NHS
Worcestershire Acute Hospitals
NHS Trust

Date of meeting	9 November 2017
Paper number	G1

Update on Trust's Winter Plan

For approval:		For assurance:	√	To note:		For information:	

Accountable Director	Inese Robotham Interim Chief Operating Officer
Presented by	Inese Robotham Interim Chief Operating Officer
Author	Inese Robotham Interim Chief Operating Officer

Alignment to the Trust's strategic priorities (√)	Deliver safe, high quality, compassionate patient care	√	Design healthcare around the needs of our patients, with our partners	√
	Invest and realise the full potential of our staff to provide compassionate and personalised care		Ensure the Trust is financially viable and makes the best use of resources for our patients	√
	Develop and sustain our business			

Alignment to the Single Oversight Framework (√)	Leadership and Improvement Capability		Operational Performance	√
	Quality of Care	√	Finance and use of resources	
	Strategic Change		Stakeholders	

Report previously reviewed by		
Committee/Group	Date	Outcome
Trust Board (in private)	14/09/17	Approved
TLG	September/October	Approved

Assurance: *Does this report provide assurance in respect of the Board Assurance Framework strategic risks?*	Y	BAF number(s)	R1.1 R1.3 R2.1

Level of assurance and trend

		√	↑ ↓ →	
	Significant			
	Limited	√	→	
	None			
	Not applicable			

Purpose of report	To give an overview of the main strands of the Trust's winter plan, governance arrangements and progress to date.
Summary of key issues	The Trust's winter plan consists of four main components: • Countywide frailty model at Alexandra Hospital • Expanded Ambulatory Emergency Care (AEC) model at Worcestershire Royal Hospital • Additional bed capacity on Evergreen 2 ward at Worcestershire Royal Hospital • A range of supportive schemes to extend services The frailty model has commenced as scheduled. The first two weeks saw 63 patients assessed and 41% able to be discharged home. The development of the AEC model is on track for operation as of 20 November, with capital works beginning as scheduled. Quality Impact assessments have been undertaken and will be reported to Quality Governance Committee. The Trust's Winter plan and associated expenditure of up to £1.7million was approved by the Trust Board (in private) on 14/09/2017. The financial governance of the implementation of the plan is overseen by Finance and Performance Committee. The workforce element of the plan is overseen by People and Culture Committee. The Winter plan is part of a wider Local Health Economy strategy and the Trust is working collaboratively with our partners in all sectors. A joint Winter Room will be in operation from 06/11/17 to 31/03/18. A targeted communication strategy has been developed and will be launched on 06/11/17.
Recommendations	The Trust Board is asked to note the assurance in relation to the progress to date against the Trust's Winter Plan.

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

Winter Plan

1   Introduction

The Trust has developed a comprehensive plan to deal with winter pressures through both admission avoidance and additional capacity. The Trust's winter plan is part of a wider local health economy winter plan and consists of four main components:

- Countywide frailty model at Alexandra Hospital.
- Expanded Ambulatory Emergency Care model at Worcestershire Royal Hospital.
- Additional bed capacity on Evergreen 2 ward at Worcestershire Royal Hospital.
- A range of supportive schemes to extend services.

2   Background

Worcestershire Acute Hospital site consistently shows bed occupancy levels above 100% in medicine and in the high 90s for surgery. NHSI guidance for winter recommends that Trusts work to a maximum of 92% bed occupancy.

These high occupancy rates directly impact on performance against the four hour Emergency Access Standard leading to an inability to move patients from Emergency Department (ED) leading to overcrowding in ED and patients receiving care in the corridor.

Demand and capacity analysis shows that in order to achieve 92% occupancy level additional 79 beds are required on WRH site.

The combined effect of all the components of the plan provides an equivalent of 40 beds either through admission avoidance or increased physical bed capacity. This leaves a shortfall of 39 beds which will be mitigated via additional capacity schemes resourced jointly with our local health economy partners.

3   Current situation
3.1   Countywide Frailty Pathway at Alexandra Hospital Redditch

The countywide Frailty Pathway at Alexandra Hospital commenced on 16/10/17. This is one of the Worcestershire urgent care systems winter initiatives whereby all frailty patients regardless of where they live in Worcestershire are conveyed to the Alexandra Hospital.

The ethos of a dedicated Frailty Pathway is based on national best practice with a focus on maintaining independence and admission avoidance.

The model consists of the following components:

3.1.1   Frailty Assessment Unit

The Unit has been located in the previously vacant MAU bays adjacent to the

Alexandra Emergency Department. The Unit has a bespoke multidisciplinary team to provide holistic care to frail elderly patients. It is expected to help to avoid circa four hospital admissions per day for this vulnerable patient group.

Up to 27th of October 2017 (inclusive) the Frailty Assessment Unit has:

- 63 attendances
- 26 discharges (41%) directly from the unit back to the patients' usual place of residence.

Assuming that every discharge notionally saves 3 bed days this equals to 78 bed days (or equivalent of 6.5 beds) saved over initial twelve day period.

Initial patient feedback has been very positive. A formal evaluation of the unit is planned at the end of week 12. This will include patient feedback. An external peer review is being arranged for early December 2017.

3.1.2 Frailty ward

The frailty ward opened on 16/10/2017 on Ward 12 at the Alexandra Hospital. This is a 26 bedded ward dedicated to the needs of those frail elderly patients who require up to 72 hours stay in acute environment.

3.1.3 'Evergreen' model at Alexandra Hospital

Ward 14 at the Alexandra Hospital (19 beds) has been transferred from Surgery to Medicine to provide a therapy led step down facility for patients who no longer require acute hospital intervention but require further rehabilitation and enablement.

3.2 Expansion of Ambulatory Emergency Care (AEC) services and Primary Care streaming at Worcestershire Royal Hospital site.

The current AEC unit at WRH is too small for activity demand. In order to increase capacity the Clinical Decisions Unit is being converted into a medical AEC containing 6 trolleys and 10 chairs. The current medical AEC area will become a dedicated surgical AEC. Also included in the new foot print will be three GP consulting rooms.

The closure of Clinical Decision Unit was completed as scheduled and capital works to expand the AEC footprint commenced as planned on 30/10/17; the plan is on track for the unit to be fully operational on 20/11/17.

Activity modelling suggests an average of twenty nine patients a day will be diverted from emergency admission pathways to these ambulatory care options.

3.3 Additional bed capacity on Evergreen 2 ward at WRH.

A model of palliative care provision on Evergreen 2 was explored; however, the End of Life team are currently piloting a successful model of admission avoidance in Emergency Department and targeted in-reach to specialty wards. Both approaches are felt to be more appropriate and patient centred.

Alternative options of expanding and enhancing the successful therapy led

Evergreen 1 model and associated staffing implications are currently being worked through.

3.4 Additional supportive measures

3.4.1 Reducing numbers of stranded patients who are medically fit for discharge

Health economy wide multi agency discharge events (MADE) have been scheduled to take place on both WRH and Alexandra Hospital sites from October 2017 to end of January 2018. The multi-agency approach has demonstrated reduction in delays for safe appropriate discharge for patients requiring additional support outside of the acute setting.

Stranded patient processes will be led strategically and operationally on behalf of the Worcestershire health economy by the Director of Operations for Worcestershire Health and Care Trust with effect from 06th of November 2017 to 31st of March 2018.

3.4.2 Ambulatory Heart Failure service

Heart failure patients requiring IV diuretics are currently treated as inpatients. The cardiology department has identified ring fenced seating areas to deliver treatment in an ambulatory care setting. The model used will follow national best practice which is expected to deliver a reduction in bed occupancy of around 10% of the current cohort of heart failure patients which equates to 700 bed days or equivalent of 2 beds per annum.

Planned commencement date for the service is 01st of December 2017.

3.4.3 Dedicated oncology service bay on Laurel 3 ward at WRH

The capital works are planned to be completed by 31st of December 2017 to increase the ward capacity by 3 additional beds. These beds will be used for repatriation of head and neck oncology patients as well as neutropenic sepsis patients.

3.4.4 Phasing of elective surgery on WRH site

Elective surgical activity on WRH site will be reduced for the period of the week before Christmas to the end of January 2018. The surgical division will transfer as much activity as possible to the Alexandra Hospital and Kidderminster Treatment Centre to minimise impact on elective waiting times. The impact of the phasing of elective surgery for the aforementioned period was built in the Trust's Referral to Treatment trajectories.

3.4.5 Additional gynaecology capacity

Following the recent building works the Gynaecology Assessment Unit's capacity was increased from 2 to 4 examination rooms in July 2017; the unit is operational 24/7.

The 4-6 beds on the antenatal ward will continue to be used as inpatient capacity throughout the winter for screened selective elective gynaecology cases to support elective gynaecology activity. It is planned to reduce gynaecology activity that is not suitable for the antenatal ward between the week before Christmas to the end of January 2018 to coincide with the phasing of the rest of the elective surgery on the

WRH site for the aforementioned period of time.

3.4.6 Additional paediatric capacity

The Women and Children's Division will free up additional capacity in Children's clinic at WRH to provide additional flexible assessment space in times of excessive paediatric emergency activity. Nursing rotas have been reviewed to ensure adequate and dedicated paediatric nurse cover for the assessment pathway.

A proportion of elective paediatric surgery activity will be transferred to Kidderminster Treatment Centre as of 01st of December 2017 to facilitate additional bed availability on the Riverbank ward.

4 Implications
4.1 Ward reconfiguration on Worcestershire Royal Hospital site

The transfer of Ward 14 from surgery to medicine as part of the implementation of the frailty model provided an opportunity for ward reconfiguration on Worcestershire Royal Hospital site. Silver ward (previously care of elderly/frailty) became a dedicated oncology ward on 16/10/17.

Further ward moves are planned once expanded Ambulatory Emergency Care becomes operational on 20/11/17. As part of the expansion the current Clinical Decision Unit's footprint becomes part of Ambulatory Emergency Care. Week commencing 20/11/17 Medical Short Stay ward will move off the Hazel ward footprint to Severn Unit and vascular surgery will move off Severn Unit to the vacated part of the Hazel ward. This will co-locate surgical specialties on one floor and will allow creation of dedicated female surgical beds to accommodate gynaecology patients.

4.2 Joint Health Economy working

There is a concern nationally that the NHS will be under significant pressure during the winter of 2017/18 due to rising emergency department attendances and a potential flu epidemic. In response to this and learning from Worcestershire 16/17 winter local health economy partners have agreed to implement a joint Winter Room. This will strengthen existing urgent care system management arrangements and will act as a focal point for receiving and responding in a timely manner to external and regulator requests for information and assurance.

It is anticipated that centralising the functions of a Winter Room will:

- Make best use of staff capacity and reduce duplication of effort.
- Ensure that consistent and accurate data and information is collated and shared across the system and with external organisations such as the Regional Capacity Management Team (RCMT) and other regulatory organisations.
- Standardise the approach taken to determining escalation status and particularly reporting the Operational Pressure Escalation Level (OPEL) to NHS England and NHS Improvement.
- Ensure consistent and appropriate escalation actions are taken in line with the Worcestershire System Escalation Management Plan to result in responsive and timely escalation status.

- Provide systematic overview of the delivery of the Worcestershire winter plan initiatives.
- Provide a visible message to the system of an enhanced systematic approach to winter 17/18

4.3 Communications
A joint health economy wide targeted communication strategy has been developed and will be launched on 06/11/17. This includes open staff briefings on all three hospital sites.

4.4 Quality implications
Quality Impact assessments have been undertaken and will be reported to Quality Governance Committee.

4.5 Financial implications
The associated expenditure of up to £1.7million of the Trust's winter plan was approved by the Trust Board (in private) on 14/09/2017. Financial governance of the implementation of the plan is overseen by Finance and Performance Committee.

4.6 Staffing implications
The workforce element of the plan is overseen by People and Culture Committee.

5 Recommendations
The Trust Board is asked to note the assurance in relation to the progress to date against the Trust's Winter Plan.

Compiled by
Inese Robotham
Interim Chief Operating Officer

Director
Inese Robotham
Interim Chief Operating Officer

NHS
**Worcestershire
Acute Hospitals**
NHS Trust

Date of meeting	9 November 2017
Paper number	G2

Patient Flow Update

For approval:		For assurance:		To note:	√	For information:	

Accountable Director	Inese Robotham Interim Chief Operating Officer
Presented by	Inese Robotham Interim Chief Operating Officer
Author	Inese Robotham Interim Chief Operating Officer

Alignment to the Trust's strategic priorities (√)	Deliver safe, high quality, compassionate patient care	√	Design healthcare around the needs of our patients, with our partners	√
	Invest and realise the full potential of our staff to provide compassionate and personalised care		Ensure the Trust is financially viable and makes the best use of resources for our patients	
	Develop and sustain our business			

Alignment to the Single Oversight Framework (√)	Leadership and Improvement Capability	√	Operational Performance	√
	Quality of Care	√	Finance and use of resources	
	Strategic Change		Stakeholders	

Report previously reviewed by		
Committee/Group	Date	Outcome
Trust Leadership Group	11/10/2017	Noted
Finance and Performance Committee	23/10/2017	Noted

Date of meeting	9 November 2017
Paper number	G2

Assurance: *Does this report provide assurance in respect of the Board Assurance Framework strategic risks?*	Y	BAF number(s)	R1.1 R1.3 R2.1

Level of assurance and trend				
		√	↑ ↓ →	
	Significant			
	Limited	√	↑	
	None			
	Not applicable			

Purpose of report	To provide the Trust Board with an update on current and planned actions to improve patient flow and associated performance indicators.
Summary of key issues	Improving the patient flow from Emergency Departments through to the hospital wards and on to a safe and timely discharge remains the top priority for the Trust.
	Two patient flow events took place on 21st and 29th of September 2017. Following the two sessions internal professional standards have been agreed and launched along with a set of specific interventional actions.
	Whilst there have been intermittent improvements against a number of metrics, it is too early to identify any trends or draw assurance of sustainable improvement.
	A number of key initiatives that are part of the Trust's Winter Plan are still in planning and implementation stages and are expected to have further positive impact on patient flow.
	It is planned to cease to nurse patients in Emergency Department's corridor at Worcestershire Royal Hospital and to remove all associated equipment as of 01 December 2017.
Recommendations	The Board is asked to:
	Note the actions being taken to improve patient flow and associated key performance indicators.

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

Patient Flow Update

1   Introduction

The Trust has continuously experienced significant issues with patient flow through the hospital particularly on the Worcester Royal Hospital site manifesting in over-crowded Emergency Department and fluctuating numbers of patients in Emergency Department's corridor.

Two Trust wide Patient Flow events took place on 21st and 29th of September 2017. A further follow up session took place on 10th of October 2017.

A number of key initiatives that are part of the Trust's Winter Plan are still in planning and implementation stages and are expected to have further positive impact on patient flow

2   Current situation

During the first Patient Flow session on 21st of September 2017 internal professional standards were agreed; the standards were expanded further to include some specific guidance for the nursing staff after the second Patient Flow session. On 29th of September 2017. The final version of the standards is included as Appendix 1.

A set of following specific interventional actions were also agreed and implemented post second event (as of 03 October 2017):

- By 8.00 am ED/MAU colleagues will identify all those patients who can be appropriately transferred to a ward.
- By 8.30 am a nursing representative from each ward will visit ED/MAU/SCDU to identify at least one patient for immediate transfer and a second for transfer by 9.30am. Any ward transfers will be completed by 10.00 am.
- As soon as a patient is admitted a medical/nursing plan will be prepared including Expected Day of Discharge and triage as well as referral to the Patient Flow Centre (if required). This process will be actively managed, on a named patient basis, by Directors of Operations through bed meetings, with updates provided to the HUB.
- Each ward to facilitate the discharge, by a Consultant, of at least one patient by 10.00am, at least one more by 12 noon and at least one more by 2.00pm each day.
- Bed meetings to be held in ED each day at 9.00am, 12 noon, 4.00 pm and 6.00 pm. On-call Consultants should attend these meetings if at all possible.
- Each ward to ensure a member of staff is available to focus on the discharge process.
- Each ward to provide for Evergreen Ward colleagues, by 4.00pm each day, a list of patients suitable for transfer to Evergreen (transfers to then take place the following morning).
- All specialty Consultants to take ownership of "pulling" patients from ED or outlying wards to their wards.
- The Urgent Care Division will be accountable for the Hazel discharge lounge

and ensure it is staffed every day.

The impact of the interventions is monitored via a weekly Urgent Care and Flow Dashboard (an example is attached as Appendix 2).

It is too early to utilise the data to identify trends or draw conclusions of sustainable improvement. Nevertheless there have been intermittent improvements against a number of metrics, for example:

- On 02 October 2017 WRH Emergency Department's safety metric was 'Normal' for the duration of the whole day.
- On 04 October 2017 there were no patients in ED corridor from approximately 8.00am to 3.00pm, the site was working to a four hour clock and delivered an EAS performance of 78.85% for the day (compared to year to date performance of 64.89%).
- No 12 hour trolley breaches since July 2017 to date compared to 22 for the same time period last year.

A number of key interventions related to the Trust's winter plan have been/will be implemented with the following timescales:

- Two week trial of 'Palliative Care at the Front Door' - as of 09 October 2017.
- A formal countywide frailty pathway on Alexandra Hospital site – as of 16 of October 2017.
- Ward reconfiguration on WRH site following the frailty move – as of 16 of October 2017.
- Expansion of current AEC footprint on WRH site to increase AEC throughput, co-locate and increase GP streaming and introduce surgical ambulatory care model – as of 20 November 2017.

A formal Standard Operating Procedure for authorising the use of the ED corridor will be in force for the transitional period from 16 October 2017 to 01 December 2017.

It is planned to cease to nurse patients in Worcestershire Royal Hospital's Emergency Department's corridor and to remove all associated equipment as of 01 December 2017.

4   Recommendations
The Trust Board is asked to:

Note the actions being taken to improve patient flow and associated key performance indicators.

Compiled by
Inese Robotham
Interim Chief Operating Officer

Director
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NHS
Worcestershire Acute Hospitals
NHS Trust

Safer faster hospital: internal professional standards

In the Emergency Department (ED) and Clinical Decision Unit (CDU)

ST3▲

1. All ED referrals to admitting specialty teams will be made to a registrar ST3 grade or higher. This doctor will triage referrals for urgency and clinical need.

60 mins

2. A senior decision-making doctor should see new patients in the ED so that a management plan is documented within 60 minutes of referral by the ED team.

1 12 24

3. Tests requested in the ED will be completed and the results available within one hour (critical tests), 12 hours (urgent tests) and 24 hours (non-urgent tests).

4. If another specialty would provide more appropriate care, it is the responsibility of the first specialty, not the ED, to make the second referral and arrange transfer of care.

ED

5. Patient care and admission will not be delayed by interspecialty dispute over clinical ownership. ED consultants have the authority to allocate immediate clinical ownership to ensure timely care and admission.

6. The Trust does not admit patients who are likely to be able to go home from the ED to avoid a breach of the emergency care quality indicators.
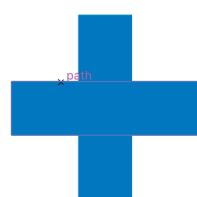
7. Patients will not transferred from outpatient areas to the ED unless they require immediate emergency medical care.

8. Specialities will manage the entire emergency pathway in compliance with the local Quality Standards for Acute Emergency Care.

9. A telephone call from primary care to specialty will not be a prerequisite for ED to stream patients directly to an admitting specialty team.

10. Accepting referrals from primary care means that specialities take responsibility for evaluating the patient in the ED or elsewhere, or for directing the patient to an agreed alternative pathway for the condition.

Campaign from King's College Hospital NHS Foundation Trust. Design by Techniqueprint.

HOSPITAL FLOW WILL BE CONSULTANT-LED

Safer faster hospital: internal professional standards

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In all wards - expectations for nursing and AHP teams

7.00am - 7.30am **1.** 7.00 – 7.30 am: Focus Nurse handover on priority safe care (NEWS/HAPU/falls). Plan and discharge planning.
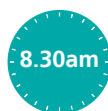
**8.30am** **2.** 8.30 am: One patient to Discharge Lounge. Pull one patient from MAU/SCDU/ED.
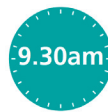
9.30am **3.** Consultants will begin their ward round in ED. Board/ward rounds will be performed by 9.30am, Monday to Friday, led by a consultant, registrar or specialty doctor. Expected discharge dates and diagnostics required before discharge will be identified as will referrals to therapies/social services. If not completed, Nurse in Charge (NIC) to escalate.

11.00am **4.** TTAs will be written the night before discharge and flagged during board rounds. Discharges should be made before 11am. NIC to ensure prescriptions made at both ward rounds and liaise with pharmacy.

10.00am **5.** 10.00 am: Second patient "pull" from MAU/SCDU/ED.
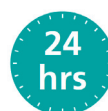
24 hrs **6.** All patients to have a documented expected discharge date (EDD) within 24 hours of admission, set and changed by a consultant. If this standard is breached the ward manager should escalate to the divisional manager and clinical lead. A multi-professional assessment for complex needs will be performed within 14 hours of all admissions. NIC to monitor and escalate if this does not occur.

7. Delays in referrals and diagnostics will be escalated to consultants for action. Deteriorating patients should be identified for consultant review directly after the board round, and critical care outreach/ITU review considered. NIC will collate information on delays for 0800 in time for board round/ward round.

8. Patients within acute medical and surgical units should be seen and reviewed by a consultant during twice-daily ward rounds. The aim is for continuity of care from the same consultant. NIC will ensure clear documented plan for patients to ensure outstanding actions/diagnostics.

8 **9.** Cross-cover of consultant absence will be transparent and all planned leave will be arranged eight weeks prior to the absence. Ward manager/Matron to clarify if unclear.

10. Referrals for specialist opinion will be seen by specialties within 24 hours and no paper referral will be necessary. Specialties cannot refuse to see a patient based on incomplete diagnostics. Nurse handover to be clear about referrals and escalate if no follow up within 24 hours.

Name DOB Date Time **11.** Documentation will be made according to current standards, in particular date, time, name, grade and contact details for medical staff in capitals. All nurses to order stamp to ensure consistency of response.

12. All patients must have a clear management plan documented in the medical notes. If this is not present, the ward manager should escalate to ward registrar and consultant.

LOS **13.** All patients with a length of stay over seven days should have their clinical plan reviewed weekly by the consultant and ward manager, informing the relevant clinical lead and head of nursing. NIC to monitor and ensure continuity through handover.

14. Consultants should be freed of daytime clinical duties whilst on-call. Senior decision-making and leadership should be available on medical and surgical units seven days a week.

15. If patients re-attend the hospital within 48 hours with the same problem, they will be seen by the specialty team.

16. Staff huddles at two-hourly intervals to ensure all professional standards are being monitored and escalated and patients being managed safely.

Campaign from King's College Hospital NHS Foundation Trust. Design by Techniqueprint.

HOSPITAL FLOW WILL BE CONSULTANT-LED

Safer faster hospital: internal professional standards

In the Emergency Department (ED) and Acute Medical Unit (AMU)

60 mins

1. Specialties must have a decision-maker to assess emergency or accepted patients referred from primary care within 60 minutes of arrival in ED. Breaches will be escalated to the appropriate consultant and clinical director by the ED senior clinical decision-maker.

2. No admitting team can refuse a request to assess a patient in the ED or AMU. Seeing the referred patient is not dependent on diagnostic results being available.

3. If admission or transfer is obvious, specialties must not insist on tests that do not contribute to the decision to admit or transfer, or to the immediate management of the patient. Once a decision to admit or transfer is made, stable patients will not be kept in the ED or AMU for further review or assessment.

4. Patients requiring admissions from outpatients under the acute physicians should be referred by registrar grade ST3 or higher, to the on-call medical ST3 or higher, who will triage the patient to the appropriate location.

HOSPITAL FLOW WILL BE CONSULTANT-LED

Safer faster hospital: internal professional standards

In the Acute Medical Unit (AMU)

1. All new medical admissions will be admitted to the AMU, unless advised by the acute physician.

14 hrs

2. Patients will have a consultant review within 14 hours of admission. Expected date of discharge and location of discharge/transfer will be accepted within 24 hours of admission.

3. AMU staff will compile a daily list by 8.30am of those patients requiring specialty in-reach review. Reviews should occur by 11am the same day to maximise discharge planning at the consultant-led board round.

4. A programme of standardised transfer of patients is under development. Once rolled out, there will be no delay in taking over accepted patients from the AMU due to specialty bed capacity issues.

5. The patient must be taken over immediately by the speciality team on the AMU once the transfer has been accepted. If necessary, the patient will be an outlier on the AMU under the specialty team.

HOSPITAL FLOW WILL BE CONSULTANT-LED
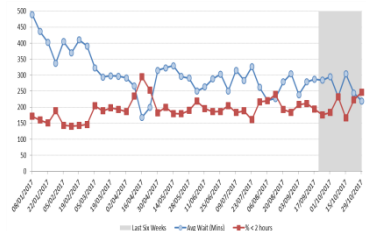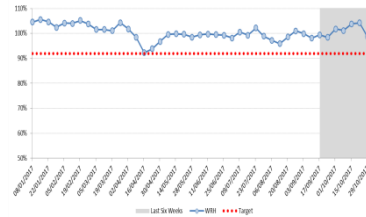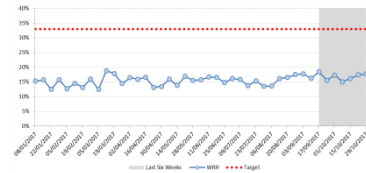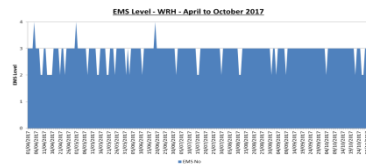
Weekly Urgent Care and Flow Dashboard – WRH - w/e 29th October 2017

	Description	How we did	Trend	Key actions	Target
EAS Performance % within 4 hours	The Trust should see 90% of patients within 4 hours from arrival to admission, transfer or discharge	**70.33%**	For the latest week 70.3% of patients were seen, treated admitted or discharged within 4 hours. This is compared to 66.8% the previous week.	Implementation and enforcement of internal professional standards. AEC expansion on WRH site. Countywide Frailty pathway at Alex. Health Economy wide winter control room	**90%**
Ambulance Handovers	All handovers should be within 60 minutes	**5**	5 handovers breached 60 minutes this week compared to 36 the previous week.	ED Escalation matrix Proactive monitoring of the CAD Conveyancing of Ambulances between sites.	**0**
Time to Triage	The % of patients that are triaged within 15 minutes of arrival	**91.05%**	91.0% of patients were triaged within 15 minutes compared to 81.1% the previous week	ED Escalation matrix Robust monitoring of SIAN staffing levels	**95%**
Patients in the corridor	How many patients spent time on the corridor (checking whether SIAN is included) On average how long did patients spend in the corridor.	**101** **176**	101 patients spent part of their attendance on the corridor this week. Down from 200. On average patients spent 176 minutes on the A&E corridor this week, down from 202.	Implementation and enforcement of internal professional standards. Formal SOP for authorisation of use of corridor (16/10-01/12/17) Formal corridor spaces and associated equipment removed as of 01/12/17	**0**
Arrival to Specialty Referral	% with a Specialty Referral within 2 hours, and Average Waiting time	**60.89%** **123**	Arrival to Specialty Referral averaged 123 minutes versus 142 the previous week. 60.9% were referred within 2 hours compared to 49.8% previously.	Profile capacity and demand through ED. Develop a plan to realign resources to activity levels. Additional middle grade doctor overnight at WRH.	**2 hours**

Key:

Red Arrow – Deterioration in performance, **Green Arrow** – Improvement in performance

Down Arrow – Downward movement in Numerical value (not performance related), **Up Arrow** – Upward movement in Numerical value (not performance related)

Red Circle – Target missed, **Green Circle** – Target achieved

Weekly Urgent Care and Flow Dashboard - WRH - w/e 29th October 2017

NHS Worcestershire Acute Hospitals NHS Trust

Description	How we did	Trend	Key actions	Target
Specialty Review — The % of patients that have had a specialty review within 1 hour of request. Target is 80%.	**45.45%** — 45.5% of specialty reviews were carried out within an hour of request at an average time of 120 minutes.		Implementation and enforcement of internal professional standards. Adherence to standards monitored by a weekly divisional leadership meeting and non compliance escalated to CMO	**80% in 60 mins**
DTA to Admission — The % of patients Admitted to a bed within 2 hours from DTA and the Average wait	**220** / **49.41%** — Patients waited an average of 220 minutes from DTA to Admission compared with 245 the previous week. 49.4% of patients waited less than 2 hours, up from 44.6%.		Implementation and enforcement of internal professional standards. Early identification of discharges and proactive discharge management by Ward sisters and Matrons. Daily stranded patients meetings.	**2 hours**
Bed Occupancy — % of G&A Occupied Beds	**98.73%** — Core Bed Occupancy % as at the 22nd October was 98.73% compared to 104.26% the previous week.		Implementation and enforcement of internal professional standards. Early identification of discharges and proactive discharge management by Ward sisters and Matrons. Daily stranded patients meetings.	**92%**
Discharges by Midday — The % of Inpatients that are discharged by Midday.	**17.69%** — 17.7% of patients were discharged before 12 this week compared to 17.4% the week before.		Early identification of discharges and proactive discharge management by Ward sisters and Matrons. Proactive utilisation of discharge lounge	**33%**
EMS Escalation Level — Number of days above Level 2 in the Healthcare Economy	**5** — The EMS level was above Level 2 on 5 days last week compared to 6 the previous week.		Implementation and enforcement of internal professional standards. AEC expansion on WRH site. Countywide Frailty pathway at Alex. Health Economy wide winter control room	**Level 2**

Key:
Red Arrow – Deterioration in performance, **Green Arrow** – Improvement in performance
Down Arrow – Downward movement in Numerical value (not performance related), **Up Arrow** – Upward movement in Numerical value (not performance related)
Red Circle – Target missed, **Green Circle** – Target achieved

Date of meeting	09 November 2017
Paper number	H1

Data Sharing Charter

For approval:	√	For assurance:		To note:		For information:	

Accountable Director	Michelle McKay Chief Executive Officer
Presented by	Michelle McKay Chief Executive Officer
Author	Kimara Sharpe Company Secretary *(based on a paper from Wyre Forest Council)*

Alignment to the Trust's strategic priorities (√)	Deliver safe, high quality, compassionate patient care	√	Design healthcare around the needs of our patients, with our partners	√
	Invest and realise the full potential of our staff to provide compassionate and personalised care	√	Ensure the Trust is financially viable and makes the best use of resources for our patients	√
	Develop and sustain our business			

Alignment to the Single Oversight Framework (√)	Leadership and Improvement Capability		Operational Performance	
	Quality of Care	√	Finance and use of resources	√
	Strategic Change		Stakeholders	√

Report previously reviewed by		
Committee/Group	Date	Outcome
TLG	25-10-17	Approved

Date of meeting	09 November 2017
Paper number	H1

Assurance: *Does this report provide assurance in respect of the Board Assurance Framework strategic risks?*	N	BAF number(s)	

Level of assurance and trend				
		√	↑ ↓ →	
	Significant			
	Limited			
	None			
	Not applicable	√		

Purpose of report	To seek the Board's endorsement of the data sharing charter that will underpin the work of the Worcestershire Office for Data and Analytics.
Summary of key issues	This report provides an update on progress with the Worcestershire Office for Data and Analytics. It sets out the background to the programme, summarises progress to date, outlines planned next steps and seeks endorsement of the data sharing charter. Endorsement is being sought through the governance structures of all partner organisations.

The Trust's Senior Information Risk Owner (SIRO) has endorsed the Charter. |
| Recommendations | The Trust Board is asked to endorse the Worcestershire data sharing charter in the Appendix. |

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

DATA SHARING CHARTER

1   Introduction

This report provides an update on progress with the Worcestershire Office for Data and Analytics. It sets out the background to the programme, summarises progress to date, outlines planned next steps and seeks endorsement of the data sharing charter. Endorsement is being sought thorugh the governance structures of all partner organisations

2   Background

Arising from the work on public service reform and devolution, in May 2016, KPMG was commissioned to co-produce a roadmap strategy which set out the current state of data sharing across partners, a vision for the future, and a set of practical and costed steps and interventions to improve the delivery of public services in Worcestershire through innovation and process excellence. The roadmap recommended the development of a Worcestershire Office for Data and Analytics (WODA.   The Worcestershire Partnership Executive Group, comprising all AOs/CEOs of public sector entities in Worcestershire, agreed to a 12 month pilot to test the benefits of enhanced data sharing, demonstrated through a number of "use cases" (i.e. pilot initiatives that involve practical processes and service delivery being changed and enhanced through better data sharing than exists now).

WODA aims to facilitate enhanced data sharing between partner organisations. If successful, this will lead to reduced demand for local services and improved outcomes for local service users. It will also promote opportunities for preventative action, support compliance with the EU General Data Protection Regulation (GDPR) and Data Protection Bill and identify innovation opportunities and deliver savings for partner organisations. While several other areas have adopted similar approaches, none embraces all local public sector organisations as Worcestershire does.

3   Key achievements to date

Key achievements to date include:

Initiation of the programme – The WODA programme has been successfully initiated, with an embedded reporting process and clear lines of accountability. The office has a robust governance structure, which has included a Project Steering Group that convened weekly and an Executive Board in the form of the Partnership Executive Group;

Recruitment of a Chief Data Officer (CDO) – Neill Crump has been recruited as Chief Data Officer to lead the WODA team and help to publicise the office's activities on both a local and national scale. He commenced in post on 1 September;

Creation of a WODA Information Governance group –a WODA information Governance group has been established, comprising information governance leads from a range of partner organisations. It is scheduled to meet on a quarterly basis, with a remit to provide expert support and guidance regarding the ethical and lawful sharing of information;

Development of use case prioritisation and development process –a robust approach was developed for use cases, spanning from the initial identification of hypotheses to the prioritisation and selection process. Six initial use cases were selected and there has been close work with local stakeholders to design and develop implementation plans. Implementation has commenced for some of them. Outlined below is a summary of the use cases that are being taken forward:

Use Case	Summary
Business Rate Register	Local partners currently do not have shared access to local business data, such as turnover or employment size. This use case involves the pooling of business data from local partners and HMRC, so that local authorities and the LEP can target business support services to those who would benefit the most.
Patient Flow Integration	This use case aims to support the Patient Flow Centre (PFC), Acute Trust and Brokerage team in organising patient care packages by digitising the referral form and strengthening current information flows between the organisations so that they have access to real-time data.
Domestic Violence	Under the current system, police do not currently share interest markers or flags to indicate whether the individual is a repeat victim/offender. This use case entails the sharing of these data points as well as the enhanced sharing of domestic violence-related data between the Acute Trust and the social care team.
Falls & Frailty	This use case proposes a partnership between GP practices, the Clinical Commissioning Groups and the Fire Service with the aim of providing the Fire Service with the details of local vulnerable individuals who consent to receiving 'Safe and Well' visits. The Fire Service would expand their current service provision to undertake Falls assessments, ensuring that individuals get the support they need.
Local Resilience Planning	The Cabinet Office have developed Resilience Direct, a resilience planning platform, and are currently encouraging Local Resilience Forums across the country to adopt it as their main resilience planning system. This use case focuses on the enhanced sharing of vulnerability data between relevant agencies and first responders, via the Resilience Direct platform.
Connecting Families	The Connecting Families team have struggled to undertake a thorough evaluation of the programme as they face consistent difficulty in accessing the relevant data from partner organisations. This use case involves the creation of

	information sharing pathways for the transfer of these data points.

3.2 Next steps

3.2.1 Staffing WODA, which in the pilot phase is expected to be achieved mainly through secondments from partner organisations

3.2.2 Use case development and benefits realisation. The use cases are at various stages of maturity. As implementation takes place, it will be possible to collect outcome data which in turn will be used to evidence the efficacy of the programme and provide baseline data against which to make future investment decisions.

3.2.3 Launching WODA, which is scheduled for November, in order to raise public awareness and provide information about such things as the objectives and strategic ambitions of WODA, and the commitment to lawful sharing and processing of data in order to provide public reassurance that their data are safe and will be used appropriately;

3.2.4 Developing the business case for WODA beyond its pilot phase. This will draw on evaluation and appraisal activity undertaken for each of the six use cases, as well as the proposed benefits associated with enabling the next tranche of data driven solutions for Worcestershire. It will present a fully costed work-programme addressing both capital and revenue requirements and setting these against the benefits identified. The CDO will lead on compiling the business case and will draw on resources from each of the partner organisations to ensure it reflects their ambition and ability to contribute.

3.3 Key Issues

The approach to data sharing in Worcestershire is wide-ranging and innovative and has the ability to support transformation of public service delivery. The initial use cases will help to prove the concept and, subject to the business case for the future, offer the prospect of potential significant financial and non-financial benefits for the Trust.

In order to demonstrate the Trust's commitment to working together with the other partner organisations, the Board is asked to endorse the Worcestershire data sharing charter. The charter sets out the underlying principle which is a duty to share data unless there are legal or ethical reasons that prevent sharing. However this in no way undermines compliance with data protection legislation which will continue to govern the partner organisations' work in this area.

4 Implications

4.1 Financial

There are no additional financial implications for the Trust arising directly from this report. The CCGs have funded the health financial contribution to the pilot stage. The costs of supporting WODA in the future will be identified in the detailed business case that is to be prepared over the coming months. This will also address potential savings and non-financial benefits for partner organisations. A separate decision will be sought on future financial support for WODA.

4.2   Legal and Policy

Collection, holding and processing of personal data are subject to the requirements of the Data Protection Act 1998. The legislation will be superseded by the EU's General Data Protection Regulation which comes into force in May 2018 and subsequently by the proposed Data Protection Bill which the Government has announced and which will take full effect once the UK leaves the European Union. The Trust operates policies and procedures that comply with the legislation on data protection. Any sharing of data within the framework of WODA will comply with relevant legislation, including obtaining prior consent where applicable.

The Chief Data Officer has also requested that the Board note that the Senior Information Risk Owner (SIRO) (the Director of Finance) received the Charter at the TLG meeting.

There are no other known implications.

5   Recommendations

The Trust Board is asked to endorse the Worcestershire data sharing charter in the Appendix.

Compiled by
Kimara Sharpe
Company Secretary

Michelle McKay
Chief Executive Officer

Worcestershire Data Sharing Charter

Our Purpose

Our goal is to ensure that Worcestershire's residents are safe, happy and healthy. As a Partnership group, we are committed to empowering local service providers with the information they need to make the right decisions. Enhanced data sharing across our organisations will play a pivotal role in shaping our approach and underpin our strategies around prevention, protection and intervention.

Our Commitment

"Worcestershire partners will deliver cultural and systematic change in the way we approach data sharing across the county. Collectively, we will work from a default premise of the "duty to share" data being equal to the "duty to protect" it. That is, in all circumstances, we will share data unless there is a legal or ethical reason not to. We will do this in the pursuit of improved outcomes for residents, businesses and the wider community."

The following organisations have agreed to work together to support delivery of this vision:

Our Guiding Principles

To ensure a consistent approach is taken towards achieving Worcestershire's vision, we have agreed a set of principles that will guide work towards delivering the local mandate:

Worcestershire Partners will **start with a premise of duty to share**, unless there is a legal or ethical reason not to do so.

Worcestershire Partners will **engage with stakeholders regularly and empower organisations and staff** to share data competently through a no-blame culture.

Worcestershire Partners **will comply with all relevant legislation** when sharing data.

Worcestershire Partners will **invest real energy in achieving and delivering change**.

Worcestershire Partners **will develop clear and compelling use cases** to ensure that we are able to demonstrate the impact of data sharing.

Worcestershire Partners **will undertake thorough evaluation of projects and programmes** to ensure value for money is being delivered.

Worcestershire Partners will **be transparent and build trust with residents, businesses and communities** through the publication of key datasets wherever possible. Every effort will be made to put the resident at the centre of decisions about their data.

Worcestershire Partners will **prioritise outcomes led initiatives** with genuine prospects for improving outcomes for residents, businesses and the wider community.

Worcestershire Partners will **provide expert strategic leadership** with clear lines of accountability to ensure confidence throughout the system.

Worcestershire Partners will **provide a clear mandate for prioritising data sharing initiatives**.

Worcestershire Partners **will consider data sharing when commissioning new projects**.

Worcestershire Partners **will champion change in central government** and encourage government departments to lead the way in sharing data and breaking down silos.