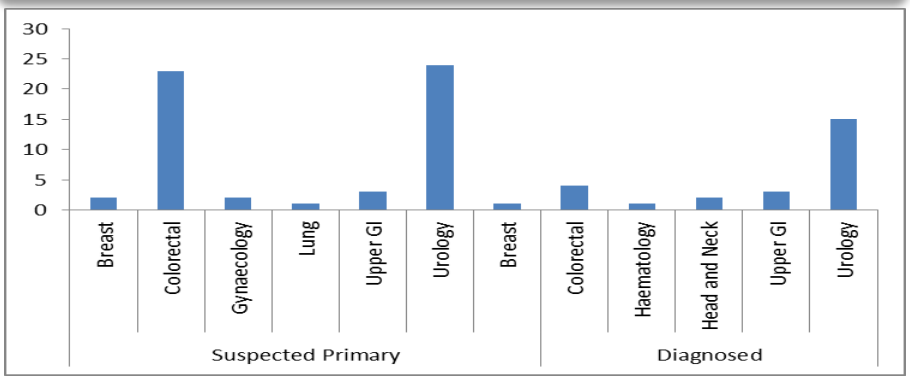


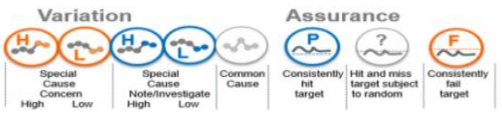
Backlog Patients waiting 104 day or more

81



104+ Day Backlog profile by specialty





Key

\+ phase 3 target

\- Internal target

\- Operational standard

Lockdown Period

COVID Wave

Operational Performance: Cancer Benchmarking

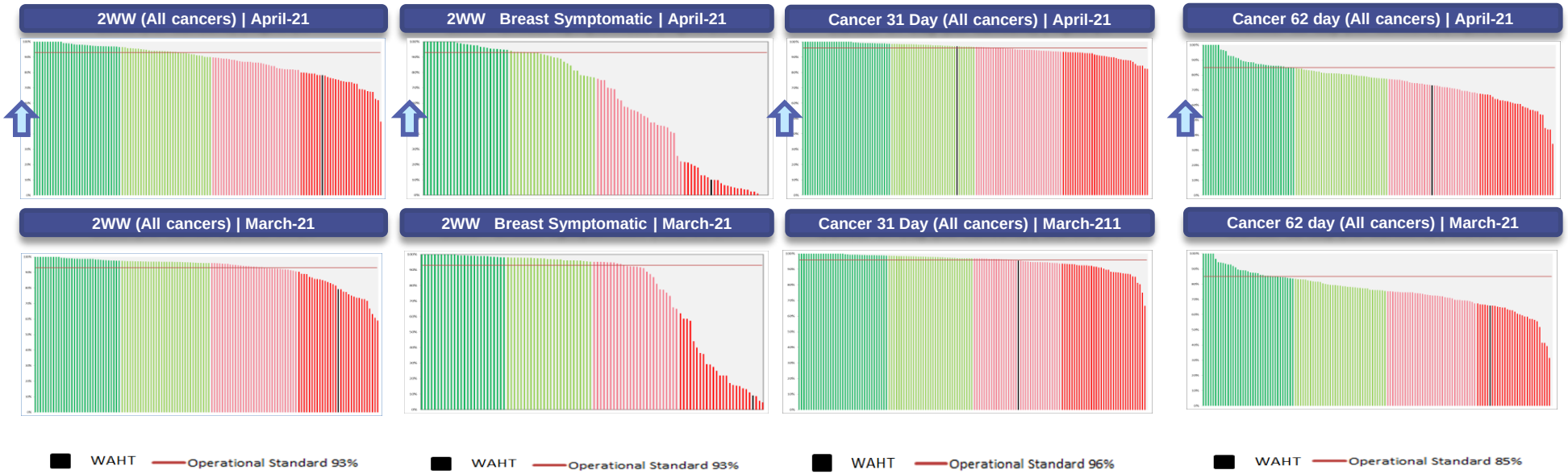
National Benchmarking (April 2021)

2WW: The Trust was one of 8 of 13 West Midlands Trust which saw a decrease in performance between Mar-21 and Apr-21 This Trust was ranked 9 out of 13; where we were 8 previous month. The peer group performance ranged from 67.32% to 91.06% with a peer group average of 79.08%; declining from 81.90% the previous month. The England average for Apr-21 was 85.44% a -5.8% decrease from 91.25% in Mar-21.

2WW BS: The Trust was one of 4 of 13 West Midlands Trust which saw a increase in performance between Mar-21 and Apr-21 This Trust was ranked 11 out of 13; where we were 12 previous month. The peer group performance ranged from 2.41% to 100.00% with a peer group average of 39.91%; declining from 52.43% the previous month. The England average for Apr-21 was 62.07% a -14.8% decrease from 76.90% in Mar-21.

31 days: The Trust was one of 10 of 13 West Midlands Trust which saw a increase in performance between Mar-21 and Apr-21 This Trust was ranked 5 out of 13; where we were 6 previous month. The peer group performance ranged from 84.37% to 100.00% with a peer group average of 92.18%; improving from 89.57% the previous month. The England average for Apr-21 was 94.70% a -0.5% decrease from 94.74% in Mar-21.

62 Days: The Trust was one of 13 of 13 West Midlands Trust which saw a Trusts in performance between Mar-21 and Apr-21 This Trust was ranked 6 out of 13; where we were 7 previous month. The peer group performance ranged from 44.76% to 82.31% with a peer group average of 67.49%; improving from 59.86% the previous month. The England average for Apr-21 was 75.37% a 1.4% increase from 73.94% in Mar-21.



Operational Performance: RTT

2.4 - Maintain access to all emergency surgery (inc trauma) and triage elective waiting list to prioritise access for those at greatest risk of harm from delay

Total Waiting List	Number of patients waiting over 18 weeks	Percentage of patients on a consultant led pathway waiting less than 18 weeks for their first definitive treatment	Number of patients waiting 40 to 52 weeks or more for their first definitive treatment	52+ weeks	Of which, waiting 70+ weeks	RTT Referrals (Routine and Urgent) received
51,005	24,477	52.01%	4,072	5,920	2,318	4,940

What does the data tells us?

- The Trust has seen a further 4.14% increase in the overall wait list size in May-21 compared to April-21; from 48,976 to 51,005.
- The number of patients over 18 weeks who have not been seen or treated within 18 weeks has increased to 24,477 This is 415 more patients than validated April-21 snapshot. RTT performance for May-21 is validated at 52.01% compared to 50.87% in April-21. This remains sustained, significant cause for concern in May-21 and the 92% waiting times standard cannot be achieved.
- The number of patients waiting between 40-52 weeks for treatment is 4,072, and those patients waiting over 52 weeks which has reduced slightly to 5,920 from 6,287 (April 2021). The reduction in referrals during wave 1 of the pandemic accounts for the shift in the number of patients waiting over 52 weeks being more than the 40-52 weeks cohort and is also contributing to the reduction in patients waiting 52+ weeks.
- Of the 5,920 patients waiting over 52 weeks, 2,318 have been waiting over 70 weeks with 516 requiring T&O treatment, 508 patients requiring oral surgery / orthodontics treatment and 506 requiring urology treatment.
- Seven specialties have over 1,000 patients waiting over 18 weeks; this is 76% of all our 18 week breaches. Three of those specialties now have over 3,000 patients breaching and those seven specialties contribute 85% of all patients waiting over 52 weeks.
- **Referrals** - a total of 6,962 electronic referrals were made to the Trust in May-21, this is higher than the total received in Apr-21 (6,809) and an increase per working day (Apr-21 = 340.5, May-21 = 366.4)
- Of the 6,962 electronic referrals received in May-21 37.1% of these were 2WW cancer which is the lowest 2WW % against any of the previous 12 months.
- When compared with Apr-21 there was improvement in the rate of triaging RAS referrals for non-2WW with 79.9% of non-2WW RAS referrals triaged within 2 working days representing a month on month improvement from 58% in Jan-21.
- **Advice & Guidance (A&G)** - this continues to be well used and responded to in a timely manner, 2,355 A&G requests received in May-21 with 93.5% A&G requests responded to within 2 working days which is the best rate compared to any of the previous 12 months and 97.3% within 5 working days also amongst the highest we've seen in any of the last 12 months.
- ERS A&G requests were responded to within 2 working days 90.5% of the time and within 5 working days 96.9% of the time
- Non-ERS (email) A&G requests were responded to within 2 working days 96.6% of the time and within 5 working days 97.7% of the time.
- 70.1% of the 2,117 A&G request in Feb-21 didn't result in a referral being made for that specialty within 3 months of the response i.e. 1,426 didn't result in a referral. This should emphasise the benefit of A&G on avoiding an outpatient appointment being booked.

Current Assurance level: 3 (May-21)	**When expected to move to next level of assurance:** This is dependent on the programme of restoration of elective activity and reduction of long waiters
Previous Assurance Level: 3 (Apr-21) Agreed at F&P Committee (28th April 2021)	**SRO: Paul Brennan**