Worcestershire Acute Hospitals NHS Trust

Trust Board
There will be a meeting of the Trust Board on Thursday 15 October 2020 at 10:00. It will be held virtually and live streamed on You Tube.

Sir David Nicholson
Chairman

Agenda			Enclosure
1	**Welcome and apologies for absence**		
2	**Staff story** *Colleagues from BAME network attending*		
3	**Items of Any Other Business** *To declare any business to be taken under this agenda item.*		
4	**Minutes of the previous meeting** *To approve the Minutes of the meeting held on **10 September 2020** as a true and accurate record of discussions.*	*For approval*	**Enc A** **Page 1**
5	**Action Log**	*For noting*	**Enc B** **Page 10**
6	**Report from the Provider Oversight Committee** Chief Executive		**Enc C** **Page 11**
7	**Chairman's report** *To report the chairman's actions*	*For noting*	**Enc D** **Page 14**
8	**Strategy**		
8.1	**Recovery and Reset** Director of Strategy and Planning	*For assurance*	**Enc E** **Page 15**
9	**Performance**		
9.1.1	**Integrated Performance Report** Chief Digital Officer	*For assurance*	**Enc F** **Page 24** **Attachment 1**
9.1.2	**Committee Assurance Reports** Committee Chairs		**Attachment 2** **Page 81**
10	**Assurance Reports**		
10.1	**Audit and Assurance Committee Report** Audit and Assurance Committee Chairman	*For assurance*	**Enc G** **Page 87**
	Any Other Business *as previously notified*		
	Date of Next Meeting *The next public Trust Board meeting will be held on 12 November 2020, virtually.*		

Enc A

Worcestershire Acute Hospitals NHS Trust

MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON THURSDAY 10 SEPTEMBER 2020 AT 10:00 hours VIRTUALLY

Present:

Chairman:	Sir David Nicholson	
Board members: (voting)	Paul Brennan	Deputy Chief Executive/Chief Operating Officer
	Anita Day	Non-Executive Director
	Mike Hallissey	Chief Medical Officer
	Matthew Hopkins	Chief Executive
	Dame Julie Moore	Non-Executive Director
	Vicky Morris	Chief Nursing Officer
	Robert Toole	Chief Finance Officer
	Stephen Williams	Non-Executive Director
	Mark Yates	Non-Executive Director
Board members: (non-voting)	Richard Haynes	Director of Communications and Engagement
	Colin Horwath	Associate Non-Executive Director
	Vikki Lewis	Chief Digital Officer
	Jo Newton	Director of Strategy and Planning
	Tina Ricketts	Director of People and Culture
	Kimara Sharpe	Company Secretary
	Fleur Blakeman	NHS Intensive Support Director
In attendance	David Hill	System Improvement Director
	Clementine Stott	Specialist nurse, *item 52/20 only*
	Ellie Wells	*item 52/20 only*
	Victoria Ker	Specialist nurse, *item 52/20 only*
	Steven Haynes	Consultant Anaesthetist, lead for organ donation *item 52/20 only*
	Tracey Cooper	Deputy Director of Infection Control *item 061/20/1 only*
Public	33	Via YouTube
Apologies	Bill Tunnicliffe	Non-Executive Director
	Richard Oosterom	Associate Non-Executive Director

051/20 **WELCOME**

Sir David welcomed everyone to the meeting, particularly those viewing via YouTube.

052/20 **PATIENT STORY**

Sir David introduced Ellie Wells who was present to tell her story. He was particularly pleased to welcome her as her story was about organ donation and the meeting was being held in Organ Donation week. He emphasised the necessity to continue to raise awareness in respect of organ donation.

Mrs Morris introduced Ellie. She commented that the video that Ellie had made for

Organ Donation week was very powerful and urged members to view it.

Ellie explained that she was a staff nurse in the Emergency Department at Worcestershire Royal. Her brother, Jake, took his own life six years previously. He was cared for in ITU for two days and despite hard work to save him, it was determined that he could not be saved. His body was starting to fail and Ellie and her family discussed the position with the consultants. The options were to withdraw treatment or organ donation. Ellie had had several conversations with her brother who had expressed a desire for his body to be used for scientific research. Ellie knew that organ donation would be what Jake would have wanted, but this was against the views of her mother. Eventually it was agreed to donate Jake's organs.

Ellie and her family met with the specialist nurse who Ellie could not fault. She was incredibly compassionate and explained the process in a calm way. By agreeing to organ donation, the family had an extra 12 hours with Jake in ITU before life support was turned off. This was invaluable and meant that goodbyes could be said.

Jake's organs saved the lives of three people. The family have had letters from the recipients. The family attends regular support meetings held in the Trust. The gift of life has bought so much joy and peace to the family.

Ellie stated that the family were given a box containing hair and a handprint. She was very grateful that she had this. She stated that 'in a time of great darkness, [organ donation] was a beacon of light for us'.

Ms Stott thanked Ellie for her story. Sir David echoed the thanks and commented that it was remarkable as well as moving.

Ms Day also thanked Ellie. She wondered whether Ellie's mother had had any regrets. Ellie stated that her mother knows that it was the right decision and she is now a great supporter of organ donation through the family network.

Dr Haynes then presented the statistics associated with organ donation locally. In 2012, there were approximately 3 people dying each day who needed an organ donation. This had fallen to 1 per day in 2020. There had been a huge improvement in the last eight years. In 2019 there were 6000 patients on the transplant list. Opportunities still exist for organ donation. In Wales the opt out was instigated in 2016 and now 80% of organs are donated whilst in the rest of the UK, this figure is 66%.

The law changed in the rest of the UK in May 2020. Anyone who is normally resident in the UK in the last 12 months and has mental capacity can be assumed to consent for organ donation. Recent local figures show that there were 23 referrals in 2019 and 14 so far in 2020 (includes the shutdown period). When the specialist nurses are present, there is 100% consent.

COVID-19 resulted in an almost complete shutdown of the transplant programme. However, transplants are now getting back on track.

Dr Haynes concluded by stating that there were ongoing investigations into why there are missed opportunities. The education of medical staff is of paramount importance. He encouraged early referral to the team.

He finally thanked the specialist nurses for their continued work in this area. Ms Stott reminded members that there was another slide presentation which showed the ongoing work and was within the reading room for members.

Mr Hopkins added his thanks. He stated that the topic was close to his heart as he had received a cadaver renal transplant and a living donor transplant. He was pleased that the topic was being focussed on by the Board in national transplant week. He emphasised the courageous nature of the day to day conversations taking place with families by the Trust staff and pleased with those present to discuss the issues with their families. It was vitally important – up to 9 people could benefit from one person's donations.

Sir David added his thanks. He also asked everyone to ensure that loved ones were aware of personal views.

053/20 **ANY OTHER BUSINESS**

There were no items of any other business.

054/20 **DECLARATIONS OF INTERESTS**

There were no additional declarations of interest. The Board noted that the full list of declarations of interest were on the website.

055/20 **MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON 9 JULY 2020**

RESOLVED THAT the Minutes of the public meeting held on 9 July 2020 be confirmed as a correct record and signed by the Chairman.

056/20 **MATTERS ARISING/ACTION SCHEDULE**

Mrs Sharpe reported that there no outstanding actions and all other actions had been completed. She stated that training on the mental health act for board members would take place on 10 December.

057/20 **CHAIRMAN'S REPORT**

Sir David thanked Mr Williams for his term of office which would conclude at the end of December. He congratulated Ms Day on her recent reappointment to the Board for 4 years. He was now recruiting to two posts, a non-executive director and an associate non-executive director and was keen to ensure better diversity within the Board members.

RESOLVED THAT The Trust Board

- Approved the allocation of non-executive directors to committees
- Noted the recruitment to NED positions

058/20 **CHIEF EXECUTIVE'S REPORT**

Mr Hopkins stated that he was pleased with the progress in introducing a single improvement methodology. A readiness assessment would be undertaken by NHS I.

He welcomed Mr Hill to the health care system. This post was recommended in the CQC report published in 2019 and would focus on urgent care provision and emergency care.

He was particularly pleased to report that teams had been shortlisted for national awards.

Finally he raised awareness of the development of the National Institute for Health Protection and the appointment of Marie Gabriel as Chair of the NHS Race and Health Observatory.

Mr Yates wondered whether the Trust could place the increased number of medical students. Mr Hopkins confirmed that there was ongoing work with the University of Worcester and other universities to ensure that placements were available.

RESOLVED THAT the Board

- **Noted the report**

059/20 **STRATEGY**

059/20/1 **COVID-19 Restoration & Recovery Plan Phase 3 - Recovery**

Mrs Newton presented part one of a two part report. The second was in private as it contained draft information. She was keen to emphasise that the trust was committed to returning to normal activity with safe sustainable services, taking account of lessons learnt during the COVID pandemic

She stated that it was essential to ensure that the work was inclusive and took account of the vulnerable people within the local population. She was pleased that a health inequalities board was being set up across the STP. She was also linking to the Director of Public Health to discuss further the Joint Strategic Needs Analysis (JSNA) and its implication for the Trust.

She confirmed that the submission would meet the deadline of the 21 September. There were three main elements, activity, people and finance.

Mr Hopkins reported that the meeting with regional representatives in the last week had been positive but there had been a request to move faster to re-establish services such as routine surgery and endoscopy. He confirmed that there was a substantial piece of work underway to re-establish services and his main priority was to ensure that services were re-established safely. The approach had been discussed at QGC recently.

Dame Julie asked whether there had been any modelling with respect to the increase in COVID-19 cases as being seen in neighbouring areas. Mr Brennan confirmed that cases within the community were increasing in Worcestershire although absolute numbers were small. There was a good sensitive early warning system in place and he predicted a 15-16 day lag between community cases being identified and presentation to hospital. The numbers have been modelled within the phase 3 work with two assumptions – the return to 50% of the April peak and a return to 100% of the April peak. He was also monitoring the increase in numbers within Birmingham and the Black Country.

Mr Hopkins emphasised the need for working with Public Health and keeping to the social distancing rules. He was confident that the early warning system in place would alert to changes in the number of cases.

Sir David stated that as a Board, it was imperative to deal with COVID but also to restore safe services to patients. He stated that there had been spikes in the north of the county and visiting to care homes in Bromsgrove had been suspended. He was pleased with the approach to modelling but was aware of the need to rapidly restore services to prevent harm to waiting patients.

RESOLVED THAT the Board noted

- Noted the guidance, timelines and proposed approach to and timeline for the Phase 3 planning submission

059/20/2 **People & Culture Update**
COVID-19 – Safety and welfare of the workforce

Ms Ricketts introduced her report. It was in three sections. Firstly, workforce safety – she was pleased that 96% of colleagues had returned a workplace assessment (94% of BAME colleagues). The forms have shown that 25% of the workforce have some risk to COVID and she detailed some of the interventions within her report.

Secondly, the impact of COVID on sickness absence, particularly mental health related absences. These absences were now back to near normal levels but peaked during COVID. There were proactive support packages in place and a well-being guardian was being identified (as set out in the National People plan).

Finally she turned to employee wellbeing and the importance of staff engagement. The BAME network was continuing to meet weekly and the lead would be announced in the next week. She was also working to set up an LGBT+ network and a disability network.

Mr Horwath asked how staff were supported if they worked for long periods of time away from the office. Ms Ricketts described the staff welfare telephone calls and confirmed that there were no trends of illness reported within this group of staff.

Ms Day asked about staff resilience, given the possibility of a second peak. Ms Ricketts stated that this was a worry as staff were tired. However she has a task and finish group with representation from all staff areas to test and obtain feedback. This met weekly.

Mr Hopkins added that his 'meet the chief' sessions also tested the resilience. Mr Haynes added that the new staff app (to be launched shortly) would also form another vehicle for interaction with front line staff.

Sir David commended the support put in for staff. He welcomed the app. He was very pleased with the progress with the risk assessments and thanked the team that made this happen. He was also pleased with the networks in place to monitor staff sickness and resilience.

RESOLVED that the Board noted

- the actions that have been taken to reduce the risk of potential COVID-19 related work hazards for all colleagues
- the wellbeing support that has been put in place to support colleagues with both their physical and mental health

There followed a break from 11:04-11:15

060/20 **PERFORMANCE**

060/20/1 **Integrated Performance Report**

060/20/1/1 **Executive Summary/SPC charts**

Sir David invited Mrs Lewis to introduce the IPR and highlight the three key issues for discussion.

Mrs Lewis explained that the presented validated IPR for July was a transitional report. It was of a different format and she had been discussing with colleagues the best format going forward. She confirmed that the second cover sheet for the quality metrics would not be present in future versions. She pointed to page 36 of the pack which showed the future format in greater detail.

In terms of the main challenges, the recovery of services as outlined in Mrs Newton's report previously, emergency access standard and the underpinning indicators identified through the Home First Programme and the minimisation of harm to patients waiting for care.

Mr Hopkins confirmed that the Trust is very focussed on delivering phase 3 safely and is working closely with partners to this end. He assured members that he was working to ensure the progress made relating to the ED performance remained and became embedded whilst maintaining capacity for a second COVID peak.

Mr Brennan reported that 96% of beds were now operational. He stated that in July, overall performance in ED was 92.6% which compared to July 2019 performance of 76.32%. The number of 12 hour breaches was zero, compared to 61 in July 2019. Ambulance conveyance rates were at pre-COVID levels across the Trust with Worcestershire Royal slightly above and Alexandra slightly below.

He then turned to the numbers of patients waiting. Those waiting over 52 weeks was 483 compared with 4 waiting in July 2019. The overall waiting list for July 2020 was 36384 compare to 37336 in July 2019 (but there had been a reduction in referrals).

With respect to cancer, the waiting times were also increasing with 152 waiting more than 62 days (137 in July 2019) and 161 waiting more than 104 days (36 in July 2019).

The diagnostic waiting list had increased from 6544 in July 2019 to 12206 in July 2020. This mainly related to endoscopy.

Mr Brennan stated that it was a major challenge to restore services to 100% and this would not reduce the backlog, but maintain the status quo. He estimated that to bring the waiting list down to levels seen one year ago, capacity had to work at 160%.

Dame Julie asked what the maximum was that the Trust could operate at and was the Trust operating at this maximum. Mr Brennan stated that he was confident that the Trust could operate at 100% for CT scans, 70% for MRI, 64% for endoscopy, 87% for day case and 30% for inpatient activity. The main challenge is the use of PPE. Currently theatres are running at approximately 1.2 cases per session compared with 2.4 pre-COVID.

Dame Julie wondered whether the hours worked could be expanded. Mr Brennan described in detail the workforce challenges and the creative thinking about the management of endoscopy but stated that this remains a big challenge.

Mr Yates was pessimistic. He reflected that the position could only get worse. Mr Brennan reminded members that no routine work had been undertaken for 5.5 months. He stated that different ways of working were being reviewed. He stated that the consultant led triage of all GP cancer referrals were showing that the majority did not need to be seen. His priority was to eliminate 104 day waits for treatment and reduce the number of people waiting 62 days.

Sir David asked about timescales. He wondered when the Trust would make inroads into the backlog and what would benefit from faster working.

Mrs Morris stated that patient safety was paramount. She stated that due to PPE requirements, the number of patients that could be seen was down. She confirmed that there was no shortage of PPE.

Sir David asked whether the improvements seen in the emergency access standard were real and sustainable. Mr Brennan stated that the was an increased challenge as volumes of activity had increased sharply. The position had been sustained in August but the September performance was challenging. He was disappointed that the

improvements made such as discharges prior to 12 midday had not been embedded as yet.

Mr Hopkins reflected that working together as a health economy ensured better performance. There was now variability in the systems and processes which has led to the deterioration of performance.

Sir David then turned to quality and asked for the latest positon on sepsis. Mr Hallissey reported that during COVID, the lead clinicians had been unable to progress the taking forward of sepsis. This was because they worked in ITU. This had now been rectified. He was pleased that sepsis mortality was now at 102 but the recording of all elements of sepsis 6 was not as robust at it should be. An audit was being undertaken and he would review this when it was complete.

Sir David stated that the challenges relating to sepsis 6 recording had now been apparent for several months and he wished to see progress.

Sir David then turned to finance. He was unable to understand whether progress was being made or not. Mr Toole agreed that the picture was complex. The difficulty was due to the lack of a baseline. The level of activity was less than in previous years. Spend was not as high either, mainly due to the lack of agency staff.

Sir David asked Mr Williams to express the view of the Finance and Performance Committee. Mr Williams agreed with the complexity of the situation. Without PBR, it was not possible to determine productivity. There is no dashboard to show whether productivity is up or not. The dashboard is being developed. In the short term, the activity needed to be viewed along with workforce and a view determined as to whether the workforce would be more productive. There needed to be a focus on the divisions to increase productivity.

Sir David asked about the cost base. Mr Toole confirmed that it is lower than expected. Spend is below expectations. Sir David reiterated the need for an understandable position which shows whether the management of resource was getting better or not. There needed to be grip in the light of a new financial regime in 2021/22.

Mr Hopkins reported that he has requested an integrated operational performance, workforce and finance report to obtain better clarity.

Sir David summarised by stating that the three areas identified in the IPR were the right areas of concern. The scale of the challenges facing the Trust had been clearly articulated and it was clear that there were no quick fixes. He was pleased with the A&E performance but stated that this needed to be sustainable. He expressed concern about patients who may be harmed by the delays to treatment and stated that there was still much work to do.

Sir David urged Mr Hallissey to improve the data recording for sepsis 6 and requested an in depth look at this metric by the Board.

ACTION: In depth review of sepsis 6 (Mr Hallissey, date to be determined)

Finally, Sir David expressed hope that the next meeting would show whether the Trust was making financial improvements or not.

RESOLVED THAT the report be received for assurance.

060/20/1/2 **Committee Assurance Reports**

RESOLVED THAT the reports be noted for assurance.

061/20 **GOVERNANCE**

061/20/1 **Infection Prevention & Control Update: COVID-19 National Board Assurance Framework**

Sir David welcomed Mrs Cooper to the meeting.

Mrs Morris stated that during COVID, the infection prevention and control standards had been set out in a National Board Assurance Framework and she invited Mrs Cooper to talk through the paper presented to the Board.

Mrs Cooper stated that the BAF had been issued in May by NHS E/I and detailed work had been ongoing to determine the levels of assurance for the different elements. She described the work of the Trust Infection Prevention and Control Committee (TIPCC) which reported into the Clinical Governance Group (CGG). This in turn had provided a report to the Trust Management Executive and then the Quality Governance Committee. QGC had scrutinised the work in detail and had been able to assure the Board.

Mrs Cooper then reported that there had been a meeting with the CQC to discuss the detail of the BAF. Overall, she was reporting a level of assurance of 6 out of 7. Condition 3 remained an outlier at level 3 assurance. She provided a summary of the work undertaken which has resulted in extensive clinical engagement and the progress had been shared with TME and QGC.

In summary, she confirmed to Sir David that performance had been sustained and gave some examples of work outside the COVID remit.

Sir David thanked Mrs Cooper for her work.

RESOLVED THAT the report be received for assurance

061/20/2 **Trust Management Executive**

Mr Hopkins presented the report which showed the flow of information through TME to the Committees and then to Trust Board. He has instigated a dedicated reading time which has given members more time to consider the reports. He also stated that recent reviews will be given a focus at the next meeting.

RESOLVED THAT the report be received for assurance

061/20/3 **Audit and Assurance Committee Report**

Mr Williams reported that the Committee were pleased with the progress made in areas, despite COVID. He particularly mentioned the Freedom to Speak Up Guardian.

RESOLVED THAT the report be received for assurance

061/20/3 **NHS Blood and Transplant Service**
Contract for the Provision of Blood and Blood products

RESOLVED THAT the Board approved the NHS Blood and Transplant Service contract for the provision of blood and blood products.

061/20/4 **Standing Financial Instructions (SFIs) & Scheme of Delegation (SoD)- Updated**

Mr Toole confirmed that the SFIs and SoD had been approved by the Audit and Assurance Committee and required Trust Board approval.

RESOLVED THAT The Board approved the standing financial instructions and scheme of delegation

061/20/5 **Standing Orders**

Mrs Sharpe reported that the SOs had been approved by the Audit and Assurance Committee and required Trust Board approval.

RESOLVED THAT The Board approved the standing orders

DATE OF NEXT MEETING

The next Public Trust Board meeting will be held on Thursday 15 October 2020 at 10:00. The meeting will be held virtually.

The meeting closed at 12:15 hours.

Signed _____ **Date** _____

Sir David Nicholson, Chairman

Enc C

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

PUBLIC TRUST BOARD ACTION SCHEDULE – OCTOBER 2020

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
12-9-19	Patient Story	63/19	Arrange dementia training for Trust Board members.	CNO (VM)	Oct 2019		To be programmed into a Board seminar. Dementia lead has requested face to face training. To be taken up by CNO.	
10-9-20	IPR	60/20/1/1	In depth review of sepsis	MHa	Dec 2020		To be undertaken by the QGC. Transferred to QGC. Action closed	

NHS
Worcestershire Acute Hospitals NHS Trust

Putting patients first May 2019

Meeting	Trust Board
Date of meeting	15 October 2020
Paper number	C

Provider Oversight Committee

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

Accountable Director	Matthew Hopkins Chief Executive		
Presented by	Matthew Hopkins Chief Executive	**Author /s**	Kimara Sharpe Company Secretary

Alignment to the Trust's strategic objectives							
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	23 September 2020	Noted
QGC	1 October 2020	Noted

Recommendations	Trust Board is requested to note that the Trust has exited quality special measures.

Executive summary	On 24 September 2020 NHSE/I informed the Trust (see attachment) that the Trust was no longer in Quality Special Measures. We now move from the NHS Improvement Provider Oversight Framework category 4 to category 3 which means that the Worcestershire health and care system will continue to receive support from NHS Improvement Intensive Support directorate. This support package will be co-ordinated by David Hill, our System Improvement Director. We will also need to work with the NHS Midlands team to revise the undertakings agreed with them and discussed at our Board earlier this year. I should like to thank all our staff, patients and stakeholders for their efforts in exiting quality special measures.

Office of the National Director of Improvement
Skipton House
80 London Road
London
SE1 6LH

[redacted]

David Nicholson
Chair
Worcestershire Acute Hospitals NHS Trust

Matthew Hopkins
Chief Executive
Worcestershire Acute Hospitals NHS Trust

24 September 2020

[redacted]

Dear David and Matthew

Confirmation that Worcestershire Acute Hospitals NHS Trust (the Trust) is no longer in special measures for reasons of quality

The Provider Oversight Committee (POC) of NHS England & NHS Improvement, at its meeting on the 8 September 2020, considered the recommendation that Worcestershire Acute Hospitals NHS Trust (the trust) should no longer be in special measures for reasons of quality but should receive ongoing support. I am delighted to confirm that POC made the decision to support the recommendation and the Trust will, from today, no longer be in quality special measures. I can also confirm that the trust will move from segment 4 to segment 3 of the SOF (single oversight framework) and the regional team will be in contact with you to agree refreshed undertakings shortly. I recognise the challenges that will be facing all trusts at the present time, and this will be reflected in our agreed approach for the future.

As you know this recommendation follows a period when the Trust, supported by system partners, has been able to demonstrate a sustained period of improvement with regard to the delivery of urgent and emergency care. Following our 'Board to Board' meeting with you and system partners in January 2020 we were informed of the outcome of the risk summit follow up meeting that took place in April 2020. This gave sufficient assurance that you were making good progress in responding to the concerns that were raised by the CQC in their inspections of your emergency departments in December 2019. It is important that the Trust and System partners remain focussed on sustaining these improvements as we move into winter whilst at the same time restoring and recovering elective services, as well as planning for a potential second wave of COVID 19.

This is a time to celebrate the progress that the trust and system has made, and I recognise the hard work and commitment of your Board and staff in delivering this outcome. Given that the trust's overall CQC rating is still 'requires improvement' NHS England & NHS Improvement regional and national team will continue to work with you and your system partners to provide targeted support, that will of course take into account the current situation of restoring and recovering services as well as managing the ongoing pandemic situation, and to help you build on the

commendable improvements that have already been made. Further work is also required to ensure the effective use of resources and that the board also remain focussed on the financial position and challenges at the Trust.

The proposed exit support package is set out in the attached appendix and this will be further refined in discussion with yourself and system partners by the end of September. We will continue to fund a System Improvement Director in addition to the tapered support of a part time Improvement Director for the Trust.

Congratulations to you, your system partners, the board and everyone involved in the Trust on the excellent progress made to date. I know this has only been possible because of the hard work of so many people across the trust and system.it is a positive outcome for the local population and I am sure will be welcomed both within the Trust and across the Community. I look forward to seeing the Trust's continued progress.

I am copying this letter to Simon Trickett as chair of the System Improvement Board/ICS Executive Lead and Dale Bywater, Regional Director and his regional executives.

Yours sincerely

Hugh McCaughey
National Director of Improvement

Copy:

Amanda Prichard, Chief Executive NHS Improvement / COO NHS England
Steve Powis, National Medical Director
Dale Bywater, Regional Director – Midlands
Nigel Sturrock, Regional Medical Director - Midlands
Siobhan Heafield Regional Chief Nurse - Midlands
Jeff Worrall, Regional Director of Commissioning - Midlands
Oliver Newbould – Regional Director of Intensive Support - Midlands
Julie Grant, Assistant Director of Provider Development - Midlands
Simon Trickett, ICS Executive Lead

Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	15 October 2020
Paper number	D

Chairman's Report

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

Accountable Director	Sir David Nicholson Chairman		
Presented by	Sir David Nicholson Chairman	**Author /s**	Kimara Sharpe Company Secretary

Alignment to the Trust's strategic objectives							
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 is requested to note the following Chairman's Actions, undertaken since the last Board meeting. • Contract with Dolan Park (value – £900,000 funded through national monies. This action was taken on 8 September. • Purchase of a third CT scanner (value – £650,000). This action was taken on 8 September. I can assure that Board that the CEO was also involved in the decisions.

NHS
Worcestershire Acute Hospitals NHS Trust

Putting patients first May 2019

Meeting	Trust Board
Date of meeting	15th October 2020
Paper number	E

Recovery & Reset

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

Accountable Director	Paul Brennan, Deputy CEO and COO Robert Toole, Chief Finance Officer Tina Ricketts, Director of People and OD Jo Newton, Director of Strategy and Planning		
Presented by	Jo Newton, Director of Strategy and Planning	**Authors**	Paul Brennan, Deputy CEO and COO Katie Osmond, Deputy Director Finance Tina Ricketts, Director of People and OD Jo Newton, Director of Strategy and Planning

Alignment to the Trust's strategic objectives							
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 September 2020	Endorsed the Phase 3 submission Approved NHS People Plan
Finance & Performance	30th September 2020	Noted

Recommendations	It is recommended that the Board: • Note the current COVID-19 position • Note the Restoration and Recovery Phase 3 plan submission • Note the progress of the NHS People Plan • Endorse the direction of travel

Executive summary	The NHS Chief Executive and Chief Operating Officer wrote to NHS organisations on the 31st July 2020 setting out the requirements for the Phase 3 response to COVID-19. This required acute service providers to: • Accelerate the return to near-normal levels of non-COVID health services, making full use of the capacity available between now and winter. • Prepare for winter demand pressures, alongside continued vigilance in the light of further probable local and national COVID-19 outbreaks. • Do the above in a way that takes account of lessons learnt during the first COVID peak; locks in beneficial changes; and explicitly tackles fundamental challenges including support for staff and

	action on inequalities and prevention. From an operational perspective, service restoration expected is: • Elective inpatients and day cases *80% by September and 90% in October* • Endoscopy, MRI and CT *90% by September with an ambition for 100% from October* • New and follow up outpatients *100% from September*. Restoration and recovery is challenged due to the continued impact of COVID-19 on operational delivery, with the key imperative of keeping patients safe, coupled with support for staff wellbeing. The STP submission remains challenged in terms of meeting 52 week wait requirements. From a financial perspective, work remains to close the financial gap to achieving a balanced position at STP level. Further planning assumptions around workforce and finance have been incorporated into the planning submission which will be further tested as part of the annual planning round. The NHS People Plan implementation plan was approved at TME and will go to People & Culture committee in December. The wider system operational and system framework continues to evolve and we need to remain flexible whilst amplifying key learnings and changes that meet our Clinical Services Strategy and deliver the priorities outlined in the Phase 3 guidance.

Risk	
Key Risks	BAF 1: If the System Improvement Board is not able to resolve the mismatch between demand and capacity for urgent and emergency care, then there will be delays to patient treatment, resulting in a significant impact on the Trust's ability to deliver safe, effective and efficient care to patients. BAF 3: If we do not implement the Clinical Services Strategy then we will not be able to realise the benefits of the proposed service changes in full, causing reputational damage and impacting on patient experience and patient outcomes. BAF 7: If we fail to address the drivers of the underlying deficit then we will not achieve financial sustainability (as measured through achievement as a minimum of the structural level of deficit) resulting in the potential inability to transform the way in which services operate, and putting the Trust at risk of being placed into financial special measures.

Meeting	Trust Board
Date of meeting	15th October 2020
Paper number	E

	BAF 3: If we do not implement the Clinical Services Strategy then we will not be able to realise the benefits of the proposed service changes in full, causing reputational damage and impacting on patient experience and patient outcomes. BAF 10: If we fail to sustain the positive change in organisational culture, then we may fail to attract and retain sufficiently qualified, skilled and experienced staff to sustain the delivery of safe, effective high quality compassionate treatment and care. BAF 11: If we have a poor reputation then we will be unable to recruit or retain staff resulting in loss of public confidence in the Trust, lack of support of key stakeholders and system partners and a negative impact on patient care. BAF 12: If we do not manage demand capacity (particularly ED) through the reset and restoration of services and we have a second and/or third peak of covid 19 cases, we will be unable to respond to the increase in covid 19 cases and then there is a serious risk that the safety of patients and staff will be compromised resulting in excess deaths								
Assurance	The underpinning planning assumptions will be reviewed as part of annual planning process								
Assurance level	**Significant**		**Moderate**	*X*	**Limited**		**None**		
Financial Risk	The failure to deliver the activity volumes set out in the letter from the NHS Chief Executive and Chief Operating Officer dated the 31st July 2020 will incur financial penalties.								

Meeting	Trust Board
Date of meeting	15th October 2020
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Introduction/Background

The STP successfully managed the response to COVID across the previous six months through strong collaboration and system working. COVID safe environments were quickly mobilised, staff trained/redeployed and a significantly improved length of stay achieved which played a critical role in maintaining low bed occupancy. One of the major system risks for several years has been urgent care performance in Worcestershire and at the same time as responding to COVID, the Trust has embedded new ways of working across ED, SDEC and wards which has delivered and sustained a significantly improved UEC position, with ED performance, ambulance handover delays and 12 hour trolley waits back on target and comparing favourably on a regional and national basis.

In September, the STP submitted a system wide restoration and recovery plan in response to the national Phase 3 letter setting out the expectations of NHS organisations. These highlighted the requirement to:

- Accelerating the return to near-normal levels of non-COVID health services, making full use of the capacity available between now and winter.
- Preparation for winter demand pressures, alongside continued vigilance in the light of further probable local and national COVID-19 outbreaks.
- Doing the above in a way that takes account of lessons learnt during the first COVID peak; locks in beneficial changes; and explicitly tackles fundamental challenges including support for staff and action on inequalities and prevention.

In addition, phase 3 guidance set out expectations for wider strategic requirements to become an ICS by April 2021. This paper sets out the current position and progress against key objectives.

Issues and options

1.0 COVID-19

In preparation for a potential second surge we have been closely monitoring patterns in the community and local outbreaks in conjunction with our local authority colleagues. Escalation plans have been put in place with our incident management structure remaining flexible to the recent local surge in cases.

During the period 11 July 2020 to 12 September 2020 there were two deaths for patients who had tested positive for COVID-19 however during the 18 day period from 13 September to 1 October, seven patients who were COVID-19 positive died. The total number of COVID positive hospital deaths since the pandemic started is now 284. There have been no COVID-19 positive patient deaths since the 2 October.

The average number of patients who had tested positive for COVID-19 and were inpatients in the Alex and Worcestershire Royal Hospitals was 2 per day during the period of 17 July to 22 September 2020 but this has now increased since 23 September with an average of 10 inpatients per day. Although this is a fivefold increase the number of COVID positive patients the number remains low compared to the peak of the pandemic when there were 141 positive patients in our hospitals.

The increase in positive cases is a cause for concern but at this stage we are able to continue to provide increased elective activity across surgery, diagnostics and outpatients services and are developing additional proposals to maintain this increased level of elective

activity in the event of a further surge in patients admitted to hospital who are COVID-19 positive or suspected.

2.0 Restoration & Recovery Plan (Phase 3 Submission)

2.1 Activity

COVID - The ICS System is able to operate urgent care and cancer services under all COVID planning scenarios through use of capacity across NHS estate, the independent sector and planning as part of the Adult Critical Care Review

Urgent Care - Performance will be maintained across key measures for urgent care, aiming for no EAS below 85%, continued low level of ambulance handover delays and a zero tolerance to 12-hour trolley breaches.

Cancer - The system is aiming to achieve all cancer standards with 62 day being the most challenging due to the reliance on diagnostics. As a Trust we are estimating a backlog of 200 patients at March 2021, although we have already made some significant improvements towards this. The system has committed to zero 104 day (confirmed cancers)

Diagnostics – The key risk was related to endoscopy volume however plans are in place to address this in the final submission. The key area now is non-obstetric ultrasound and the submission shows the Trust averaging 4,500 ultrasounds per month compared to 5,400 in 2019/20.

Outpatients – The national expectation is that we achieve 100% of Outpatient activity from September onwards, however due to some limitations with staff vacancies and physical space we are estimating achieving 86.4% at March 2021. We will continue to strive to gain further improvements on this during the year as technologies are implemented to support remote and virtual consultations. As a system we are focused on delivering a 30% reduction in outpatient follow up levels.

Elective – We anticipate delivering 78.6% of last year's Daycase activity by March 2021 and 69.7% of our inpatient stays. This is being impacted by current staffing levels, current theatre capacity and bed capacity, however we continue to review other interventions that will improve these predictions further. New national contract arrangements relating to the Independent Sector will reduce activity levels theatre sessions in the IS was reduced from 46 to 22 per week on the 14TH September 2020.

Long Waits – the submission shows a significant increase in 52 week waits which are forecast to increase to 2134 by the end of March 2021.

2.2 Workforce

To deliver the recovery plan the temporary workforce is projected to increase by 32.64 wte between the 2019/20 baseline and month 12 in 2020/21as more staff are required to address the backlog of work, along with an accumulation of annual leave in Q2.

To mitigate this risk, there has been a focus on domestic and international recruitment, increasing the size of the bank, and some success has been achieved in reducing the overall vacancy rate. In addition, each division is developing a staff escalation plan to enable

staff to be diverted to critical services should there be a further increase in COVID-19 admissions.

2.3 Finance

The outputs of the activity and workforce modelling have been assessed and the financial impact included within the financial forecast for months 7-12.

The national arrangements change for the second half of the year, from a block regime where actual costs were fully reimbursed through additional top-ups (where required), to a fixed allocation regime. The fixed allocations have been calculated nationally and allocated at system level, to include COVID costs.

Each system is expected to deliver its Phase 3 recovery and activity requirements and achieve financial balance within this envelope. To encourage recovery of elective activity in line with published targets, an elective incentive scheme has been introduced. Where activity levels are not achieved, system income levels will be reduced using a nationally determined formula.

As a system, we have agreed how the fixed allocations will flow to partner organisations, based on a fair allocation methodology for each element. We have collectively reviewed, challenged and triangulated financial assumptions and forecast expenditure within each organisation to ensure the system financial forecast is realistic and credible.

At the time of writing, the system modelling shows a financial gap of c.£26m, prior to any impact of the elective incentive scheme. The Trust gap over the period is c.£7m, driven primarily by anomalies in the national funding formula, where the underlying position is not fully recognised, reduced income streams (due to lower footfall) and COVID spend being greater than the allocation. Expenditure is assumed to increase over the second half of the year, in line with the workforce changes described above, to support delivery of the modelled activity levels.

Through the ICS Finance Forum, we are continuing to assess mitigations to further reduce the system gap over the period.

Risks

Activity

- Change in Independent Sector contract to significantly reduce activity
- Need to maintain infection control practices which limit productivity
- Impact of COVID-19 increase in prevalence
- Impact of delayed treatment on patients

Workforce

- Sustaining staff wellbeing
- Further redeployment of staff to cover COVID-19
- Staff recruitment to vacancies

Finance

- Financial penalties from failure to deliver against activity plan
- Financial gap at trust and STP level

3.0 STP /ICS approach

The wider system operational and system framework continues to evolve and we need to remain flexible whilst amplifying key learnings and changes that meet our Clinical Services Strategy and support Phase 3 guidance which expects to:

- restore services inclusively to September 2019 activity levels
- protect the most vulnerable from COVID-19
- develop digitally enabled care pathways in ways which increase inclusion
- accelerate preventative programmes which proactively engage those at greatest risk of poor health outcomes
- Support those who suffer mental ill-health

The STP Inequalities group will drive the system-wide approach tackling health inequalities to create a STP outcomes framework and support the work of the Worcestershire Health and Wellbeing Board (HWBB).

The **Clinical Service Strategy** refresh approach has been realigned to the Phase 3 Restoration and Recovery priorities, to include a pathway approach to deliver improved outcomes in integrated care, testing the approach with the frailty pathway in October.

Putting Patient's First – patient engagement

The trust has successfully re-engaged with patient and carer groups to determine an inclusive approach to service delivery and redesign. Dialogue with system partners is underway to agree a system first approach to engagement with a single NHS voice.

Population health management (PHM)

Knowledge building of the role and capability of PHM to provide data insights on current service delivery and future models of care is progressing consistent with the ICS programme and digital strategy.

Digital access and high impact changes (HIC's)

HIC work aligns well with recovery targets to increase virtual new and follow up outpatient appointments by 25% and 60% respectively (WAHT project 48% and 80%), whilst PIFU (patient initiated follow up) is be tested with specialities. A new clinical advice and guidance (RAS) service has been rolled out across all specialities this month.

ICS operating model and system working

The ICS executive forum is developing a proposed operating model in response to national policy development, which includes redefining the role of commissioning, developing place 'alliances' and provider collaborative leadership arrangements, as well as a joint programme of work with the local authorities. The STP or system focus will be on developing the culture of integrated working; bringing partners together to work within system resources, and ensuring the system delivers the best possible outcomes for the population. Place-based leadership arrangements are being developed through local 'Alliance' forums, with strong representation from primary care (PCN Clinical Directors), which will provide the mechanism through which agreed priorities and transformational work programmes, such as those

relating to addressing inequalities, will be delivered. Place will be defined by local authority boundaries ie Worcestershire.

In order to provide resilience, sustainability and mutual aid provider collaboratives are being encouraged across STP's, networks and partnerships. The form and footprint will continue to evolve into 2021.

We will be reviewing our role as a trust in the evolving system and structures, to both test our planning assumptions against the financial framework but also to achieve our ambition as set out in the clinical service strategy.

4.0 NHS People Plan

The NHS People Plan was launched in July 2020 and incorporates 101 actions to be implemented at both Strategic Transformation Partnership (STP) and employer level. Regional and STP People Boards have been set up to oversee the delivery of the plan with the majority of improvements requiring action within the next 12 months. A detailed implementation plan has been developed which was approved through Trust Management Executive in September.

The Trust's People & Culture Strategic Framework has been updated to respond to the People Plan which is summarised in the diagram below:

The next iteration of the people and culture strategy is in development and will be presented to the People & Culture Committee in December 2020.

Meeting	Trust Board
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Risks

Risk	Mitigation
The ICS operating framework destabilises service delivery resulting in stranded costs	Alignment of agreed programmes of work Development of an agreed financial framework Continued strong dialogue with partners
The trust does not have a strong voice in Worcestershire place alliance to meet the ambition of the Clinical services strategy	Continue: system participation (AEDB, ICS, HOSC and HWBB) Support reshaping of Worcestershire Alliance
The new financial operating framework results in misaligned incentives and behaviours with potential stranded costs	Influence and inform agreed financial framework and risk sharing arrangements with STP/ ICS Joint letter sent to clinicians from system finance and operational directors to support HIC delivery

Conclusion

- The full Recovery of services in line with plan is challenging given the ongoing and emergent surge of COVID-19
- Demand and capacity scenario modelling and operational flexibility will continue throughout the remainder of the year, including Winter planning
- Workforce and finance assumptions will be further refined in line with activity as part of the annual planning process
- The wider system operational and system framework continues to evolve and we need to remain flexible whilst amplifying key learnings and changes that meet our Clinical Services Strategy and support Phase 3 guidance requirements

Recommendations

It is recommended that the Board:

- Note the current COVID-19 position
- Note the Restoration and Recovery Phase 3 submission
- Note progress with the NHS People Plan
- Endorse the direction of travel

Appendices - none

NHS
Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	15 October 2020
Paper number	F

Integrated Performance Report – Month 5 – 2020/21

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

Accountable Director	Matthew Hopkins – Chief Executive Officer		
Presented by	Vikki Lewis Chief Digital Officer/ Executive Directors	**Author /s**	Nikki O'Brien – Associate Director Steven Price – Senior Performance Manager

Alignment to the Trust's strategic objectives							
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	23-9-20	Approved
Finance & Performance	8-10-20	Assured
Quality Governance	1-10-20	Assured
People and Culture	5-10-20	Assured

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

Executive summary	This paper provides the Trust Board with a validated overview of August 2020 against the trajectories, specifically for the NHS constitutional standards, key operational, quality and safety and workforce key metrics. The five key areas of challenge are identified as: • Restoration of treatment services following the Covid-19 pandemic: • Meeting our emergency access standard during winter through implementation of the Home First Programme • Maintaining our high standards of infection prevention and control • Improving our use of the Sepsis bundle • Finance

Key Risks	BAF 1,2,3,4,5,6,7,8,10,11 and 12

NHS
Worcestershire
Acute Hospitals
NHS Trust

Meeting	Trust Board
Date of meeting	15 October 2020
Paper number	F

Background

The Integrated Performance Report (IPR) is produced by the Trust on a monthly basis to monitor key clinical quality and patient safety indicators, national and local target performance, and financial performance.

The IPR provides assurance to the Board that all areas of actual performance, Trust priorities and remedial actions.

Issues and options

The Integrated Performance Report provided to the Board Committees is attached.

The top areas of challenge are:

Restoration of treatment services following the Covid-19 pandemic

The overall referral to treatment (RTT) waiting list continues to grow as the demand of new referrals and those patients already waiting significantly outweighs our current capacity. More than half of our patients on the list are waiting over 18 weeks, with the number of patients waiting 40+ weeks rising rapidly. The 52+ week cohort is forecast to be 2,134 by the end of March-21.

The national waiting list clinical review commenced at the end of September and the inpatient waiting list is the phase one cohort, to be completed by the 30 November 2020. The purpose of the review is to clinically prioritise patients through the identification of opportunities for treatment in other health care providers.

Performance against the core cancer waiting time standards declined in August 2020 although all within normal seasonal variation. The backlog of patients waiting 63-103 days, for diagnosis and/or treatment has reduced, as have those waiting 104+ days and both are close to being within the control limits. NHSE/I expect cancer referrals to return to pre-COVID levels.

Our capacity to undertake the combination of routine, emergency and planned diagnostic tests, whilst responding to winter pressures and cancer pathway demands underpins our restoration efforts to ensure patients are seen within the timescale of their pathways.

Diagnostics has intervention plans in place to recover activity to last year's levels, particularly focussed on endoscopy where staffing levels have been and remain a limiting factor.

Restoration activities are not yet at the level we would have expected, however, plans are constrained by staff availability and physical estate, alongside a decrease in Independent Sector capacity been offered.

Meeting our emergency access standard during winter through implementation of the Home First Programme

In August we continue to experience the same level of emergency activity as last year and still have approximately 10% of our beds unused due to ring-fencing. A comparison to our regional peers shows that we have returned to activity levels more quickly. Our urgent care and patient flow programme, Home First Worcestershire, is supporting performance and operational improvements, however, it has not yet resulted in consistent performance, particularly in response to individual day surges in demand.

NHS
Worcestershire
Acute Hospitals
NHS Trust

Meeting	Trust Board
Date of meeting	15 October 2020
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Maintaining our high standards of infection prevention and control
A spike in MSSA cases in June/July and a further two cases in August has meant that the target threshold of 10 is nearly exceeded with 9 cases year to date. A MSSA Blood stream infection **(**BSI) Action Group has met several times, providing scrutiny of divisional actions and sharing of learning between divisions. This has increased the scrutiny in relation to MSSA BSI, with DIPC and CNO oversight.

Improving our use of the Sepsis bundle
Sepsis performance is good with a HMSR of 102 but completion of the Sepsis 6 bundle within 1 hour remains below our standard. The Trust lead for Sepsis recently been able to recommence input to the wards (following the COVID pandemic) and is targeting increased compliance. Specialist Medicine and Surgery undertaking a real time review to identify blockers to documentation of bundle completion and prompt accessing the required tests.

Finance
Against our internal £(78.9)m operational plan (budget), the profiled month 5 (August 2020) deficit was £(6.5)m vs plan of £(8.0)m. Year to date deficit £(29.3)m vs Plan £(33.7)m. Members are asked to note however as a result of the interim COVID-19 framework and suspension of payment by results (PbR), income is then matched to cost resulting in a breakeven position under the NHSE/I Finance Framework.

The Trust incremental costs (included in the above) in response to COVID-19 remain stable between July and August at c.£1.3m. Year to date Covid 19 expenditure is c.£7.6m

Favourable expenditure variances against our internal budget, (month £1.7m and year to date £12.7m) despite incurring £1.3m of incremental in month COVID-19 costs which continue albeit at a reduced level as a result of the paused/reduced levels of service provision. Expenditure is also below that determined within the NHSI Finance Framework – Month 5 £0.7m and Year to date £7.2m.

The operating cost base is expectedly following an upward trend as the Trust bed base increases and services re-start.

Demand for temporary staffing is increasing and it is important that we can further demonstrate strong grip and control in the booking and utilisation of our temporary staffing resource.

Recommendations

The Board is asked to note this report for assurance.

Appendices

1. IPR – August 2020
2. Committee Assurance Statements

Integrated Performance Report

Trust Board

15th October 2020

August 2020

Month 5

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

Integrated Performance Report - Key Points

Operational Performance	Comments
Phase 3 restoration	• The draft phase 3 activity return was submitted on the 1st September by the STP. To prepare for the final submission, work was undertaken to build scenarios with Divisions and their Directorates to generate a detailed understanding of how much more activity can be safely restarted; this was aggregated with Wye Valley Trust and submitted by the STP on Monday 21st September.
Urgent Care and Patient Flow	• Emergency attendances increased again, but so did our 4 hour breaches. We did not have any 12 hour trolley breaches however ambulance handover breaches increased. Conversion rate from emergency attendance to admission remains above 30% at WRH.
RTT	• The overall RTT waiting list continues to grow as more referrals are received in line with Primary care restoring their services. More than half of our patients on the list are waiting over 18 weeks, almost triple the number compared to pre-COVID-19. The number of patients waiting 40+ and of those, 52+ continues to rise rapidly, a proportion of whom, particularly in oral related specialties, have not yet had their first appointment.
Cancer	• NSHEI, through restoration planning, are driving forward the expectation that 2WW cancer referral levels return to pre-COVID-19 levels. Although we know what this would look like numerically, it presents a challenge to plan for when the expectation has not yet been realised; Aug-20 referrals were lower than Jul-20. • Cancer patients requiring surgery are still being prioritised to be treated using our capacity at independent sector hospitals. However, there has been a reduction in the capacity available to us in the independent sector. • The backlog of patients waiting longer than 62 days for treatment has decreased with patients either being treated or diagnosed as not having cancer.
Diagnostics	• Efforts to increase diagnostics capacity have started, with further increases in radiology and endoscopy tests taking place in month. However, the proportion of our waiting list who have been waiting 13+ weeks is substantial, so more capacity needs to be identified to reduce our longest waits in conjunction with our new patients added to the waiting list.
Outpatients	• We delivered 30,695 outpatient appointments during August 2020; this is 72% of the outpatient activity level that we delivered in August 2019. • Non face-to-face appointments made up 40.77% of our total outpatient appointments. • Some of the phase 3 restoration metrics focus on consultant led activity based on our SUS data, which goes through several cycles of submission before being finalised. Initial analysis of Aug-20 activity shows that we delivered 71% of Aug-19 activity.
Theatres	• Of the available theatre capacity we have in the Trust we utilised 66%. More theatre capacity is being enabled, with two additional theatres in operation at ALX, 4 up and running at KTC and one more at WRH by the 5th October. Vacancy factors remain an issue for increasing the use of our theatres.

Integrated Performance Report - Key Points

Home First Worcestershire	Comments
Acute Front Door	• Transferring patients to SDEC areas is increasing at pace; however it isn't yet always able to offset surges in front door demand and prevent deterioration in performance. • Next steps to ensure better patient flow to specialist areas are reliant on workforce changes and approval of the AME business case
SAFER / Red to Green & LLOS	• The length of stay on non-COVID wards is increasing, mainly due to the balance of patients in the hospital being emergencies rather than routines • We continue to be under the year end target for long length of stay patients • GAP continues to be used to collect and audit results on 'Green wards' to deep dive into SAFER and triangulate recorded delays • System wide discussions continue to ensure that onward care is as efficient as possible to sustain the shorter length of stay for medically fit patients
Clinical Site Management	• The timeliness of beds being indicated that they are available need to be improved as it's currently contributing to reduced patient flow in the ED department • The discharge lounge is still under-utilised so a stakeholder Task and Finish group has been established with the objective to increasing usage of the discharge lounge to support 33% of discharges completed before midday • A system wide site escalation plan and WAHT Capacity and flow management policy have been approved and ready for implementation with supporting workforce recruited • A project lead has been asked to review our transport contract and the associated Trust processes with the aim of eliminating discharge delays caused by transport
Frailty and RESPECT	• The number of patients over 75+ with a Clinical Frailty Scale score has declined, with staff not able to determine frailty levels due to the acuity of these patients during the first COVID-19 wave, and recognising that scoring was not embedded enough prior to the COVID-19 first wave • The increase in the number of patients being discharged within 1-2 days indicates that the Discharge to Assess procedural changes that came in response to the COVID-19 pandemic supported the Trust to discharge patients more quickly to more suitable health providers. • Shortlisted finalist in Care of Older People Category, 'Integrating a frailty sensitive approach to the care of older people' • A task and finish group for End of Life care has been set up to review visiting for EOL patients whilst COVID-19 visiting restrictions remain
Patient Flow	• We having been working with our system partners supporting a 2 hour rapid response pilot in the Wyre Forest, Bromsgrove and Redditch. • Think 111 (First 111) which is a national programme aimed at reducing 'unhearalded' patients (those who have no and very minor treatment in ED) by 20% has commenced in Worcestershire Royal Hospital and we are currently receiving about 5-15 patients in allotted times • A review of the diagnostic turnaround times for CT took place with portering identified as a contributory factor for getting patients from ED to Radiology within an hour

Integrated Performance Report - Key Points

Quality & Safety	Comments
Infection Prevention & Control	• C-Diff, E-Coli and MRSA numbers are currently very close to, or lower than, internal trajectories. However, MSSA is at significant risk of not achieving the trajectory set with 9 of a maximum of 10 cases already confirmed in 20/21.
Sepsis 6	• Sepsis performance, particularly the within one hour element, is still below our internal standard. Divisional plans and the Trust lead for Sepsis re-commencing the Sepsis audits are expected to contribute to an improved position.
VTE Assessments	• Although VTE performance is high for those patients we assess, we are not testing everybody who is eligible. As well as increasing the number of eligible patients we assess, we are moving the focus to the 24 hour re-assessments.
ICE Reporting	• Viewing and filing results in ICE still remains an area of improvement. With the exception of abnormal results, discussions are being held as to the risk of harm that might arise if we batch close open reports.

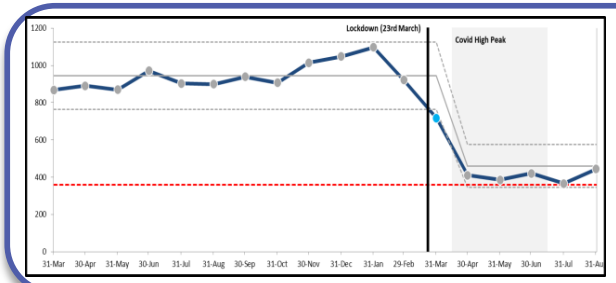
People & Culture	Comments
Appraisals and Job Planning	• Divisions are focusing on getting the basics right as our appraisal and job planning compliance remains below average. The main workforce challenge is the requirement to restore services whilst retaining the agility to respond to any further waves of the COVID-19 pandemic resulting in additional temporary staffing requirements.
Bank and Agency	• We are working with NHS Professionals to grow our bank to avoid higher agency staffing costs.
Vacancies	• Our vacancy rate has increased this period due to over 100 nursing students returning to education who have been employed as healthcare assistants during the pandemic. However, we continue to be successful with domestic recruitment and will be recommencing overseas recruitment in September.
Absence	• Sickness absence has returned to pre-COVID 19 levels but we have seen higher rates of mental health related absence due to the impact of the pandemic.
Staff well-being	• A comprehensive employee wellbeing programme is in place which is having a positive impact on performance.

Month 5 [August] 2020-21 | Operational Performance: Urgent Care & Patient Flow

Responsible Director: Chief Operating Officer | Validated for August-20 as 15th September 2020

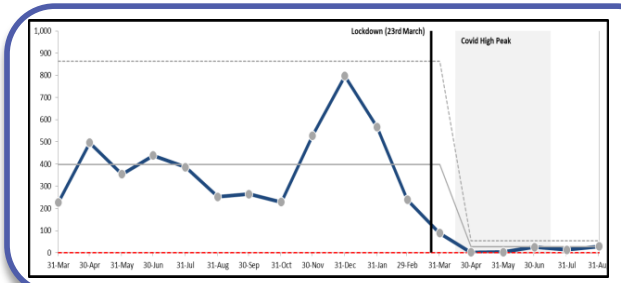
Total time spent in A&E (95th Percentile)

489



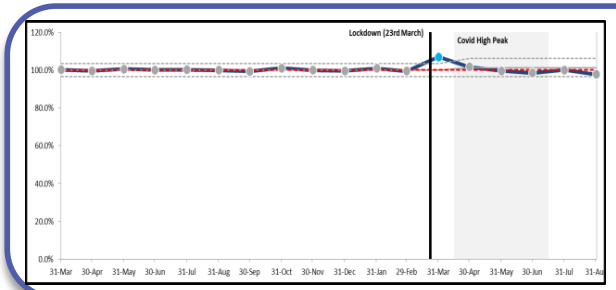
60 minute Ambulance Handover Delays

28



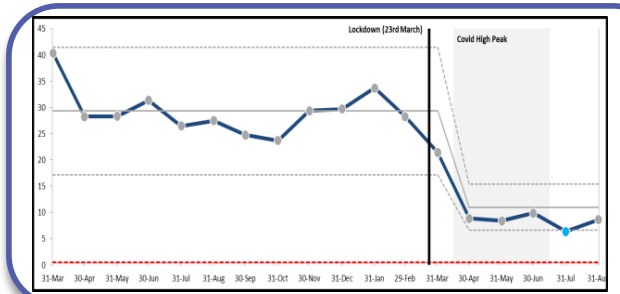
Discharge as a percentage of admissions

97.04%



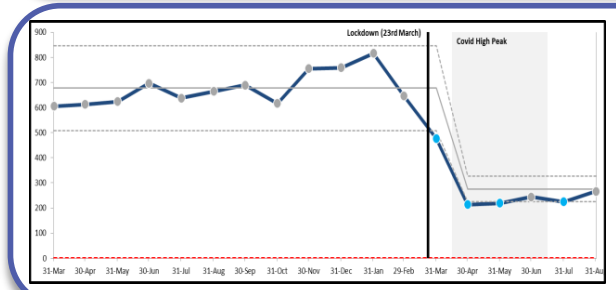
Capacity Gap (Daily avg. excl. EL)

8.16



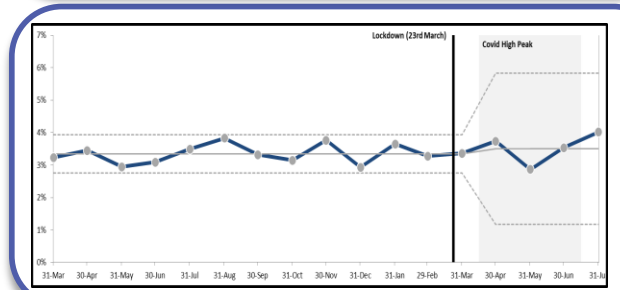
Aggregated Patient Delay (APD)

265



30 day readmission rate for same clinical condition (July-20)

4.01%



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.

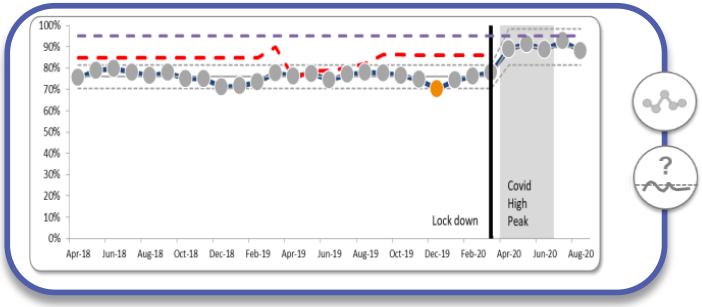
Month 5 [August] 2020-21 | Operational Performance: Urgent Care & Patient Flow

Responsible Director: Chief Operating Officer | Validated for August-20 as 15th September 2020

NHS Worcestershire Acute Hospitals NHS Trust

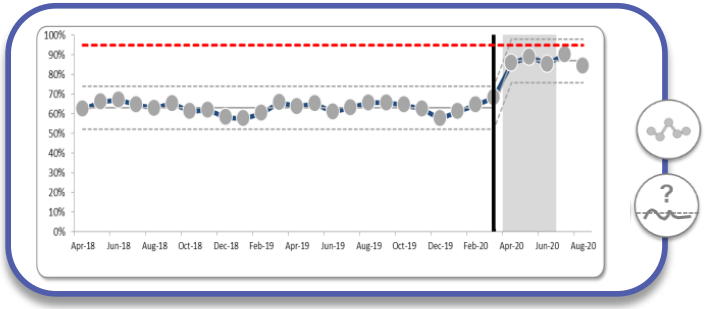
4 Hour EAS (all)

88.05%



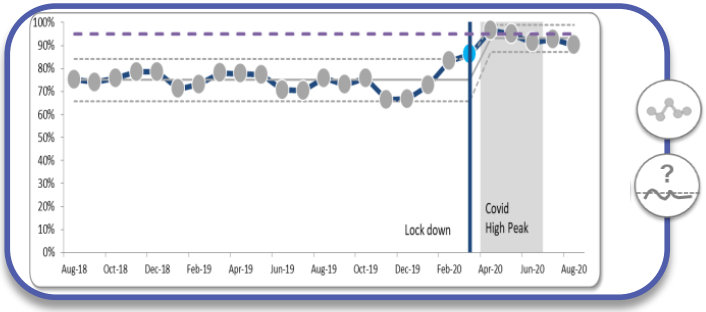
4 Hour EAS (Type 1)

84.23%



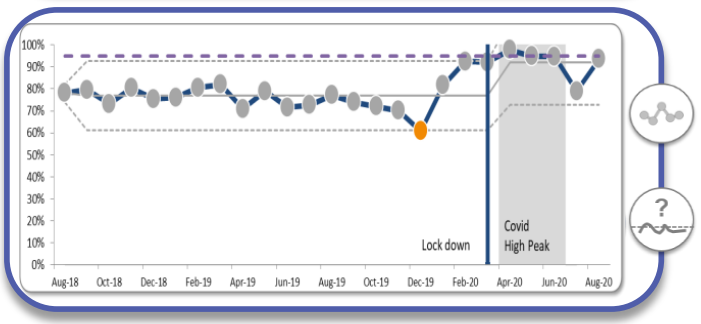
TTIA - % within 15 minutes WRH

90.26%



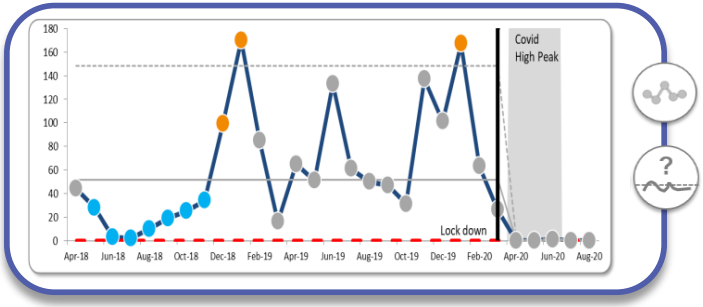
TTIA - % within 15 minutes ALX

93.87



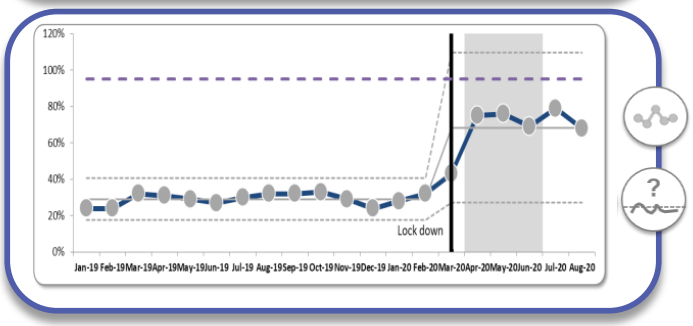
12 Hour Trolley Breaches

0



Specialty Review within 1 hour

68%



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.

Operational Performance: Patient Flow– What does the data tell us?

12 Hour Breaches	Ambulance Handover Delays (Home First Programme metric)			Average Occupancy			
	15-30 mins	30-60 mins	60+ mins				
0	933	172	28	WRH	82.99%	ALX	55.51%

What does the data tell us?

- **EAS** - The overall Trust EAS performance which includes KTC and HACW MIUs decreased to 88.05% in Aug-20, compared to 92.60% in Jul-20. **September month to date is 82.74%.** The EAS performance at WRH decreased by 6.40 percentage points with 284 more ED attendances and 475 more 4 hour breaches than July (August breaches – 1,310). The ALX EAS also decreased, by 5.47 percentage points, with 330 more attendances and 277 more 4 hour breaches (August breaches – 519). Total Type 1 attendances across ALX and WRH was 11,598; a 5.59% increase on the previous month and a 1.75% increase on Aug-19.
- **Ambulance Handovers** - There were 28 60 minute ambulance handover delays; all but one of those were at WRH. These ambulance handover breaches occurred on 5 individual days, so 25 days of August experienced no delays.
- **12 hour trolley breaches –** There were no reported 12 hour trolley breaches in August, but we have had 2 in September to date. We have now reported 3 x 12 hour trolley breaches in 20/21 compared to 409 by the end of September 19/20.
- **15 minute time to triage –** The Trust performance is 91.76%, the target is 95%. The ALX improved it's performance whilst WRH deteriorated; however both were within normal variation of the re-based performance.
- **Conversion rates** - 3,333 Type 1 patients were admitted which is a conversion rate of 29.34%. The conversion rate at WRH was 31.29% and the ALX was 26.62%. The conversion rate at WRH in Aug-20 compared to Aug-19 is 5.69 percentage points higher continuing the recent trend of higher patient acuity for people requiring urgent care.
- **Specialty Review times** – Data provided as part of the Internal Professional standards shows that Specialty Review times for the Trust are consistently around 40-50% of all patients who need a specialty review being seen within 30 minutes and 60-70% within 60 minutes. The results of a recent audit in Worcestershire Royal highlighted both data quality and processes that are contributing to poor data capture and performance. The same audit will now be repeated at the Alexandra Hospital.
- **Discharges –** The % of discharges compared to admissions at the WRH has been between 66% and 122% and fluctuates significantly from day to day – the target is 100%. The ALX has a similar profile with the range between 36% and 140%. Before midday discharges are on an increasing trajectory, however there is still a lower performance on weekends. The number of patients with a length of stay in excess of 21 days increased to 44 but only 9 of those were deemed clinically optimised.

National Benchmarking (August 2020) | The latest published national data is for August 2020. The Trust was one of 12 of the 13 West Midlands Trusts which saw a decrease in EAS performance between July and August. This Trust was ranked 6th of 13; we were 5th previous month. The peer group performance ranged from 77.04% to 94.66% with a peer group average of 88.00%; decreasing from 92.07% the previous month. The England average for August was 89.3%, a 1.8 percentage point decrease from 91.10%, in July.

Home First Programme Summary Update - What does the data tell us?

Total time in A&E – 95th percentile (Target – 360 mins)	Overnight Bed Capacity Gap (Target – 0)	30 day re-admission rate	Aggregated patient delay (APD) (Target – 0)	Discharges as a % of admissions – (Target >100%)			
489 minutes	8 beds	4.01%	265 possible patients	WRH	99.1%	ALX	93.1%

What does the data tell us?

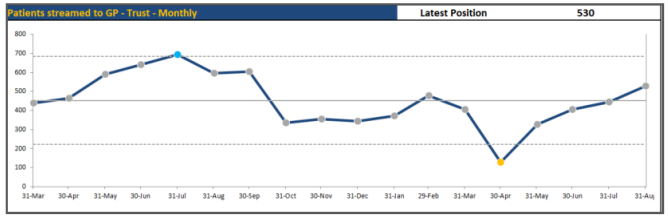
- **Total Time in A&E:** The 95th percentile for patients total time in the Emergency departments has increased from 366 in July to 489 minutes. The allocation and availability of the bed type needed has contributed towards this. This metric is showing normal variation, but the statistical process chart indicates we will not achieve our target without intervention.
- **Occupancy -** G&A bed occupancy averaged at 71.74% across the Trust, with the WRH increasing week on week in August to as high as 90% at month end and the ALX increasing week on week to 58.64% at month end and went over 65% on some days. Overnight bed capacity has increased to an average of 5 per night at WRH and 3 per night at ALX. Although bed type has been one of the main contributions to this i.e. having a clinically suspected Covid or Green bed available.
- **Bed Capacity** - We have increased our bed base by opening previously closed wards at the ALX. Our G&A bed base is current 761, but with closed wards and unused beds during August it averaged 679.
- The **re-admission rate has crept to the highest it has been for several months**, although it is within normal variation, but the control limits are wide which indicates a change during Covid 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 is within the control limits following the re-base post covid. The statistical process chart indicates we will not achieve the target of 0 without intervention.
- **We have no corridor care at either site.** *Please note: the corridor is used for some triage activity but not treatments.*

Month 5 [August] 2020-21 | Home First Project – Acute Front Door

Responsible Director: Chief Operating Officer | August 2020 – September 18th 2020

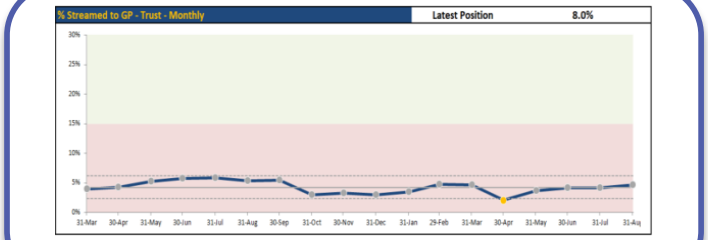
No of patients streamed to GP services (Trust)

530



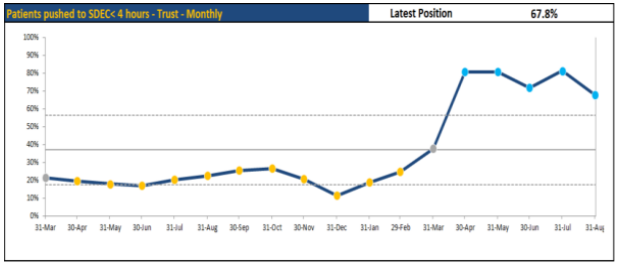
% of patients attending ED streamed to GP services (Trust)

8%



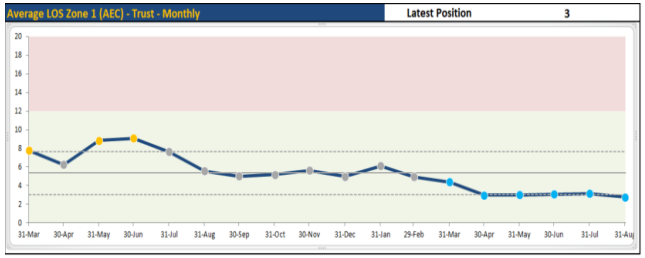
% of patients attending ED that are transferred to SDEC areas. (Trust)

67.8%



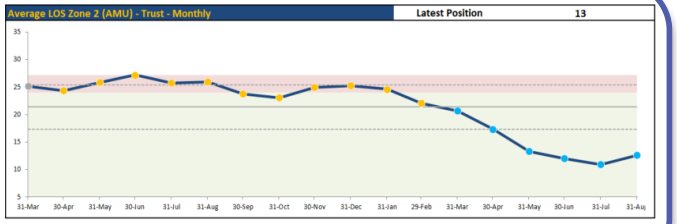
Average LOS in hours in AEC – Zone 1. (in hours) (Trust)

3



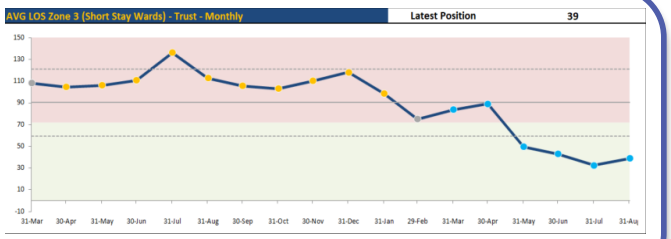
Average LOS in hours in AMU – Zone 2 (in hours) (Trust)

13



Average LOS in short stay wards – Zone 3 (in hours) (Trust)

39



Home First Project Update – Acute Front Door

Data – August 2020

Average LOS in hours in AEC – Zone 1 (in hours) WRH (Target – 12 hours)	Average LOS in hours in AEC – Zone 1 (in hours) ALX (Target – 12 hours)	Average LOS in hours in MAU – Zone 2 (in hours) WRH (Target – 24 hours)	Average LOS in hours in AMU – Zone 2 (in hours) ALX (Target – 24 hours)	Average LOS in short stay wards – Zone 3 (in hours) WRH (Target – 72 hours)	Average LOS in short stay wards – Zone 3 (in hours) ALX (Target – 72 hours)
3 hours	2 hours	14 hours	11 hours	47 hours	29 hours

What does the data tells us?

- Although the number of patients streamed to GP primary care has improved it is not yet at the levels seen last year.
- The number of patients being transferred to SDEC areas has increased significantly – this statistical process chart will need to be re-based shortly.
- All zones have an average number of hours per patient well within the targets.
- We need to monitor the number of patients within the Emergency Departments to see whether the SDEC areas can do more to prevent the declining performance when surges occur.

What have we been doing?

- Primary Care Navigation at the ED Front Door & Primary Care Resources in ED
- New navigation process continues to receive positive feedback and data shows impact (see dashboard)
- Consistency in ANP cover now being achieved and extended until November. ANP also supporting ED when streaming work completed
- ED Assessment Process
- ED Matron / ED clinical completed process mapping.
- Reviewed AEC criteria and specialist pathways with all Divisions eg abdominal pain, review of fractured NoFs
- Medical Workforce Review - Recruitment and retention proposal HRBP feedback and attraction package agreed by HRBP and submitted to TME for approval.
- Paediatric Assessment Unit - Meeting scheduled for ED / Paediatric consultants to work together on winter planning and jobs approved for recruitment to cover evening paediatric clinic and locum ATR approved with November start date

What are we doing next?

- Primary Care Navigation at the ED Front Door & Primary Care Resources in ED
- Formal evaluation of role and impact to be completed by end September and results presented to HFW on 6th October
- Medical Workforce Review - Interviews for Emergency Consultant posts (provisionally booked for Sept).
- Paediatric Assessment Unit – Await the outcome of the AMU business case at TME in September.
- AMU Business case – Awaiting outcome of business case at TME in September.

Assurance Level for this project : LEVEL 3 (AMBER)
Proposal for change in level : On full implementation as business as usual of the AMU changes at the Alexandra Hospital (October 2020)

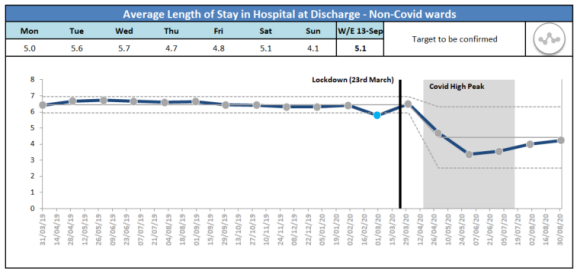
Month 5 [August] 2020-21 | Home First Project – SAFER / Red to Green Update

Responsible Director: Chief Operating Officer | August 2020 – September 18th 2020

NHS Worcestershire Acute Hospitals NHS Trust

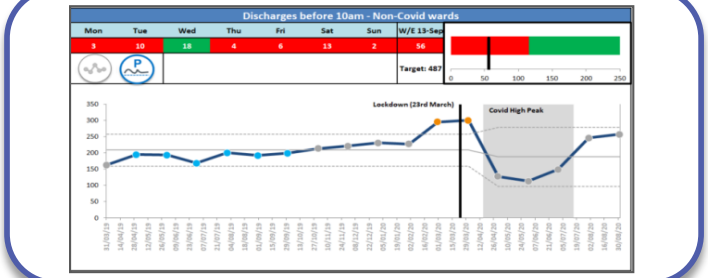
Average length of stay in hospital at discharge – NON Covid wards

4.2 days



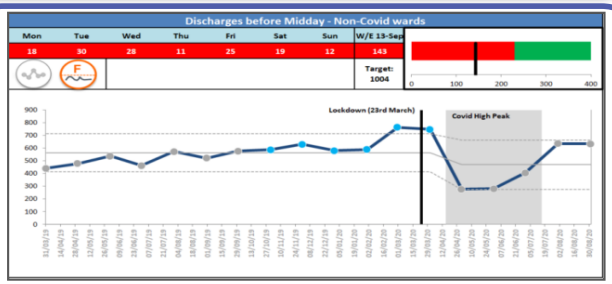
Discharges before 10am (Non Covid wards)

258



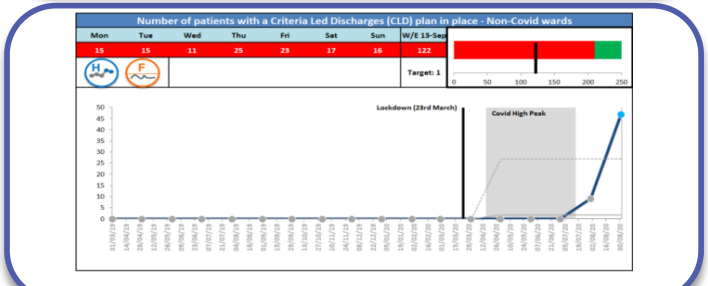
No. of discharges and transfers before midday – Non Covid

634



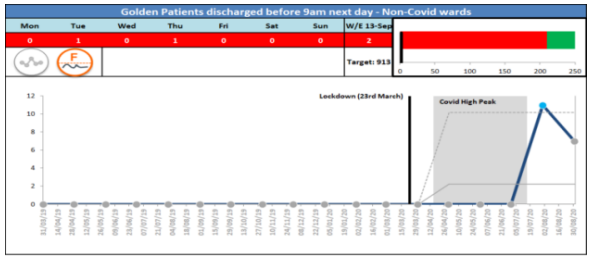
Number of pts with a criteria led discharge plan in place (Non Covid Wards)

47



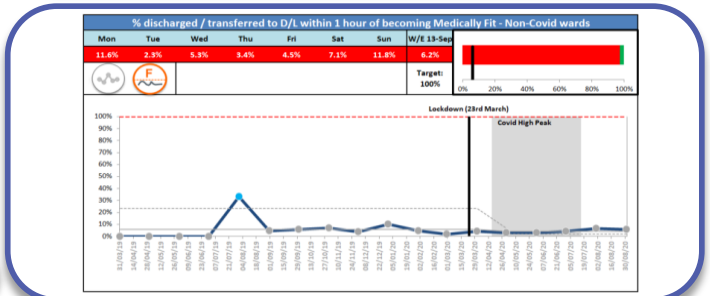
Golden patients leaving before 9am (Non Covid wards)

7



(Non Covid) % of patients moving to the Discharge Lounge within one hour of becoming med fit

5.3%



Home First Project Update – SAFER / Red to Green & LLOS

No. of patients at the end of the month with a length of stay 21 days or longer	No of bed days for patients who were in the hospital over 21 days	%/no. of simple discharges	% of patients discharged on a pathway	Expected emergency admissions in September per day	Referrals made to onward care team
44	408	86.3% (3,753)	13.7% (597)	118	614

What does the data tells us?

- Length of stay for the Non Covid wards has had four months of consecutive rise, although this is within the statistical control limits. The modelling for winter pressures stated that length of stay for emergency patients (which these will predominantly be as we have not restarted all elective activity on Trust sites yet) should be between the pre and post LOS (c7 days for emergency surgical patients and c3.6 days for other emergency patients.
- WRH achieved 18.7% of discharges before midday, the ALX achieved 23.2%. The target per day is 33%.
- The number of patients with a criteria led discharge plan has increased but is still not at the level needed, particularly at weekends to support the demands for beds.
- Only 7 golden patients in August were recorded as going before 9am, despite the actual number identified being 23.
- LLOS continues to be below the year end target of 58, there were 44 in August.

What have we been doing?

- "Know How You are Doing" Dashboards developed. This provides a view of the Metrics at Ward level. Admin post recruited to and will start 14th September
- Seconded flow matron will be extended for a further 2 months
- Continue to utilise GAP audit results 'Green wards' to deep dive into SAFER and triangulate recorded delays to ensure all delays are correct

What are we doing next?

- One Stop ward rounds tests to be further analysed for impact i.e. shift to a sustained trend of performance measures and collate qualitative feedback (staff survey). This will be shared at the next HFW Board.
- Plan to roll out of Criteria Led Discharge to all wards, some wards have already implemented CLD.
- Roll out of phase 2 plan for One Stop Ward Rounds: working with Pharmacy to enable ability for 7 day timely discharges not delayed/prevented through inability to provide TTO`s (dependant on findings)
- Audit and deep dive being carried out in order to identify specific issues with not fit patients with an NF3 code (waiting for internal test, specialist opinion or similar), this will be reported in October board meeting.
- System wide discussions to ensure that onward care is as efficient as possible to sustain the lower length of stay for medically fit patients.

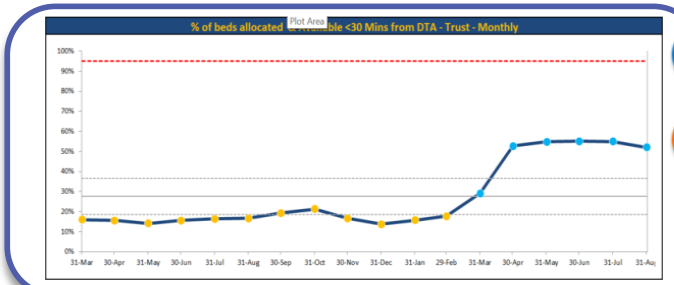
Assurance Level for this project - Level 6
Proposal for change of assurance level – Before midday discharges are sustained at 33%.

Month 5 [August] 2020-21 | Home First Project – Clinical Site Management

Responsible Director: Chief Operating Officer | August 2020 – September 18th 2020

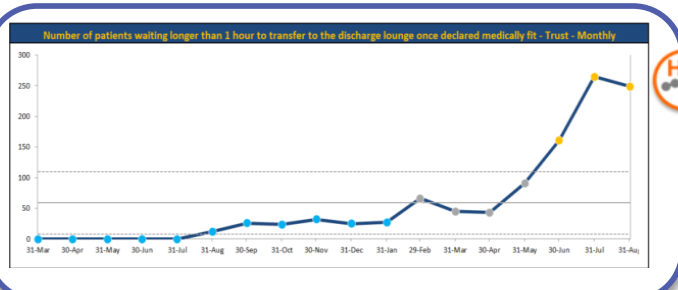
% of beds allocated and available within 30 mins of DTA (Trust)

52%



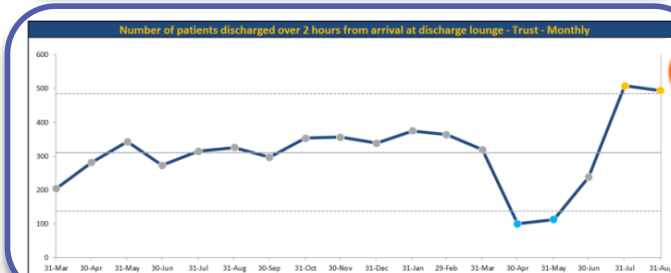
Number of patients waiting longer than one hours to transfer to discharge lounge once med fit (Trust)

249



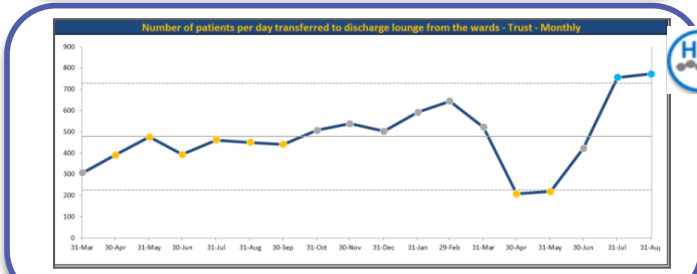
No. of patients discharged over 2 hours of arrival on discharge lounge (Trust)

494



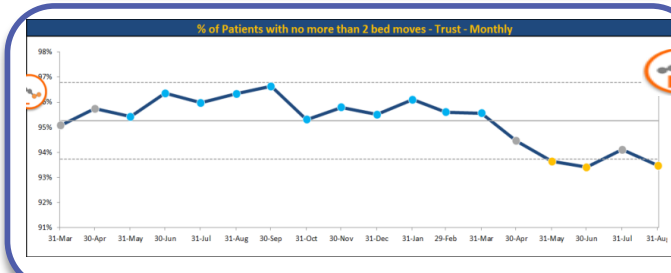
No. of patients transferred to the discharge lounge (Trust)

774



% of patients with no more than 2 ward moves (Trust)

93%



Home First Project Update – Clinical Site Management

No.of patients transferred to the discharge lounge WRH	No. of patients discharged after more than 2 hours - ALX	No. of patients with no more than 2 ward moves - WRH	No. of patients with no more than 2 ward moves - ALX	% of beds allocated and available in 30 mins of DTA - WRH	% of beds allocated and available in 30 mins of DTA - ALX
446	262	92% - SIGNIFICANT CAUSE	96%	44%	65%

What does the data tells us?

- Beds that are indicated as becoming available, do become available but not within the 30 mins that they should , this delay creates a backlog in the ED department, particularly at WRH. This metric is above the upper control limit, but will not achieve the target without change.
- Despite this the number of bed moves for patients is reducing at the WRH, hopefully indicating patients are moving to the right ward for their needs as early as possible. This metric is showing a change in trend – improvement.
- The number of patients moving to the Discharge Lounge at WRH has improved but is still only at 25% maximum occupancy. Only 25% of these patients attend the Discharge lounge before midday.

What have we been doing?

- Recruitment: All three experienced CMS Matrons now in post. Induction packs ready for new CSM Band 7 posts
- Site escalation: the System wide site escalation plan and WAHT Capacity and flow management policy both approved and ready for implementation
- Bed Management: the specialty medicine "huddles" which were established to ensure that 20 beds become available before midday continue.
- Weekend Bed Management: the trial of the new weekend planning template continues. Medical review of outliers was identified as a specific issue. An additional doctor has been rostered to work w/e 4th September to assess impact on discharges over the weekend
- Real time bed capacity: CSM team have been evaluating the real time OASIS bed management module to establish if this would benefit the site management team to manage bed capacity.
- Discharge Lounge: Stakeholder Task and Finish group commenced with the objective to increasing usage of the discharge lounge to support 33% of discharges completed before midday. A comprehensive list of issues has been identified by the stakeholders.

What are we doing next?

- Launch, communicate, implement and embed the System wide site escalation policy and the WAHT Capacity and Flow Management Policy
- CSM Matrons and project group to evaluate the initiatives mentioned above.
- Discharge Lounge task and finish group to agree priority areas for change and plan next steps to ensure capacity is available to meet demand, including accepting amber and the majority of patients unable to be discharged direct from the ward
- CSM Matrons and Project group to review discharge lounge SOP and agree how to ensure compliance
- Project Lead to review transport contract and associated Trust processes with the aim of eliminating discharge delays caused by transport

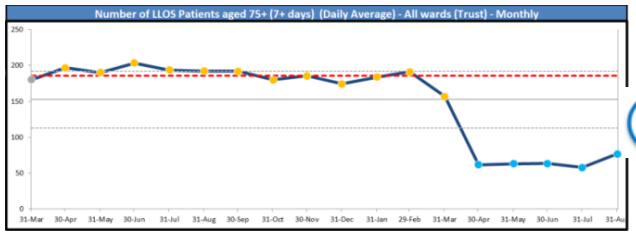
Assurance Level for this project - Level 4
Proposal for change of assurance level – Evidence that the escalation triggers are effective in supporting ED to reduce breaches during periods of increased pressure (End of Sept 2020)

Month 5 [August] 2020-21 | Home First Project – Frailty

Responsible Director: Chief Operating Officer | August 2020 – September 18th 2020

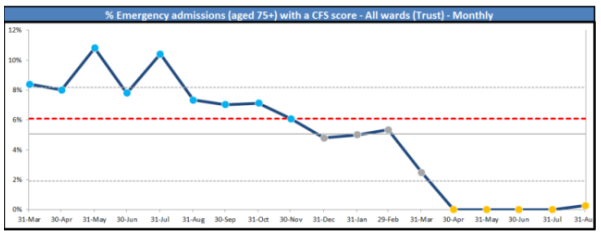
Number of over 75 year olds with a LOS 7 or above

76



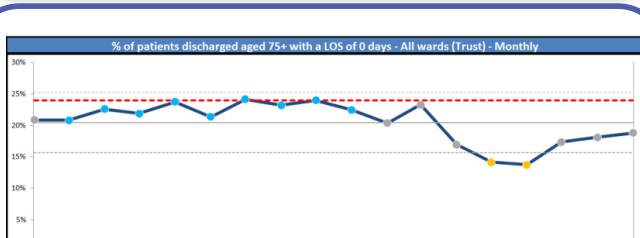
% of emergency admissions (aged 75+) with a clinical frailty score

2%



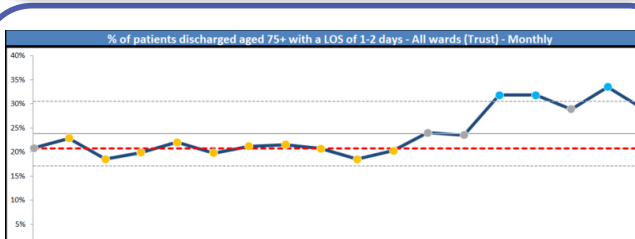
% of patients discharged aged 75+ with a LOS of 0 days

18%



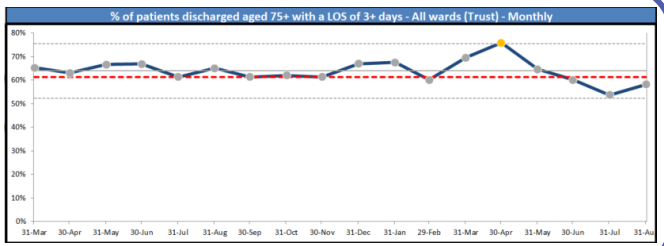
% of patients discharged aged 75+ with a LOS of 1-2 days

28%



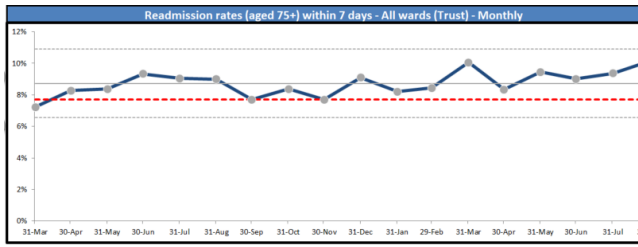
% of patients discharged aged 75+ with a LOS of 1-2 days

58%



Readmission rate (aged 75+) within 7 days

10%



Home First Project Update – Frailty and RESPECT

Number of over 75 year olds with a LOS 7 or above - WRH	Number of over 75 year olds with a LOS 7 or above - ALX	% of patients discharged aged 75+ with a LOS of 0 days WRH	% of patients discharged aged 75+ with a LOS of 0 days ALX	Readmission rate (aged 75+) within 7 days WRH	Readmission rate (aged 75+) within 7 days ALX
50	27	18.7%	18.8%	9.5%	11%

What does the data tells us?

- The Covid first wave impacted the older generation significantly, and therefore it makes it difficult to identify what is a trend as a result of the virus or change to process /pathway within the hospitals.
- The number of patients over 75+ with a CFS has declined, this may be because the ambulance and ED staff could not determine frailty levels due to the acuity of these patients during the first wave, it could be that the scoring was not embedded enough prior to the Covid first wave commencing.
- The increase in the number of patients being discharged within 1-2 days though could indicate that the Discharge to Assess procedural changes that came in response to the Covid pandemic supported the Trust to discharge patients more quickly to more suitable health providers.
- The readmission rate has started to increase with 7 days with a slower rate of increase over 28 days, this could be again due to Covid infections. We will look at separating the Covid clinically suspected from the non Covid to see if this highlights any significant changes.
- RESPECT – Awareness is now above the target of 75%, however authorship is still below the target of 75% - end of August position was 60.23%

What have we been doing?

- ICOPE Business Case approved at TME May-20; risk share model agreed in principle to be signed off by 10th September .
- AMU business case will include an improved Frailty Pathway to correlate and co-develop with the ICOPE delivery.
- A front door GEMS service has been piloted and is going through PDSA cycles of improvement.
- We have recruited Geriatrians and have further recruitment to a total of 13 funded and 10 funded ACP posts continues.
- Home First Programme Clinical Lead - Clinical Director Endocrine, Frailty and Gastroenterology appointment to be discussed
- RESPECT – The national e-learning programme is now available through ESR.

What are we doing next?

- Shortlisted finalist in Care of Older People Category, 'Integrating a frailty sensitive approach to the care of older people' embedded. Award ceremony 14th October 2020
- Rockwood Clinical Frailty Scale is being integrated into a number of our clinical forms and letters.
- We have agreed the metrics that we will use to monitor the success of this project.
- A task and finish group for End of Life care has been set up to review visiting for EOL patients during the Covid period.

Assurance Level for this project - Level 3
Proposal for change of assurance level – On evidence of change from the Geriatrician at the front door pilot.

16

Operational Performance: Patient Flow

Home First Overarching metrics (*Ambulance H/O's earlier slide)	Selected key supporting metrics

Annual Plan: Strategic Objective One | Best services for local people
1.2 URGENT AND EMERGENCY CARE: Countywide service/pathway development for urgent and emergency care

How have we been doing?

- The business case for the WRH development of the AMU was reviewed at an extraordinary strategy and planning meeting. We are looking at what can be put in place realistically in the immediate future to support the Winter pressures.
- We having been working with our system partners supporting a 2 hour rapid response pilot in the Wyre Forest, Bromsgrove and Redditch. This project will aim to provide care in the community within 2 hours and reduce ambulance conveyances to the Alexandra Hospital. We are now at the stage where we are identifying the data to monitor progress.
- Think 111 (First 111) which is a national programme aimed at reducing 'unhearalded' patients (those who have no and very minor treatment in ED) by 20% has commenced in Worcestershire Royal Hospital. The pilot has not yet been communicated to the public. We are currently receiving about 5-15 patients in allotted times.
- CT scanning delays – we have undertaken an audit and as a result agreed to have timed slots for ED radiology patients on trial.
- Education of new ED doctors taking place to ensure understanding of radiology processes
- Agreed one day PDSA trial of non-clinical helpdesk role supporting duty radiologist call. Trial undertaken on 28/8/20 and data captured ready for analysis

What improvements will we make?

- A review of the diagnostic turnaround times for CT is taking place and results took place and we are trialling some changes.
- We are ensuring that our Winter plan strategy is communicated effectively, so that everyone knows which surge capacity to open as the occupancy levels increase.
- We have launched an escalation policy for the hospital that has clearly set out actions to be used to prevent times of capacity crisis in the hospital. We are just finalising the data trigger points that will accompany the policy and how best to make these triggers visible.
- Phase 3 modelling has been completed and the activity plans for Elective Outpatient, inpatients and diagnostics has been submitted. We will be monitoring our performance against the plan as frequently as coding allows.
- CT scanning delays – review of portering which has been identified as a contributory factor for getting patients from ED to Radiology within an hour.

Overarching Home First Programme Level – 4 – July 2020
Previous Assurance Level - 4 – June 2020

To improve to next assurance level:
AMU fully embedded at the ALX. WRH AMU commenced implementation.

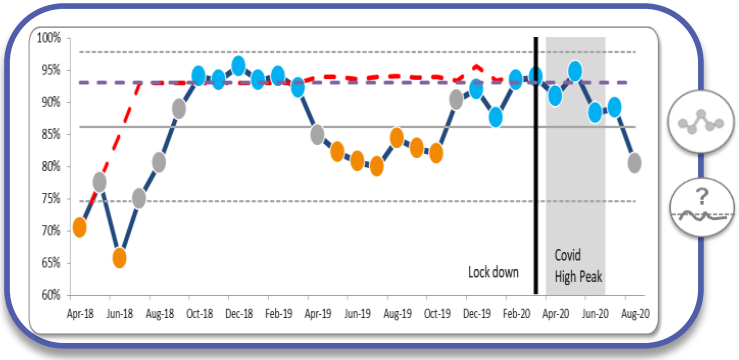
Month 5 [August] 2020-21 | Operational Performance: Cancer

Responsible Director: Chief Operating Officer | Unvalidated for August-20 as 15th September 2020

Worcestershire Acute Hospitals NHS Trust

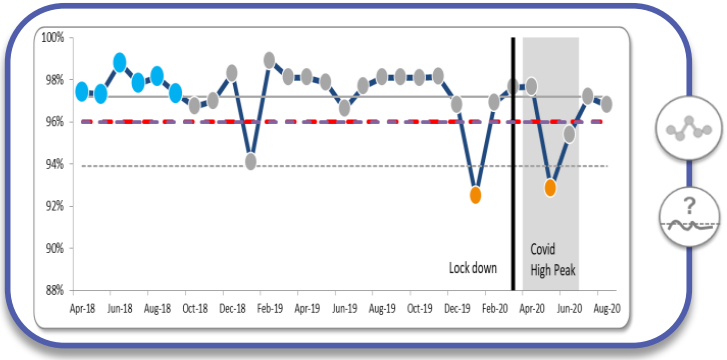
Cancer 2WW All

80.48%



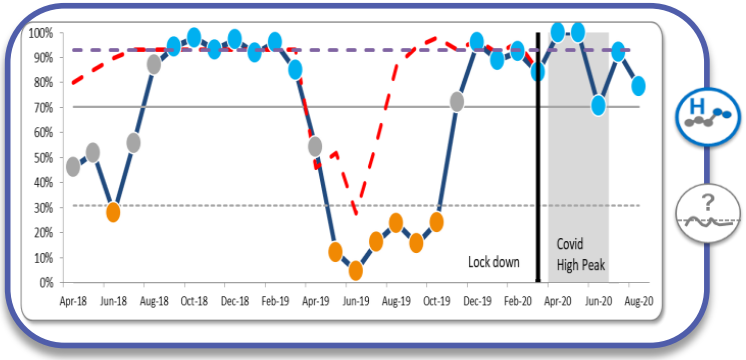
Cancer 31 Day All

96.79%



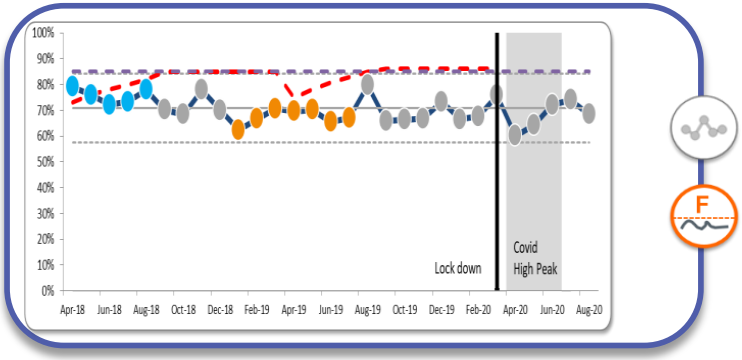
Cancer 2WW Breast Symptomatic

77.78%



Cancer 62 Day All

69.52%



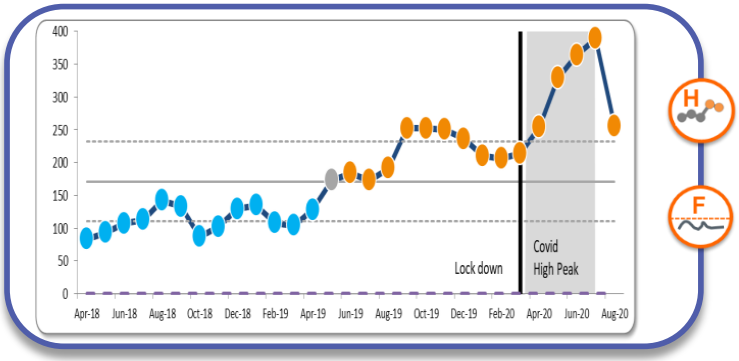
Month 5 [August] 2020-21 | Operational Performance: Cancer

Responsible Director: Chief Operating Officer | Unvalidated for August-20 as 15th September 2020

NHS Worcestershire Acute Hospitals NHS Trust

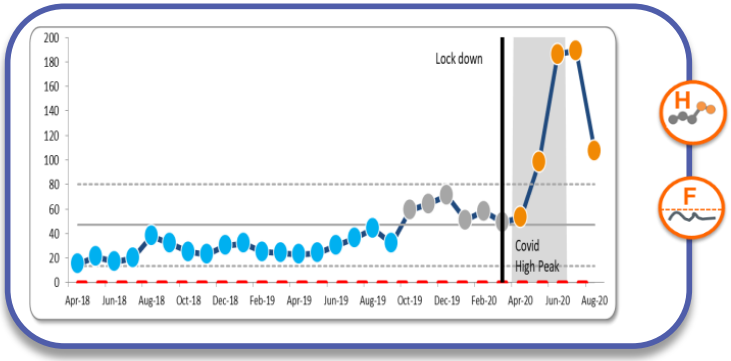
Backlog 62+ Day Waiters

255



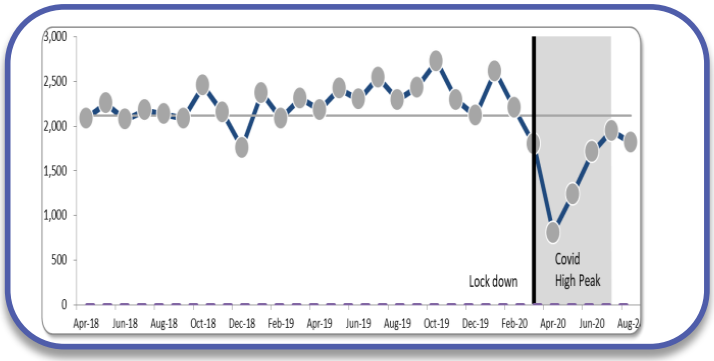
Backlog 104+ Day Waiters

107

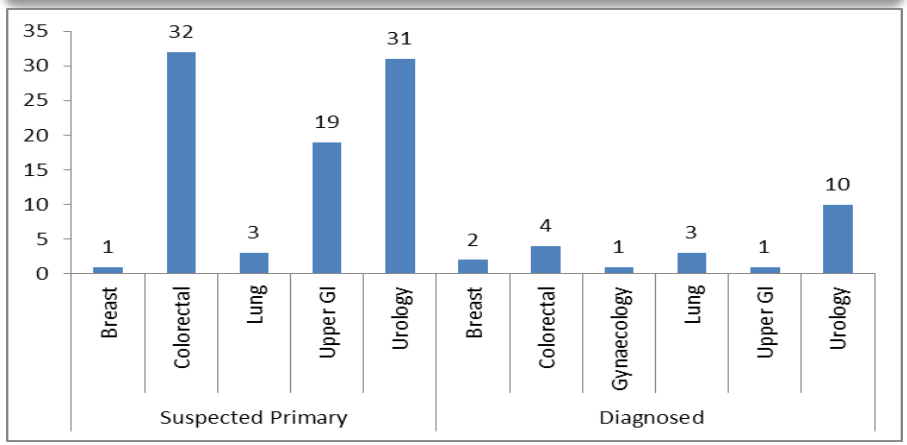


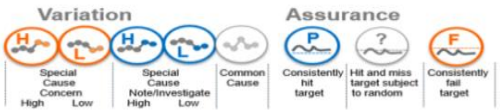
2WW Referrals

1,813



104+ Day Backlog profile





Operational Performance: Cancer

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

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	Back log of patients waiting 62+ days	Back log of patients waiting 104+ days
1,813	80.48% (1,783 seen)	77.78% (90 seen)	96.79% (218 Treated)	69.52% (158.5 Treated)	255	107

What does the data tells us?

- **Referrals:** The recent trend of month on month increases in 2WW referrals has not continued in Aug-20 with 135 fewer than Jul-20 and 20% lower than Aug-19. Only Lower GI, Lung and Upper GI saw an increase in referrals in the month.
- **2WW:** The Trust saw 12% more patients in Aug-20 than Jul-20 and 80.48% were within 14 days. Three specialties were below the 93% standard, these were Upper GI, Skin and Urology. Of the 348 breaches, 213 (61.2%) were attributable to Upper GI with the diagnostic pathway continuing to impact timeliness of appointments. Across all tumour sites, 63 2WW breaches were due to patient choice.
- **2WW Breast Symptomatic:** The Trust saw fewer patients referred for breast symptoms but their waiting time performance declined to 77.78% in Aug-20 from 91.95% in Jul-20.
- **31 Day:** Of the 218 patients treated in Aug-20, 211 waited less than 31 days for their first definitive treatment from receiving their diagnosis; 7 patients breached.
- **62 Day:** There have been 158.5 recorded treatments in Aug-20 to date and 69.10% were within 62 days. This is currently 8.5 more treatments than in Jul-20 and only 6.5 fewer than Aug-19.
- **Backlog:** The number of patients waiting 62+ days for their diagnosis and, if necessary, treatment has reduced from 389 in Jul-20 to 255 in Aug-20, with 107 of those patients waiting 104 days or more, down from 189. Colorectal, upper GI and urology continue to contribute the most patients to this waiting list. 10 patients are waiting for diagnosis or treatment at a tertiary centre.

What have we been doing?

- To meet the fluctuations in demand, capacity was flexed including the creation of additional 2WW WLI clinics where consultant capacity allowed
- Upper GI have now set up MDT triage
- Continued prioritisation of cancer surgery within available theatre capacity
- Specialty medicine still have some 2WW capacity to re-start.

What are we doing next?

- The expectation from phase 3 restoration is that 2WW referrals return to pre-COVID-19 levels so further increases in capacity will be required; therefore additional demand and capacity exercises will be undertaken across all elements of the patients pathway to ensure there is adequate capacity available as these numbers are realised.
- Focus on actions to prevent 62 day breaches whilst addressing the current backlog
- The restart of endoscopy diagnostics should see an improvement in the coming months in the Upper GI cancer pathway times with a plan being reviewed to increase endoscopy PAs
- Continue to focus on PTL management to ensure patients have greater certainty regarding their care in a shorter period of time.

Operational Performance: Cancer continued

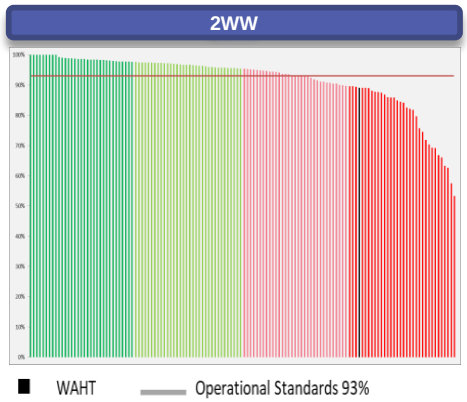
National Benchmarking (July 2020)

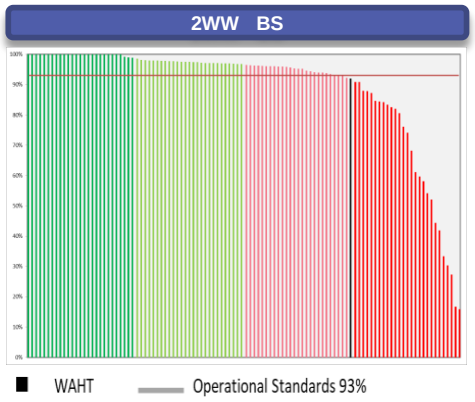
2WW: The latest published national data is for July 2020. The Trust was one of 4 of the 13 West Midlands Trusts which saw an increase in performance between June and July. This Trust ranking changed from 12th to 11th out of 13. The peer group performance ranged from 53.29% to 98.10% with a peer group average of 94.10%; decreasing from 94.10% the previous month. The England average for July 2020 was 90.38%, a 3.72 percentage point decrease from 92.50% in June.

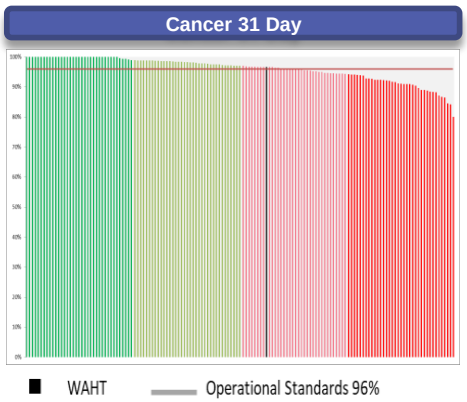
2WW BS: The latest published national data is for July 2020. The Trust was one of 5 of 12 West Midlands Trusts who saw an increase in performance between June and July. This Trust was ranked 11 of 12. The peer group performance ranged from 15.87% to 100% with a peer group average of 96.81%; decreasing from 97.33% the previous month. The England average for July 2020 was 86.43%, a 4.16 percentage point decrease from 90.59%, in June.

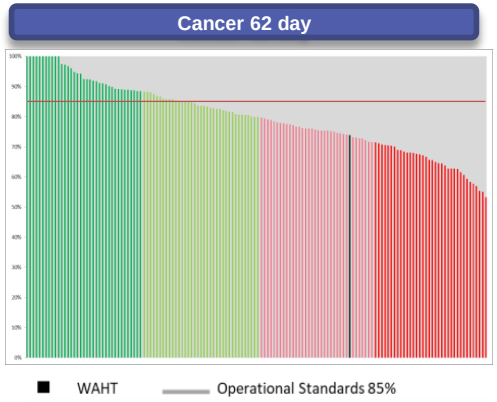
31 days: The latest published national data is for July 2020. The Trust was one of 5 of the 12 West Midlands Trusts who saw a decrease in performance between June and July. This Trust was ranked 5 of 12. The peer group performance ranged from 86.49% to 98.57% with a peer group average of 95.24%; increasing from 93.62% the previous month. The England average for July 2020 was 90.05%, a 3.70 percentage point decrease from 93.75%, in June.

62 Days: The latest published national data is for July 2020. The Trust was one of 7 of the 13 in the West Midlands Trusts who saw a decrease in performance between June and July. This Trust was ranked 7th of the 13. The peer group performance ranged from 53.28% to 86.59% with a peer group average of 73.84%; increasing from 69.28% the previous month. The England average for July 2020 was 78.41%, 3.2 percentage point decrease from 75.21% in June.









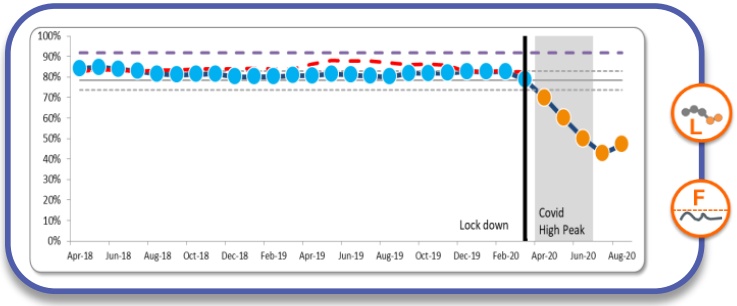
Month 5 [August] 2020-21 | Operational Performance: RTT

Responsible Director: Chief Operating Officer | Validated for August-20 as 21st September 2020

Worcestershire Acute Hospitals NHS Trust

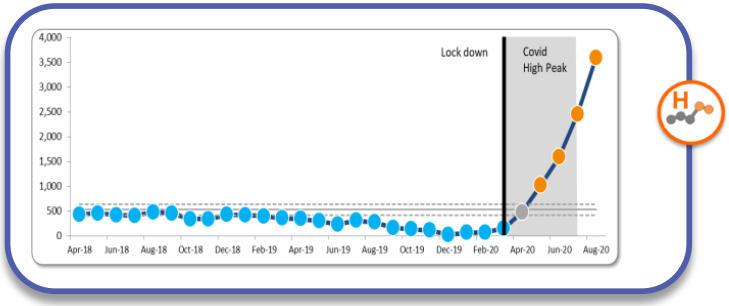
RTT % within 18 weeks

47.84%



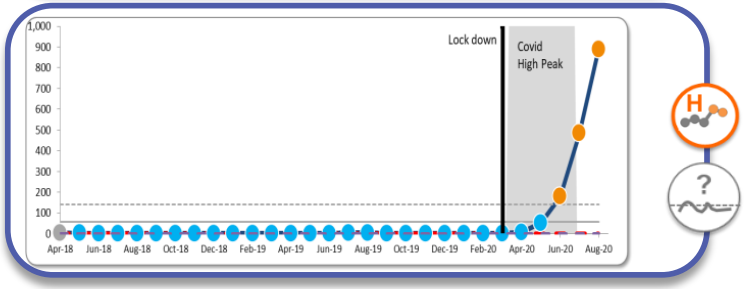
40-52 week waits

3,557



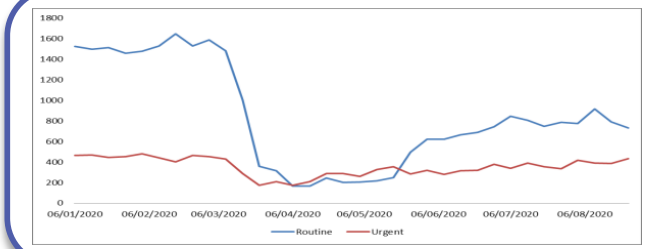
52+ week waits

873

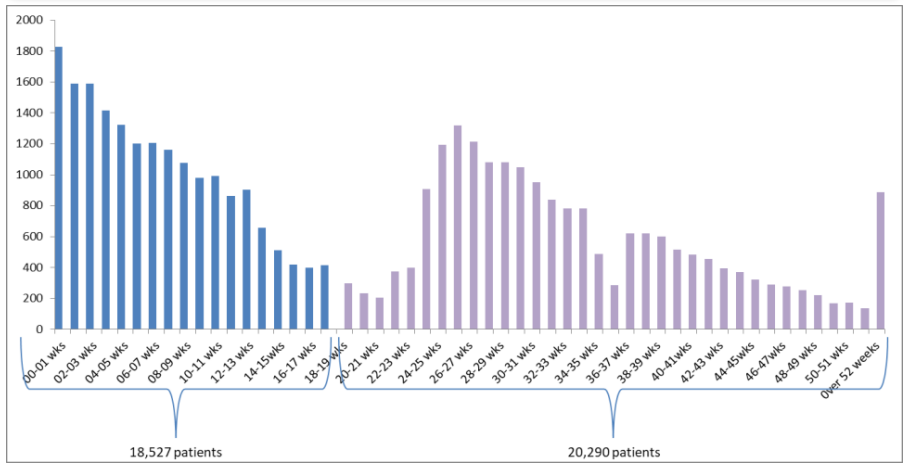


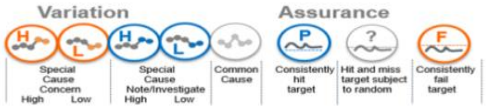
RTT Referrals

4,932



August RTT Waiting list profile split by 0-18 and 18+ weeks





Operational Performance: RTT

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

Percentage of patients on a consultant led pathway waiting less than 18 weeks for their first definitive treatment	Total Waiting List	Number of patients waiting over 18 weeks	Number of patients waiting 40 to 52 weeks or more for their first definitive treatment	52+ weeks	RTT Referrals (Routine and Urgent) received
47.84%	38,511	20,087	3,557	873	4,932

What does the data tells us?

- The Trust has seen a 5.85% increase in the overall wait list size in Aug-20 compared to Jul-20; from 36,384 to 38,511.
- The number of patients over 18 weeks who were unable to be treated remains above 20,000, with a reduction of 558 patients from Jul-20. The combination of a larger waiting list with new patients being added to it and a slight reduction in the total number of patients above 18 weeks has seen an improvement in validated RTT performance from 42.70% in Jul-20 to 47.84% in Aug-20.
- The Trust is reporting 4,430 patients waiting over 40 weeks for treatment, and 889 of those patients waiting over 52 weeks.
- Surgical specialties contribute 55% of all breached patients. The following specialties have more than 1,000 patients waiting over 18 weeks; ophthalmology, general surgery, urology, ENT, oral surgery, T&O, and gynaecology. Gastroenterology is close behind with 931 breached patients at the time of writing.
- RTT referrals (urgent and routine) have decreased by 7.76% from Jul-20 to Aug-20 and 4,932 is 33% fewer referrals than Aug-19 when we had 7,409.

What have we been doing?

- Escalation of long waiting patients to the appropriate consultants for review and validation
- Fully functioning and now well used advice and guidance across Specialty Medicine division
- Triage of all routine referrals to ensure appropriate patients receive face-to-face appointments

What are we doing next?

- Restart of OPA activity with the plan to see long waiters and clinically urgent patients first whilst continuing with non face-to-face activity
- Increase in theatre lists on WRH site to ensure there is enough capacity for complex/long wait/cancer work
- A meeting has been planned for September with specialist commissioners to agree a plan for the oral surgery / OMF cohort as there are nearly 700 patients waiting 40+ weeks for their first OPA

National Benchmarking (July 2020) | The latest published national data is for July 2020. The Trust was one of 12 of the 13 West Midlands Trusts who saw a decrease in performance between June and July. This Trust is now ranked at 9 of 13 where the previous month we were ranked 8th. The peer group performance ranged from 33.41% to 63.69% with a peer group average of 45.44%; decreasing from 51.30% the previous month. The England average July 2020 was 46.8%, a 5.2 percentage point decrease from 52%, in June.

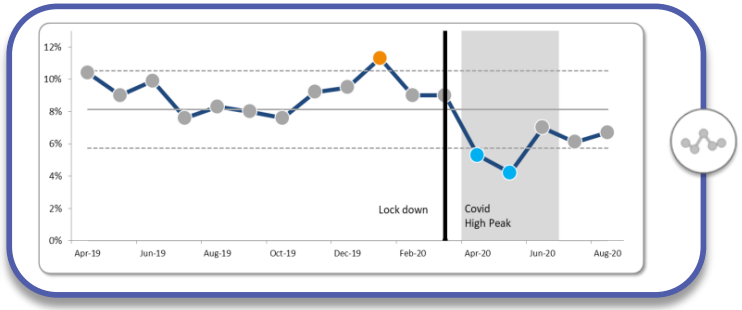
Nationally, there were 81,939 patients waiting 52+ weeks, 481 (0.59%) of that cohort were our patients.

Month 5 [August] 2020-21 | Operational Performance: Theatre Utilisation & Outpatients

Responsible Director: Chief Operating Officer | Unvalidated for August-20 as 15th September 2020

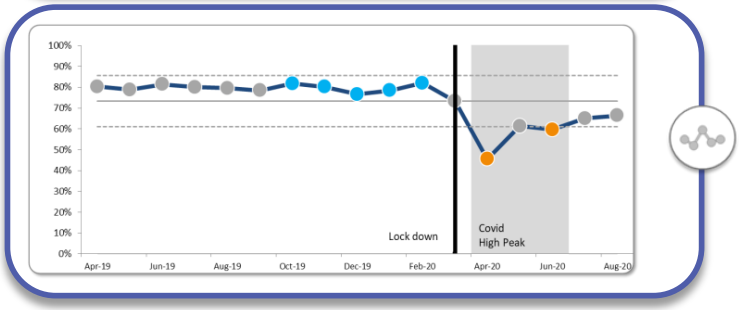
On the day cancellation as a percentage of scheduled procedures (%)

6.70%



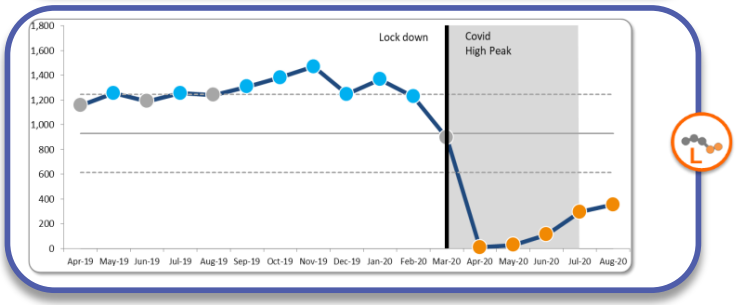
Actual Theatre session utilisation (%)

66.40 %



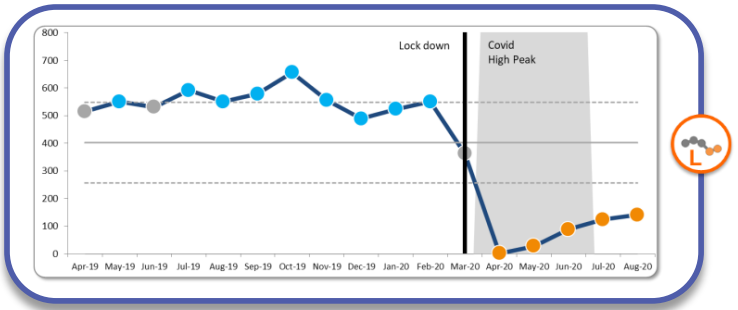
Day cases on elective theatre sessions (n)

355



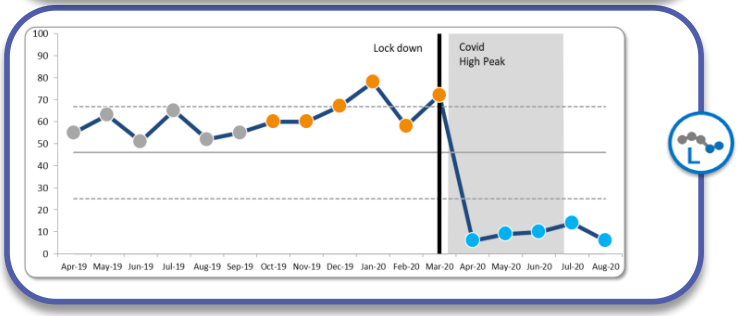
Electives on elective theatre sessions (n)

141

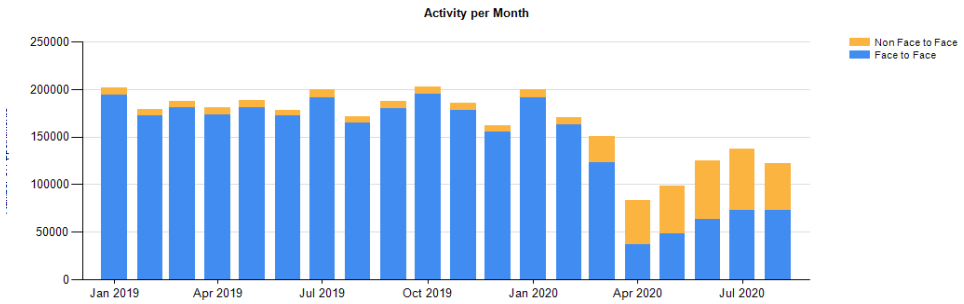


Non-electives & emergencies on elective theatre sessions (n)

6



Outpatient Activity split by Face to Face and Non Face to Face



Operational Performance: Outpatients and Planned Admissions

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

Outpatients

News Face to Face (excl OP+ – all other activity)	News Non Face to Face (excl OP+ – all other activity)	News % Non Face to Face	Follow ups Face to Face (excl OP+ – all other activity)	Follow ups Non Face to Face (excl OP+ – all other activity)	Follow ups % Non Face to Face	Total % Non Face to Face
7,519	2,097	21.81%	10,663	10,416	49.41%	40.77%

What does the data tell us?

- The Trust undertook 30,695 outpatient appointments in Aug-20. This is 12,096 fewer appointments than Aug-19 (71% of Aug-19 activity), and 3,723 fewer than Jul-20. When looking specifically at consultant led activity as captured in SUS, and in line with phase 3 restoration monitoring expectations, Aug-20 unvalidated activity is 72% of Aug-19.
- In Aug-19 1,637 non-face-to-face appointments took place which increased to 12,513 in Aug-20. That is 10,876 more appointments, an increase of 664.39% and represents 40.77% of all appointments in the month.
- 14,870 appointments that were scheduled for Aug-20 were cancelled with 11,982 being cancelled by the Trust and 2,888 cancelled by the patient.
- As at 15th September the outpatient backlog for new outpatients was over 44,000 with ~18,500 on an RTT pathway and ~25,700 on a non-RTT pathway. Just over 9,000 patients had been dated but that does leave almost 35,000 not yet dated. Nearly 35,000 patients, of the total new outpatient waiting list are deemed to be routine.

What have we been doing?

- Through the Outpatients Restart Group, Restoration Forum and Restoration Oversight Group, 30 service restarts have been approved.
- Divisions and Directorates have been providing scenarios to model, alongside baseline activity achieved to date, to demonstrate how much activity can be undertaken and what the gaps to the NSHEI expectations are. This work been reviewed by the corporate support teams to better understand the potential impact on finances and workforce and highlight any additional transformational work that would support the required activity levels.

What are we doing next?

- Increasing the approved activity that takes place on all of our sites, plus increased utilisation of Community Hospitals (Evesham, Malvern and Tenbury) and, where possible, Independent Sector sites (Spire, BMI and Dolan Park)

Planned Admissions

On the day cancellations	Theatre Utilisation	DC on EL theatre sessions (n)	EL on EL theatre sessions (n)	NEL on EL theatre sessions (n)
6.70%	66.40%	355	141	6

What does the data tell us?

- On the day cancellations are still showing normal variation having been statistically lower for April and May. However, it remains below the mean for the period Apr-19 to Aug-20.
- Theatre utilisation remains within normal variation but it is clear that we have a long way to go to achieve pre-COVID utilisation.
- 884 planned admissions that were scheduled for Aug-20 were cancelled. 471 were cancelled by the Trust (+5.6% increase) and more notably, 413 were patient cancellations, an increase of 32.8% compared to Jul-20.

What are we doing next?

- More Trust theatres are being operationalised in September and October with agreement in place to across the Divisions on maximising surgical capacity as equitably as possible. This offsets, rather than increases our total capacity to operate on our patients now that the Independent Sector has reduced its available theatres.

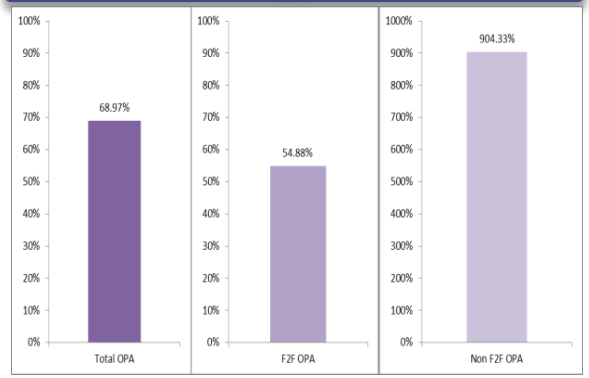
Month 5 [August] 2020-21 | Operational Performance: Outpatients

Responsible Director: Chief Operating Officer | Unvalidated for August-20 as 15th September 2020

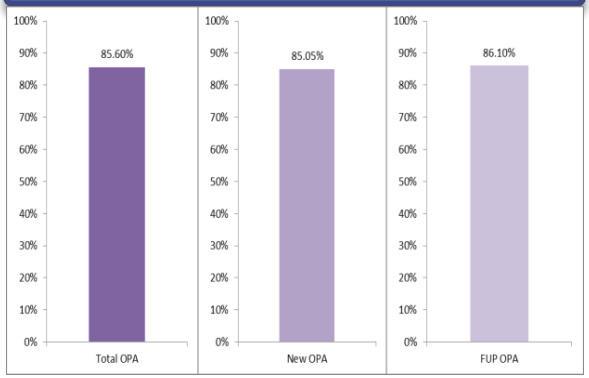
NHS Worcestershire Acute Hospitals NHS Trust

Outpatients Activity | Aug-20 activity as a percentage of Aug-19 activity (all activity apart from excluding OP+)

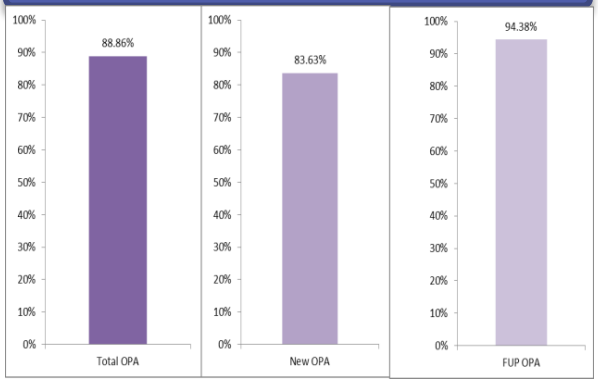
New



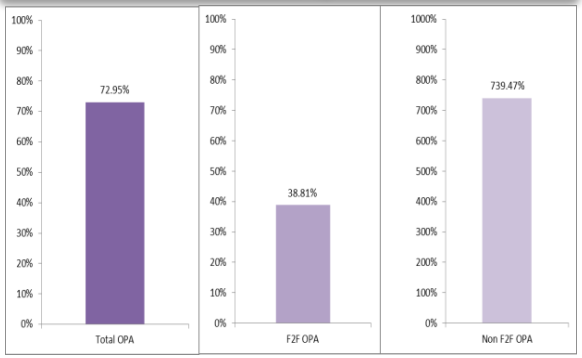
Emergency



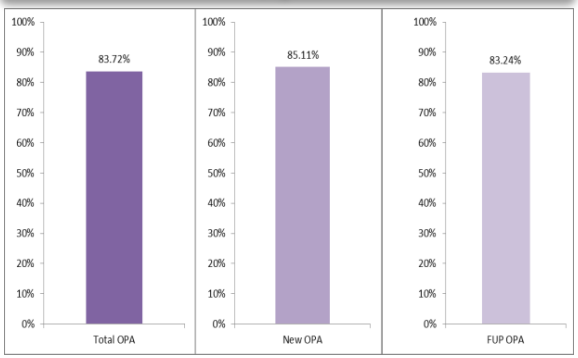
Cancer



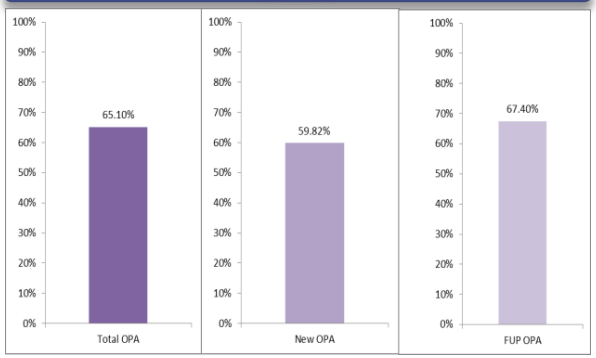
Follow up



Urgent



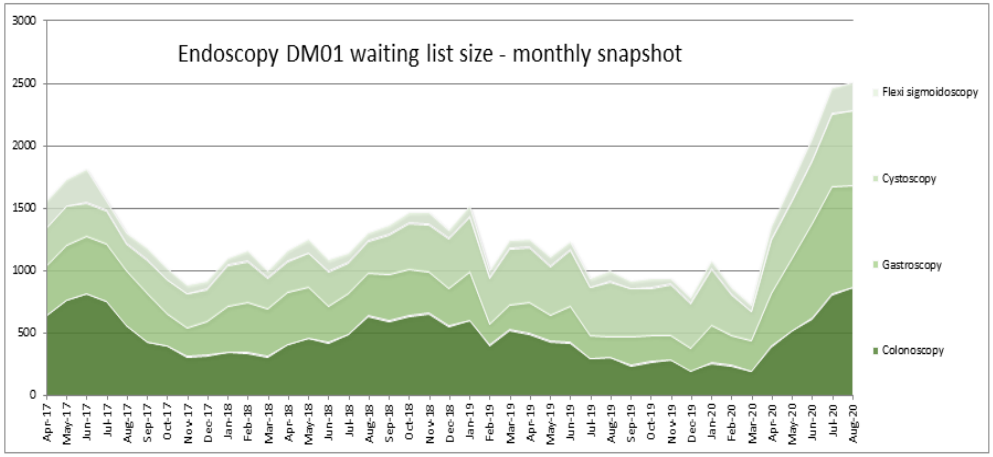
Routine

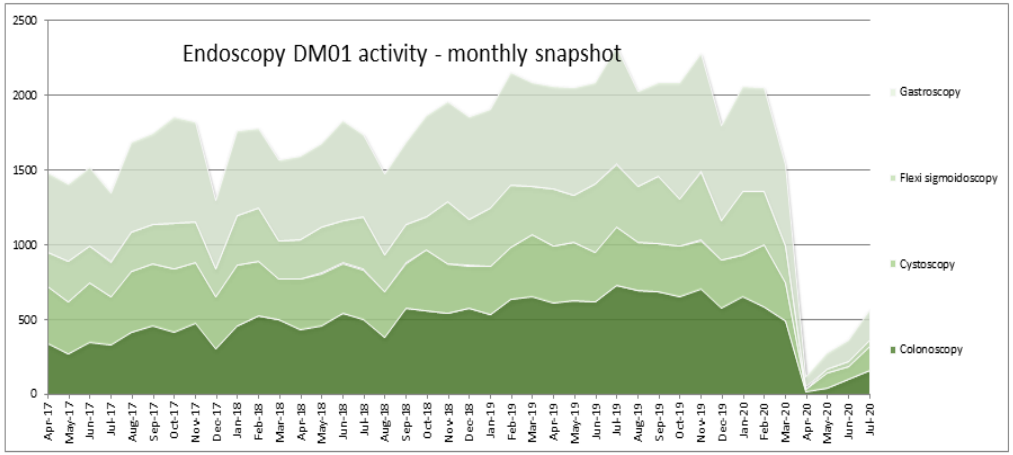


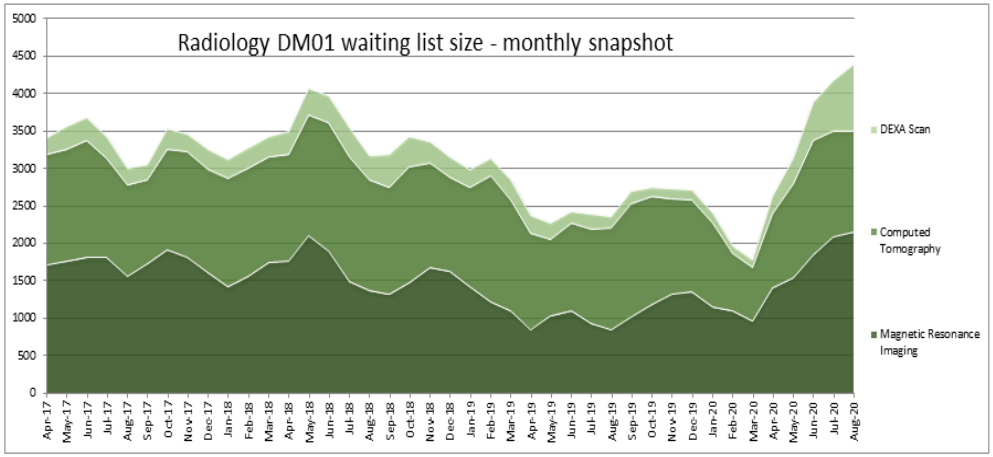
1. Phase 3 restoration is based on consultant-led activity only that has been submitted via SUS. These graphs are reflective of **all** the activity that has been delivered by the Trust
2. Please note the 1000% scales on the New and Follow non face-to-face activity graphs., This is due to the significant increase in non face-to-face appointments in 2020.

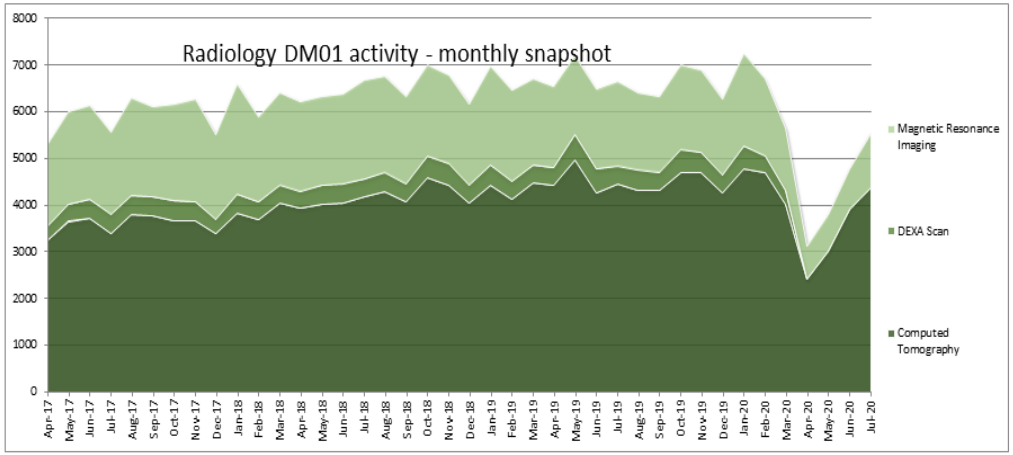
Month 5 [August] 2020-21 | Operational Performance: DM01 Diagnostics

Responsible Director: Chief Operating Officer | Validated for August-20 as 21st September 2020









Note the different scaled axis on the graphs when comparing them

Operational Performance: DM01 Diagnostics

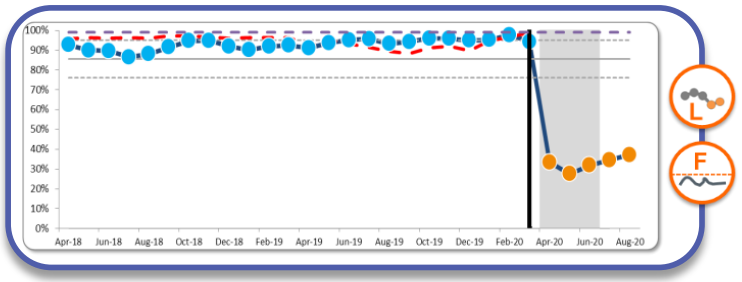
Responsible Director: Chief Operating Officer | Validated for August-20 as 21st September 2020

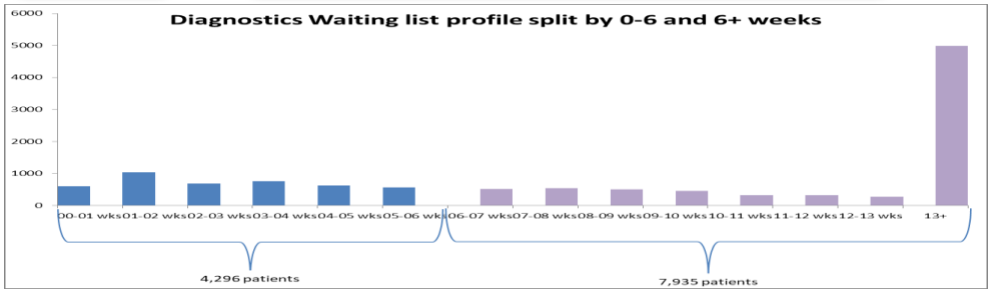
NHS Worcestershire Acute Hospitals NHS Trust

The total waiting list, the number of patients waiting more than 6 weeks for a diagnostic test, t and % waiting less than 6 weeks											
Trust Total			Radiology			Physiology			Endoscopy		
12,501	7,851	37.20%	7,966	4,982	37.50%	1,905	1,179	38.10%	2,630	1,690	35.70%

DM01 Diagnostics % patients within 6 weeks

37.20%





What does the data tell us?

- The DM01 performance is validated at 37.20% of patients waiting less than 6 weeks for their diagnostic test.
- The diagnostic waiting list continues to grow as more patients are added to it. The waiting list is currently 12,501 patients, an increase of 477 (3.97%) from the previous month and the total number of patients waiting 6+ weeks has decreased by 137 patients (-1.71%).
- Radiology has the largest number of patients waiting at 7,963 but has been able to restart more activity compared to Endoscopy, particularly CT scans.
- 11,716 diagnostics tests were undertaken in Aug-20, 8.89% more than Jul-20 however, this is 23.33% lower than Aug-19.
- Radiology were able to undertake 718 more tests in Aug-20 with increases across all modalities
- Physiology completed 62 fewer tests in Aug-20, with echocardiography and neurophysiology undertaking 72 fewer and audiology completing 10 more.
- Endoscopy completed 301 more tests in Aug-20 with all modalities apart from cystoscopy increasing the number of tests undertaken.

National Benchmarking (July 2020) | The latest published national data is for July 2020 and reports on the percentage of patients waiting 6+ weeks. All 13 West Midlands Trusts saw an improvement in performance; however this Trust was ranked 13 of 13 in July 2020. The peer group performance ranged from 1.78% to 65.44% with a peer group average of 38.78%; decreasing from 48.45% the previous month. The England average for July 2020 was 39.6% of patients waiting 6+ weeks, a 8.2 percentage point reduction from 47.80% in June.

There were 291,982 patients waiting 13+ weeks for their test in England; 5,655 (1.9%) of those were on our waiting list.

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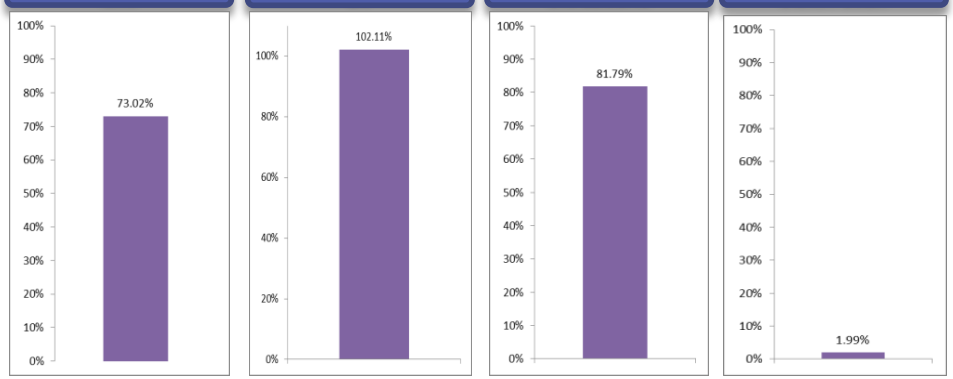
Month 5 [August] 2020-21 | Operational Performance: Diagnostics

Responsible Director: Chief Operating Officer | Validated for August-20 as 16th September 2020

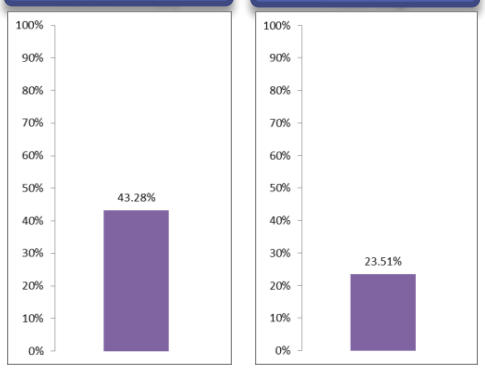
Worcestershire Acute Hospitals NHS Trust

DM01 Diagnostics Activity | Aug-20 activity as a percentage of Aug-19 activity

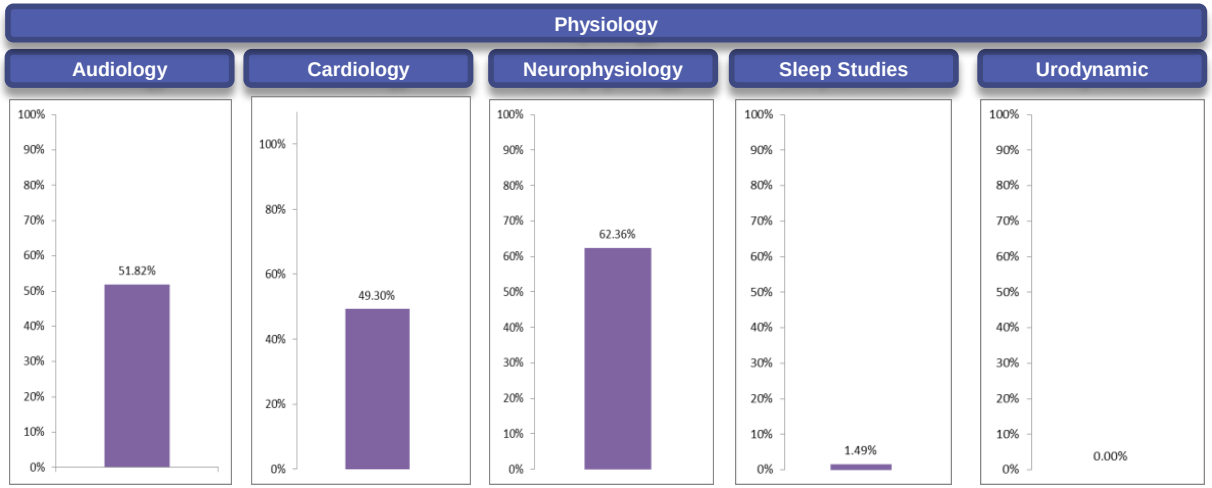
Radiology

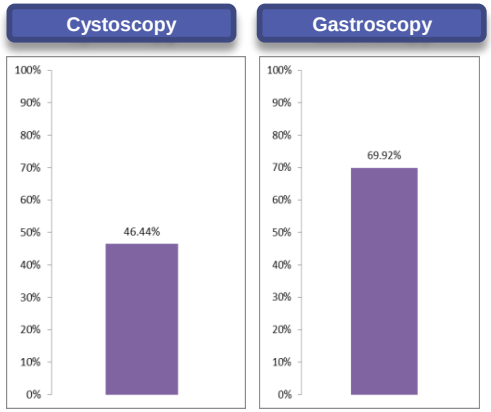


Endoscopy



Physiology





Operational Performance: DM01 Diagnostics

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

What have we been doing?	What are we doing next?
ENDOSCOPY (inc. Gynaecology & Urology) • Continuing the use of IS at BMI and Spire – reduced number of lists now available • Utilising all countywide sites • WLI lists routinely being undertaken at weekends at KTC/ALX • Increased number of urology patients per list to 7, running 7 sessions per week – giving capacity for 49 slots. • Re-start of the job plans for colorectal consultants completing Endoscopies.	• Introduce forward look meeting with Speciality DMs • Finalise endoscopy timetable with Surgery / Medicine Divisions • Look to relocate Urology sessions to KTC, with lists concentrated into 8 sessions over 2 days – increasing Urology capacity by 1 session. This would co-locate non-swabbed/non-isolated patients and would open up additional sessions for GI activity at ALX • Commence evening WLI sessions for Urology at ALX • Explore the use of WRH site for weekend WLI • Commencement of 18 Week Support insourcing team in room 1 ECH 7-days per week from 14th September, and room 2 every weekend – 18 sessions per week • Increased number of colons from 4 to 5 patients per list • Increased number of oesophago-gastro duodenoscopy (OGD) from 5 to 6 patients per list • Re-start of the job plans for colorectal consultants completing Endoscopies. • We are expecting to recover more than 100% of last years Sep to Mar activity during the remainder of this financial year.
RADIOLOGY • Continued provision of all 2WW and urgent referrals • Reinstated routine activity on community sites for Ultrasound (no CT or MRI equipment on community sites) • Reinstated 5pm-8pm for MRI Routine referrals on KTC site • Utilising CT mobile on KTC site for routine and planned referrals (back log only) • Utilising Independent sector capacity at BMI (CT) and SPIRE (CT) • Utilising SPIRE CT Cardiac capacity	**RADIOLOGY** • QIA to reinstate routine activity on all sites agreed Sept therefore lists being booked and all available staffed capacity will be utilised. • Extension to CT mobile contract secured until March 2021 • Increased CTC referrals from lower GI pathway will displace 7 sessions/week of CT activity that will need to be re-provided elsewhere. In discussion with IS • We are expecting to recover 97% of last years Sep to Mar activity during the remainder of this financial year.
NEUROPHYSIOLOGY • Restart of services in June 2020 up to around 75% capacity due to infection control and social distancing measures • To achieve 100% capacity of service additional rooms in the community or on Kidderminster and Redditch sites need to be sourced, This is to allow social distancing and infection control measures. • Approx. 12 – 15 week wait	**NEUROPHYSIOLOGY** • Continue to aim for 80% capacity by September • Waiting for additional rooms at ALX and KTC to be identified to allow additional clinics to re-start

Operational Performance: DM01 Diagnostics

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

What have we been doing?	What are we doing next?
CARDIOLOGY – ECHO • Currently seeing urgent patients only • Restoration of service has been approved, with reduced capacity • To achieve 100% capacity additional rooms would be required on a permanent basis outside of the designated units due to waiting room limitations • Approx. 12-16 week wait	• When services have been resumed the backlog will be managed in priority order. • Performing WLI clinics to reduce the backlog • Looking at room solutions to full restore clinics

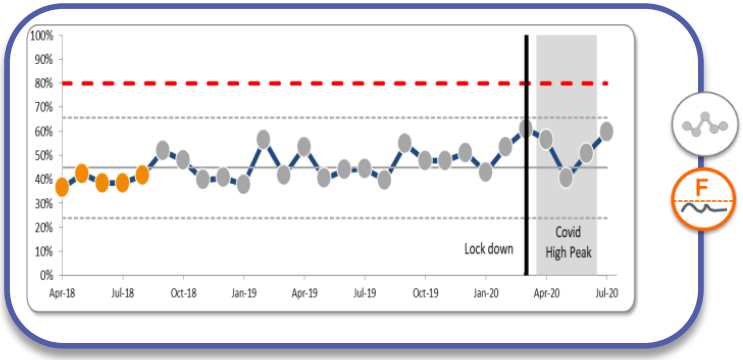
Month 4 [June] 2020-21 | Operational Performance: Stroke

Responsible Director: Chief Operating Officer | Validated for July-20 as 15th September 2020

Worcestershire Acute Hospitals NHS Trust

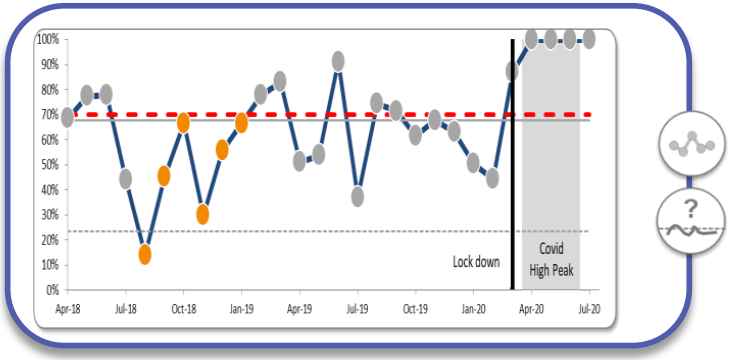
Stroke : % CT scan within 60 minutes

59.50%



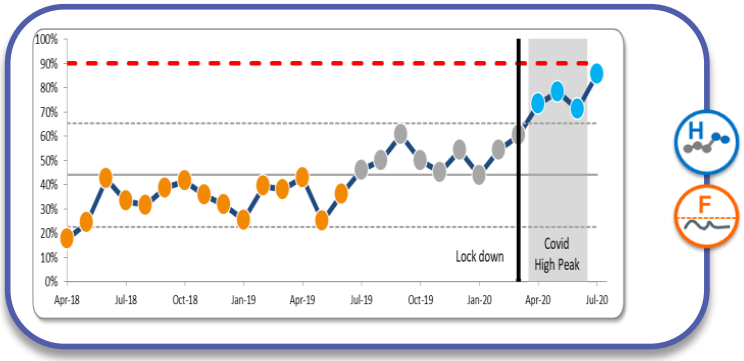
Stroke: % seen in TIA clinic within 24 hours (May)

100%



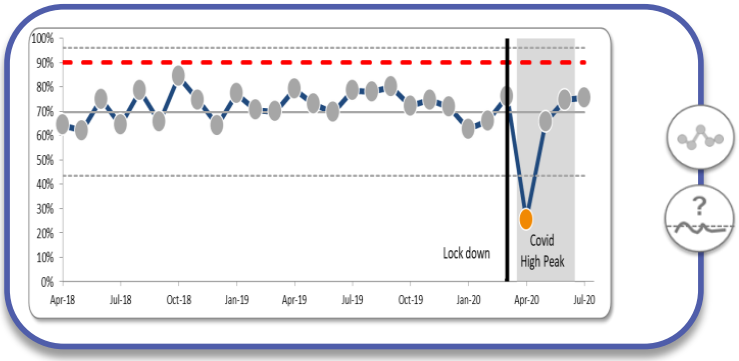
Stroke : % Direct Admission to Stroke ward

85.50%



Stroke: % patients spending 90% of time on stroke unit

75.60%



Operational Performance: Stroke

% of patients spending 90% of time on a Stroke Ward	% of patients who had Direct Admission (via A&E) to a Stroke Ward	% patients seen in TIA clinic within 24 hours	% of patients who had a CT within 60 minutes of arrival	SSNAP Q4 Jan-20 to Mar-20			
75.60%	85.50%	100%	59.50%	Score	69.3	Grade	C

What does the data tell us?

- We are anticipating Q1 (Apr-20 to Jun-20) SSNAP to be published in September. Internal forecasts predict an increase in the score and therefore an improvement in the grade. This will be confirmed on release of the analysis from the SSNAP team.
- Three stroke metrics have maintained their common cause variation. The direct admission metric has maintained it's special cause improvement for the fourth month in a row. The SPC chart for patients seen in TIA clinic within 24 hours continues to mask the sustained improvement of 100%. This has been achieved by a change in process which means that, following triage by a consultant, the appointment is held non face-to-face. This graph will be re-based when a sufficient number of data points are captured to be statistically valid.

What have we been doing and what are we doing next?

The SOP was updated to reflect current changes in service provision. This includes detail on the Trust's agreement to ring-fence all Stroke beds, the contribution from support services and a dedicated front door team focused on ensuring Stroke patients are seen/reviewed within the national recommended guidance. In August, the updated SOP was provisionally agreed and was then approved by the Divisional Management Board in September.

In addition to the SOP, further Stroke related documents were also approved including:

- **Exception Report Template** – This is in respect of two key indicators: patients admitted to the Stroke Unite within 4 hours of arrival and the percentage of patients spending 90% of their stay on Stroke unit. The introduction of exception reporting will enable close monitoring of performance and help to establishing key themes so improvement can be made.
- **Stroke Pathway Booklet** – This was updated based on SNNAP data requirement and completion of this paperwork will provide all the data required by the Data Clerk. This should in return help with Audit Compliance Process.
- **TIA Form** – This was updated to remove the option of ticking boxes to encourage detailed referral information to be provided. This will help with triaging patients and reduce inappropriate referrals.

The service has been successful in recruiting a consultant on a 12 month fix term contract and is due to start in September. We are currently in the process of recruiting a permanent consultant; the ATR was approved, however we are awaiting RCP approval. A successful appointment will increase the capacity within the team and would enable us to explore further the option of providing a local 24/7 Stroke rota.

The CNS acting up and covering to the Ward Manager post has now accepted the role on a permanent basis. The ATR has been approved to recruit her replacement. The Data Clerk has also indicated her intention to retire end of October and the team have acted swiftly in successfully recruited a replacement so smooth transition is anticipated.