NHS
Worcestershire
Acute Hospitals
NHS Trust

Date of meeting	15 March 2018
Paper number	E1

Financial Performance – Month 10 2017/18

For approval:	✓	For assurance:	✓	To note:	

Accountable Director	Jill Robinson – Chief Finance Officer		
Presented by	Jill Robinson – Chief Finance Officer	**Author**	Jo Kirwan - Assistant Director of Finance Katie Osmond – Assistant Director of Finance

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
Finance and Performance Committee	26.02.2018	Limited Assurance Received

Assurance: *Does this report provide assurance in respect of the Board Assurance Framework strategic risks?*	Y	BAF number(s)	R4.1

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

Recommendations	The Trust Board is asked to: • Note the YTD financial position at the end of Month 10 • Note the YTD Month 10 delivery to the revised forecast • Note the discussion of the detailed key risks to delivering the

	revised full year forecast of £57.9m at the Finance and Performance Committee and be assured that sufficient mitigation exists to deliver this financial position • Note that further cash support has been approved by both NHSI and DH through uncommitted term loans in line with the revised forecast outturn deficit of £57.9m • Approve submission of documentation to draw down the £5m emergency capital loan (Q4 - £2.4m)

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Executive Summary

The purpose of this paper is to update the Board on the financial performance of the Trust.

This paper summarises the Trust's financial performance for months 1 to 10 and includes information on healthcare activity, expenditure variances and cost improvement plan (CIP) delivery. This paper also provides an update on delivery against the financial recovery plan (FRP), and performance against the month 10 forecast position – required to ensure delivery of the revised full year position of £57.9m deficit.

The Trust has recorded a deficit of £50.9m pre Sustainability and Transformational Funding (STF) for months 1 to 10 of 2017/18 financial year which is £14.6m worse than the original operating plan submitted to NHSI.

Inclusion of the STF from Q1 reduces the YTD deficit to £48.8m against this agreed plan of £26.5m resulting in a £22.3m adverse variance to post STF plan.

This adverse position is largely driven by non-delivery of CIP, the provision of additional operational capacity (including RTT business case investment) and workforce pressures.

The Trust delivered the month 10 forecast deficit of £5.5m and recorded £0.5m of non-recurrent delivery against the £2m non recurrent element of the FRP target. This resulted in a £5.0m deficit in month 10. Both CIP and FRP respectively delivered to forecast.

As agreed with NHSI in December 2017, the Trust submitted a revised forecast outturn of £57.9m deficit. A number of risks were discussed in detail at the Finance and Performance Committee (FPC). These are subject to on-going management and mitigation in order for the Trust to meet this revised forecast outturn.

As a result of the revised I&E forecast to £57.9m deficit, the Trust will need to increase its planned interim revenue support to maintain payments to suppliers. The Trust has agreed Interim Revenue Support in February and March, which has been approval by both NHSI and DH.

The capital programme is being closely monitored to ensure spend remains within plan. The business as usual capital loan application has not been approved, however on the 2nd March the Trust was notified that an emergency capital bid for £2.4m in 2017/18 and £2.6m in 2018/19 had been approved. The Board are asked to approve the submission of the acceptance of this emergency capital loan, which is granted on terms consistent with regular capital loans.

Background

The financial performance of the Trust to date, and the projected pre mitigation full year forecast deficit of £64.9m refreshed at M7, demonstrated the size of the financial challenge for the Trust to deliver its pre STF financial plan of £42.7m in 2017/18. As a result the Trust developed a financial recovery plan.

In implementing the FRP as outlined in the accompanying report, this position is forecast to be mitigated to deliver a £57.9m deficit.

The Trust's FRP is focused on a limited number of key projects to ensure capacity and capability is targeted at those schemes with the greatest potential to reduce the impact of the drivers of the deficit. Key projects include theatre productivity, use of temporary staffing, rostering, recruitment & retention, procurement and grip and control measures.

Delivery of the FRP/CIP actions and overall performance against Divisional control totals are monitored through fortnightly Confirm & Challenge meetings with each of the Divisions. Where a Division falls behind the agreed recovery plan, this monitoring is escalated to weekly.

Issues and options

Income and Expenditure

The Trust has recorded a deficit of £50.9m pre STF for months 1 to 10 of 2017/18 financial year which is £14.6m worse than the original operating plan submitted to NHSI.

Inclusion of the STF from Q1 reduces the YTD deficit to £48.8m against this agreed plan of £26.5m resulting in a £22.3m adverse variance to post STF plan.

This adverse position is largely driven by non-delivery of CIP, the provision of additional operational capacity (including RTT business case investment) and workforce pressures.

Specifically related to CIP, although delivery continues to deliver to the revised forecast, there remains a significant adverse variance to the original plan. YTD the Trust was expecting to deliver £16.4m of savings, but has only achieved £7.1m of savings resulting in an £9.3m adverse variance against plan.

The other operational capacity and workforce pressures have been largely offset by a release of reserves and non-core income receipts above planned levels.

As part of the FRP, the Trust had a baseline forecast of £6.6m deficit in month 10 and financial recovery actions of £1.1m resulting in a forecast deficit of £5.5m. Overall the Trust delivered the month 10 requirement of £5.5m and also recorded £0.5m of non-recurrent delivery against the full year £2m target. This has resulted in a £5.0m month 10 deficit.

The Surgical, Women and Children and SCSD Divisions reported favourable variances against their respective control totals - noting that this position is inclusive of expenditure underspends against the RTT business case. Medicine was £58k adverse against the monthly profiled control total, but remains within their year to date control total and as a result, remains on fortnightly monitoring. Although Asset Management & IT and Corporate both report an adverse variance against their control totals, performance in these areas has improved this month with increased FRP and CIP delivery.

It is positive that for the third consecutive month, the Trust has delivered against its forecast position with both CIP and FRP delivering to plan. This level of focus on financial delivery must continue throughout the remainder of Q4 as the size of the challenge increases due to an increase in the required level of FRP delivery. It is also essential to embed these actions as 'business as usual' across the Trust. The strong governance and reporting processes that the Trust has implemented will continue through the remainder of Q4 and in 2018/19. This will be supplemented by a financial training package which has been developed by the

finance department and rolled out to all budget managers early in the new financial year.

There are a number of financial risks that the Trust is actively managing in order to achieve the revised forecast out turn position of £57.9m deficit. These were reviewed by FPC in their February meeting, together with the actions and mitigations being taken to secure overall delivery of the revised financial position.

In light of the current financial performance, the Trust continues to be subject to the NHSI enhanced oversight regime. Weekly status updates continue to be provided to NHSI including performance against forecast for key expenditures lines such as temporary staffing (bank and agency) and discretionary expenditure. Elective activity levels are also monitored, assessing the mobilisation of the Trust's plan to increase activity following the national directive to cancel elective activity over winter. Outputs from the Divisional confirm and challenge meetings are also reviewed and discussed with NHSI.

In addition to the close management of the 2017/18 outturn position of the Trust, NHSI are also assessing the robustness of the 2018/19 plan, particularly the readiness and deliverability of the CIP.

Cash
As a result of the revised I&E forecast, the Trust has continued to require increased interim revenue support. The Trust has received Interim Revenue Support in February and approval from both NHSI and DH for the requested March funding.

Capital
The Trust has limited internally generated capital funding. Approved prioritised schemes are being monitored through the Capital Prioritisation Group (CPG), reporting to FPC. The forecast position is kept under monthly review, with reprioritisation of schemes undertaken through this group, which includes divisional and operational representation, to ensure spend continues to be managed within the overall funding envelope.

The business as usual capital loan application for 2017/18 submitted in July 2017 for £16.721m has not been approved. The Trust also submitted a new Emergency Capital Loan application in January amounting to £5m (£2.4m in 2017/18 and £2.6m in 2018/19) on the basis that capital funds were urgently needed. The Trust was notified on 2 March 2018 that this has been approved. The Trust is required to submit a Board Resolution as part of the draw down request to access this funding. The Board is asked to approve the submission of the drawdown request for the loan.

The Trust continues to engage with NHSI and the DH to access the Sustainability and Transformation capital funding of £29.6m for the Acute Service Review in a timely manner. The Trust has been advised that the link bridge element of the programme can proceed to enable better access to the Aconbury buildings in time for next winter.

Recommendations

The Trust Board is asked to:

- Note the YTD financial position at the end of Month 10
- Note the YTD Month 10 delivery to the revised forecast
- Note the discussion of the detailed key risks to delivering the revised full year

forecast of £57.9m at the Finance and Performance Committee and be assured that sufficient mitigation exists to deliver this financial position

- Note that further cash support has been approved by both NHSI and DH through uncommitted term loans in line with the revised forecast outturn deficit of £57.9m
- Approve submission of documentation to draw down the £5m emergency capital loan (Q4 - £2.4m)

Appendices

Finance Report

Worcestershire Acute Hospitals NHS Trust

Finance Report

Jill Robinson

Chief Finance Officer

January 2018

Month 10

Use of Resources Risk Rating Summary

Worcestershire Acute Hospitals NHS Trust

	Metric Definition	How we did YTD at M10	Risk Rating		Previous Month YTD	Full Year Plan (Forecast)
I&E margin rating	I&E surplus or deficit / total revenue.	(15.04%)	4	Adjusted financial performance deficit of **£49,262k** (£49,262k exc 16/17 STF allocation of £419k) / total operating income (exc impact of 1617 STF allocation of **£327,617k** = **(15.04%).**	4	4
I&E margin: distance from financial plan	YTD actual I&E surplus/deficit in comparison to YTD plan I&E surplus/deficit.	(7.17%)	4	I&E margin YTD actual of **(15.04%)** less I&E margin YTD plan of **(7.86%)** = **(7.17%)**.	4	4
Liquidity rating (days)	Measures the days of operating costs held in cash, cash-equivalent and liquid working capital forms.	(57.079)	4	Working Capital of (£66,473) / YTD Operating Expenditure of £356,364 multiplied by the number of YTD days (275) = (57.079).	4	4
Capital service cover rating	Degree to which the organisation's generated income covers its financing obligations.	(1.869)	4	Revenue available for service capital (£28,310)/ capital service **£15,147k** = **(1.869)**	4	4
Agency rating	Total agency spend compared to the agency ceiling	(7.02%)	1	Total agency spend of **£17,759k** less agency ceiling of **£19,100k** / divided by agency ceiling of **£19,100k** = **(7.02%).**	1	1

Income & Expenditure Overview – M10

Worcestershire Acute Hospitals NHS Trust

In the month of January the Trust is reporting an in month pre Sustainability and Transformational Fund (STF) deficit of £5.0m, this is £1.8m worse than plan.

This has increased the year to date (YTD) deficit to £50.9m pre STF which is £14.6m worse than plan. A breakdown of the key variances to plan at the end of January are detailed on page 4.

Overall the Trust delivered the month 10 control total of £5.5m and is reporting £1.38m of FRP delivery in month. The Trust was also able to record a further £0.5m of non recurrent delivery against the £2m non recurrent target which resulted in a £5.0m month 10 deficit.

In Month

Income & Expenditure	January 18 (Month 10)			Year to Date			Full Year
	Plan	Actual	Var	Plan	Actual	Var	Forecast
	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Operating Revenue & Income							
Patient Care Revenue (pre STF)	26,732	27,111	379	267,559	268,339	780	
Other Operating Income	2,323	3,264	941	22,201	24,475	2,274	
Non PBR Drugs	3,142	2,901	(241)	31,421	30,150	(1,271)	
Non PBR Devices	272	335	63	2,648	3,051	403	
Total Operating Revenue pre STF	**32,469**	**33,611**	**1,142**	**323,829**	**326,015**	**2,186**	**394,819**
Operating Expenses							
Pay	(20,953)	(22,288)	(1,335)	(211,734)	(222,809)	(11,075)	
Non Pay	(9,246)	(10,826)	(1,580)	(93,950)	(100,025)	(6,075)	
Non PBR Drugs	(3,162)	(3,043)	119	(31,620)	(30,288)	1,332	
Non PBR Devices	(265)	(462)	(196)	(2,650)	(3,398)	(748)	
Total Operating Expenses	**(33,627)**	**(36,619)**	**(2,992)**	**(339,954)**	**(356,520)**	**(16,566)**	**(427,152)**
EBITDA *	**(1,158)**	**(3,008)**	**(1,850)**	**(16,125)**	**(30,505)**	**(14,380)**	**(32,333)**
EBITDA %	-3.6%	-8.9%		-5.0%	-9.4%		
Depreciation	(830)	(856)	(26)	(8,219)	(8,983)	(764)	(11,052)
Net Interest, Dividends & Gain/(Loss) on asset disposal	(1,232)	(1,131)	101	(11,947)	(11,491)	456	(14,633)
Reported Total Surplus / (Deficit)	**(3,220)**	**(4,995)**	**(1,775)**	**(36,291)**	**(50,978)**	**(14,687)**	**(58,018)**
Less Impact of Donated Asset Accounting	4	10	6	37	101	64	121
Surplus / (Deficit) against Control Total pre STF	**(3,216)**	**(4,985)**	**(1,768)**	**(36,254)**	**(50,877)**	**(14,623)**	**(57,897)**
STF	1,477	0	(1,477)	9,708	2,034	(7,674)	2,034
Surplus / (Deficit) against Control Total inc STF	**(1,739)**	**(4,985)**	**(3,245)**	**(26,546)**	**(48,843)**	**(22,297)**	**(55,863)**

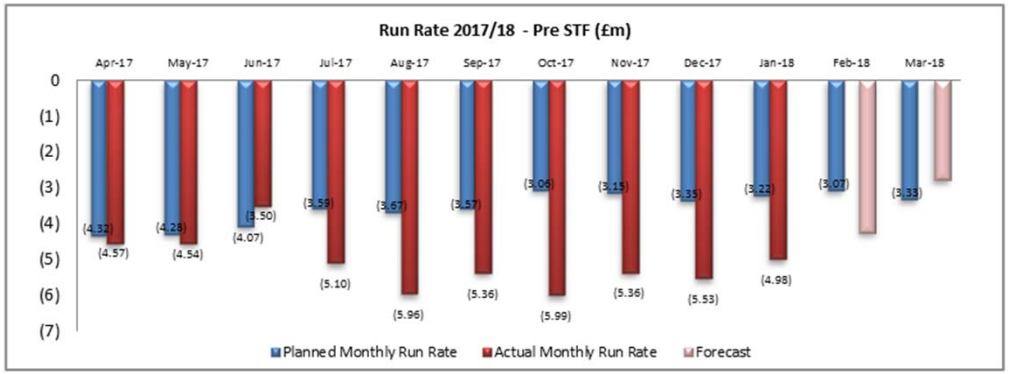
* EBITDA = earnings before interest, tax, depreciation and amortisation

At the end of January the Trust is reporting an in month pre Sustainability and Transformational Fund (STF) deficit of £5.0m, which is £1.8m worse than plan.

Inclusion of the STF increases the adverse variance by a further £1.48m due to lost STF from performance (£0.44m) and finance (£1.04m).

This has increased the year to date (YTD) deficit to £50.9m pre STF which is £14.6m worse than plan. Inclusion of the STF (relating to Q1) reduces the YTD deficit to £48.8m against a plan of £26.5m resulting in a £22.3m adverse variance to plan.

Monthly (Deficit) / Surplus Run Rate



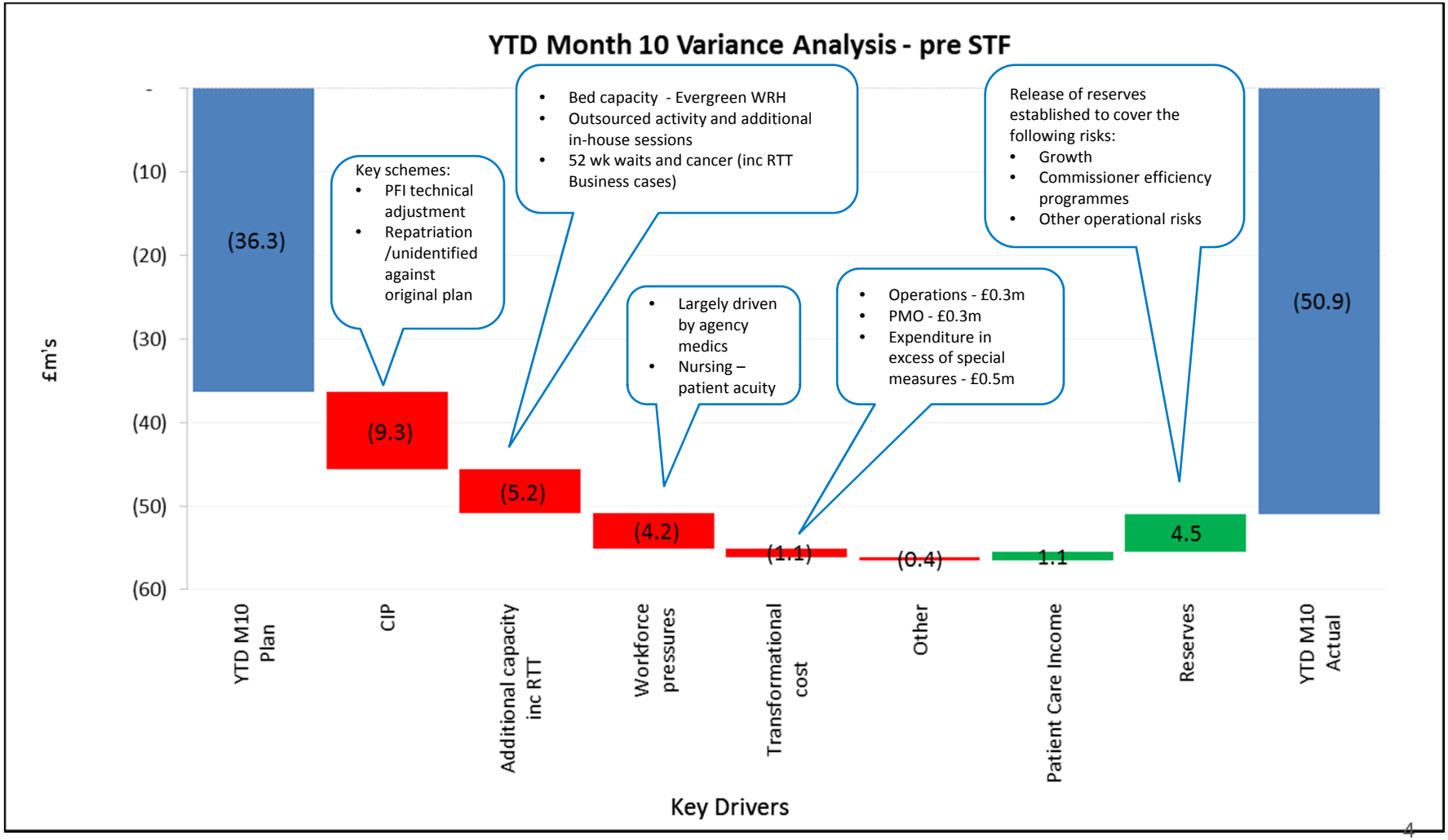
The actual run rate deficit improved from December to January by £0.5m. This is largely due to an increase in patient care income and reduction in pay spend. The Trust delivered the month 10 control total of £5.5m, as agreed with NHSI, and recorded £0.5m of non recurrent delivery against the £2m non recurrent target.

A breakdown of the financial recovery performance is detailed on page 5.

2017/18 – YTD Key Variances pre STF

Worcestershire Acute Hospitals NHS Trust

At the end of month 10, the Trust is reporting a year to date deficit of £50.9m. This position is £14.6m adverse to plan, the key variances are presented below.



Run Rate & FRP Performance
January 2018 – M10

Worcestershire Acute Hospitals NHS Trust

The Financial Recovery Programme is focused on a limited number of key projects to ensure capacity and capability is targeted at those schemes with the greatest potential to reduce the impact of the drivers of the deficit.

Overall the Trust delivered the month 10 control total of £5.5m and recorded £0.5m of non recurrent delivery against the £2m target.

This resulted in a £5.0m month 10 deficit.

Total I&E Run Rate

I&E Run Rate with Original FRP Plan	Actual M1	Actual M2	Actual M3	Actual M4	Actual M5	Actual M6	Actual M7	Forecast M8	Forecast M9	Forecast M10	Forecast M11	Forecast M12	FY Forecast
Run Rate - Baseline (£m)	(4.6)	(4.5)	(3.5)	(5.1)	(6.0)	(5.4)	(6.0)	(5.7)	(6.6)	(6.6)	(5.6)	(5.4)	**(64.9)**
FRP (£m)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.3	0.7	1.2	1.4	1.4	**5.0**
Non Recurrent	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.0	**2.0**
Forecast inc FRP	**(4.6)**	**(4.5)**	**(3.5)**	**(5.1)**	**(6.0)**	**(5.4)**	**(6.0)**	**(5.4)**	**(5.8)**	**(5.5)**	**(4.2)**	**(2.0)**	**(57.9)**
Reprofile £2m Non Recurrent									0.288	0.456	0.162	(0.905)	**0.000**
Reprofiled Forecast inc FRP	**(4.6)**	**(4.5)**	**(3.5)**	**(5.1)**	**(6.0)**	**(5.4)**	**(6.0)**	**(5.4)**	**(5.5)**	**(5.0)**	**(4.0)**	**(2.9)**	**(57.9)**
Actual								(5.4)	(5.5)	(5.0)			

FRP Performance – In Month

FRP Performance M10	Jan-18 Plan £m	Jan-18 Actual £m	Jan-18 Variance £m
Substantive Pay	0.18	0.26	0.08
Temporary Pay	0.53	0.36	(0.16)
Pay Financial Recovery Plans	**0.71**	**0.63**	**(0.09)**
Procurement	0.14	0.09	(0.06)
Discretionary spend	0.19	0.12	(0.07)
Theatre Productivity	0.04	0.04	0.00
Other	0.11	0.51	0.40
Non Pay Financial Recovery Plans	**0.48**	**0.75**	**0.28**
Total Financial Recovery Plans	**1.19**	**1.38**	**0.19**

Receipt of training funds in Corporate.

Income Summary
Month 10 – January 2018

Worcestershire Acute Hospitals NHS Trust

Income including STF was £0.3m below plan in January. Excluding STF £1.2m favourable.

Inpatients were £1.0m favourable in January:

- Day case activity 4% below plan
- Elective activity 23% below plan
- Emergency activity 13% above plan - winter pressures.

Outpatients breakeven, ED/MIU £0.1m favourable, Maternity £0.5m and Other Income £0.4m are adverse.

Other Operating Income £1.0m favourable.

STF £1.5m adverse; Trust has not achieved the financial control and performance targets.

Income – The combined total reported income (including STF) **is £5.5m below the YTD plan**. Prior to STF funding there was an over performance of **£2.2m at the end of January**. In month there was an adverse variance of **£0.3m** to plan (pre STF **£1.2m** favourable).

Key movements in January:
Inpatients £1.0m favourable – Emergencies £1.4m were favourable, Day cases £0.1m and Electives £0.3m adverse.
Emergency activity 13% above plan – Medicine £1.1m, W&C £0.2m (uncoded activity for deliveries; will offset below with the Maternity line once coded) and Oncology £0.1m (new ward) were favourable. Additional capacity for winter pressures and cancer work with the postponement of routine operations.
Day case activity was 4% below plan; surgical areas were down £284k (General Surgery - £121k, T&O -£83k, ENT -£53k and Vascular -£24k - postponement of elective work) offset by Cardiology £64k and Acute Medicine/Gastro £99k (insourcing of endoscopies/increased levels of staffing).
Elective activity 23% below plan; surgical areas -£319k (ENT -£28k, T&O -£221k and Urology -£74k), postponement of routine operations during winter.
Outpatients breakeven; Cardiology £30k and Oncology £36k offset by Oral Surgery -£47k (less procedures undertaken than planned level).
ED/MIU £0.1m adverse – Winter pressures higher attendances across all sites . **Maternity £0.5m adverse** – Deliveries £310k and Antenatal visits £180k were below plan. **Other Income £0.4m adverse;** PbR Excluded/CDF Drugs -£753k, Critical Care -£120k less Winter Monies £467k (£1.5m tranche).
Other Operating Income £0.9m – £850k relates to the reclassification of the PFI credit release to income from expenditure.
STF Funding £1.5m adverse – Both the financial control(70%) and performance element(30% - Emergency Access Standard) targets have not been met in month.

CQUINs – Total CQUIN is worth £7.5m; Worcestershire CCGs £6.2m; Associate CCGs £0.5m and NHS England £0.8m. Failure to deliver the CQUIN targets will result in a risk to payments, albeit the £6.2m for the Worcestershire CCGs is mitigated through the cap/collar arrangement. NHS England and NHSI have confirmed the Trust can account for the £1.3m (0.5% 2016/17 CQUIN Risk Reserve) towards the 2017/18 control total. Quarter 3 CQUIN returns have been made to commissioners at the end of January (waiting confirmation of the outcome).

By Commissioner: Over-performance reported against Worcestershire CCG contract £3.9m (before Cap/Collar adjustment**)**. NHS England contract is (Prescribed Services/Dental/Screening) 7% above YTD plan but this is offset by the non-contracted CDF drugs . Associate contracts; -£0.6m adverse/3% under performance(B'ham CCGs, South Warwickshire CCG, Powys LHB are under plan). Non Contract/Out of Area activity is18 % or £522k above plan YTD.

	In Month				YTD			
	Plan £'000	Actual £'000	Var £'000	% £'000	Plan £'000	Actual £'000	Var £'000	% £'000
Inpatient	12,193	13,167	974	8%	125,474	130,536	5,062	4%
Outpatient	3,957	4,001	44	1%	36,587	36,766	179	%
ED/MIU	1,610	1,730	120	7%	17,635	17,577	(57)	(%)
Maternity	2,250	1,744	(506)	(23%)	21,953	19,954	(1,999)	(9%)
Paediatrics	1,247	1,174	(73)	(6%)	12,488	11,702	(786)	(6%)
Other	8,889	8,535	(354)	(4%)	87,494	85,008	(2,486)	(3%)
Patient Care Income	**30,146**	**30,350**	**204**	**1%**	**301,629**	**301,543**	**(86)**	**(%)**
Other Operating Income	**2,331**	**3,279**	**948**	**41%**	**22,201**	**24,475**	**2,274**	**10%**
Patient Care & Other Operating Income	**32,477**	**33,629**	**1,152**	4%	**323,830**	**326,018**	**2,188**	1%
STF	**1,477**	**0**	**(1,477)**	**(100%)**	**9,708**	**2,034**	**(7,674)**	**(79%)**
Total Income	**33,954**	**33,629**	**(325)**	**-1%**	**333,538**	**328,052**	**(5,486)**	**-2%**

Note the table above reflects the adjusted Cap/Collar position based on the annual phased limits - Collar £264.4m and Cap £271.4m .

Pay Expenditure
Month 10 – January 2018

Worcestershire Acute Hospitals NHS Trust

Pay expenditure in January was £22.3m, an over spend against plan of £1.3m.

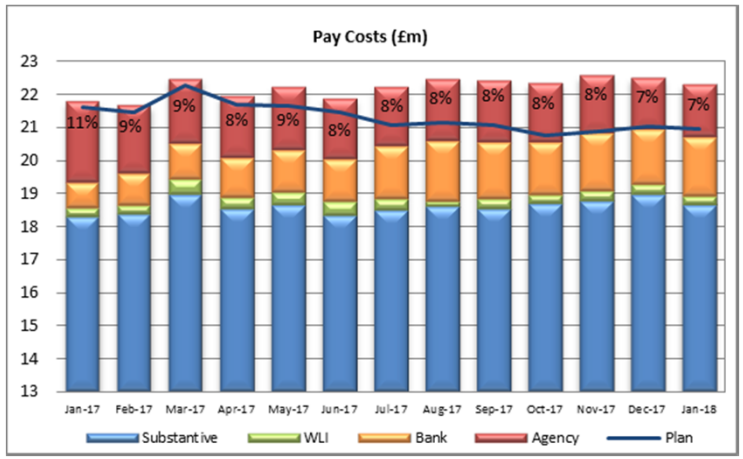
- Substantive pay spend was £18.9m (inc additional sessions).
- Bank pay spend was £1.8m.
- Agency pay spend was £1.6m.

The overall pay run rate reduced in month by £0.2m with reductions of £0.4m on substantive staffing being largely offset by an increase of £0.2m in temporary staffing. The majority of this increase is aligned to the NHSE winter plan which is funded through a corresponding increase in income.

In January total pay expenditure was £22.3m, which is an adverse variance to plan of £1.3m. YTD the Trust is reporting a pay position of £222.8m, an £11.1m over spend against plan.

FT Subjective	Jan-18 Budget £000s	Jan-18 Actual £000s	Jan-18 Variance £000s	Year to Date Budget £000s	Year to Date Actual £000s	Year to Date Variance £000s
Medics - Consultants	(3,712)	(3,456)	256	(37,553)	(34,046)	3,508
Medics - Other	(2,272)	(1,847)	425	(22,920)	(17,699)	5,221
Medics - Agency / Bank	(86)	(1,707)	(1,621)	(2,348)	(17,975)	(15,628)
Total Medics Pay	**(6,070)**	**(7,010)**	**(940)**	**(62,821)**	**(69,720)**	**(6,899)**
Non Clinical	(3,394)	(3,214)	180	(33,890)	(32,419)	1,471
Non Clinical - Agency / Bank	(24)	(98)	(73)	(301)	(1,291)	(990)
Total Non Clinical Pay	**(3,418)**	**(3,312)**	**107**	**(34,190)**	**(33,710)**	**480**
Nursing & Midwifery	(8,201)	(7,657)	544	(82,561)	(76,713)	5,847
Nursing & Midwifery - Agency / Bank	(43)	(1,423)	(1,380)	(844)	(12,662)	(11,818)
Total Nursing Pay	**(8,244)**	**(9,080)**	**(836)**	**(83,405)**	**(89,375)**	**(5,971)**
ST&T	(2,872)	(2,853)	19	(28,810)	(27,890)	919
ST&T - Agency / Bank	87	(145)	(232)	467	(1,493)	(1,960)
Total ST&T Pay	**(2,785)**	**(2,997)**	**(212)**	**(28,343)**	**(29,383)**	**(1,041)**
Other	(437)	110	547	(2,975)	(621)	2,354
Total Other Pay	**(437)**	**110**	**547**	**(2,975)**	**(621)**	**2,354**
TOTAL PAY	**(20,953)**	**(22,288)**	**(1,335)**	**(211,734)**	**(222,809)**	**(11,076)**

Key scheme within FRP plan - improve recruitment process to reduce reliance and minimise spend on temporary staffing.



Percentages shows proportion of agency spend against total spend.

Run Rate Changes

The overall pay run rate saw a reduction of £0.2m in month. The key driver of this is an increase in FRP savings of £0.2m, as well as a credit of £0.2m relating to undistributed pensions for months 1 to 10. This is a correction on the pension contributions made by the Trust which was previously held on the balance sheet. Substantive pay also saw a benefit of £90k due to a lower payment for bank holidays in month than the provision made.

These benefits have been largely offset by an increase in both substantive and temporary pay spend relating to Evergreen 2 (£26k) and the NHSE winter plan (£285k).

Key YTD Variances:

Medics – At month 10 the Trust reports 124.46 wte medical vacancies across all grades and this explains the favourable variance against the substantive cost lines. The overall medics position is an adverse in month variance of £0.9m and £6.9m YTD and is mainly due to the costs incurred by bank and agency staff to cover the vacant posts, as well as non delivery of CIP schemes.

Nursing – Nursing continues to over spend overall, both in month (£0.8m) and YTD (£6.0m). Under spending on substantive nursing is due to vacancies, with the cost of covering these vacant posts reported within bank and agency. The key drivers of the nursing variance include:

- Additional bed capacity - £2.9m.
- Patient acuity/specialing - £0.8m.
- Slippage against CIP schemes - £1.4m.

Other

Contained within "Other" is a CIP and phasing adjustment reconciling the overall Trust budget to the plan submitted to NHSI and release of Trust wide reserves. Actual spend on this line relates to the Apprenticeship Levy charge.

Temporary Pay Expenditure Month 10 – January 2018

Worcestershire Acute Hospitals NHS Trust

The Trust set an internal agency target for 2017/18 of £17.3m.

NHSI set the Trust an annual agency expenditure ceiling for 2017/18 of £22.9m.

At the end of January, YTD agency spend is £17.8m, £1.3m under the YTD agency ceiling of £19.1m. This represents 8.0% of gross staff costs.

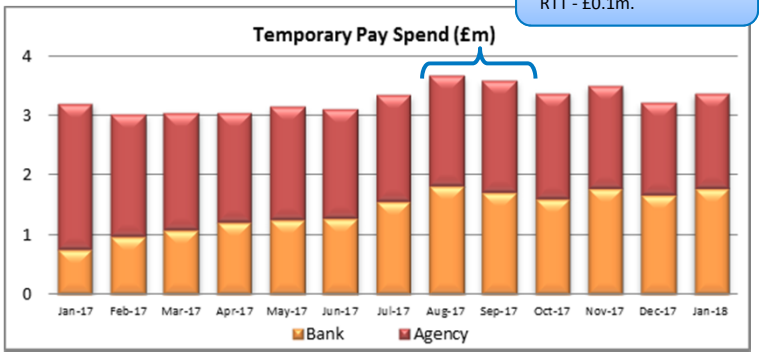
The YTD medical agency reduction target at the end of month 10 is £8.8m. The Trust is reporting YTD medical agency expenditure against this of £8.7m, £117k under target.

FRP plan - improve quality and safety through recruitment of substantive clinical staff.

The Trusts spend on its temporary workforce was £3.4m in January, £1.6m on agency and £1.8m on bank. Overall this is an increase of £150k compared to December, £114k on agency and £36k on bank.

Nursing reports the most significant increase in month (£197k) with temporary nursing spend at it's highest for this year. This is largely due to the costs associated to the NHSE Winter Funding (£70k) and Evergreen 2 (£4k) as well as increases across all clinical divisions (£117k) ST&T and non clinical also saw small increases in month, £7k and £2k respectively, with Medics temporary spend reducing by £56k compared to December.

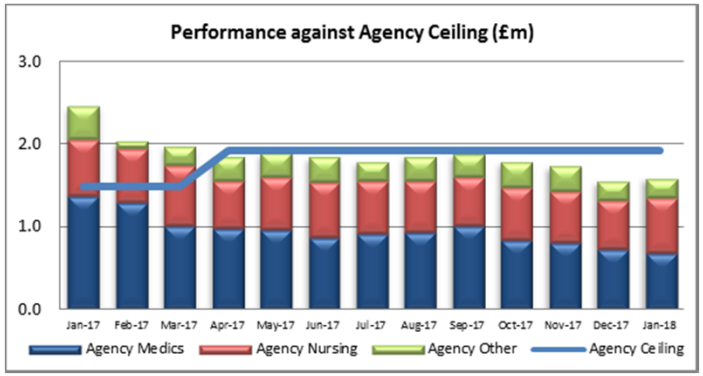
Addtl rota gaps - £0.3m.
Increase on call - £0.1m.
RTT - £0.1m.



Agency

Agency staffing costs of £1.6m in month is an increase of £36k compared to last month. This is £320k under the monthly NHSI agency ceiling.

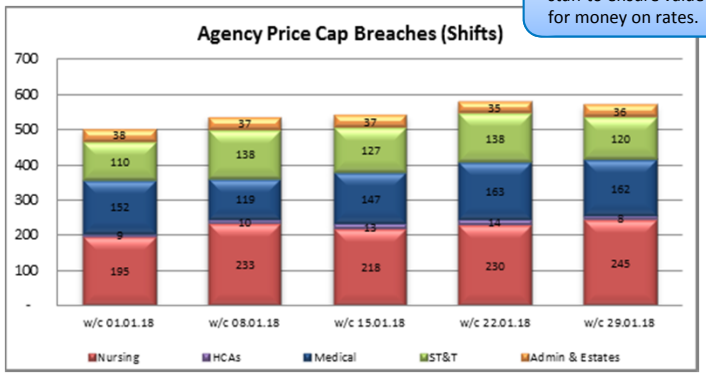
The run rate has increased in month due to the additional costs associated to the NHSE Winter Funding. £46k of the increase relates to medics, £51k to nursing and £5k relates to ST&T agency staff. A corresponding increase in the income run rate can however be seen to offset this.



Agency Price Cap and Frameworks Compliance

The Trust is obliged to comply with mandatory price caps and approved frameworks for procuring agency staff. In cases where a framework is not used to procure an agency shift these "overrides" are reported to NHSI. In addition to this the Trust is also required to report to NHSI on a weekly basis regarding bank shifts requested and worked.

FRP plan - engage with suppliers of temporary staff to ensure value for money on rates.



The chart above includes price cap performance only.

Non Pay Expenditure
Month 10 – January 2018

Worcestershire Acute Hospitals NHS Trust

In January non pay expenditure was £14.3m, an over spend against plan of £1.7m. YTD is a £5.5m over spend against plan.

Overall the key driver of this YTD adverse position is within clinical supplies and services and this variance is largely driven by the cost of outsourcing activity in support of delivering RTT and supporting flow.

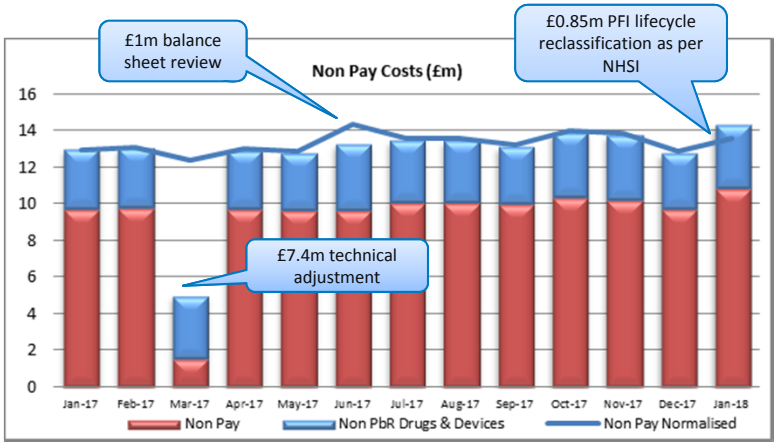
The Trust has undertaken a major reclassification of expenditure in line with NHSI coding. This has resulted in a disparity of budgets against actual spend but does not affect the bottom line non pay position at cost centre level. Budgets will be realigned as part of the 2018/19 budget setting process.

FRP plan - ensure larger commercial contracts are managed robustly, deliver value for money and re-negotiate accordingly.

In January total non pay expenditure, excluding depreciation, PDC and interest payable, was £14.3m. Including these items total non pay expenditure is £16.3m.

FT Subjective	Jan-18			Year to Date		
	Budget £000s	Actual £000s	Variance £000s	Budget £000s	Actual £000s	Variance £000s
Clinical Supplies & Services	(3,391)	(3,751)	(360)	(34,968)	(38,093)	(3,124)
Drugs	(687)	(718)	(30)	(6,902)	(7,250)	(348)
Non PbR Drugs	(3,162)	(3,043)	119	(31,620)	(30,288)	1,332
Non PbR Devices	(265)	(462)	(196)	(2,650)	(3,398)	(748)
Establishment Expenses	(356)	(386)	(30)	(3,659)	(3,714)	(54)
General Supplies & Services	(613)	(659)	(46)	(6,134)	(5,847)	287
Other	(4,198)	(5,312)	(1,114)	(42,285)	(45,122)	(2,837)
TOTAL NON PAY	**(12,673)**	**(14,331)**	**(1,658)**	**(128,220)**	**(133,712)**	**(5,492)**
Depreciation	(830)	(856)	(25)	(8,219)	(8,983)	(763)
PDC - Dividend	(0)	(0)	0	(0)	0	0
Interest Payable	(1,196)	(1,131)	65	(11,947)	(11,509)	438
Impairment Losses	0	0	0	0	0	0
GRAND TOTAL	**(14,700)**	**(16,318)**	**(1,618)**	**(148,386)**	**(154,203)**	**(5,817)**

As part of the FRP plan authorisation levels were reduced in Sept. In Oct non-clinical items were removed from the iProc catalogue and a process established for requesting non-clinical items deemed essential.



Run Rate Changes

The non pay line excluding Non PbR, depreciation, PDC and interest payable saw an increase £1.1m in month. Including these items total non pay increased by £1.8m.

The key driver of the in month increase was the reclassification of PFI lifecycle credits of £850k between non pay and directorate income in line with NHSI reporting requirements. This has increased the non pay run rate, but does not affect the bottom line. In addition to this there was a movement of £476k due to a normalisation of the year to date position in December, mainly within PDC. A further £0.2k of the increase was on Non PbR drugs which is offset through an increase in income. A further £0.1m relates to the NHSE winter plan which is also offset through increased income.

Key YTD Variances:

Clinical Supplies & Services

The key drivers of the YTD adverse variance are:

- Radiology increase in outsourced reporting following the switch of the 2nd CT scanner to support in patient flow - £0.5m.
- Outsourced T&O activity - £0.4m (outside RTT business case).
- Pathology are currently outsourcing a significant volume of tests due to consultant vacancies in Histopathology - £0.38m.
- Dermatology start point activity reduction - £0.4m.

Other

Contained within the "Other" line is Reserves, which contains CIP and phasing adjustments reconciling the overall Trust budget to the plan submitted to NHSI.

The £2.8m YTD adverse variance on this line is predominantly due to unidentified CIP schemes against the original plan, offset by Reserves phasing, as well as the impact of the £850k for PFI lifecycle credits as detailed above.

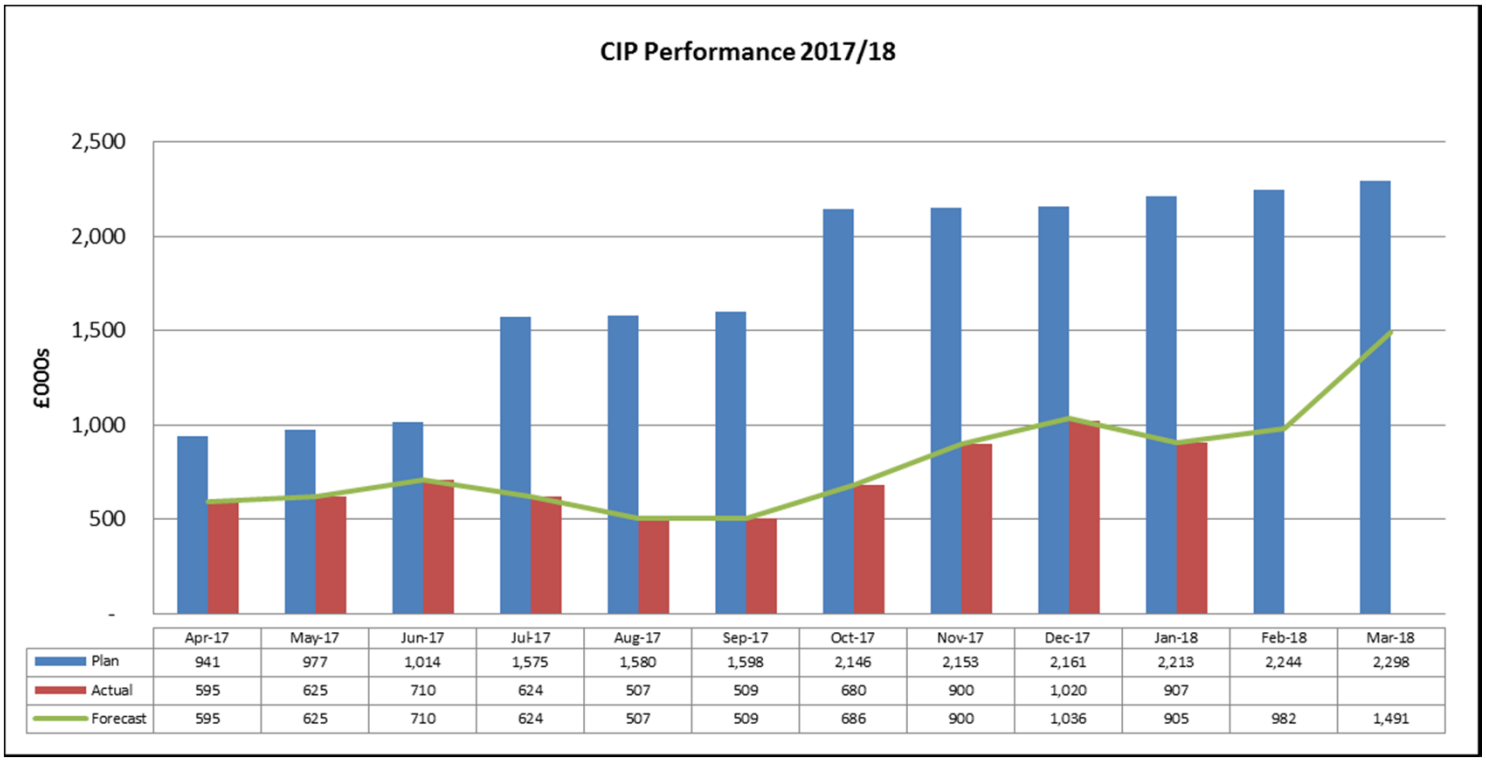
CIP Performance
Month 10 – January 2018

Worcestershire Acute Hospitals NHS Trust

The financial plan assumes efficiency savings of £20.9m (5.3% turnover) are delivered in 2017/18.

In January the Trust had a plan to deliver £2.213m of savings and has achieved £0.907m of savings. This is a £1.306 adverse variance against plan.

YTD the Trust had a plan to deliver £16.358m of savings and has achieved £7.075m of savings resulting in an £9.283 adverse variance against plan.



	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Plan	941	977	1,014	1,575	1,580	1,598	2,146	2,153	2,161	2,213	2,244	2,298
Actual	595	625	710	624	507	509	680	900	1,020	907		
Forecast	595	625	710	624	507	509	686	900	1,036	905	982	1,491

- The Trust delivered a CIP position in line with forecast.
- The Trust continues to forecast £9.5m of CIP delivery.
- Weekly tracking in place to monitor confidence against remaining procurement schemes and escalate where required.
- Dashboard available at Divisional level.

Balance Sheet

Worcestershire Acute Hospitals NHS Trust

In January the Balance Sheet is behind the plan by £9.6m

Overall, the key drivers of the YTD variances are linked to the I & E performance resulting in increased Trade and Other Payables (£18.1m), Revenue Support Loans (£15.8m).

Stock value is higher than anticipated (£5.1m), mainly due to decline in elective activity and purchase of a large quantity of implants stock to receive bulk discount from a supplier.

The cost of Property, Plant and Equipment (PPE) is behind the plan (£7.1m), mainly due to capital loans not being approved by NHSI and DH, capital loans behind the plan by £10.1m.

Private Finance Initiative (PFI) borrowings differ from the plan by £7.3m due to PFI availability credit received at the end of 2016/17 financial year resulting in reduction of the long-term liability.

	Budget	Actual	Fav/(Adv)	Annual Plan	Forecast	Fav/(Adv)
	£000s	£000s	£000s	£000s	£000s	£000s
Assets						
Property, Plant and Equipment, non current	174,793	168,637	(6,156)	177,152	172,376	(4,776)
PFI Property, plant & equipment, non current	77,388	81,432	4,044	77,316	81,332	4,016
Intangible Assets, non current	3,716	2,767	(949)	3,768	3,521	(247)
Trade and Other Receivables, non current	2,202	2,751	549	2,204	2,785	581
Total Non Current Assets	**258,099**	**255,588**	**(2,511)**	**260,440**	**260,014**	**(426)**
Inventories	5,932	11,103	5,171	5,625	10,253	4,628
Trade and Other Receivables, current	14,176	23,060	8,884	9,463	14,712	5,249
Other Assets, Current	4,012		(4,012)	3,316	0	(3,316)
Cash and Cash Equivalents	1,900	3,268	1,368	1,900	1,900	(0)
Assets Held for Sale	0	570	570	0	0	0
Total Current Assets	**26,020**	**38,001**	**11,981**	**20,304**	**26,865**	**6,561**
Total Assets	**284,119**	**293,589**	**9,470**	**280,744**	**286,878**	**6,134**
Current Liabilities						
Trade and Other Payables	(25,214)	(43,394)	(18,180)	(20,054)	(28,569)	(8,515)
Borrowings PFI	(321)	(2,078)	(1,757)	(2,106)	(2,106)	(0)
DH Revenue Support Loan	(667)	(39,506)	(38,839)	(39,506)	(39,743)	(237)
DH Capital Loan	(1,218)	(2,693)	(1,475)	(2,689)	(2,904)	(215)
Interest payable on DH Loans	0	(440)	(440)	0	(556)	(556)
Provisions	(345)	(746)	(401)	(618)	(899)	(281)
Other Liabilities	(436)	(865)	(429)	(494)	(630)	(136)
Total Current Liabilities	**(28,201)**	**(89,722)**	**(61,521)**	**(65,467)**	**(75,408)**	**(9,941)**
Net Current Assets/(Liabilities)	**(2,181)**	**(51,721)**	**(49,540)**	**(45,163)**	**(48,543)**	**(3,380)**
Non Current Liabilities						
Borrowings PFI	(70,114)	(61,055)	9,059	(68,008)	(60,703)	7,305
DH Revenue Support Loan	(137,749)	(114,728)	23,021	(102,344)	(127,550)	(25,206)
DH Capital Loan	(35,114)	(23,452)	11,662	(35,532)	(24,569)	10,963
Provisions	(1,429)	(2,899)	(1,470)	(1,653)	(3,155)	(1,502)
Other Liabilities	(3,349)	(3,255)	94	(3,011)	(3,255)	(244)
Total Non-Current Liabilities	**(247,755)**	**(205,388)**	**42,367**	**(210,548)**	**(219,232)**	**(8,684)**
Total Assets Employed	**8,163**	**(1,521)**	**(9,684)**	**4,729**	**(7,761)**	**(12,490)**
Financed by Taxpayers Equity:						
Public Dividend Capital	185,017	186,147	1,130	185,017	186,947	1,930
Revaluation reserve	54,320	59,107	4,787	54,320	59,107	4,787
Other reserves	(861)	(861)	0	(861)	(861)	0
I&E Reserve - Breakeven Performance	(193,005)	(208,607)	(15,602)	(196,439)	(215,647)	(19,208)
I&E Reserve - IFRS Transition and non breakeven	(37,308)	(37,308)	0	(37,308)	(37,308)	0
Total Taxpayers Equity	**8,163**	**(1,521)**	**(9,684)**	**4,729**	**(7,761)**	**(12,490)**

Cash

At the end of January the cash balance was £3.2m, £1.2m of which was allocated for NHS creditors payment run on 1st of February. The creditor payments are still behind by £6.2m. The Trust has requested additional revenue support loans to address the issue of paying the creditors.

Interim Support/Borrowings

The Trust has requested £25.7m additional revenue loan support in 2017/18 in line with the revised I&E deficit forecast. Total current and non-current borrowings as at January are summarised in the table below.

	Borrowing Balances		
	Capital	Revenue	Total
	£000s	£000s	£000s
Radiotherapy Loan	18,059		18,059
IT Infrastructure Loan	2,475		2,475
Emergency Department Loan	3,169		3,169
Capital Emergency Loan	2,442		2,442
Interim Revenue Support Loan		154,234	154,234
PFI Borrowings	63,133		63,133
Total borrowing	**89,278**	**154,234**	**243,512**

The Trust has received £7.460m Interim Revenue Support in February and requested £6.571m in March, pending approval by NHSI and DH.

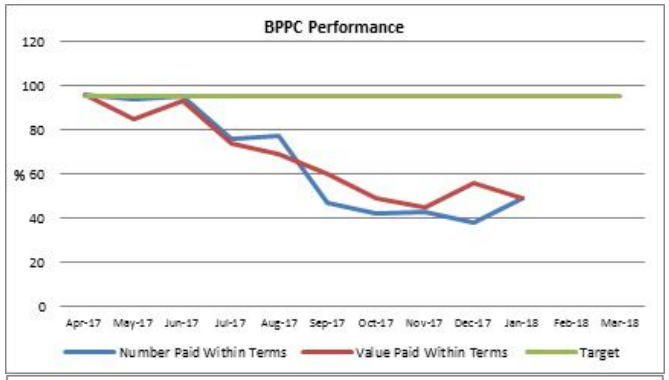
As per the Board Resolution, the Finance and Performance Committee are asked to recommend to the Board that the March Revenue Loan be approved.

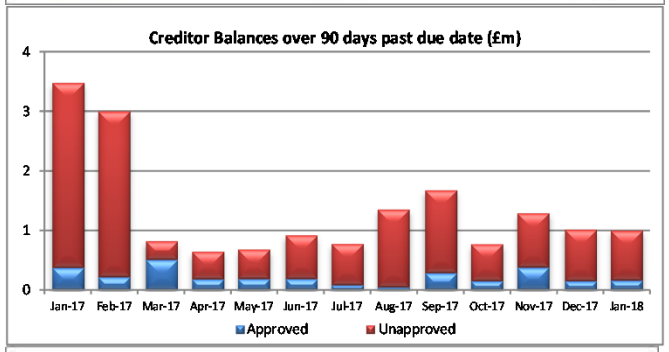
Working Capital

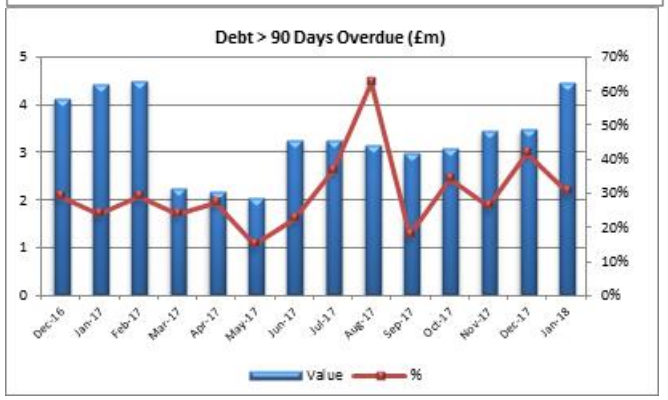
The working capital balance remains negative in January (£66m).

The value has increased this month by £40m as a result of loan repayments due in the next financial year. This means that the Trust has greater difficulty in covering its operational costs. In addition, the Trust would require revenue loans for the principal repayments in 2018/19. All of this will be reflected in the annual plan submissions.

The liquidity ratio has a direct impact on the Trust's ability to pay creditors within their agreed credit terms.







Better Payment Practice Code (BPPC) performance in number of invoices paid on time have increased, however the value of invoices paid on time has decreased, which means that more low value invoices have settled this month. Only 4,275 invoices have been paid on time out of a total of 8,815 invoices in January; in monetary terms the values show that £21.9m of invoices were received and only £10.6m were paid within BPPC terms. This has stabilised due to the additional cash support received.

Outstanding creditors over 90 days past due date have marginally decreased in January by £0.09m. The Trust prioritises older invoices during periods of tight cash flow, meaning that the BPPC target is not achieved; however the over 90 days profile will remain low, providing the invoices are approved on a timely basis. The most significant aged creditors are Birmingham W&C NHST £174k, UHCW NHST £241k, Heart of England NHSFT £93k.

The debt over 90 days overdue has increased further by £1m during January with the value at the end of the month being £4.452m. The £1m increase relates to the over performance on the CCG contract which will not be paid until year end is agreed. The invoices for IT services with the three Worcestershire CCG's to a value of £696k, for pharmacy gain share, over performance and other invoices with South Worcestershire CCG to a value of £1,699k remain unpaid. The other significant debtors are Worcester County Council £109k for community services, antenatal and other SLA's, Birmingham Women's and Children's NHSFT £153k for antenatal and other SLA's.

Capital Position 2017/18 – High Level

Worcestershire Acute Hospitals NHS Trust

The capital programme can be broken down into three key areas; Trust position, External PDC Funding & Donations and STP Capital (ASR Project)

On 2nd March the Trust was notified that the urgent loan application of £5m has been successful. The Trust will drawn down £2.4m in March 2018 and £2.6m in Q1 2018/19.

Trust position

- The Trust had £3.768m funding available internally from planned depreciation and sale of assets. Depreciation has been revalued in year resulting in an increase to £4.357m available internally.
- The Trust estimated full year forecast is breakeven following detailed mitigation, the revaluation of depreciation and the reassessment of sale of land/building.
- The Trust has formally requested a re-set of its CRL in 2017/18 to match the revised available funding.
- The Trust submitted a loan of £16.721m in July 2017, which has not been approved.
- The Trust submitted an urgent interim capital loan for £5m in January 2018 of which £2.4m is requested in 2017/18. **This application has been successful.**

External PDC Funding & Donations

- The Trust has drawn down the £210k Public Dividend Capital (PDC) for Wi-Fi Services.
- The Trust has been awarded £920k PDC for the Primary Care Streaming services at WRH to implement primary care streaming at WRH.
- The Trust has been successful with the £800k to develop A&E Streaming/Discharge lounge and the cash will be drawn down in March 2018.
- The County Air Ambulance Trust has donated the 1st payment of £625k towards the cost of the new helipad next to the Oncology Centre £1.25m.

STP Capital - ASR

- An STP capital submission was made in April 2017 for the ASR scheme totaling £29.6m.
- The Trust identified £500k of internally generated funds to continue with the project costs until September 2017. The Trust requested the project costs funding prior to approval of the FBC but understands this is not a possibility.
- The Trust has received agreement from NHSI to progress the link bridge element of the ASR scheme to facilitate access to the bed capacity in time for winter 2018 (£3m).

NHS
Worcestershire Acute Hospitals NHS Trust

Date of meeting	15 March 2018
Paper number	E2

Patient Flow Update

For approval:		For assurance:	x	To note:	

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	x	Design healthcare around the needs of our patients, with our partners	x	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	x		

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

Report previously reviewed by		
Committee/Group	Date	Outcome
N/A		

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

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

Recommendations	To receive for assurance the update on patient flow and the report from external support provided by Carnall Farrar to the Trust.

NHS
Worcestershire
Acute Hospitals
NHS Trust

Date of meeting	15 March 2018
Paper number	E2

Executive Summary

The Trust's Winter Plan was implemented as part of Local Health Economy wide Winter Plan and has been delivering expected outcomes.

There has been unprecedented increase in emergency demand compared to last winter manifesting itself in increased attendances, ambulance conveyances and emergency admissions.

Whilst there has been some reduction in the number of patients spending time on Emergency Department's corridor at WRH, both Emergency Departments remain severely overcrowded and both hospital sites continue to operate at bed occupancy of close to 100% or above.

The Trust has been allocated additional improvement support by Carnall Farrar funded by NHS England with a targeted focus on improving patient flow and resolving overcrowding in the Emergency Departments.

Background

The Trust winter plan consists of four components:

- **Countywide frailty model at Alexandra Hospital**
  Up to 18 February 2018 (inclusive) the Frailty Assessment Unit has had 576 attendances and discharged 244 patients (42.36%) directly from the unit back to their usual place of residence.
- **Expanded Ambulatory Emergency Care model at Worcestershire Royal Hospital**
  The medical Ambulatory Emergency Care containing 6 trolleys and 10 chairs opened on 20 November 2017. On 13 December 2017 the GP out of hours service was co-located with AEC as planned. Up to 14 February 2018 inclusive the unit had seen 1025 patients (both new and follow up) with admission rate of new patients of circa 41%.
- **Additional bed capacity on Evergreen 2 ward at Worcestershire Royal Hospital**
  Evergreen 2 opened on Monday 27 November 2017. Currently both Evergreen wards are open to full capacity with 28 beds on each ward.
- **A range of supportive schemes to extend services**

The Trust has experienced unprecedented emergency demand compared to last winter (November – February inclusive):

- **Attendances**
  Between November and February Emergency Department attendances have increased by **+2,075 (+4.5%)** compared to the same period last year, increasing from 46,159 to 48,234. This is equivalent of additional 17 patients per day.
- **Ambulance Conveyances**
  Between November and February ambulance conveyances have increased by **+1,142 (+7.34%)** compared to the same period last year, increasing from 15,561 to 16,703. This is equivalent of additional 10 patients per day.
- **Admissions**
  Between November and February non elective admissions have increased by **+668 (+4.25%)** compared to the same period last year increasing from 15,713 to

Date of meeting	15 March 2018
Paper number	E2

16,318. This is equivalent to 6 additional patients per day.

Due to increased emergency demand a number of surge areas have been used as additional inpatient areas on both hospital sites. These include Medical Day Case Unit, Ambulatory Emergency Care and Endoscopy Unit on the WRH site and the Frailty Assessment Unit, Surgical Decision Unit and a number of additional bays at the ALX.

Whilst utilisation of these areas alleviate the immediate pressures on both Emergency Departments, there is detrimental impact on patient flow due to reduced assessment capacity and on both endoscopy and day case capacity.

Utilisation of surge areas has further compounded the staffing issues linked to vacancies and/or sickness. These are being mitigated by bank and agency (including high cost agency funded from the winter monies) and by off line nursing covering clinical shifts.

Issues and options

Despite increased emergency demand there has been some reduction in number of patients receiving treatment in the Emergency Department corridor at WRH compared to the same period last year. Between November and February the number of patients who had spent time on the corridor has reduced by **710 patients (-18.5%)**, reducing from 3,820 to 3,110. This is equivalent of 6 less patients per day.

Equally the number of hours that patients have spent on the corridor has reduced by **3,719 hours (-19.7%)** compared to the same period last year reducing from 18,852 to 15,134 hours. This is equivalent to 31 less hours per day.

Nevertheless both Emergency Departments continue to be severely overcrowded and both hospital sites continue to operate at occupancy levels of close to 100% or above.

The Trust has been allocated external support by Carnall Farrar management consultancy funded by NHS England with a specific focus of improving patient flow and resolving overcrowding in the Emergency Departments. Carnall Farrar commenced work with the Trust beginning of January 2018 and have completed Phase 1 (Diagnostic) of their work programme. The final Phase 1 report is attached as Appendix 1. Phase 2 (Implementation) has just commenced and the latest update against the identified work streams is attached as Appendix 2.

Recommendations

To receive for assurance the update on patient flow and the report from external support provided by Carnall Farrar to the Trust.

Appendices

Appendix A – Urgent Emergency Care Systems Review Worcester Update (Phase 1 - Diagnostic) Final Report

Appendix B – Urgent Emergency Care Steering Committee Update – Week 5

Enc 2 attachment 1

UEC Systems Review Worcester Update (Phase 1 - Diagnostic)

Final report

2 February 2018

Executive Summary

Executive Summary
Insights and recommendations from Phase 1 - Diagnostic

- The Trust has a long history of poorly planned bed reductions stretching back some 20 years, which has led to the current situation where patients are routinely cared for in a corridor because of the lack of capacity to do otherwise. There have been 4 CEOs, 5 COOs, 4 MDs and 3 NDs in the last 2 years and this has fueled a sense of continual crisis and was a factor in the absence of system-working or collaboration. The pressures reached a peak last year with large numbers of breaches and so the incoming CEO was faced with an accumulation of issues to deal with.
- More recently we have heard about and observed good system working. The Trust CEO has instilled a greater sense of clarity and there is plenty of evidence of commissioners and other providers sharing in the challenge to turn things around. In terms of the headline breaches, this has had a positive affect. But despite this, the numbers of patients waiting within the A&E departments has remained at unacceptable levels. We found that many initiatives are underway and whilst some are having a positive effect, the core issue of poor patient experience and excessive waiting remains.
- One reason is that the underlying bed capacity issue has not been resolved. The system needs to support accelerating the FBC and the build of the 'bridge' to allow the conversion of some beds for acute care. The business case also needs to address the need for an interim solution to provide additional capacity in 2018. However, inadequate bed capacity is not the sole factor of the poor performance. Too many ideas have failed to 'stick' when implemented. We attribute this to what we call a 'siege mentality' that has bedded in. This is understandable in the context of a team of professionals who have had to deal with unacceptable patient experience for too long.
- We have identified actions that would enable improvements to be made. We are recommending that the support is more internally focused, to help the newly appointed DMD to make the proposals stick and to facilitate the ED team to work differently together and with other parts of the hospital in more effective ways. It is evident that there is a desire to do this - what the team need is help and support.
- The proposal is to implement the solutions alongside existing work streams. There is significant synergy with the Quality Improvement Plan being led by the Service Improvement Director and a natural alignment with the improvement plans being led by the Finance Improvement Director. The work will be coordinated with the system A&E Delivery Board to ensure that all stakeholders are sighted and aligned.

Our recommendations are to use the next two months to work across a number of defined areas where improvements are feasible. In doing this we will help the team to generate a greater sense of shopfloor 'command and control' and to develop a vision for the improvement plan that they can embark on to be ready by winter 2018. Working across these areas and at the same time putting the acute bed capacity in place, the commitment and dedication of the clinical teams can shine and the Trust can make a step change in the level of experience of patients entering the ED departments.

Introduction

Urgent & Emergency Care Transformation

Three phase approach to deliver sustainable transformation in Emergency patient care

	Diagnostic	Implementation	Sustainability
Overall	Comprehensive diagnostic for Worcester Trust ED (ALX & WRH): • ED data analytics • Extensive consultation	• 'Deliverology' approach to deliver a whole system improvement programme	• Ongoing self-assessment and improvement
1 Systems & processes	• Review of end-to-end UEC system (quantitative & qualitative analysis) • Data 'walk throughs' of ED	• Prioritisation of improvement initiatives • Implement quick wins	• Full implementation within Trust • Implement wider system interventions
2 Leadership & management	• Leadership interviews and observations	• Implement changes to management structure and leadership support	• Leadership development and support
3 Capabilities & behaviour	• Review of resources and inputs to the UEC system, with observations on gaps and current pain points	• Establish and implement a Trust-wide OD programme	• Facilitate wider system working
Outputs	• Root causes of A&E performance challenges • Alignment across system behind the 'Single version of the truth'	• UEC whole system improvement programme • Early delivery of improvement	• Establishment of system and processes as BAU • Leadership and organsation development
	1-3 months	**3-6 months**	**3-6 months**

Scope of Phase 1

Three deliverables were agreed between NHSE, NHSI and the Trust for this phase

Phase I:

Developing a detailed understanding of the issues, and identification of opportunities

	Deliverables	Key Activities	Outputs
1	**Improve data and coding within the A&E**	• Review of A&E performance data • Review of the recent coding audits conducted by NHSI • Observation and interviews (with clinicians and coders) to understand practice and behaviours • Review of structure and establishment to understand role of coders and reporting arrangements	• Separate weekly updates to Executive Team and NHSE/I • Final report summarising findings of: – Data and coding issues within the A&E and recommendations for improvement – "As is" patient flow stocktake with recommendations for improvement of understanding A&E performance data – Engagement and observation activities including recommendations on key areas of work required – Engagement and mapping exercise including recommendations on how to make most of all resource available • Advice to the A+E Delivery Board based on this final report • Agreement of actions for February and March following review
2	**A&E change management and clinical leadership support**	• Engagement with clinical leadership in UEC system (utilising existing meetings where possible) • CF senior clinicians to offer examples of national best practice and model and offer support for clinicians • CF partners to interview senior members of the trust and other local stakeholders including PULSE	
3	**Understanding of resource and input available to the UEC system**	• Map all current inputs in terms of resource, programmes, support and guidance, system-level governance and partnership working • Understand how resources and support are needed and identify gaps or overlap, through interviews with leaders in the Trust and the broader system, observing key meetings	

Diagnostic: Phase 1 Insights

Context

Centralisation of services at Worcester without additional bed capacity on that site has directly and indirectly impacted on Trust ED capacity

Pre-2000
3 sites: Worcester, Kidderminister and Redditch (ALX) exist as distinct organisations

April 2000
Merger forming Worcestershire Acute Hospitals NHS Trust following consultation

Sept 2000
Downgrade of Kidderminster Hospital A&E to MIU and closure of other services

April 2002
Worcestershire Royal Hospital opens under PFI scheme

2005-08
ALX services under risk with proposed A&E downgrade and closure of other services

2008
Centralisation of vascular services

2011
WAHT approaches PCT at the time as existing services were unsustainable

Jan 2012
Joint Services Review set up as a result of ALX downgrade proposal

Mar 2013
JRC decision made re. ALX downgrade – services remain at ALX

Jul 2013
Centralisation of stroke services

Jul 2013
Launch of *Future of Acute Hospital Services in Worcestershire* led by CCG and NHS E

Oct 2013
24/7 primary percutaneous coronary intervention begins at WRH

Feb 2014
Serious abdominal surgery moves to WRH

Dec 2014
Children's Emergency Surgery moves to WRH

Aug 2015
Emergency Gynaecology moves to WRH

Nov 2015
Booked deliveries, pre-planned elective caesareans and neonatal care moves to WRH

Feb 2016
De-escalation triggers not met – Obstetric and Neonatal services remain at WRH

Sept 2016
Inpatient paediatrics services centralised at WRH

Source: Kidderminster's health monitoring and evaluating their configuration of the NHS in Worcestershire, Future of Acute Hospital Services in Worcestershire Outline Business Case, The Future of Acute Hospital Services in Worcestershire -Stage 2 Clinical Assurance Review Panel Final Report

Diagnostic Insights

Our report is structured around the major drivers, observed cultural challenges, and unintended outcomes that have collectively impacted the Trust's ED performance

Major drivers	+	Observed culture	=	Outcomes
1 Increased attendances by ambulance				9 Overcrowding of ED
2 Lack of command and control		7 Operational: Under siege culture in A&E resulting in normalisation of A&E underperformance across Trust		10 Coding errors and ensuring data accurately reflects performance
3 GP streaming				
4 Lack of speciality responsiveness		8 Executive: A&E change management and strong clinical leadership required to drive/enable Trust culture change programme		11 Lack of improvement in A&E performance despite a number of interventions
5 Poor access to assessment units				
6 Lack of capacity against a background of historical changes				12 Good evidence of UEC system working, however intended impact not being delivered

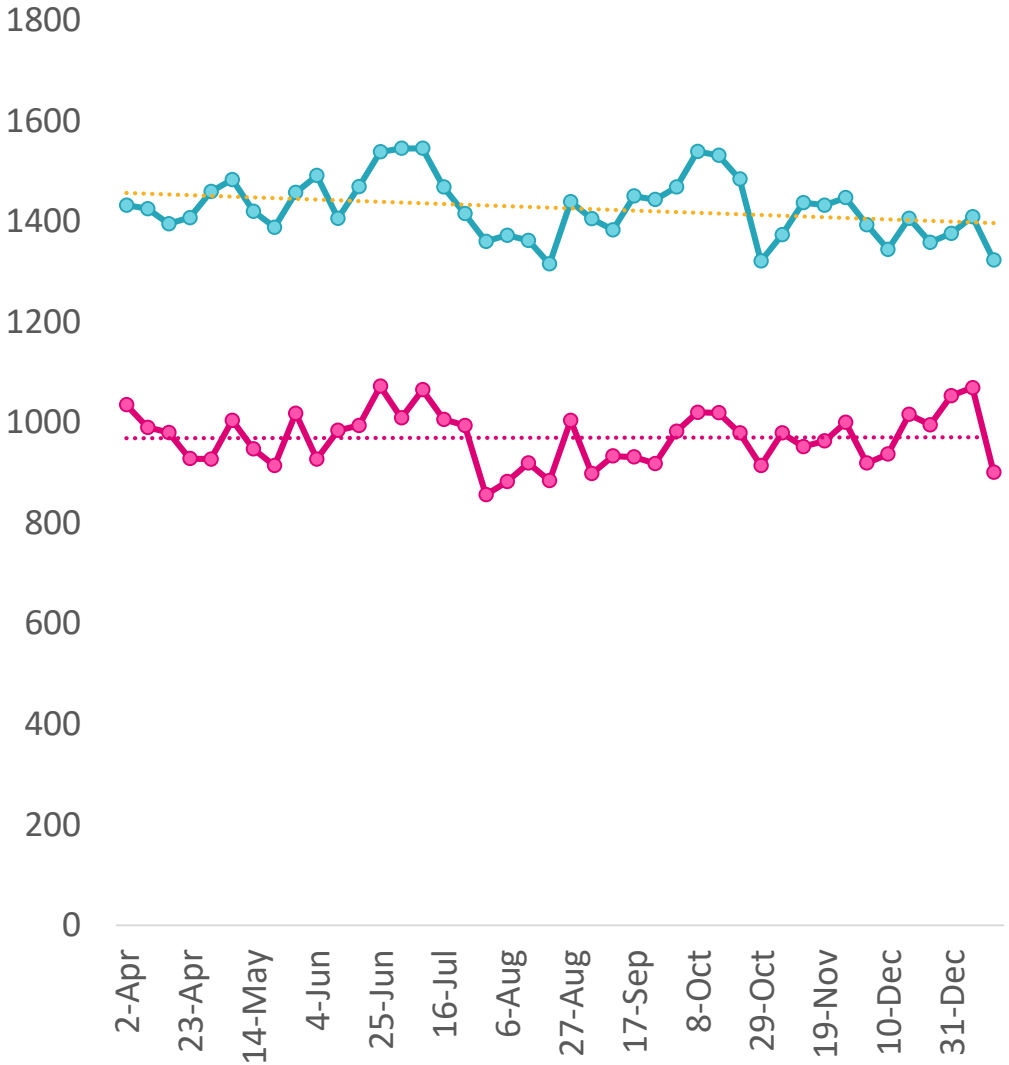
Source: Carnall Farrar analysis

1 Increased attendances by ambulance

Volume of total attendances is flat but the proportion arriving by ambulance is increasing, putting pressure on ambulance handovers and patient flow

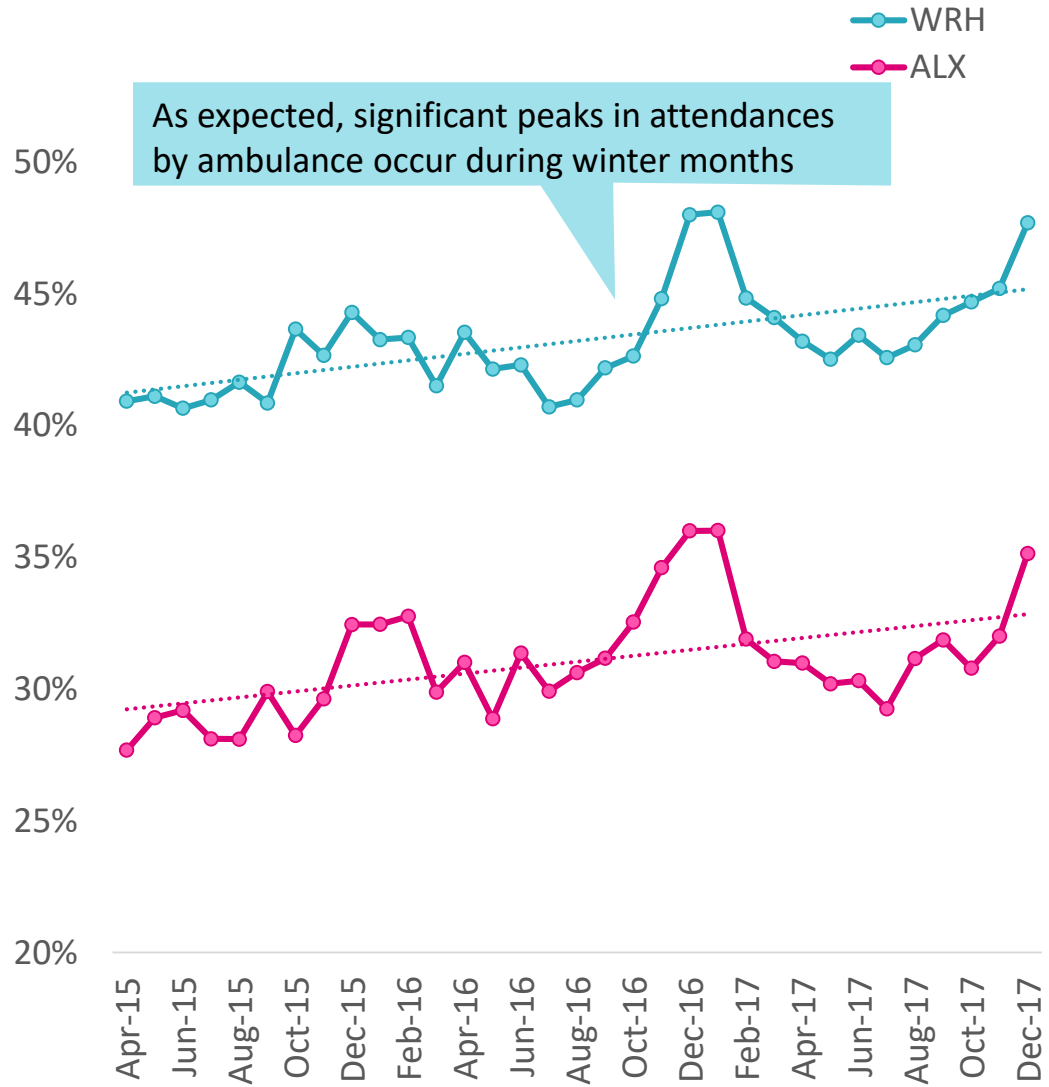
Worcestershire Acute Hospitals NHS Trust

Total attendances per week by site



Worcestershire Acute Hospitals NHS Trust

Proportion of attendances by ambulances per month by site



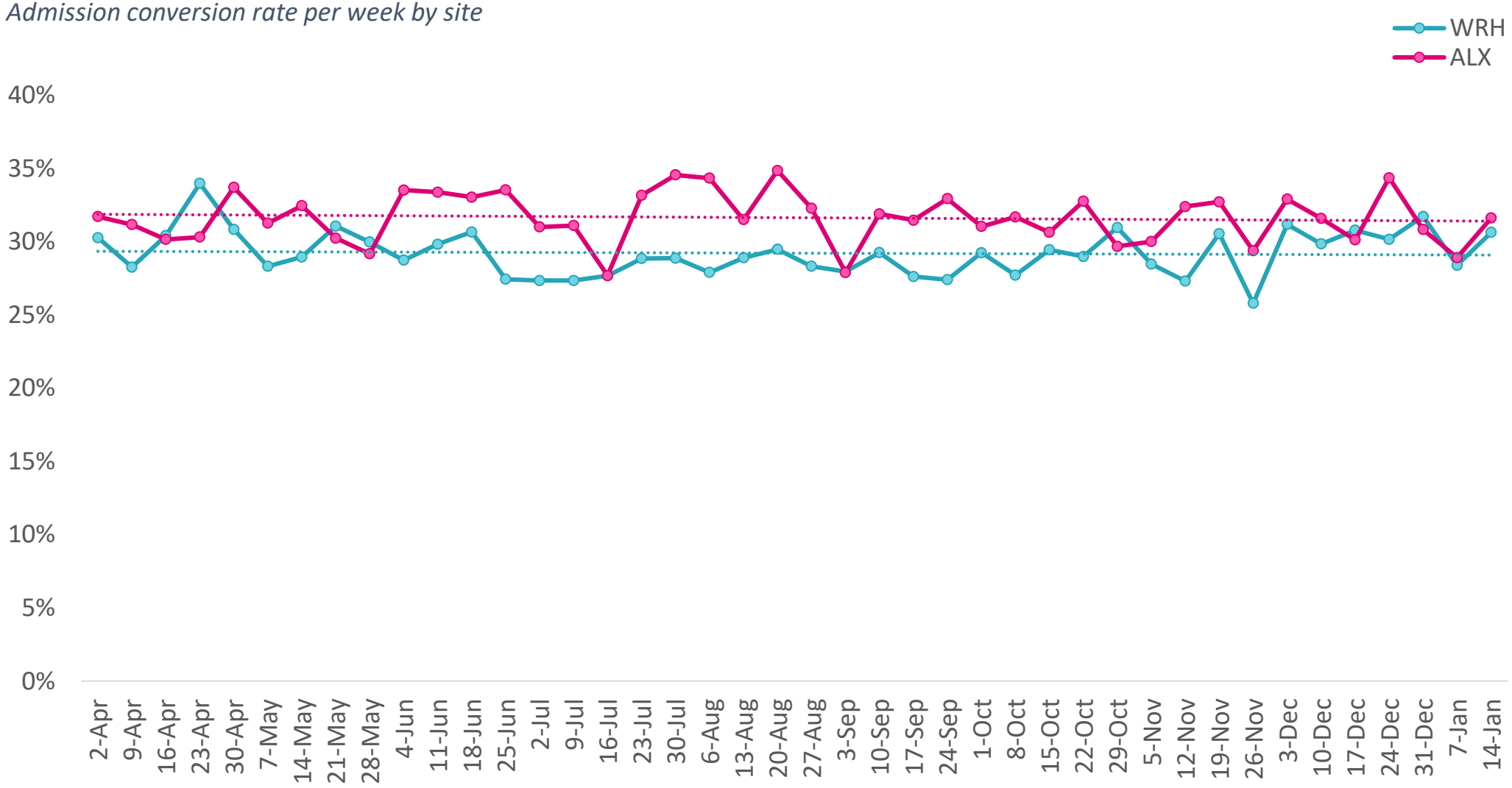
Source: Trust data, Carnall Farrar analysis

1 Increased attendances by ambulance

Conversion rates have remained broadly constant despite the rising number of ambulance attendances

Worcestershire Acute Hospitals NHS Trust

Admission conversion rate per week by site



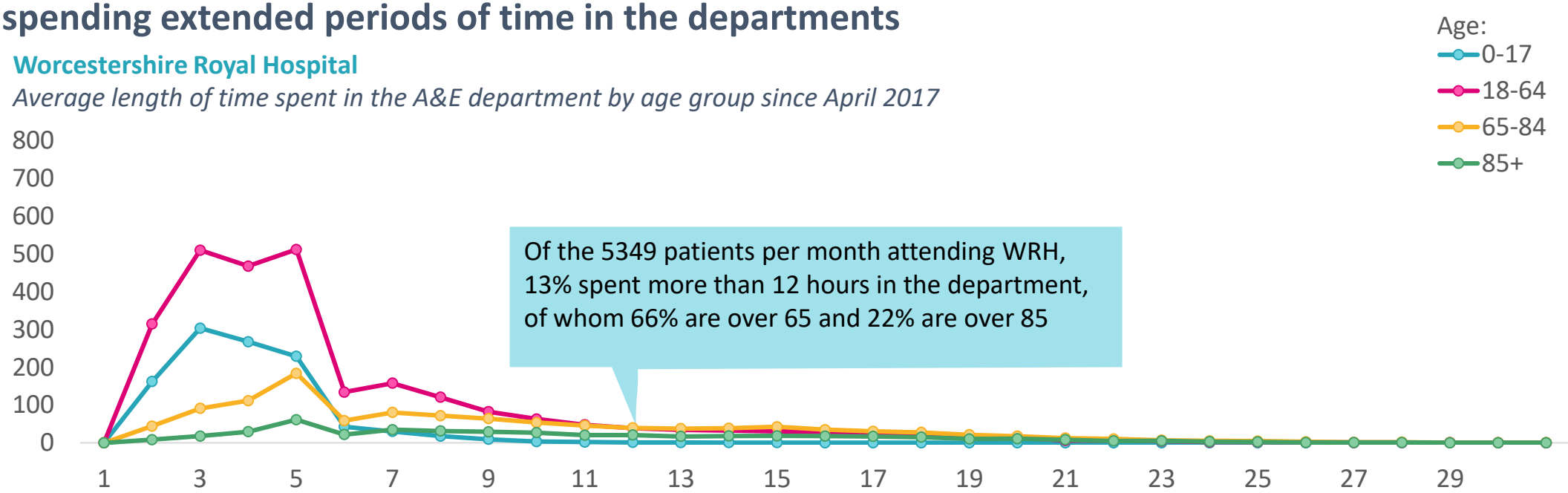
Source: Trust data, Carnall Farrar analysis

2 Lack of shopfloor command and control

There is no structured control of the length of stay in the department resulting in patients spending extended periods of time in the departments

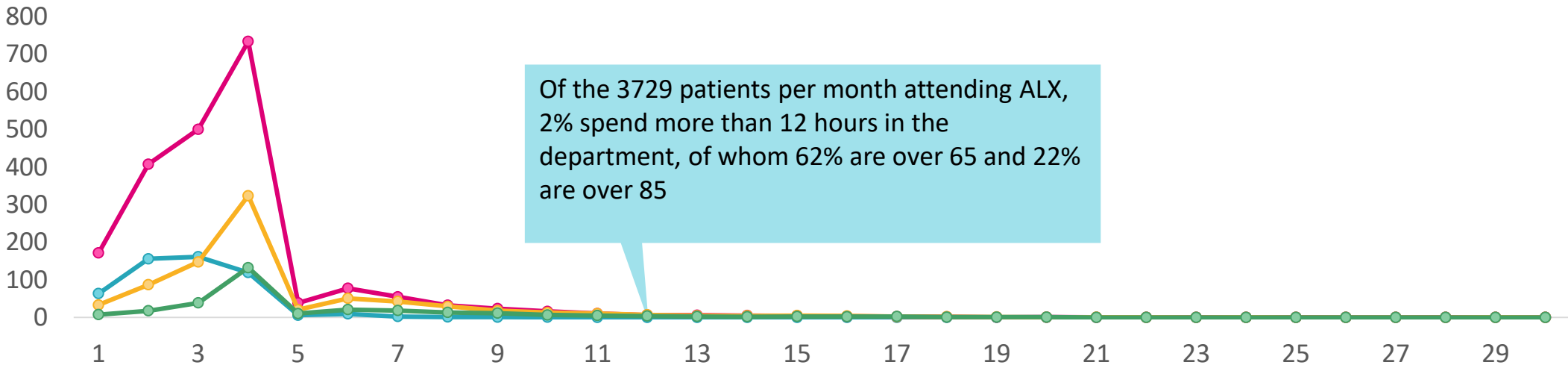
Worcestershire Royal Hospital

Average length of time spent in the A&E department by age group since April 2017



Alexandra Hospital

Average length of time spent in the A&E department by age group since April 2017



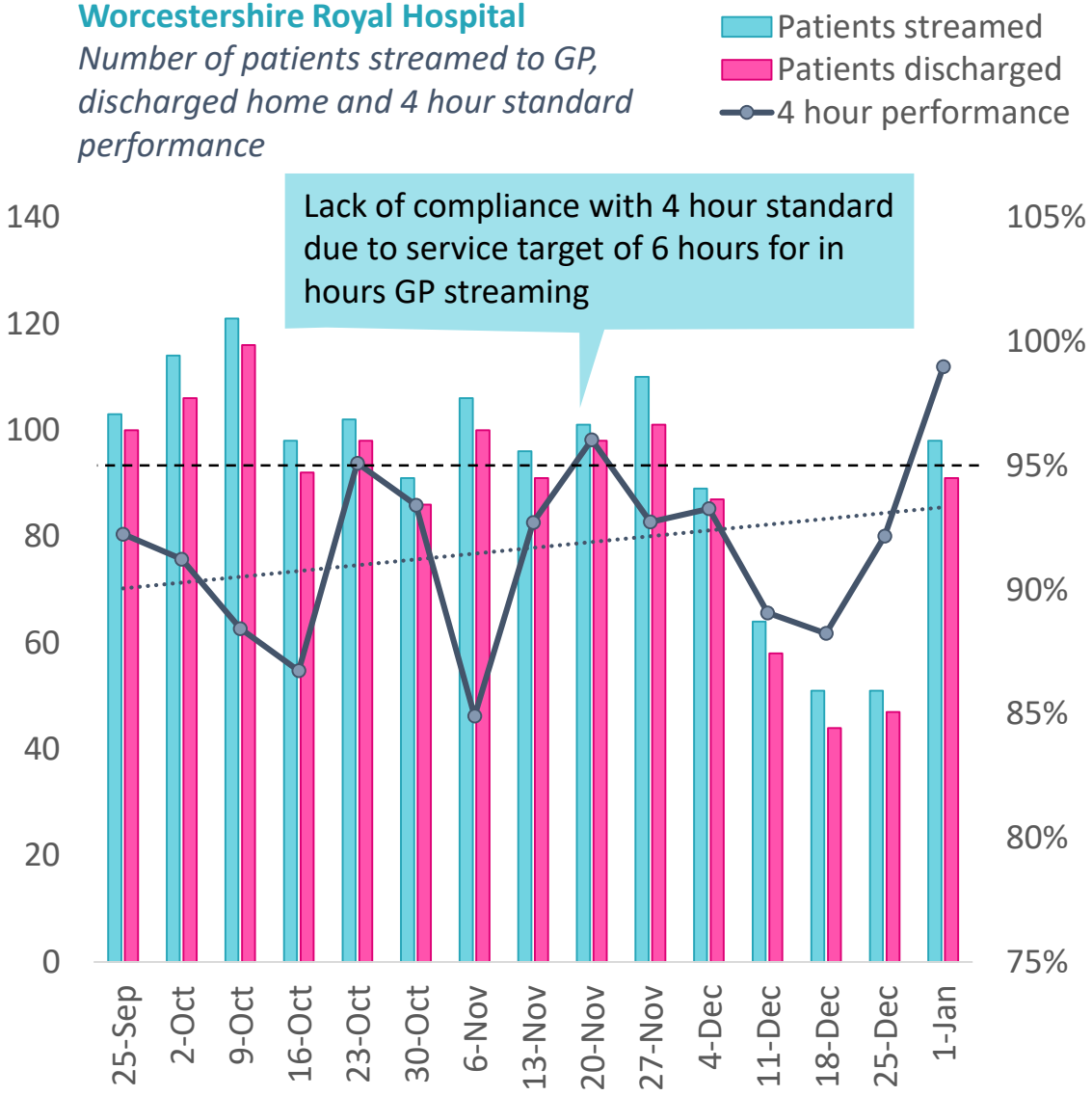
Source: Trust data, Carnall Farrar analysis

3 GP streaming

4 hour breaches exist for in hours GP streaming and for out of hours services utilisation is poor

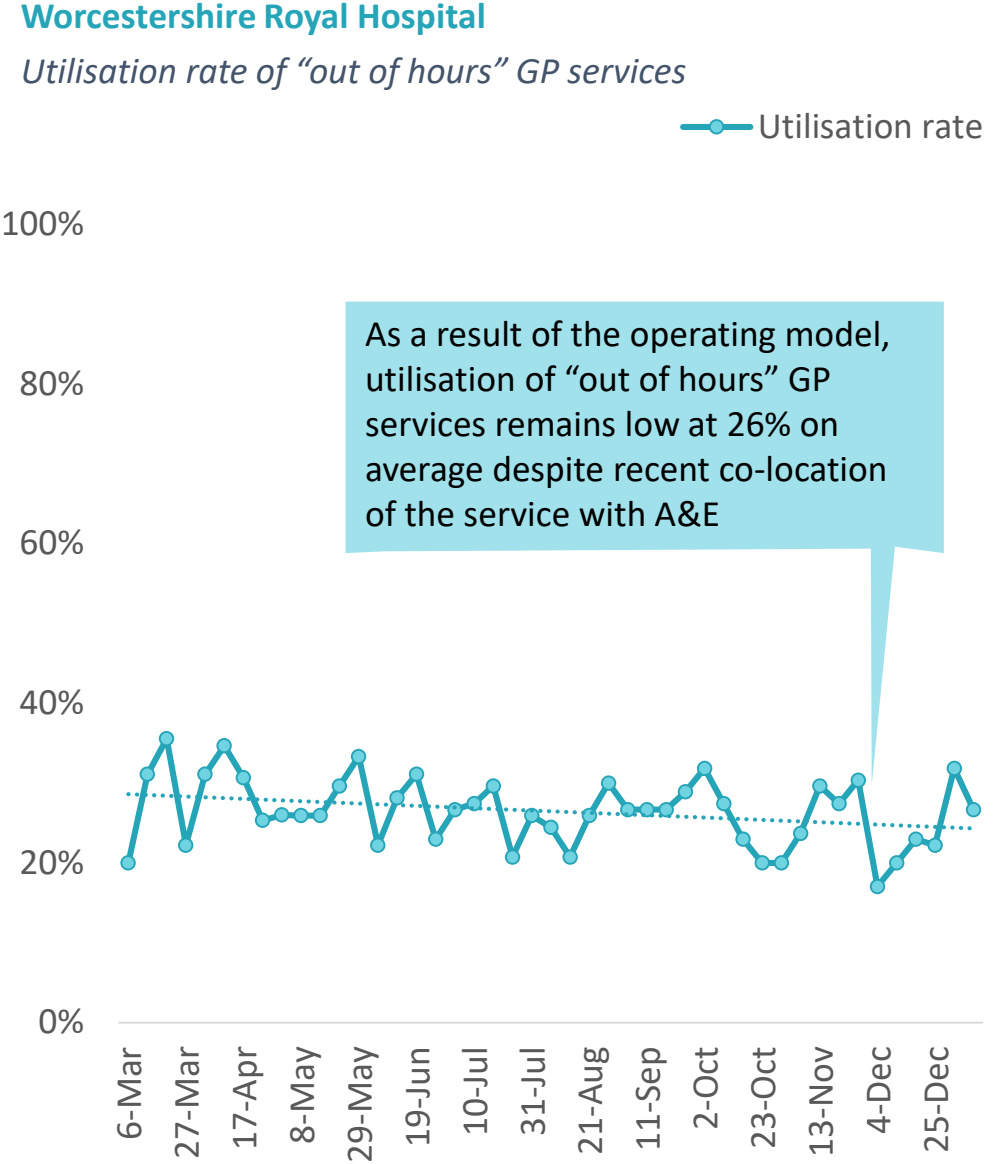
Worcestershire Royal Hospital

Number of patients streamed to GP, discharged home and 4 hour standard performance



Worcestershire Royal Hospital

Utilisation rate of "out of hours" GP services



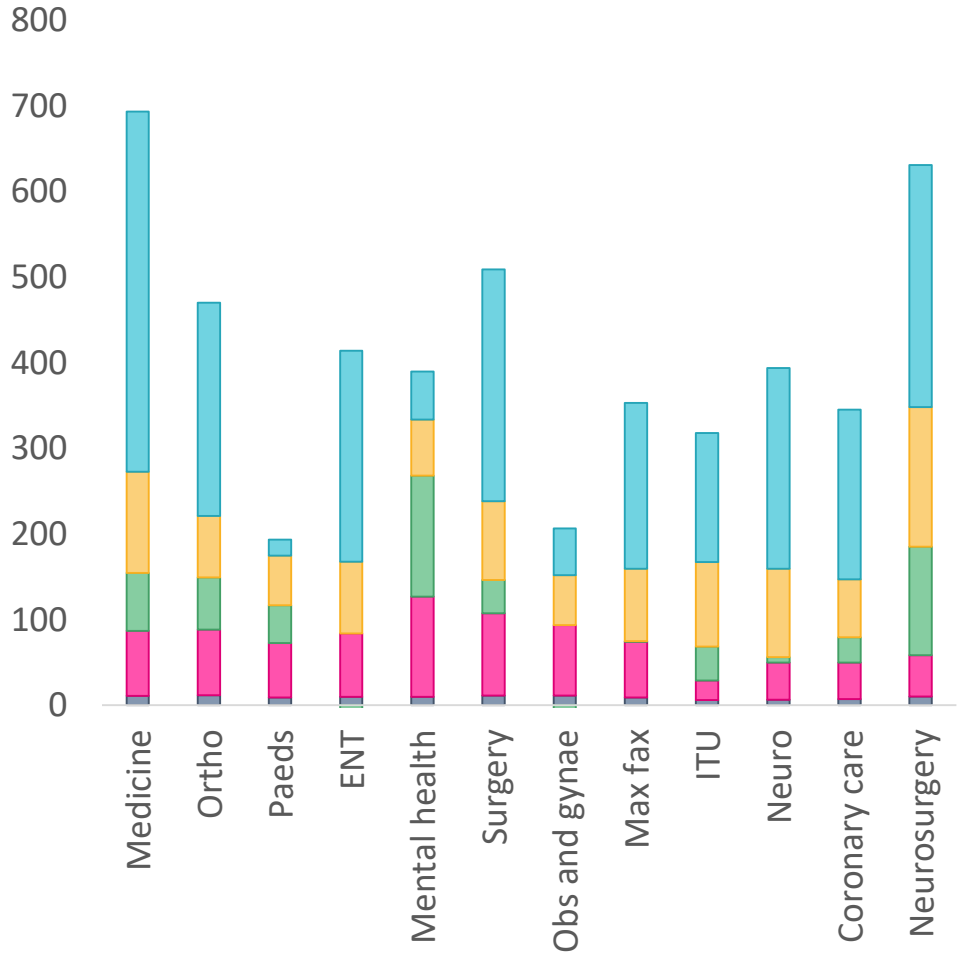
Source: AEDB dashboard, Carnall Farrar analysis

4 Lack of speciality responsiveness

Response time of speciality teams to determine DTA and subsequent time to transfer to ward makes up the majority of time spent in ED, there is an observed variance by speciality

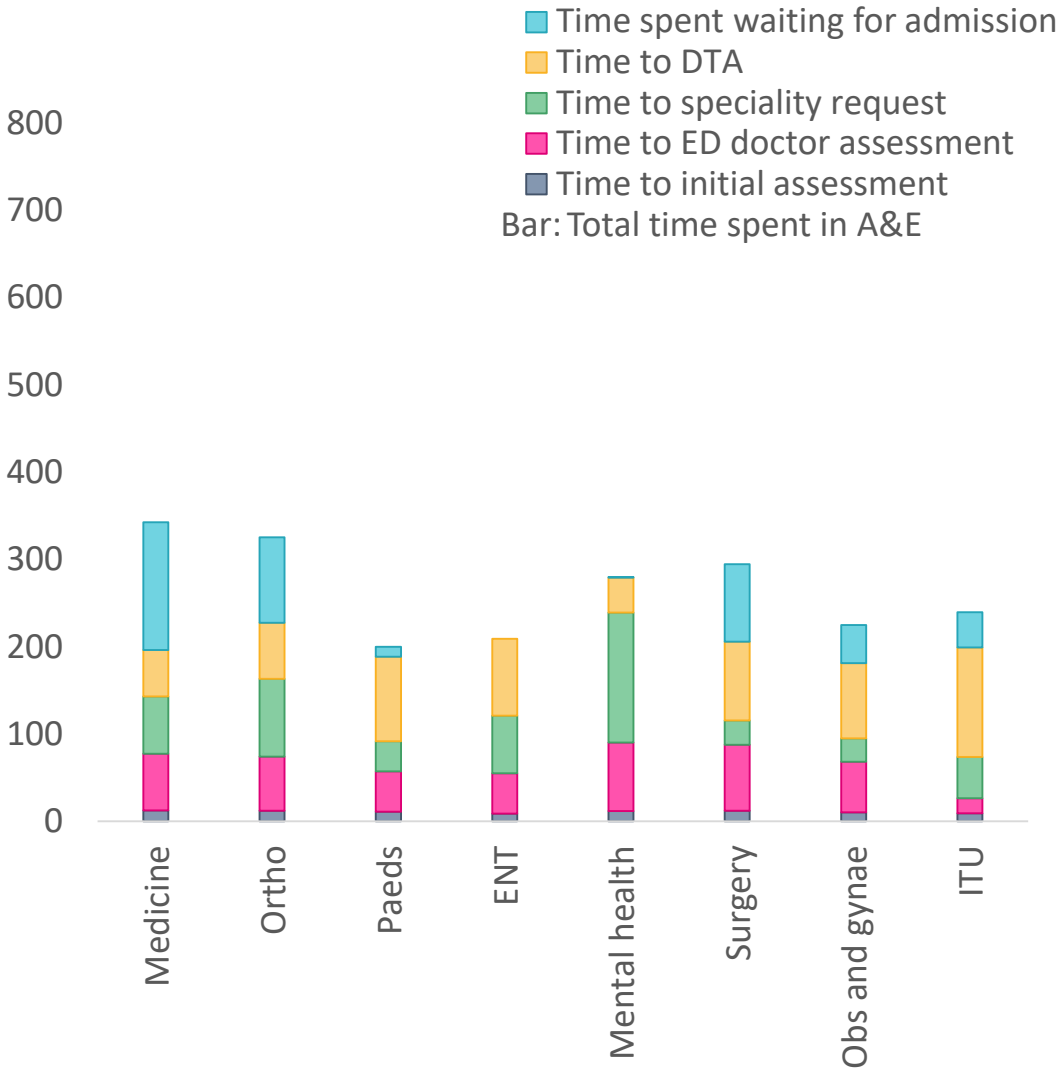
Worcestershire Royal Hospital

Average length of time along patient pathway by speciality



Alexandra Hospital

Average length of time along patient pathway by speciality



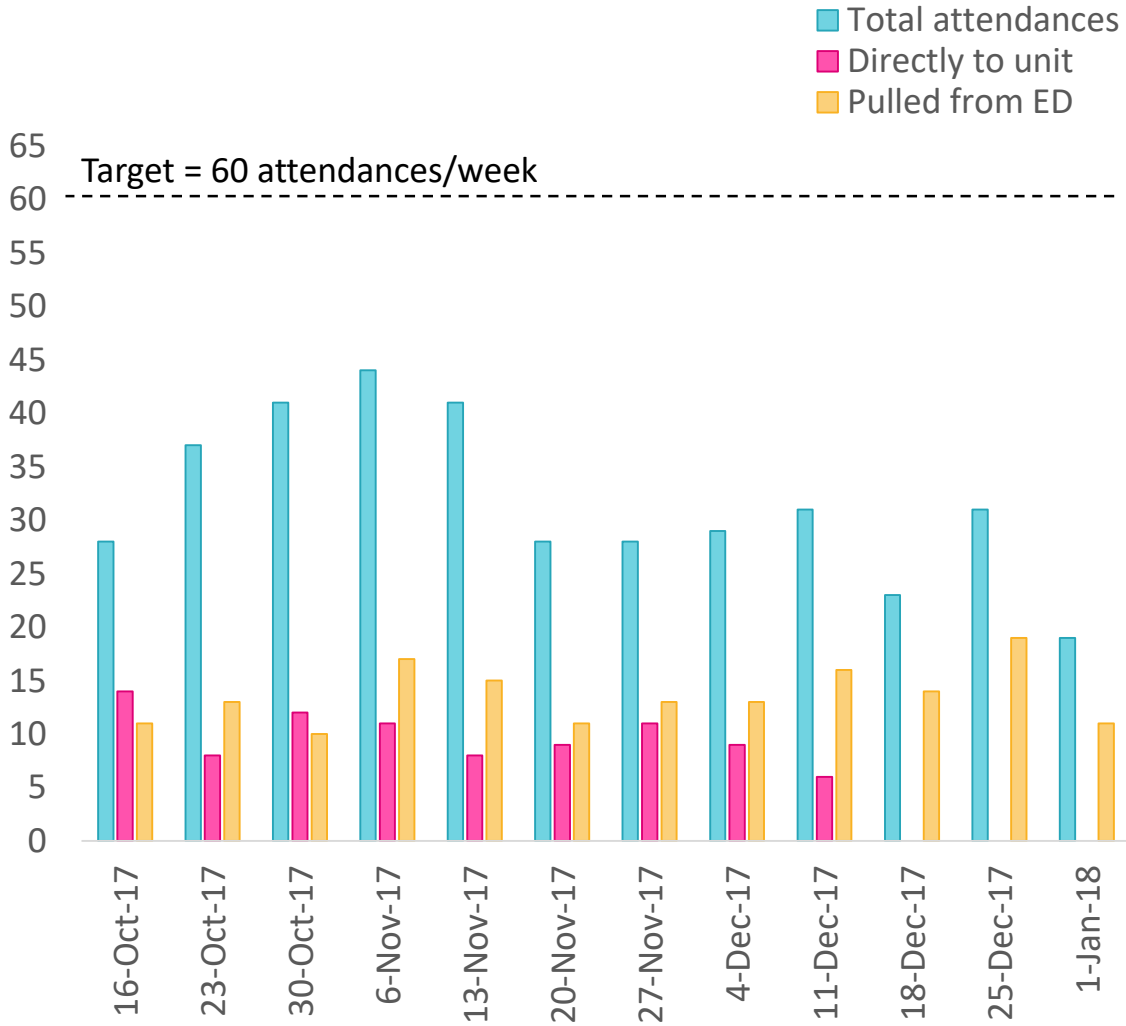
Note: specialties with less than 15 cases excluded from ALX analysis
Source: Trust data, Carnall Farrar analysis

5 Poor access to assessment units

This can be driven by acceptance criteria and lack of capacity

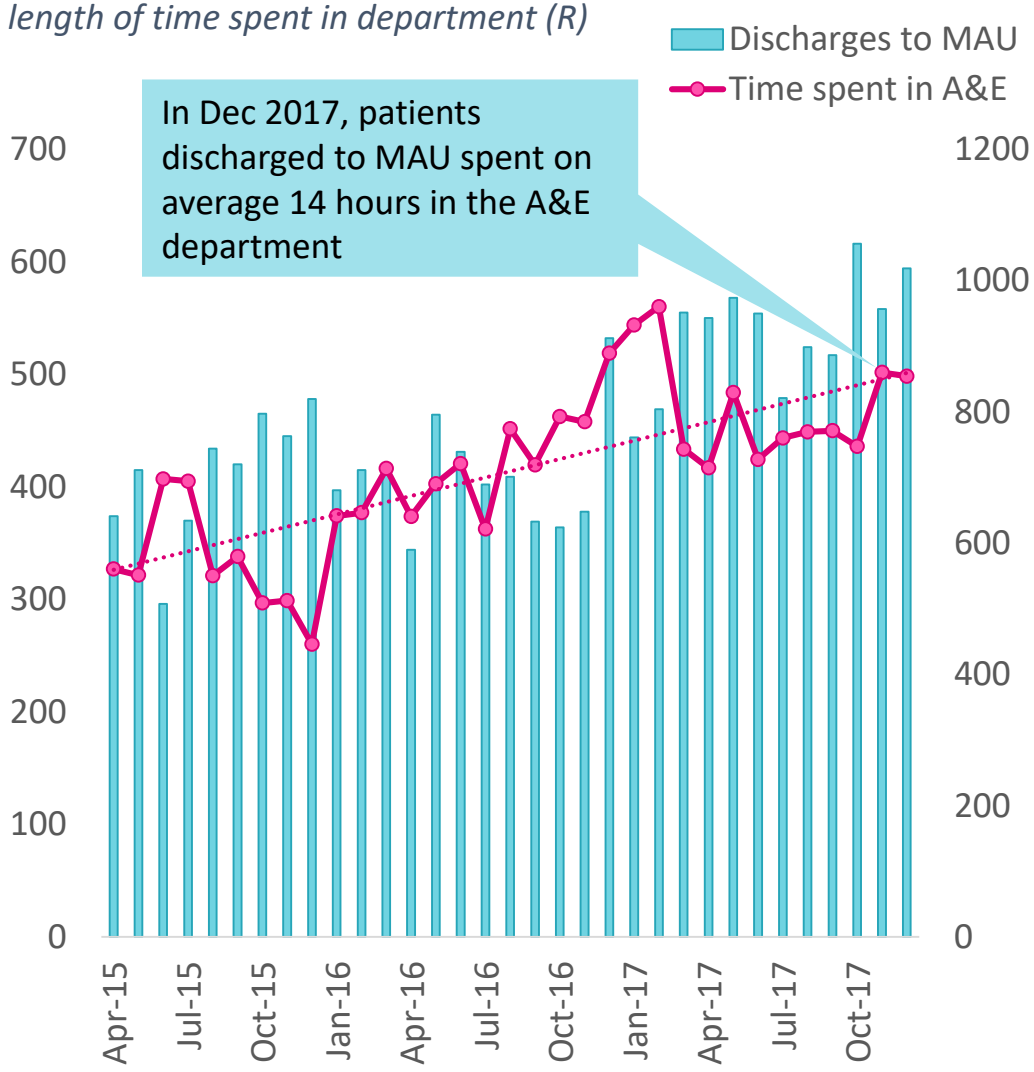
Alexandra Hospital

Total attendances to FAU, attendances directly to unit and pulled from ED (L) per week



Worcestershire Royal Hospital

Total number of "discharges" from ED to MAU (L) and average length of time spent in department (R)



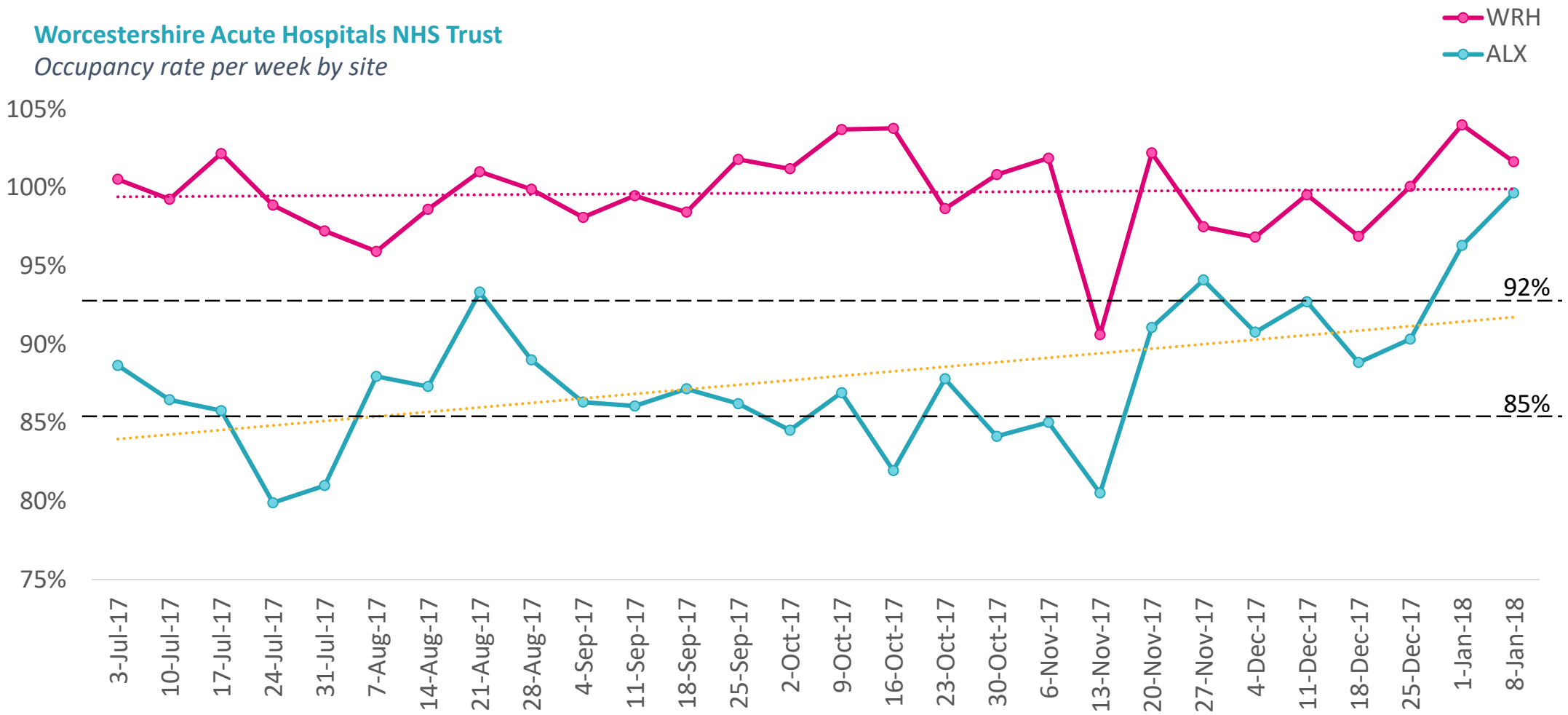
Source: FAU dashboard, Trust data, Carnall Farrar analysis

6 Lack of capacity against background of historical changes

Bed occupancy at WRH is consistently very high and has risen at ALX over recent weeks

Worcestershire Acute Hospitals NHS Trust

Occupancy rate per week by site



- WRH has been operating consistently at or above 100% occupancy and a similar upwards trend is starting to emerge at ALX since Dec
- It is important that the Business Case for Acute Services Reconfiguration is moved forward at pace, however the current OBC aims to deliver capacity in 2020, which whilst welcome is too far away - the Trust cannot enter another winter with current levels of capacity

Source: AEDB dashboard, Carnall Farrar analysis

7 Under siege culture in A&E at WRH

Comments from the frontline interviews

"We know how to manage surge – it's the day job, but you can't manage surge when you are saturated"
WRH

" Good decisions are made but change is not sustained"

"When the ED department is overwhelmed – the wards know about it and tend to respond positively to the crisis"
The Alex

"I tell the powers that be I need to clear five beds NOW as I have five critical alerts with an ETA of 5 mins, and I'm told not to worry, all is in hand… and that I'm panicking… what world are they living in? Where do I put 5 criticals?"
WRH

"Our actual patient turnover is pretty good and stable, but masked by the DTAs in ED"

"Patients waiting for hours in the ambulance waiting an area is unacceptable by anyone's standard – yet its our business as usual"
WRH

Despite everything we do work well as a team – and there's much less staff turnover than you'd expect"

"Workforce isn't the problem – I have enough staff, just not enough room for patients who are awaiting admission"
WRH

"The AEC has a real role in freeing beds earlier – we can finalize aspects of care and facilitate discharge"
The Alex

"There is a lack of command and control in the ED department"

"ED feels like the dumping ground for the hospital's system malfunctions. We feel like we are being told its all our fault and constantly being punished." WRH

"We have come a long way in terms of relationships. It was described as toxic is a report about a year ago, but since then we are working together well"

Source: Trust interviews, Carnall Farrar analysis

8 A&E change management and clinical leadership support

System wide confidence in their ability to drive and embed change is low

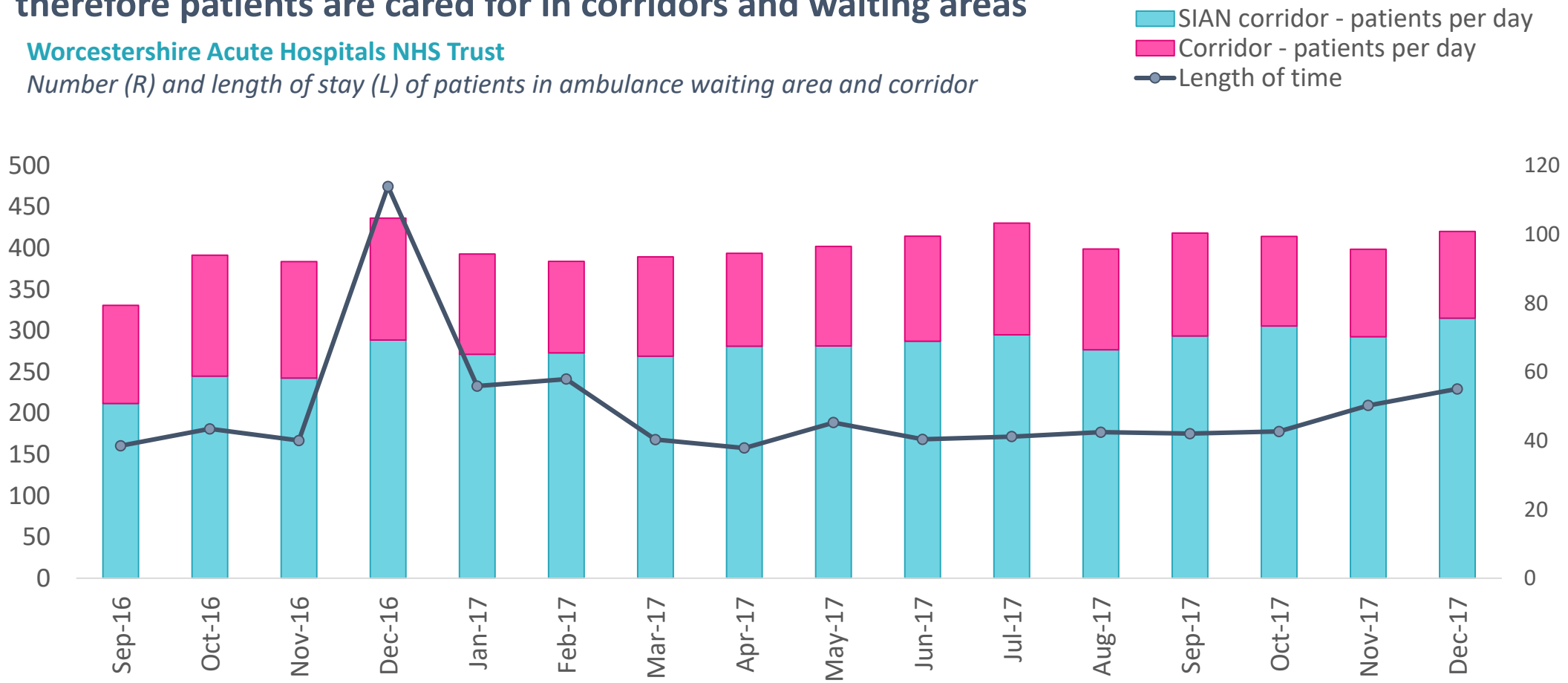
Category	Insight
System leadership	• The aggregate impact of legacy decisions (by the Trust and CCG >20 years) is crystallised within ED • Trust system leadership and ED clinical leads do not fully agree on actual cause and effect of poor performance
Clarity of vision	• The strategic vision to resolve the impact of legacy decisions and change is represented in the form of a Trust led OBC which has as yet to secure approvals to go to FBC and will not have impact until 2020 • Meanwhile, multiple system changes apart from an agreed vision for ED have been designed and implemented
Culture	• A&E at WRH has normalised the expectation of poor performance against breaches, with less tolerance at ALX • Acute physicians are working without an agreed ED model at WRH, and therefore cannot challenge practice within other parts of the system which impact their ability to perform • Medical and nursing leads outside of A&E are not seen to understand the peculiar nature of current A&E patient care
Governance and risk	• Low level of confidence in governance arrangements at divisional level, around medicine and change management • Risk tolerance levels differ between sites and between clinical and non clinical managers, which appears linked to normalisation of crisis behaviours and escalation processes not seen to have an impact
Roles and responsibilities	• Divisional Managers roles and responsibilities across sites are not clear • Absence of agreed and monitored plan around patient flow has resulted in incongruent definition of roles, responsibilities and accountabilities to execute remedial and strategic actions
Decision-making processes	• Culture of change initiatives, both within ED and specialities, to improve ED performance, not being sustained • Low confidence that decisions will be upheld over time
Data, information and reporting	• Executive focus is on “must do” data and information areas and clinicians appear frustrated at this restricted focus as they believe it generates ineffective solutions • Informatics leads and clinicians collate additional cuts on data, but this is not equally valued
PMO approach	• Whilst there are multiple initiatives running through the Trust’s transformation PMO and also coordinated through the Winter Room PMO, there is limited monitoring and review of impact and sustained change, with a persisting culture of “revert to norm”. Overall, low confidence in Trust’s ability to embed change
Continuous improvement	• Continuous improvement is not currently BAU across ED system • Although there are isolated examples of this within clinical team

9 Overcrowding of ED

The number of patients in the department at one time frequently exceeds its capacity and therefore patients are cared for in corridors and waiting areas

Worcestershire Acute Hospitals NHS Trust

Number (R) and length of stay (L) of patients in ambulance waiting area and corridor

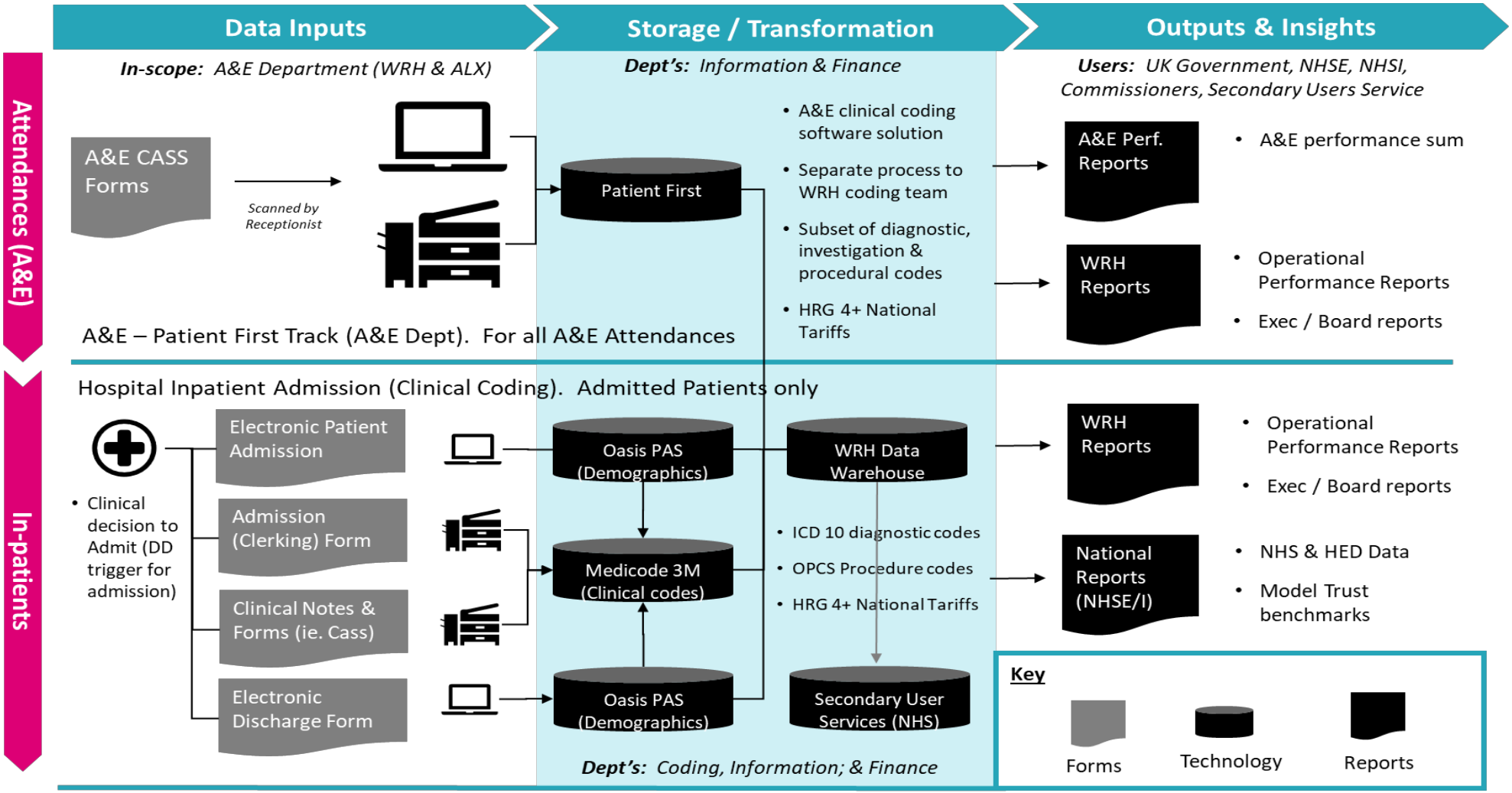


- A lack of capacity across the system has resulted in patients routinely waiting for beds in the corridor of A&E
- These patients are expected to be provided with the same level of care as patients on the ward
- Our assessment and analysis of the extra cohort in the department has approximated that at any point in time 5 patients are cared for in the SIAN/ambulance waiting area and a further 6 in the corridor
- This practice has largely been normalised and accepted as standard practice, however is putting significant pressure on the department as well as affecting patient experience

Source: Trust data, Carnall Farrar analysis

10 Coding errors and ensuring data accurately reflects performance

Data and coding practices are a blend of manual and automated processes



- Mismatch on the start of ambulance handover times
- Majors and Minors coding discrepancies with manual process currently in place
- Partial automation of Patient Care Records in A&E and tracking of paper-based processes difficult

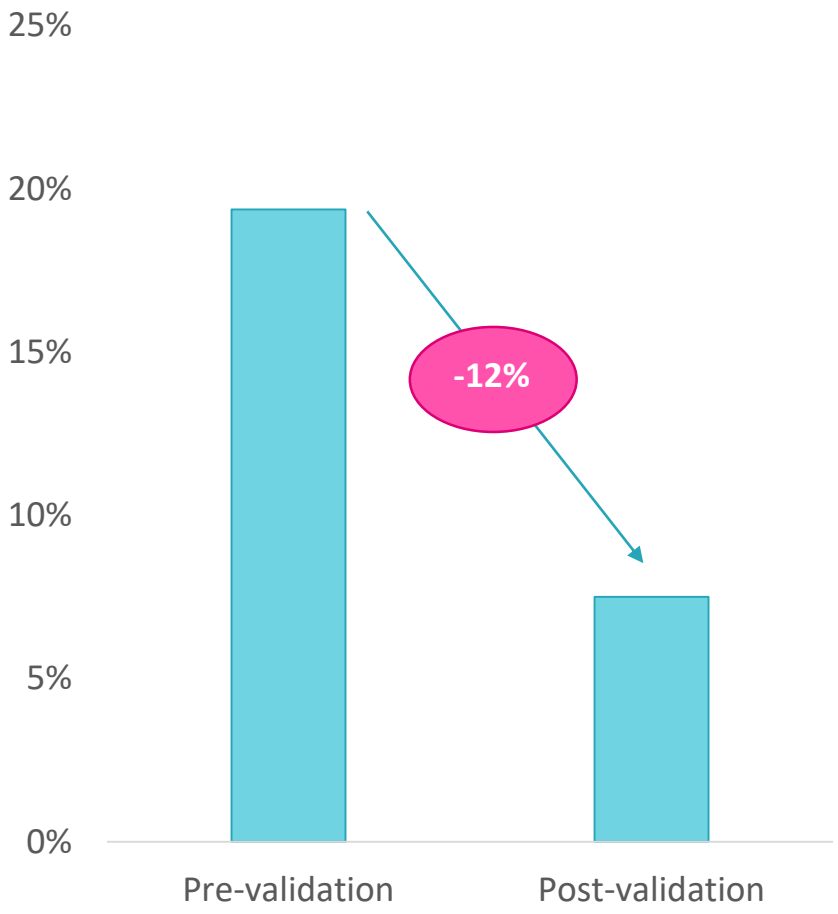
Source: Trust data, Carnall Farrar analysis

10 Coding errors and ensuring data accurately reflects performance

Due to inaccurate coding of majors/minors classification, there is a 10% difference in the number of minor breaches that occur compared to the figures that are reported by Trust

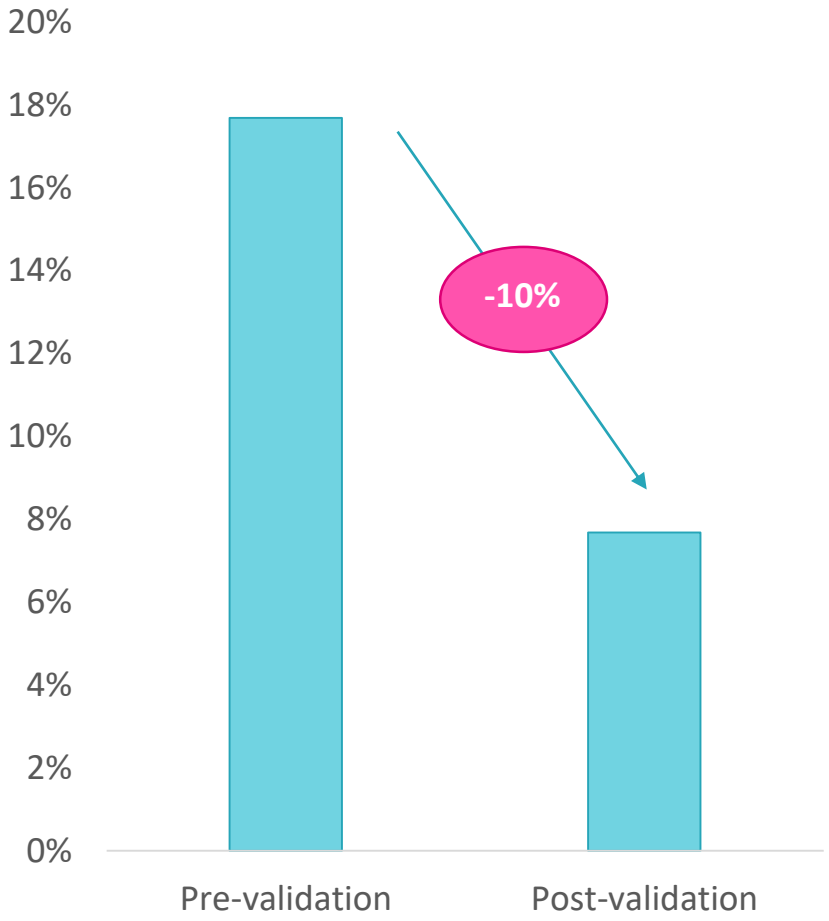
Worcestershire Acute Hospitals NHS Trust

Proportion of breaches that are classified as minor, pre and post validation



Worcestershire Acute Hospitals NHS Trust

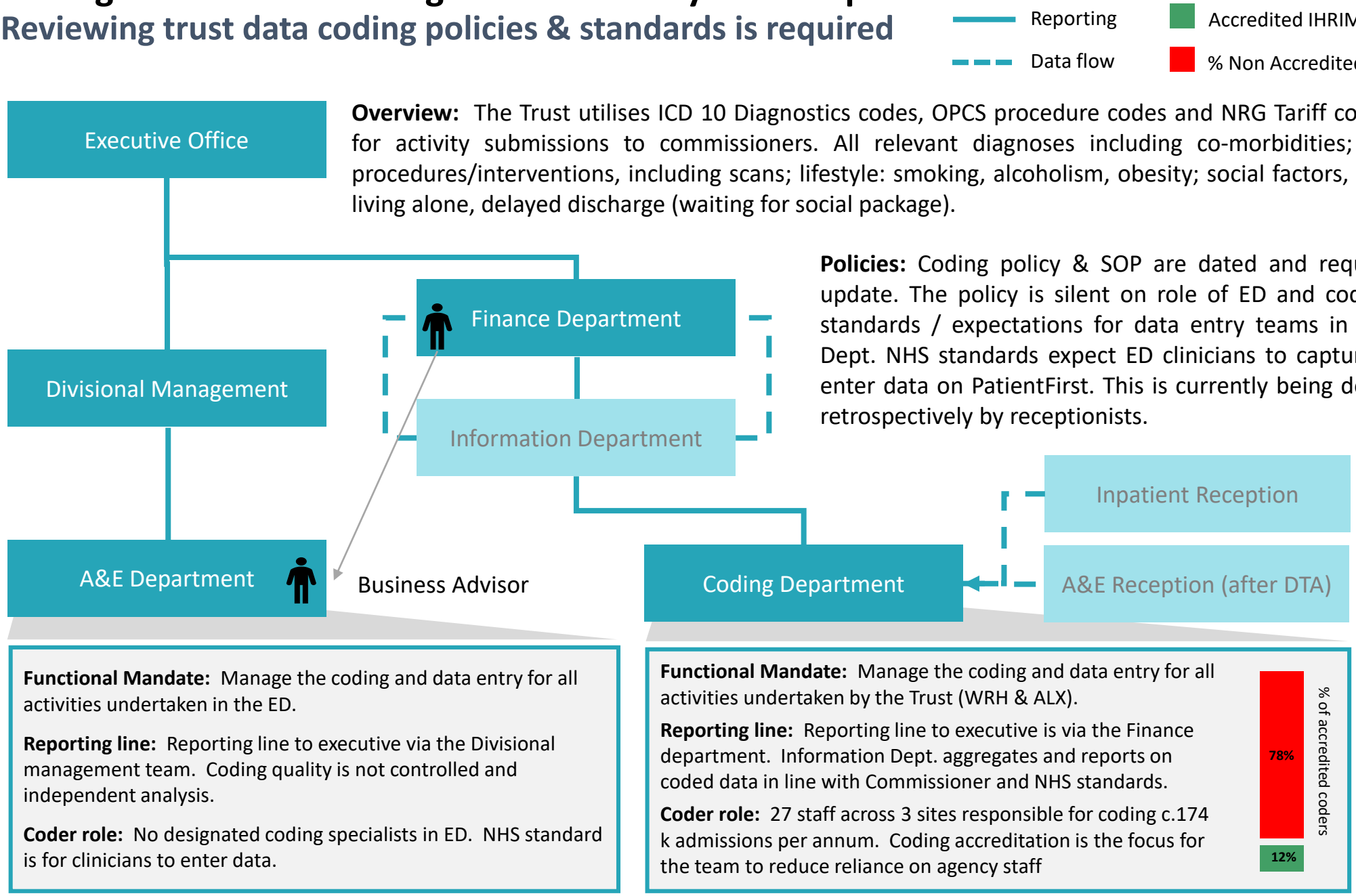
Proportion of minor attendances that breach, pre and post validations



Source: Trust data, Carnall Farrar
Note: these figures are for the period from 01/01/2018 to 28/01/2018

10 Coding errors and ensuring data accurately reflects performance

Reviewing trust data coding policies & standards is required



Overview: The Trust utilises ICD 10 Diagnostics codes, OPCS procedure codes and NRG Tariff codes for activity submissions to commissioners. All relevant diagnoses including co-morbidities; All procedures/interventions, including scans; lifestyle: smoking, alcoholism, obesity; social factors, e.g. living alone, delayed discharge (waiting for social package).

Policies: Coding policy & SOP are dated and require update. The policy is silent on role of ED and coding standards / expectations for data entry teams in the Dept. NHS standards expect ED clinicians to capture / enter data on PatientFirst. This is currently being done retrospectively by receptionists.

Functional Mandate: Manage the coding and data entry for all activities undertaken in the ED.

Reporting line: Reporting line to executive via the Divisional management team. Coding quality is not controlled and independent analysis.

Coder role: No designated coding specialists in ED. NHS standard is for clinicians to enter data.

Functional Mandate: Manage the coding and data entry for all activities undertaken by the Trust (WRH & ALX).

Reporting line: Reporting line to executive is via the Finance department. Information Dept. aggregates and reports on coded data in line with Commissioner and NHS standards.

Coder role: 27 staff across 3 sites responsible for coding c.174 k admissions per annum. Coding accreditation is the focus for the team to reduce reliance on agency staff

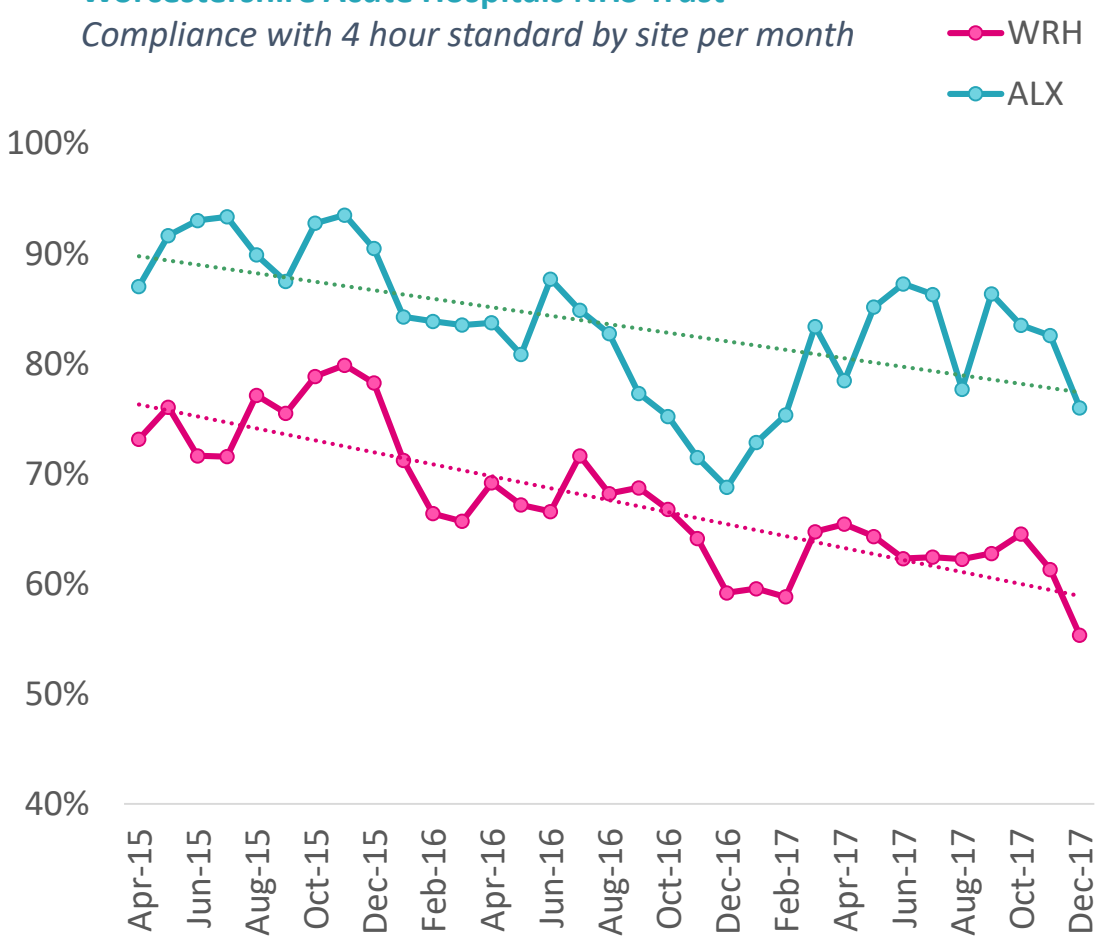
Source: Trust data, Carnall Farrar analysis

11 Lack of improvement in A&E performance despite a number of interventions

There has been a significant improvement in the number of 12 hour breaches however compliance with 4 hour standard has not improved and continues to decline

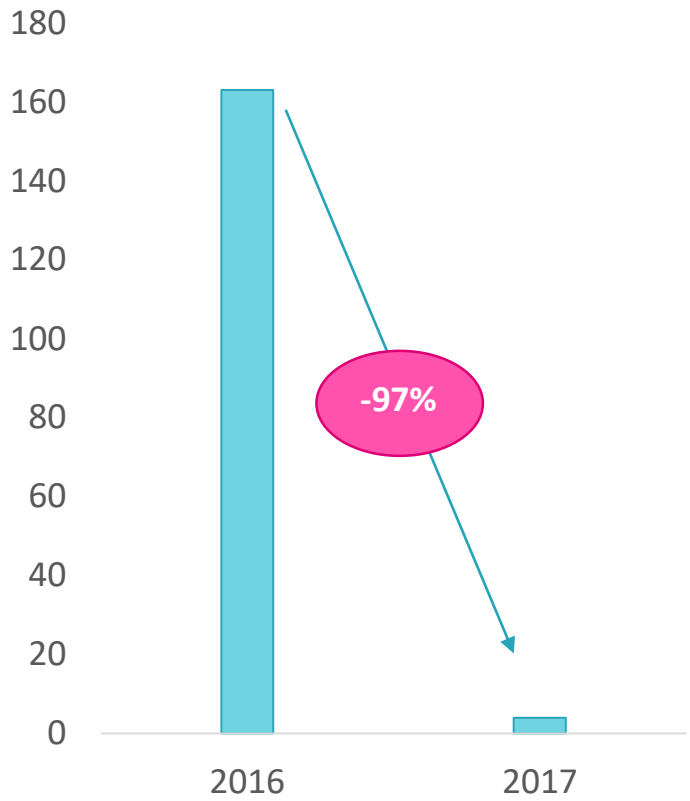
Worcestershire Acute Hospitals NHS Trust

Compliance with 4 hour standard by site per month



Worcestershire Acute Hospitals NHS Trust

Number of 12 hour breaches between 23rd Dec- 23rd Jan 2016/17 and 2017/18



- Although 12hr breaches have fallen by 97%, there has been continual decline in compliance with the 4 hour standard since April 2015 and A&E performance has continued to decline this winter despite significant effort and input from both the Trust and the wider system to improve through winter initiatives

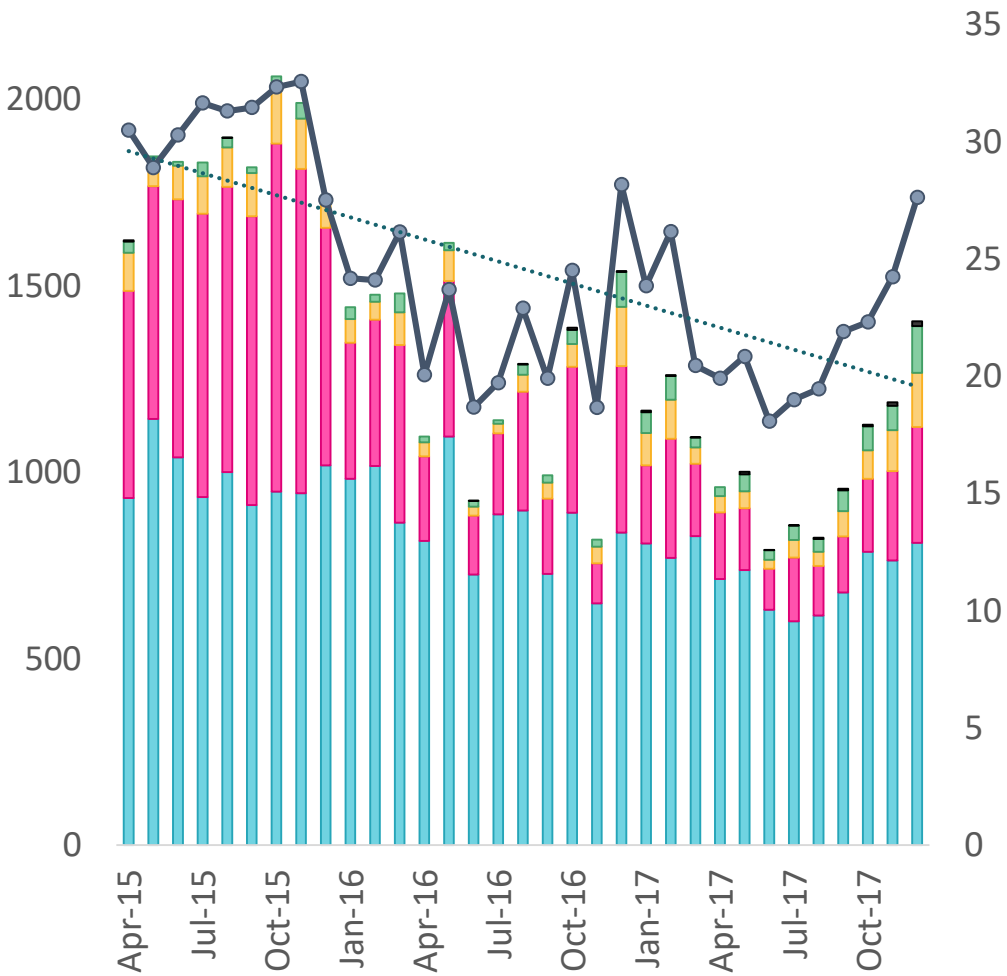
Source: Trust data, Carnall Farrar analysis
Note: 163 12hr breaches occurred at WRH between 23rd Dec 2016 and 23rd Jan 2017 compared to 4 in the same period 17/18

11 Lack of improvement in A&E performance despite a number of interventions

After a period of improvement in ambulance handover delays, performance is once again on the decline and worse than target

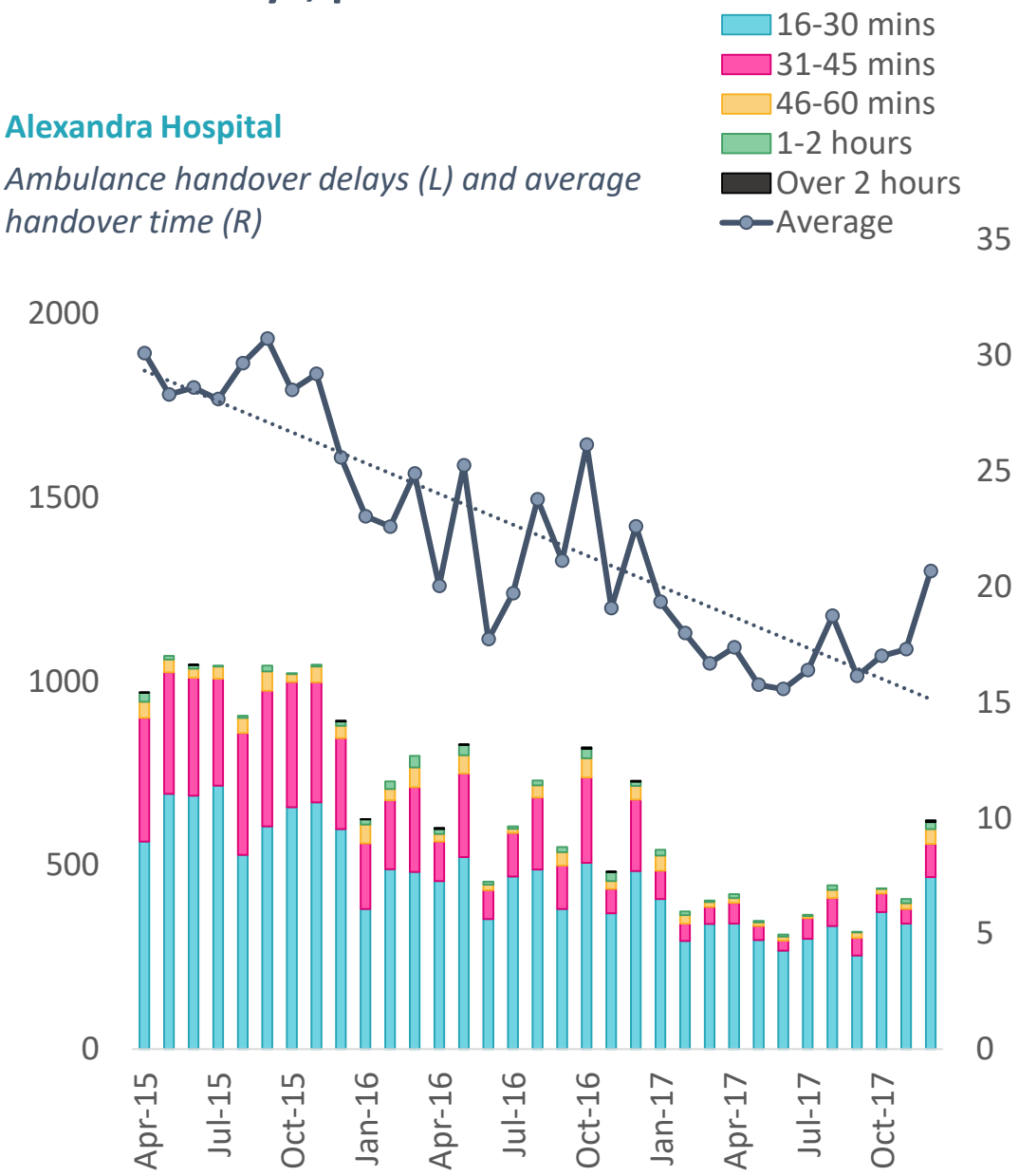
Worcestershire Royal Hospital

Ambulance handover delays (L) and average handover time (R)



Alexandra Hospital

Ambulance handover delays (L) and average handover time (R)



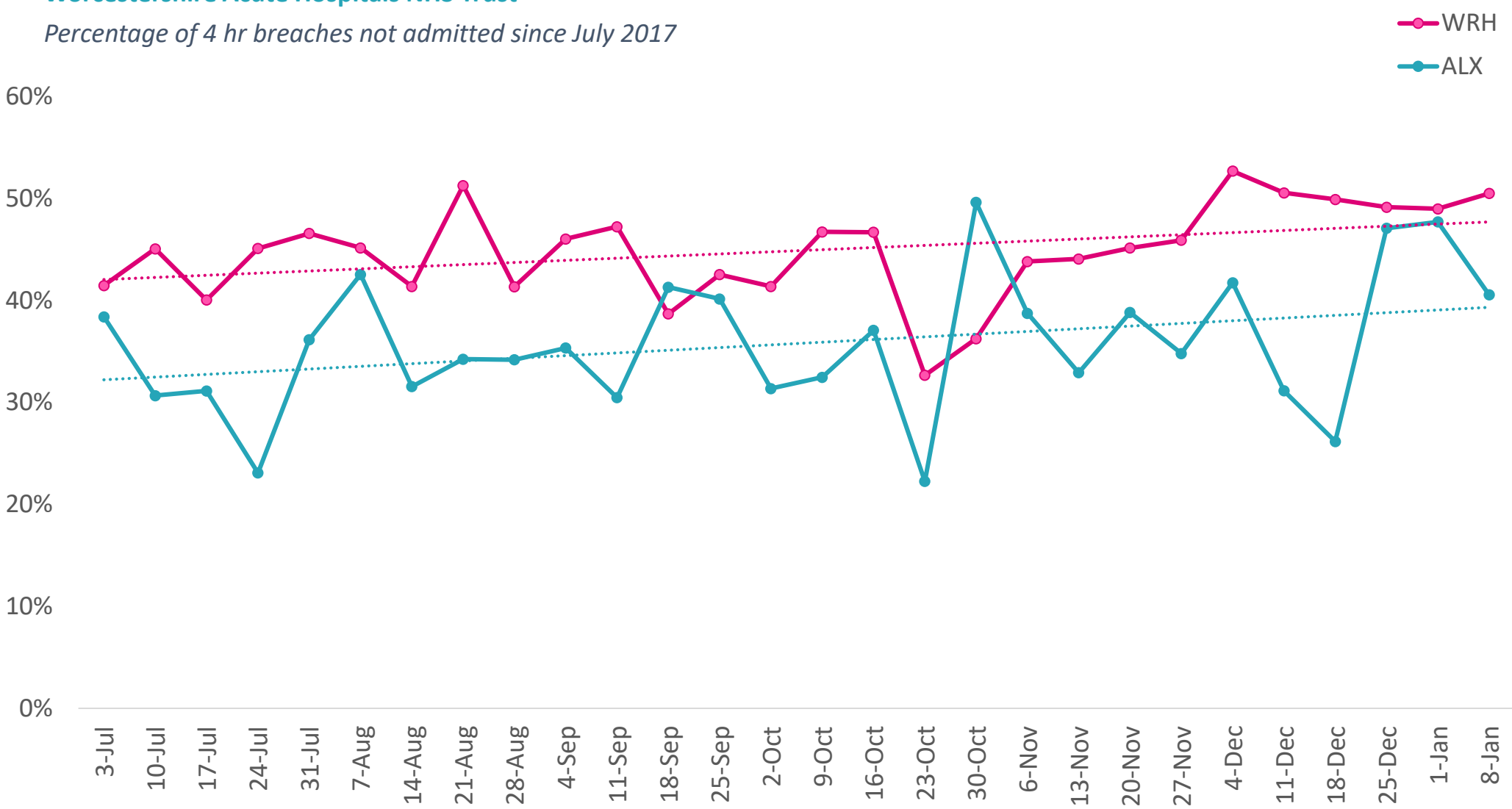
Source: Trust data, Carnall Farrar analysis

11 Lack of improvement in A&E performance despite a number of interventions

The percentage of 4 hour breaches who do not go on to be admitted is rising

Worcestershire Acute Hospitals NHS Trust

Percentage of 4 hr breaches not admitted since July 2017



Source: AEDB dashboard, Carnall Farrar analysis

12 Good evidence of UEC system working, however intended impact not being delivered

Trust governance arrangements are complex, with immature project delivery management practices impacting implementation and transformation programmes

Winter PMO

CCG puts in 7 FTE currently. CCG resource ends in April 2018.

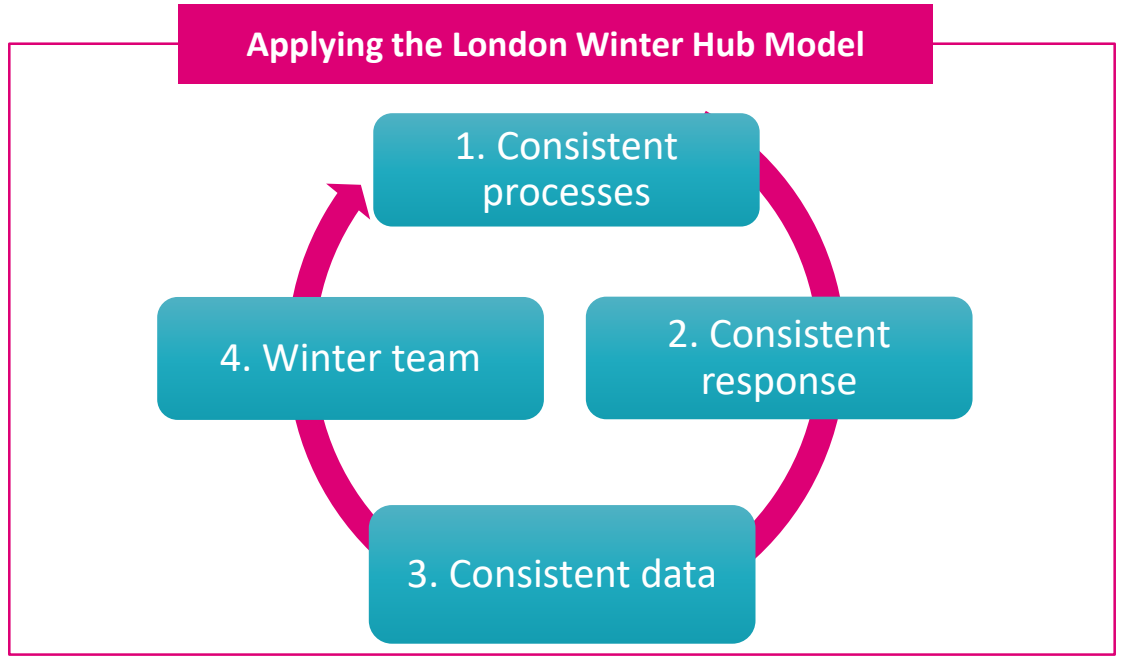
- **Context:** The Winter PMO team has been established at WRH and is delivering a positive impact across the UEC system. The team have been targeting 'at risk' aspects of patient flow currently impacting the Trust and wider UEC system performance. Relative to comparable systems around the country this is positive progress
- **Complexity:** Trust recognises that their project governance arrangements are complex and require further refinement. Work is underway in this area to clarify current discrepancies and legacy forums. There is a recognised gap in governance to enable transformation, a matter that is being addressed by the Finance and Strategy teams
- **Strategic leadership:** Clearer strategic leadership is needed in setting direction, driving cultural change within A&E and influencing the broader UEC system, with key partners across the catchment area
- **System level Governance:** there is clear recognition of mutual accountability for UEC performance. However, with significant stress across the system and scarce capacity, integrated working (at operational level) for resolving systemic issues remains patchy
- **Trust Governance (UEC only):** recognition of the need for greater "command and control" embedded across the UEC governance (Clinical and operational) forums
- **Accountability:** greater clarity is also required on key accountabilities relating to critical UEC projects, an item that will be addressed in the Project charter for Phase 2, and Terms of reference the UEC implementation Steering group / Committee
- **Project / Programme Management:** Winter Plan has 35 initiatives in 'action log' format. When these actions are seen to be complete the initiative is closed off. There is no ongoing monitoring of performance or impact and benefits are not tracked.
- **Monitoring & Reporting:** focus on National metrics with immature processes for managing trajectory of programme delivery (demand/capacity/flow/performance) parameters

Source: Carnall Farrar

12 Good evidence of UEC system working, however intended impact not being delivered

While there is good evidence of system working, there is still work to be done in order to ensure consistent processes and a consistent response is being implemented

National Winter Command & Control Centre



1. Consistent processes

- **Overarching system escalation plans exist, however not utilised** appropriately and reluctance to fully escalate
- OPEL is calculated on an aggregation of system-wide escalation and does not always reflect the escalation of the acute Trust

2. Consistent response

- Need more "live" planning for addressing crises – at present it seems as though **little change is made to pre-existing plans** with changes in demand
- Overall behaviour/culture during escalation needs to be rebalanced across the system

3. Consistent data

- **Daily winter room assurance calls** bring together stakeholders in the system to ensure data is shared particularly around situation escalation
- **Issues with data integrity**, particularly with WMAS need to be resolved in order to have consistency of data

4. Winter team

- **Good evidence of system working** with through Winter team – CCG team firmly embedded in Trust via Winter Room
- **AEDB** could benefit from **providing more challenge to performance**

Source: NHS England, NHS Improvement, London Region Winter Team, Carnall Farrar analysis

12 Good evidence of UEC system working, however intended impact not being delivered

The system initiatives are failing to address the challenges identified by this review

Winter plan & STP:

UEC System Winter Plan:
35 initiatives

UEC Winter monies:

14 initiatives

UEC STP support:

5 initiatives

PMO Transformation :

Total Trust Transformation projects:

30 initiatives

Initiatives with reasonable link to UEC:

6 out of 30 initiatives

	Challenge	Coverage
1	Increased attendances by ambulance	
2	Lack of command and control	
3	GP streaming	
4	Lack of speciality responsiveness	
5	Poor access to assessments units	
6	Lack of capacity against background of historical changes	
7	Operational culture: under siege	
8	Executive culture: A&E change management	
9	Overcrowding of ED	
10	Coding errors	
11	Lack of improvement in A&E performance despite a number of interventions	
12	Good evidence of system working, however intended impact not being delivered	

Note: In evaluating the trusts current progress in resolving the challenges identified in the Diagnostic, we use the term 'Coverage' noting that both BAU and project interventions are currently being applied across the Trust, with varying degrees of success. We have used a RAG system to identify priority areas for intervention.

Source: Trust data, Carnall Farrar

Recommendations

Recommendations (1 of 2)
Resolving ED issues and developing UEC capability

UEC 360 Components

- Systems & Processes
- Leadership & Management
- Capabilities & Behavior

Category	Intervention(s)	Impact
1 Increased attendances by ambulance	Reduce ambulance waiting times and improve ambulance data	
2 Lack of command and control	Support Clinical leadership with this priority A&E related project	
3 Lack of speciality responsiveness	Improve speed of assessment by specialities and time to admission / discharge	
4 GP Streaming	Improve GP and other service streaming at the Emergency Department front door	
5 Poor access to assessment units	Improve flow through MAU and all assessment units	
6 Lack of capacity against a background of historical changes	Ensure that the capital business case delivers acute capacity by 2018	

Recommendations (2 of 2)
Resolving ED issues and developing UEC capability

UEC 360 Components

- Systems & Processes
- Leadership & Management
- Capabilities & Behavior

	Category	Intervention(s)	Impact
7	Under siege culture in A&E And normalisation of A&E underperformance across Trust	Work with Pulse team to help realise benefits of Culture change programme for Trust and ED	
8	A&E change management and strong clinical leadership is required to drive/enable Trust culture change programme	Work with Pulse team to help embed culture change programme with Trust ED leadership team	
9	Overcrowding of ED	Develop a Demand and Capacity Planning tool	
10	Coding errors	Improve A&E operational data and recording	
11	Lack of improvement in A&E performance despite a number of interventions	Design and Implement A&E Performance Management System	
12	Good evidence of system working, however intended impact not being delivered	Provide additional specialist capacity and support to the ED teams to enable change	

Realising the impact (1 of 3)
Overview of proposed interventions and measures of success

Interventions	Description	Measures of success
1 **Reduce ambulance waiting times and improve ambulance data**	CF to facilitate discussions between A&E and WMAS to agree solutions to ensure patients are rapidly accepted into hospital care, a better use of the 2 sites is agreed operationally in response to the situation and data is collected accurately on the ground and used jointly	Reductions in WMAS handover times to ED
2 **Support clinical leadership with priority A&E related projects**	CF to support clinician team in refining the responsibilities for all operational tasks, agree these with the team and agree with key individuals.	Weekly task list agreed with actions signed off Measures of sustainability to be that tasks transfer across to department staff who undertake going forward
3 **Improve speed of assessment by specialities and time to admissions/discharge**	CF to facilitate discussions between specialities and A&E to discuss the reasons for the delays in specialists attending A&E following referral from A&E. Establish a mechanism for alerting leaders when agreed timescales are not being met to allow immediate escalation including early notice of likely DTA to bring forward Trust-wide planning	Reduction (minutes) in time patients wait in A&E to be assessed by speciality Reduction (minutes) in total time spent in ED.
4 **Improve GP streaming**	CF to facilitate discussions between A&E team and commissioners to ensure GP streaming contract to meet out of hours requirement leads to better utilisation and aligns to service standards.	Eliminate 4 hour waits for GP streaming Improve activity in evening / night periods

Realising the impact (2 of 3)
Overview of proposed interventions and measures of success

Interventions	Description	Measures of success
5 **Improve flow through admissions units**	CF to facilitate discussions between A&E leaders, speciality leads and MAU/admissions units clinical staff to enable the trust to agree solutions to the blockers that are causing the extended LOS. Help implement the agreed actions.	Reduced LOS in MAU and other admission points
6 **Ensure that the capital business case delivers acute capacity for 2018**	CF to work with the Trust and regional system leaders to unblock the funding applications and to work with the Trust to ensure that acute capacity is created by the end of 2018	Plans for capacity in 2018 are agreed between Trust and regional team
7 **Embed culture change programme in A&E**	CF to work with Pulse team to support the implementation of cultural change programme in A&E.	Increased levels of clinical staff satisfaction Greater clarity on roles of clinical and admin staff within the department
8 **Embed culture change programme with Trust ED leadership team**	CF senior leadership team to work with Pulse team and Trust executive to support the implementation of cultural change programme, as it relates to A&E. Any matters that relate to executive or senior management teams should be discussed and positively addressed.	Increased levels of clinical staff satisfaction Greater clarity on roles of clinical and admin staff within the department

Realising the impact (3 of 3)
Overview of proposed interventions and measures of success

Interventions	Description	Measures of success
9 **Develop a Demand and Capacity Planning Tool**	CF to support the Trust in improving and aligning its demand and capacity plans with the wider UEC system to ensure that the ED has required capacity to meet demand fluctuations in 'Business as usual' times and in peak load periods (ie. surges). These plans also need to align with the Trust and OPEL escalation protocols.	Reduced variation in Planned vs Actual capacity (Day, Week, Month & Annual performance)
10 **Improve A&E operational data and recording**	CF to facilitate Trust planned work with the A&E team to redesign collection and recording of minor and major definitions. CF to work with Informatics and A&E team to ensure all data fields are completed in real time	Accurate recording on minors to achieve reduction in recorded minor breaches Better coding quality (output to be defined)
11 **Design and implement A&E performance management system**	Design a Performance Management system for A&E, in line with that in place across the Trust. Define roles and accountabilities of all staff. Launch PM process and support Trust staff in running this to embed a culture of accountability (per Scope item 2)	An agreed Performance Management system agreed, launched and agreed to be effective
12 **Provide additional specialist capacity and support to the ED teams to enable change**	CF to provide additional specialist and ED operations consulting support to facilitate the rapid implementation of interventions 1 – 11. On the ground support should be fully integrated into the ED team, where CF and Trust resources co-deliver these interventions	Project progress vs plan

Worcester UEC Phase 2: Deliverables, activities and outputs (Feb 18 – Mar 18)

Scope item	Key Activities	Deliverables
1 **Help facilitate the implementation of priority A&E improvement projects**	Facilitate the implementation of priority A&E improvement projects, by: (1) developing high level PIDs, (2) tracking progress against agreed trajectories with the PMO team, (3) escalating risks / issues as required to the CEO, (4) Integrating effectively with PMO and other consulting teams where needed. The areas of focus for the Trust's ED & NHS England and Improvement are listed on the following slide.	• ED delivery working group • High level PIDs for 10 agreed priority initiative areas • Weekly progress reports against agreed trajectory for operational leads and trust management • Final Phase 2 progress report
2 **Co-design a vision and target ED operating model**	• Agree guiding design principles & model Trust stretch performance targets for improved performance • Respecting financial & physical constraints (ie. current building / access etc.), co-design an optimal operating model for the Department – covering the following layers: Patient flow & process, Trust escalation protocol, Organisation & people, Technology, Operational capacity planning, Governance (and controls). • Roadmap to test, validate & transition new processes with ED team	• Vision statement for ED 2018 • Target Operating Model (TOM) for ED by Winter 2018 approved by Staff and wider System • Org design, Workforce plan, JDs & performance management system for ED. • Updated Trust ED escalation protocol (inc. "Safety Matrix") • Build roadmap to Winter 2018
3 **Demand and Capacity assessment + UEC 360 holistic assessment**	Design a robust capacity planning tool (2018 – 2023) to improve the Trust's ability to respond to surge a) Review & validate Trust current demand plans for FY18/19 b) Assess scheduling and workforce plans for A&E c) Sign off forecasts for winter 18/19 UEC 360 holistic assessment – covering: Leadership, capability, behavior; MI; Systems and processes	• Demand, Capacity & Flow trajectories 2018 - 2023 • Validate the A&E workforce / capacity plans from Deliverable 2 • UEC360 holistic assessment report

Worcester UEC Phase 2: Our Shared Responsibilities

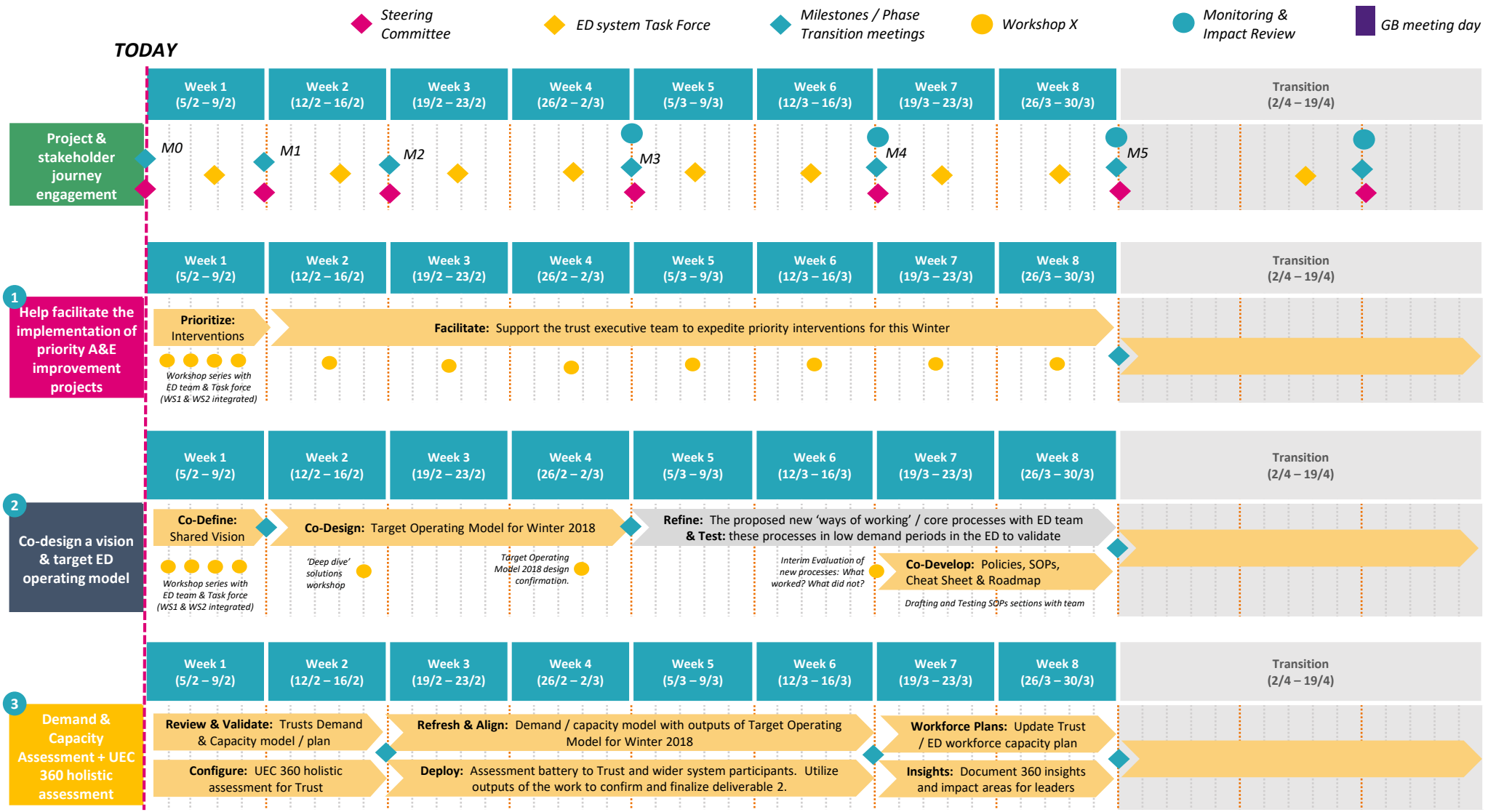
Scope item	CF Deliverables	Required input from Trust and System

1 **Help facilitate the implementation of priority A&E improvement projects**	• ED delivery working group
	• High level PIDs for 10 agreed priority initiatives
	• Weekly progress reports against agreed trajectory for operational leads and trust management
	• Final Phase 2 progress report
		1. Confirmed list of priority initiatives
		2. Identified leadership for each priority
		  1. SRO
		  2. Site specific leads: Clinical and / or Management
		3. Daily data feeds for metrics outlined in PIDs / trajectories
		4. Logistical support in setting weekly review meetings with clinicians and management

2 **Co-design a vision and target operating model for ED**	• Vision statement for ED • Target Operating Model (TOM) for ED by Winter 2018 approved by Staff and wider System • Org design, Workforce plan, JDs & performance management system for ED. • Updated Trust ED escalation protocol (inc. “Safety Matrix”) • Build roadmap to Winter 2018	• Senior stakeholder meetings to confirm guiding principles for future ED operating model • Bi-monthly multi-agency Task force to co-develop Vision, designs and refine the TOM for implementation • Work with appointed Clinician to enable more effective command & control in ED • Input from wider system
3 **Demand and Capacity assessment + UEC 360 holistic assessment**	• Demand, Capacity and Flow trajectories 2018 - 2023 • Validate the A&E workforce from Deliverable 2 and update to resolve any gaps • UEC360 holistic assessment report	1. Working group for review, iteration, handover (representatives from across the UEC system) 2. Commitment to engage / shape / sign off: 3. List of TAQ survey respondents and other participants

60 Day Action Plan

Rapid impact for immediate term & co-developing operating model



Source: Carnall Farrar

Next Steps

Transition to Phase 2 and accelerate on implementation

1

Confirm Insights
Confirm final report insights and recommendations with key stakeholders

2

Transition to Phase 2
Confirm the 60 day implementation plan and seek approval to transition to Phase 2

3

Implementation
Mobilize Phase 2 implementation team to Trust site for next rapid impact phase

Source: Carnall Farrar

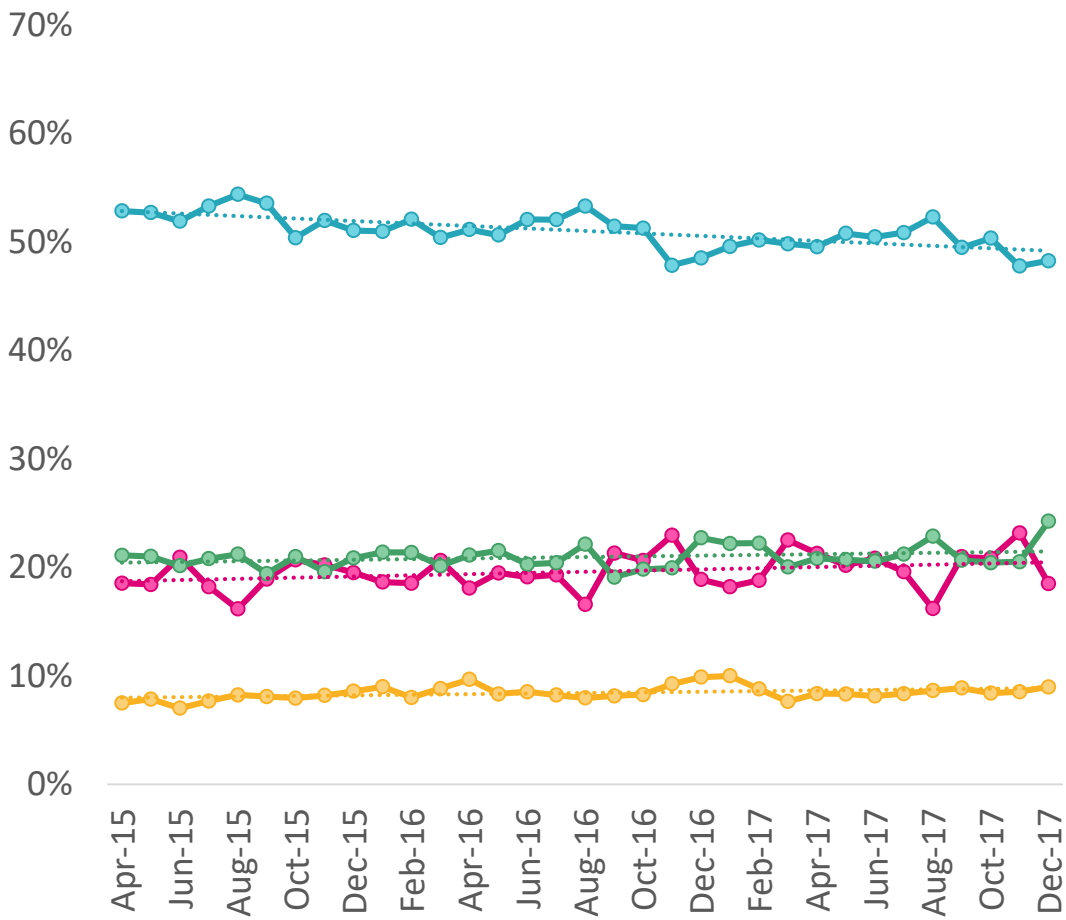
Appendices

Appendix 1: Additional analytics

There has been little variation in age range of patients attending both WRH and ALX

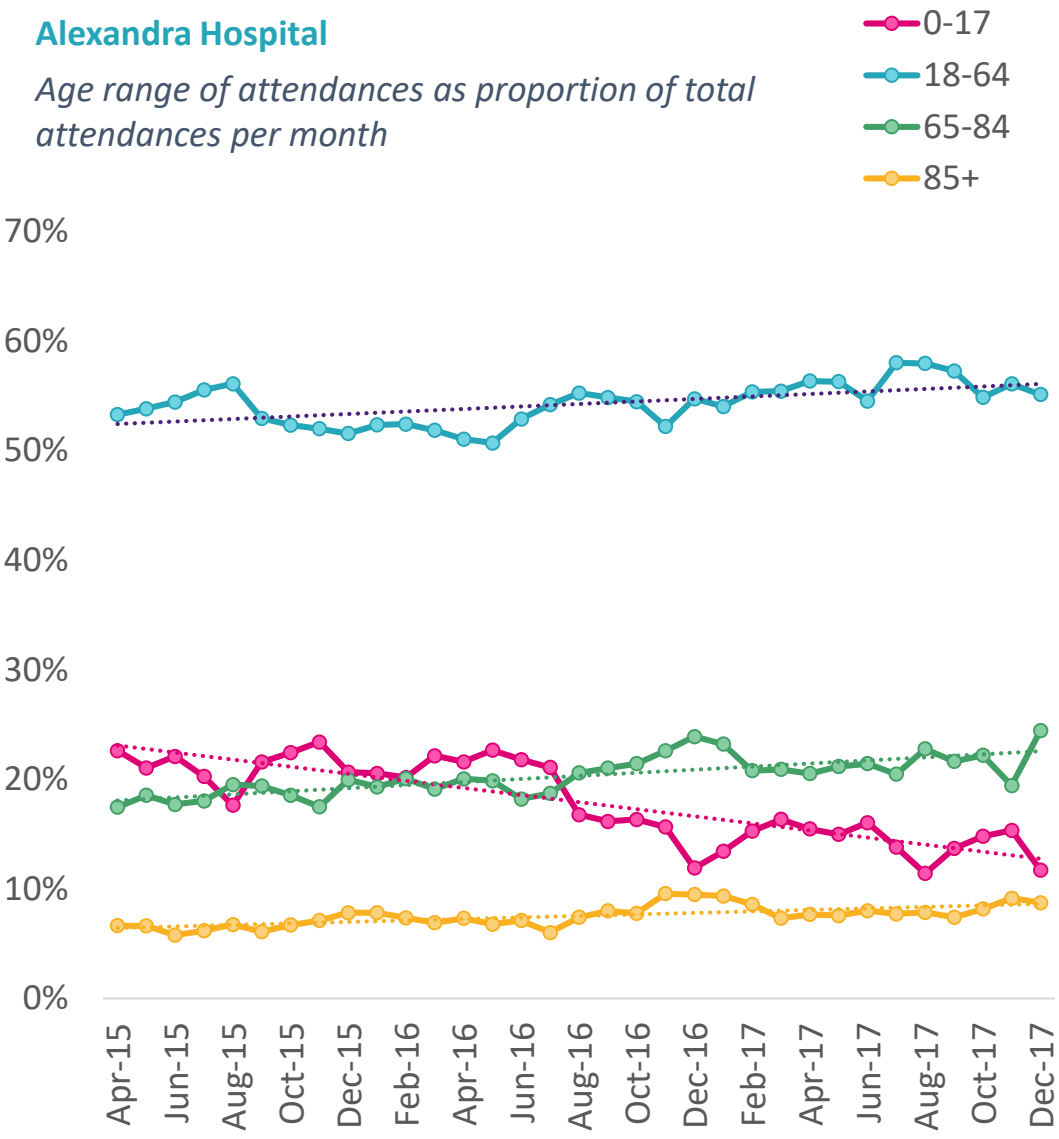
Worcestershire Royal Hospital

Age range of attendances as proportion of total attendances per month



Alexandra Hospital

Age range of attendances as proportion of total attendances per month

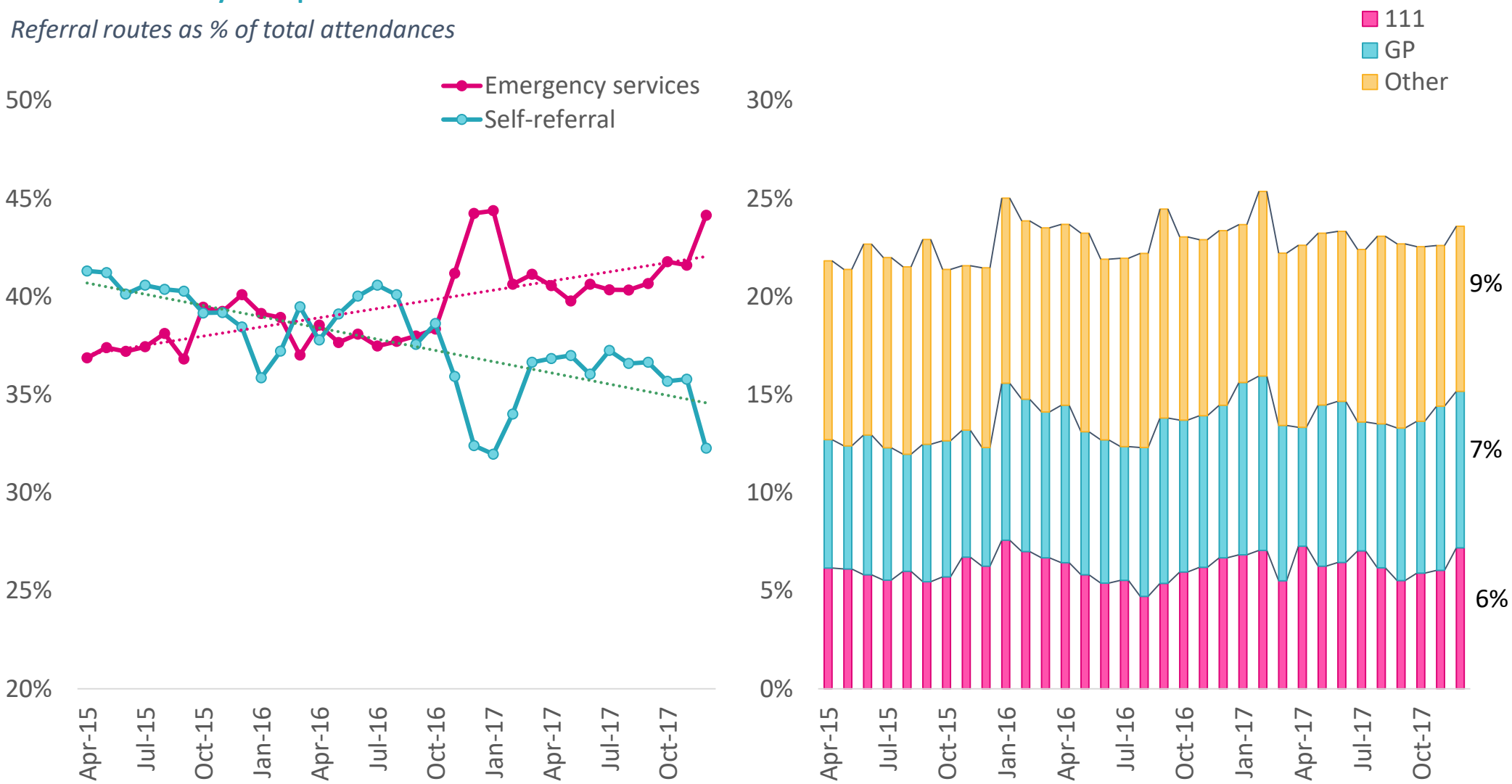


Source: Trust data, Carnall Farrar analysis

There has been an 8% increase in referrals to WRH via emergency services and a 10% decrease in self-referrals, while other referral routes have remained flat

Worcestershire Royal Hospital

Referral routes as % of total attendances

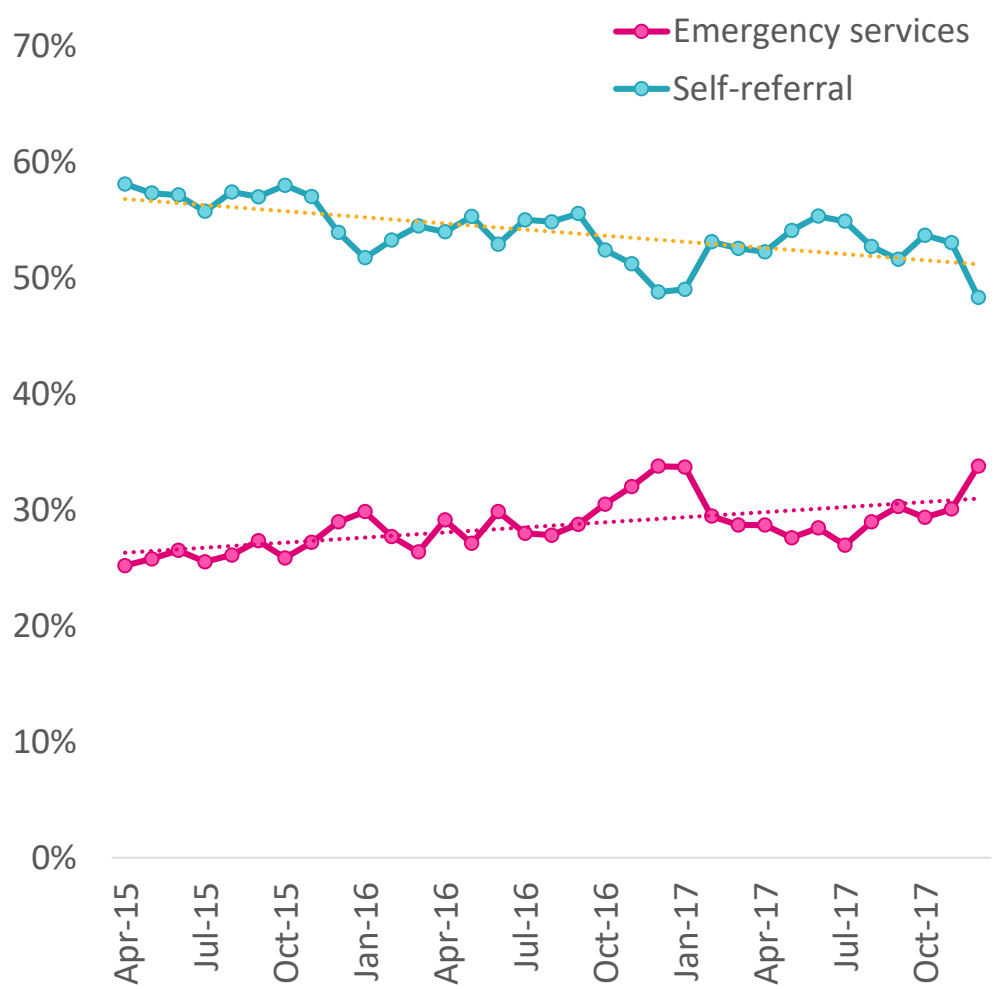


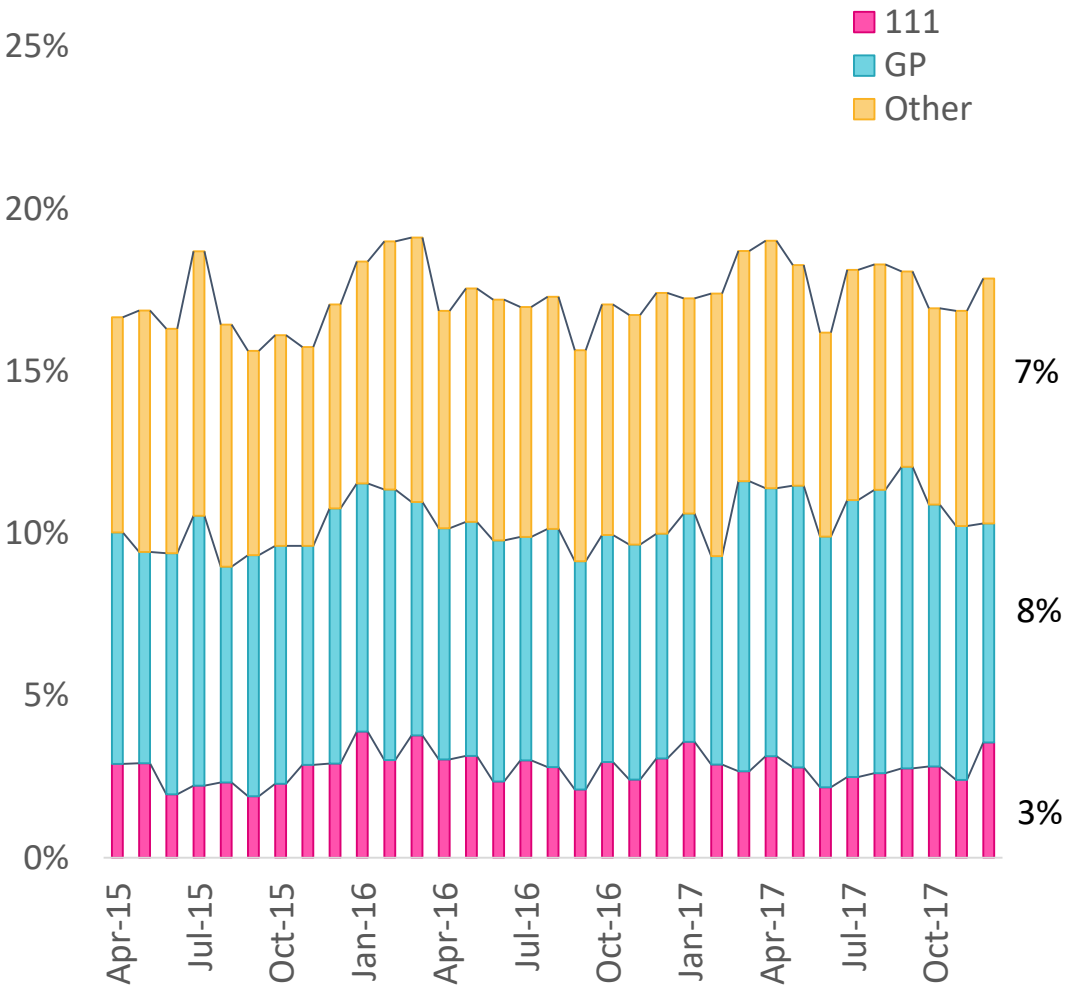
Source: Trust data, Carnall Farrar analysis

Although a similar pattern exists at ALX, the trend is of a lower magnitude and a significantly lower proportion of attendances arrive by ambulance

Alexandra Hospital

Referral routes as % of total attendances



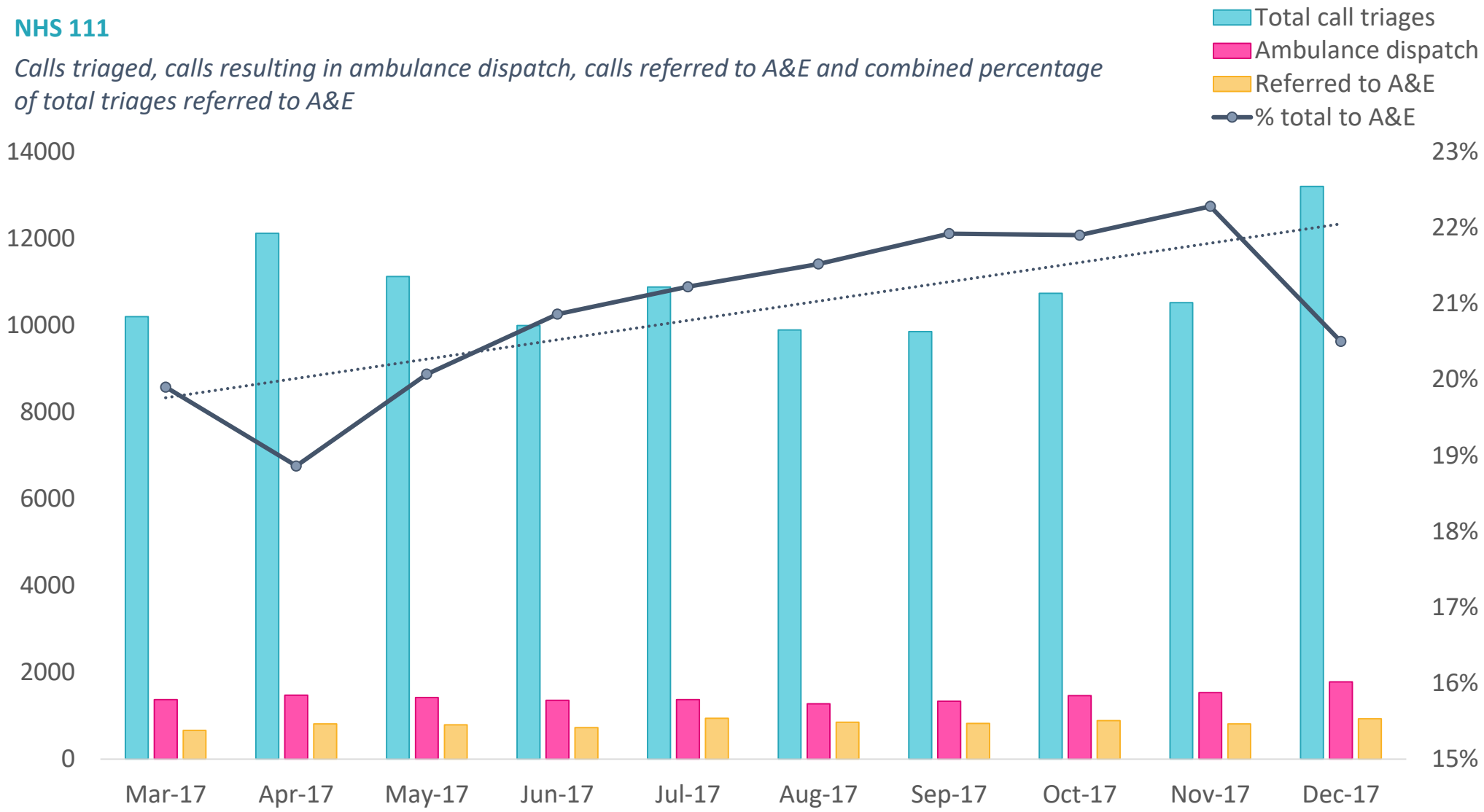


Source: Trust data, Carnall Farrar analysis

In Dec 2017, 21% of calls to NHS 111 were triaged to ambulance conveyance or advice to attend A&E, which is at the higher end of benchmarked peers

NHS 111

Calls triaged, calls resulting in ambulance dispatch, calls referred to A&E and combined percentage of total triages referred to A&E

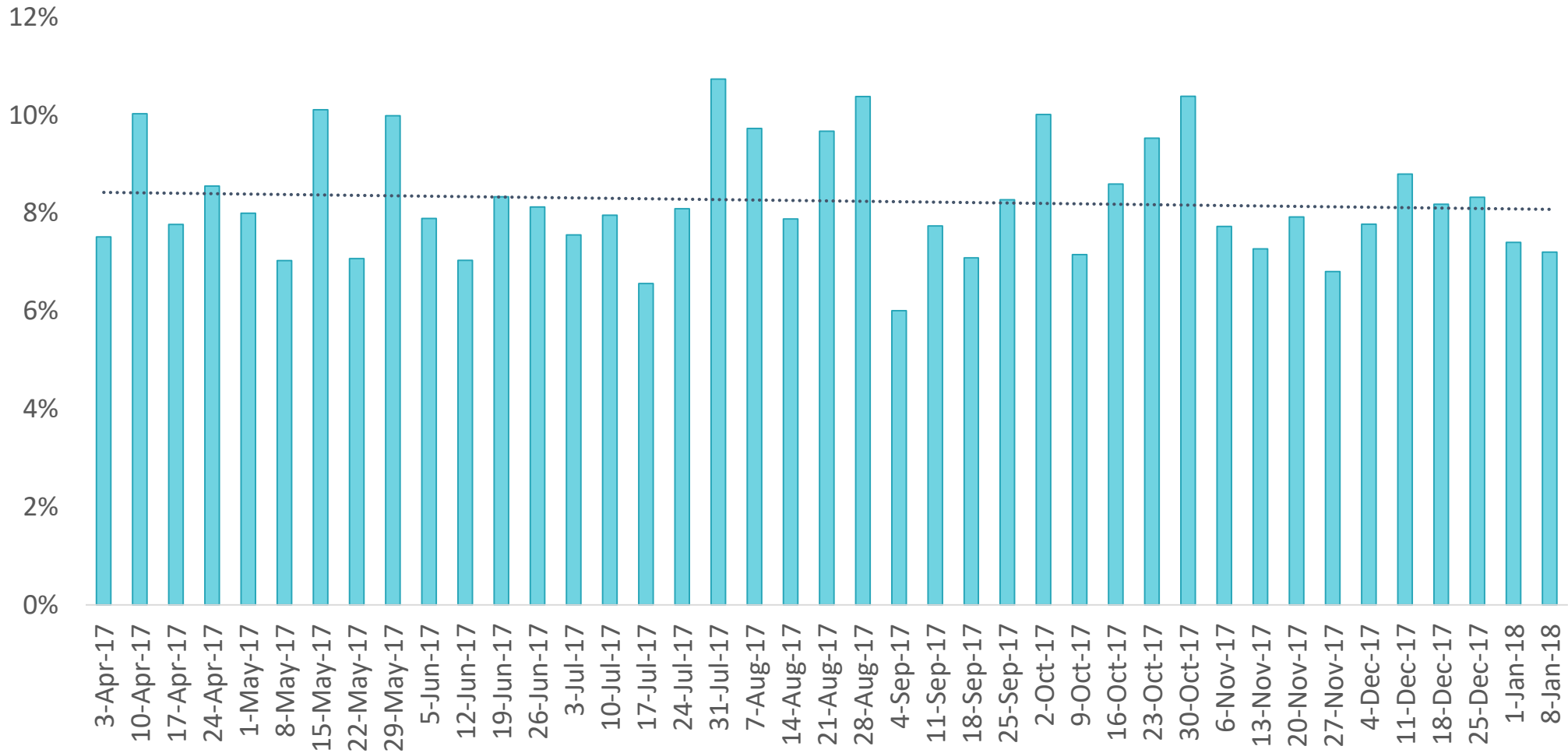


Source: AEDB dashboard, Carnall Farrar analysis

WMAS conveyances from care homes although variable week to week account for between 6 to 11% of total conveyances

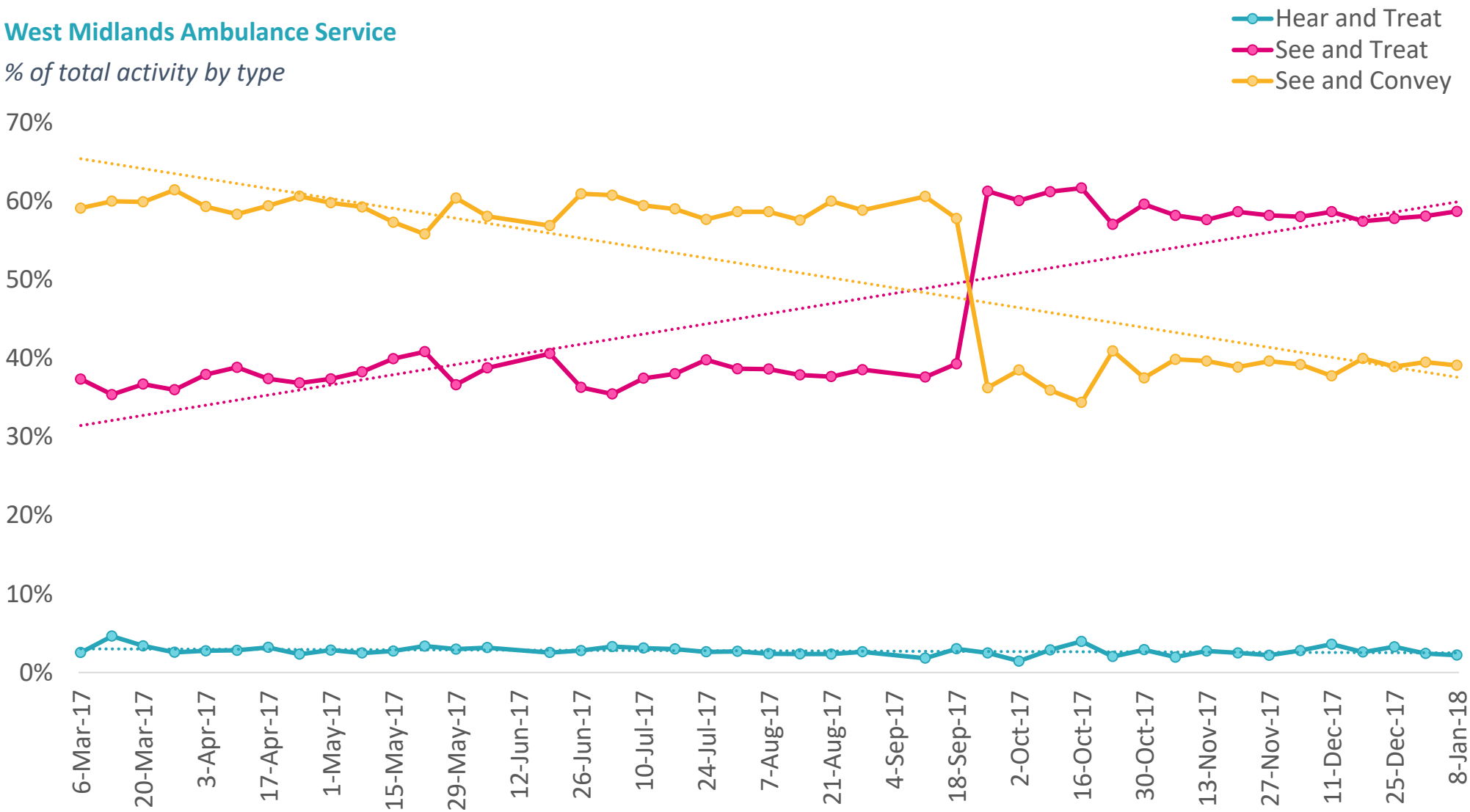
West Midlands Ambulance Service

% of total conveyances to WAHT from care homes



Source: AEDB dashboard, Carnall Farrar analysis

Since October 2017, there has been a significant decrease in the proportion of ”See and Convey” activity by WMAS

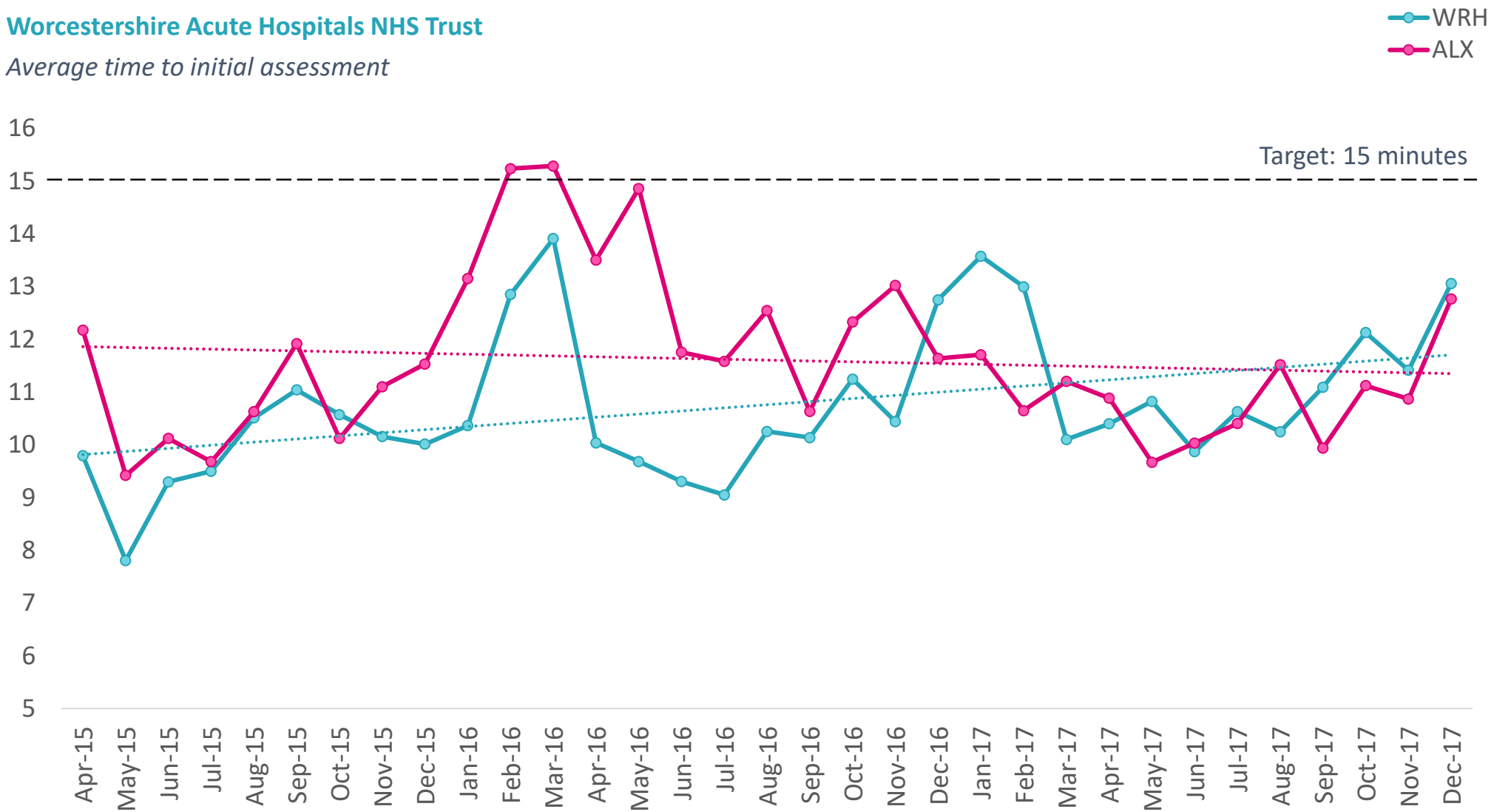


Source: AEDB dashboard, Carnall Farrar analysis

On average, both sites meet the target for time to initial assessment, however there has been an upwards trend in average time at WRH since April 2015

Worcestershire Acute Hospitals NHS Trust

Average time to initial assessment

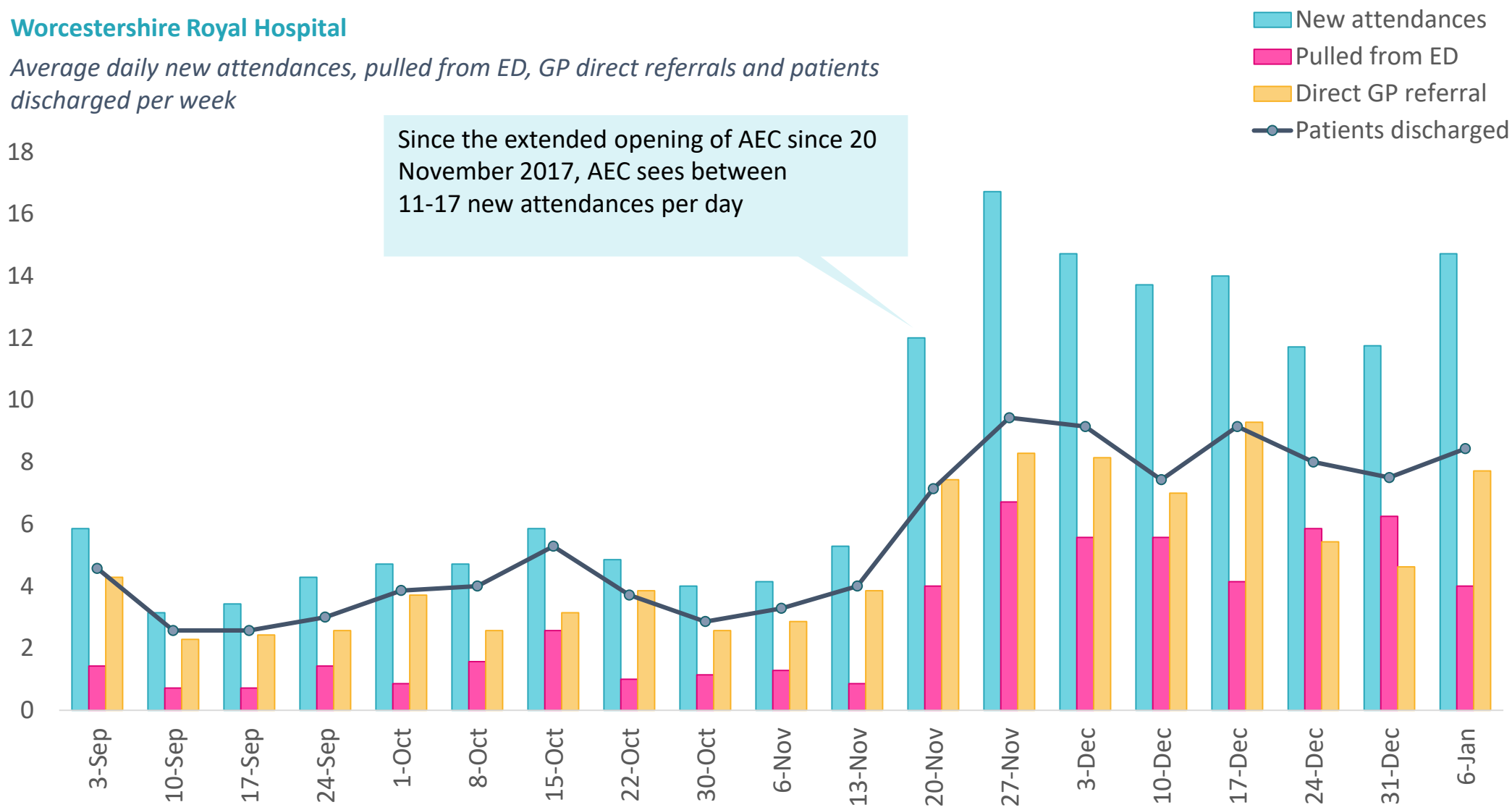


Source: Trust data, Carnall Farrar analysis

Attendances to AEC are predominantly direct referrals from the GP and since November, an average of 8 patients a day are being discharged from the unit

Worcestershire Royal Hospital

Average daily new attendances, pulled from ED, GP direct referrals and patients discharged per week

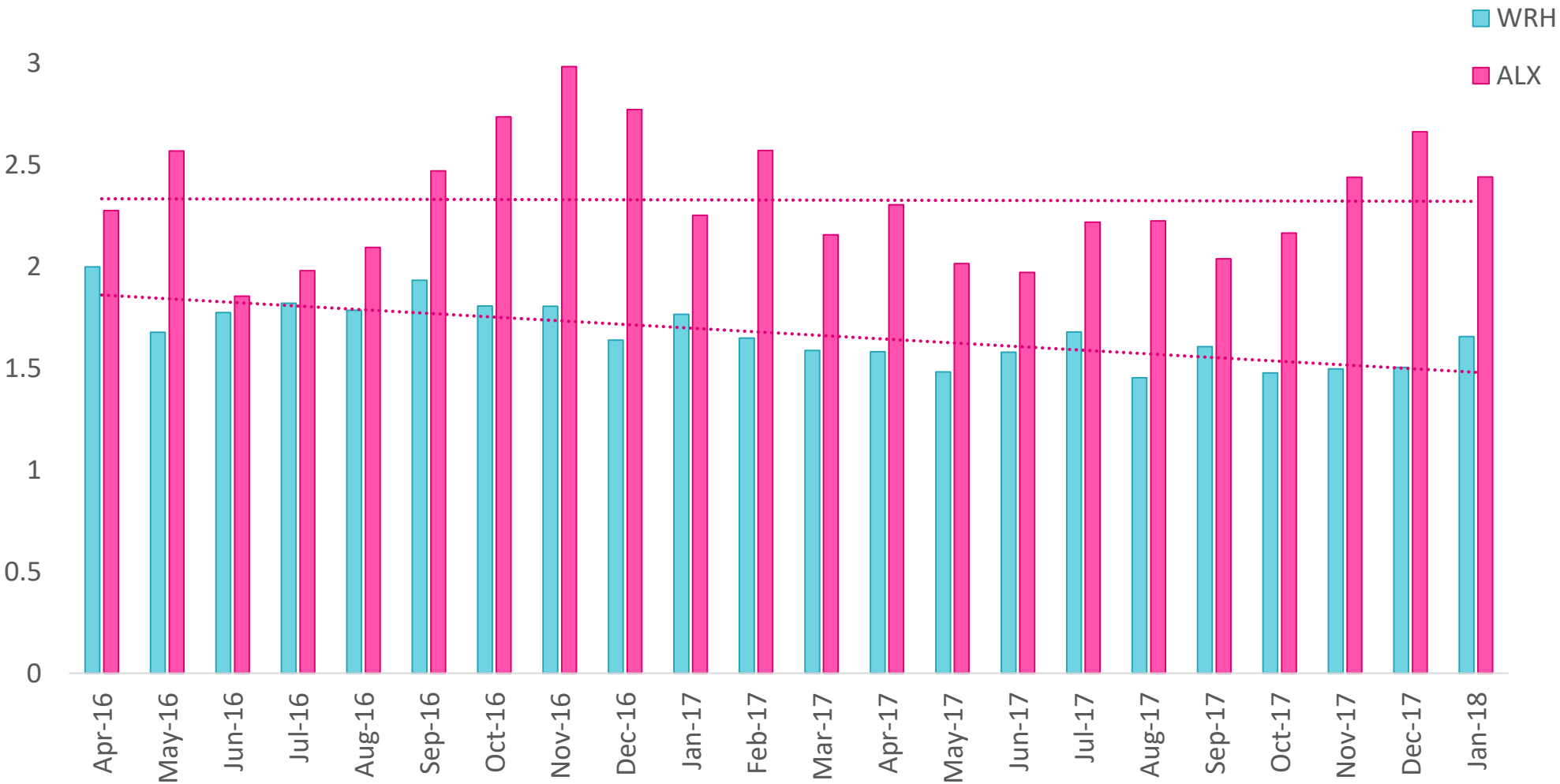


Note: AEC opening times extended to weekend from 20th November 2017
Source: Trust data, Carnall Farrar analysis

The average length of stay in MAU is 1.7 days at WRH and 2.3 days at ALX and has been reducing at WRH while remaining flat at ALX

Worcestershire Acute Hospitals NHS Trust

Average length of stay over time in MAU by site since April 2016

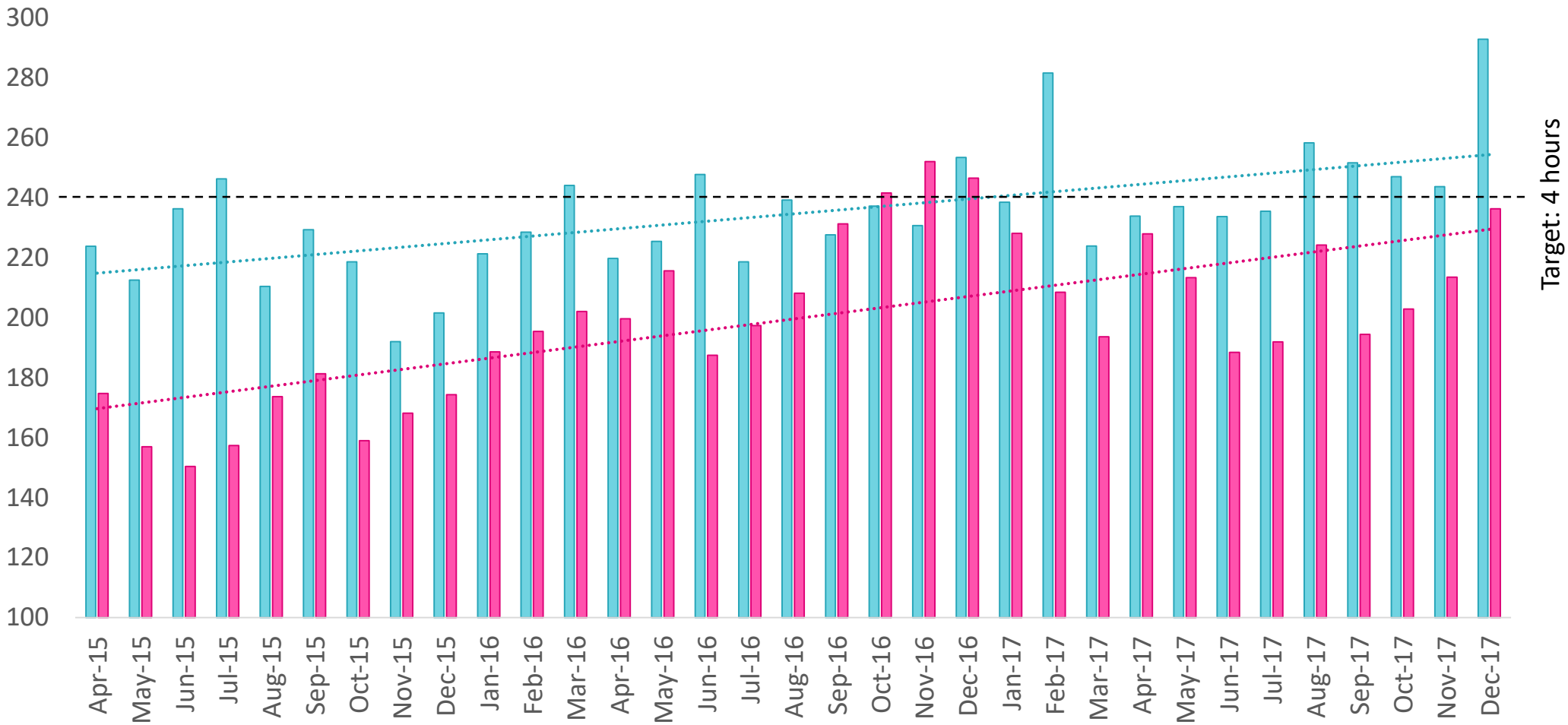


Source: Trust data, Carnall Farrar analysis

Average time to DTA has increased by 31% at WRH and 35% at ALX since April 2015

Worcestershire Acute Hospitals NHS Trust

Average time in minutes to DTA by site since April 2015

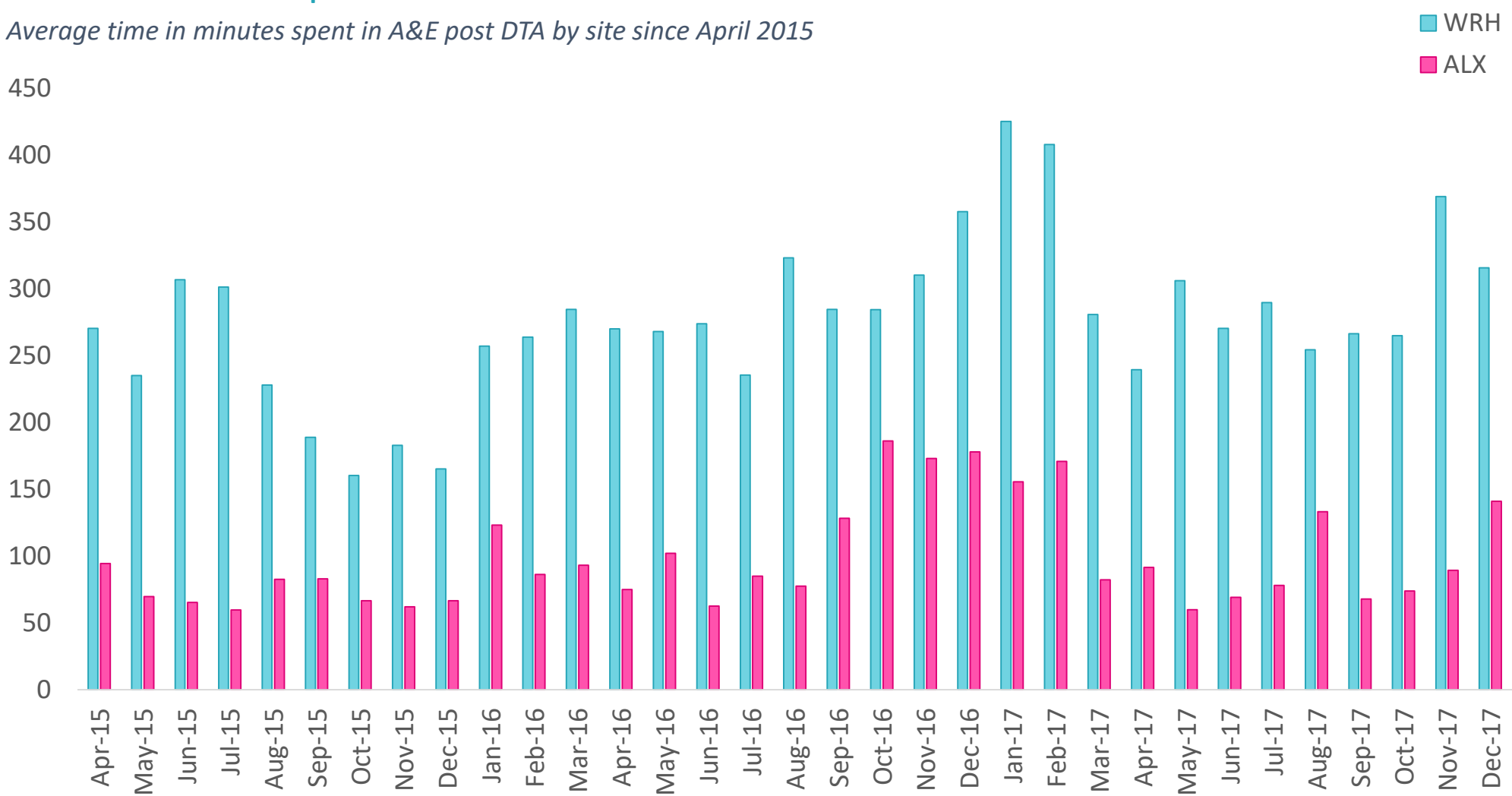


Source: Trust data, Carnall Farrar analysis

Average time spent in A&E after DTA is significantly higher at WRH than ALX, suggesting a lack of capacity for patients who need to be admitted

Worcestershire Acute Hospitals NHS Trust

Average time in minutes spent in A&E post DTA by site since April 2015

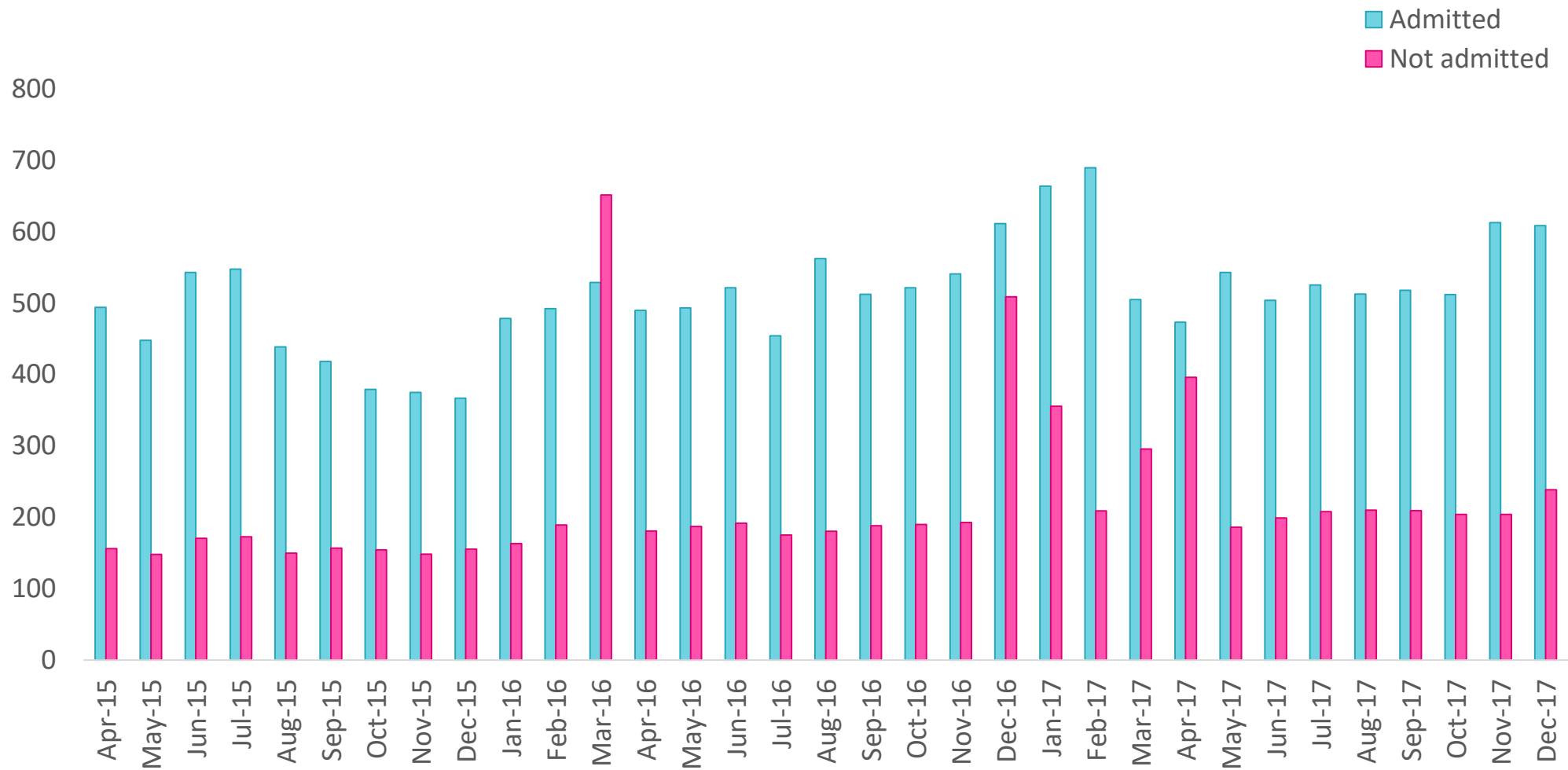


Source: Trust data, Carnall Farrar analysis

Total time spent in A&E for patients who are admitted is on average 2.3 times greater than for those who are not admitted at WRH

Worcestershire Royal Hospital

Average time in minutes spent in A&E department for patients admitted and not admitted since April 2015

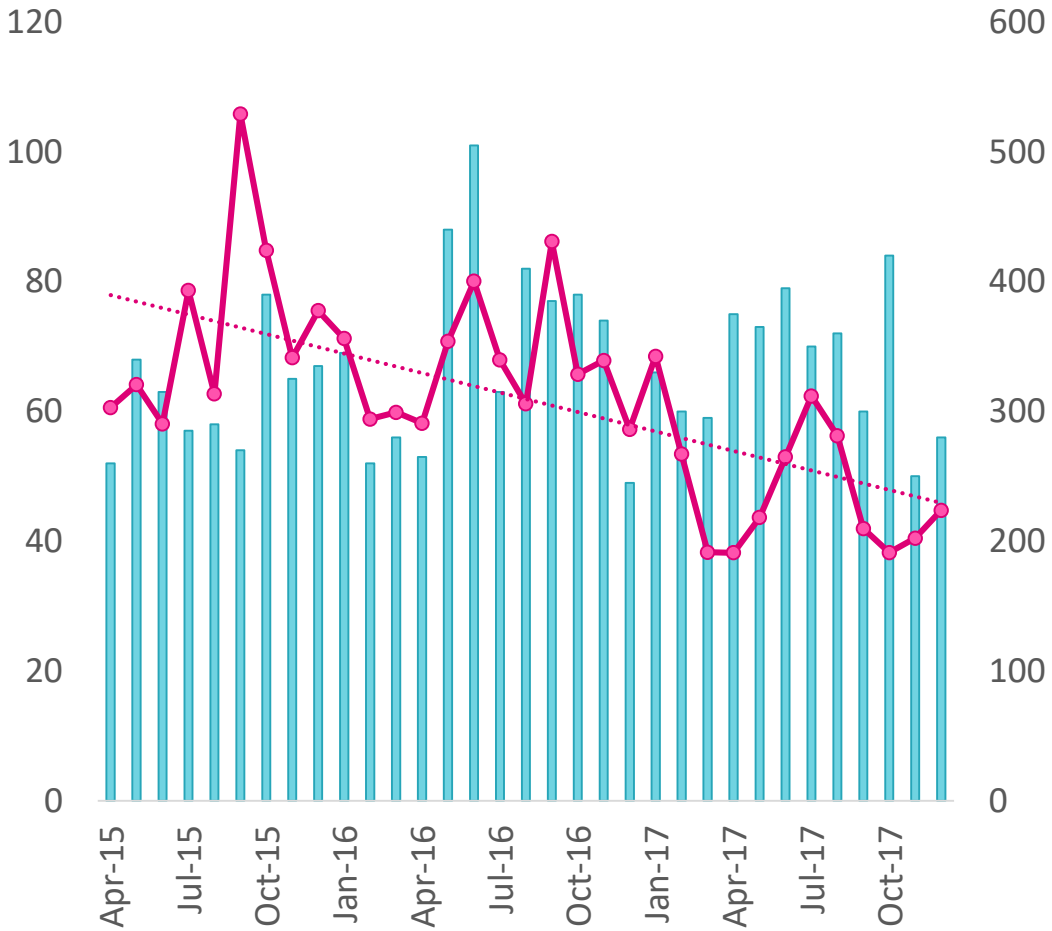


Source: Trust data, Carnall Farrar analysis

Time for speciality review for patients with mental health needs is showing a downwards trend at WRH, however is still highly variable at ALX

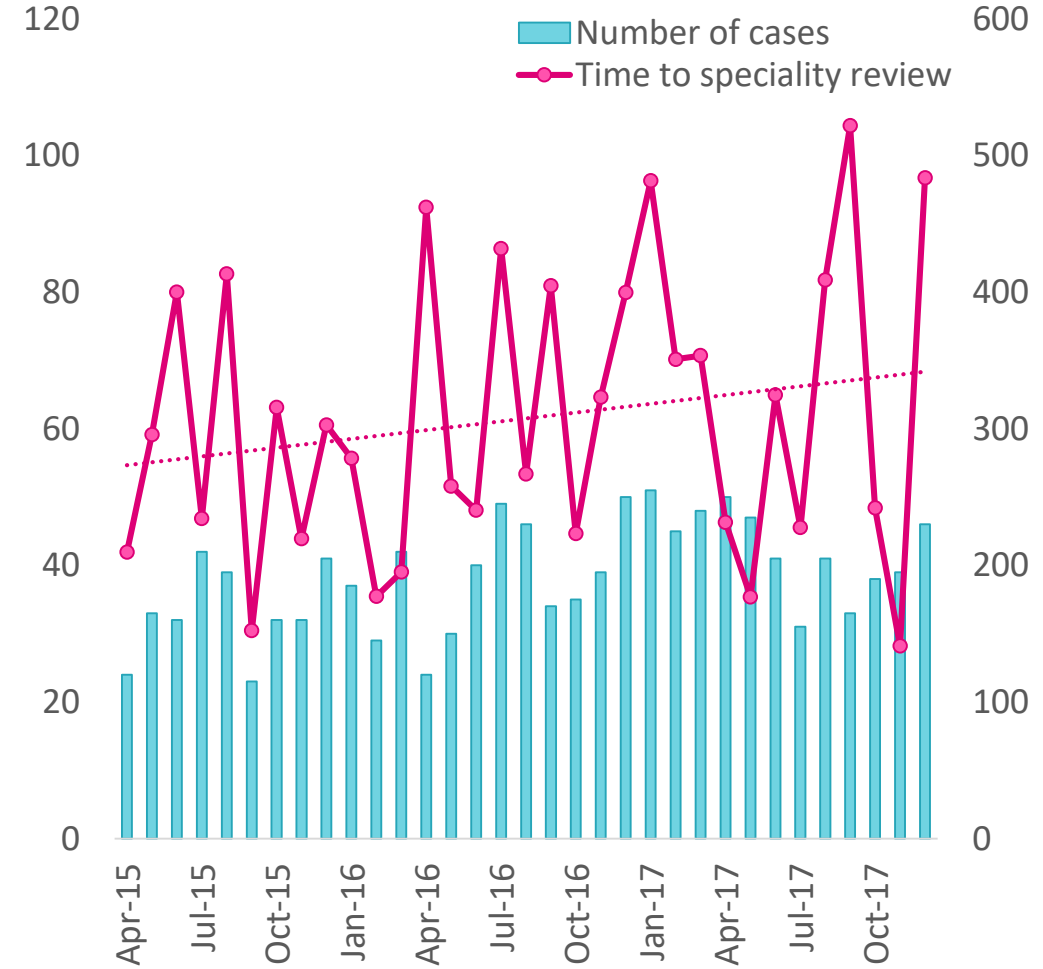
Worcestershire Royal Hospital

Total number of patients coded to "Psychiatry/Mental Health Liaison" speciality (L) and average time to speciality review (R)



Alexandra Hospital

Total number of patients coded to "Psychiatry/Mental Health Liaison" speciality (L) and average time to speciality review (R)

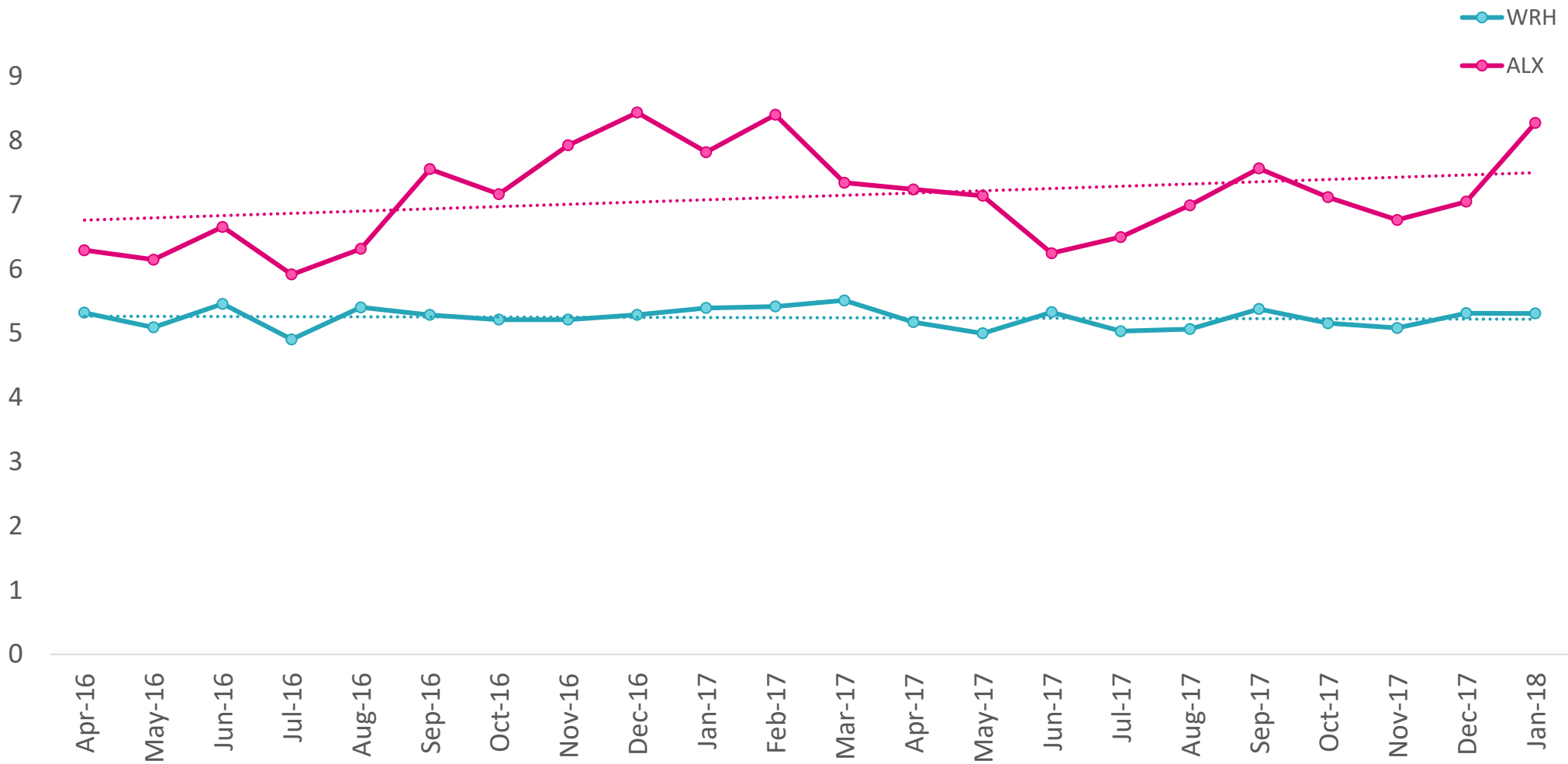


Source: Trust data, Carnall Farrar analysis

Average LoS for non-elective admissions at WRH is 5.2 days whereas at ALX is 7.1 days and generally more variable, showing an upwards trend

Worcestershire Acute Hospitals NHS Trust

Average length of stay for non-elective admissions

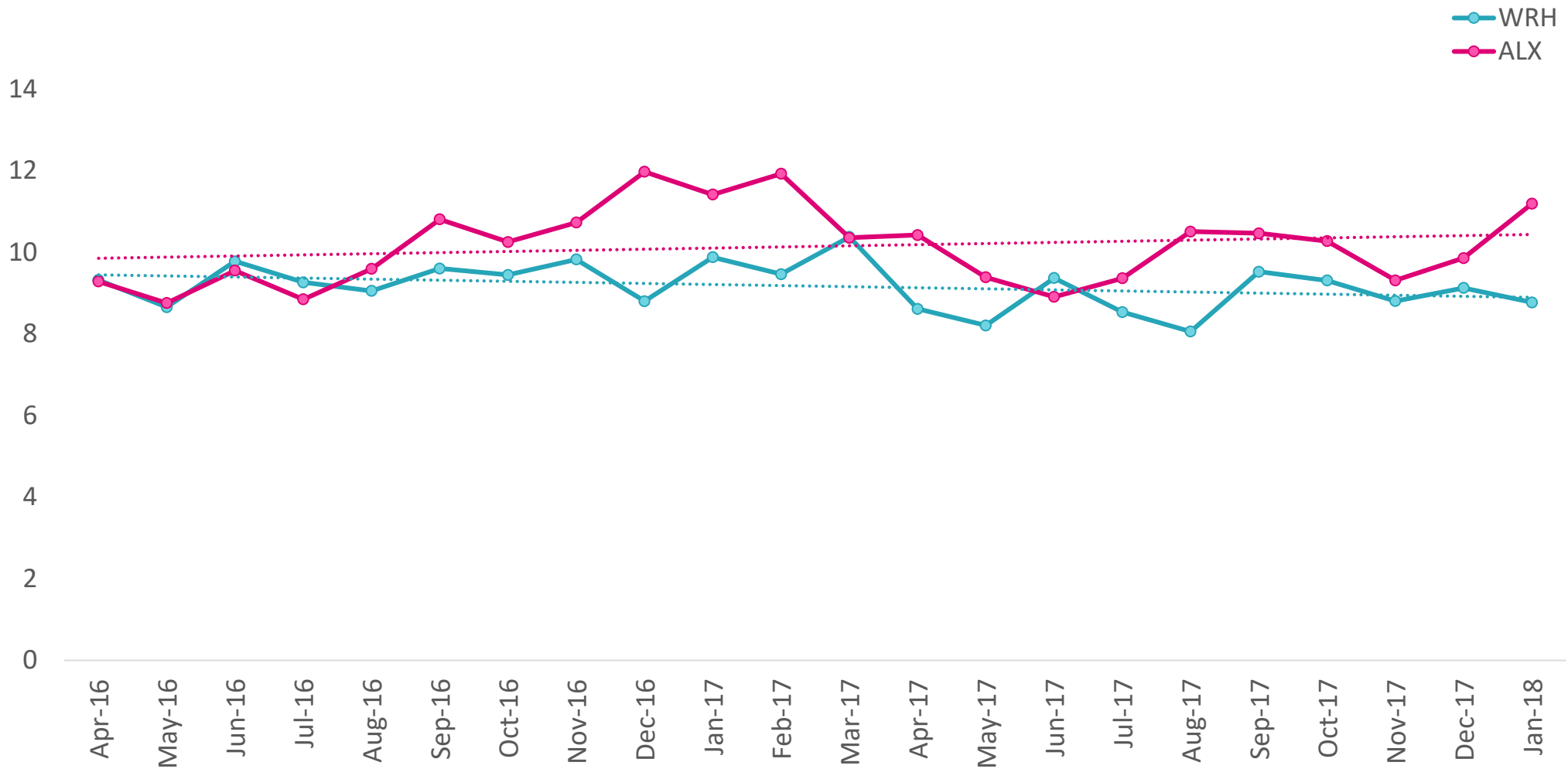


Source: Trust data, Carnall Farrar analysis

Average LoS for non-elective admissions for patients who are aged 75 or over is significantly higher and is 9.2 days at WRH and 10.1 days at ALX

Worcestershire Acute Hospitals NHS Trust

Average length of stay for non-elective admissions who are aged over 75

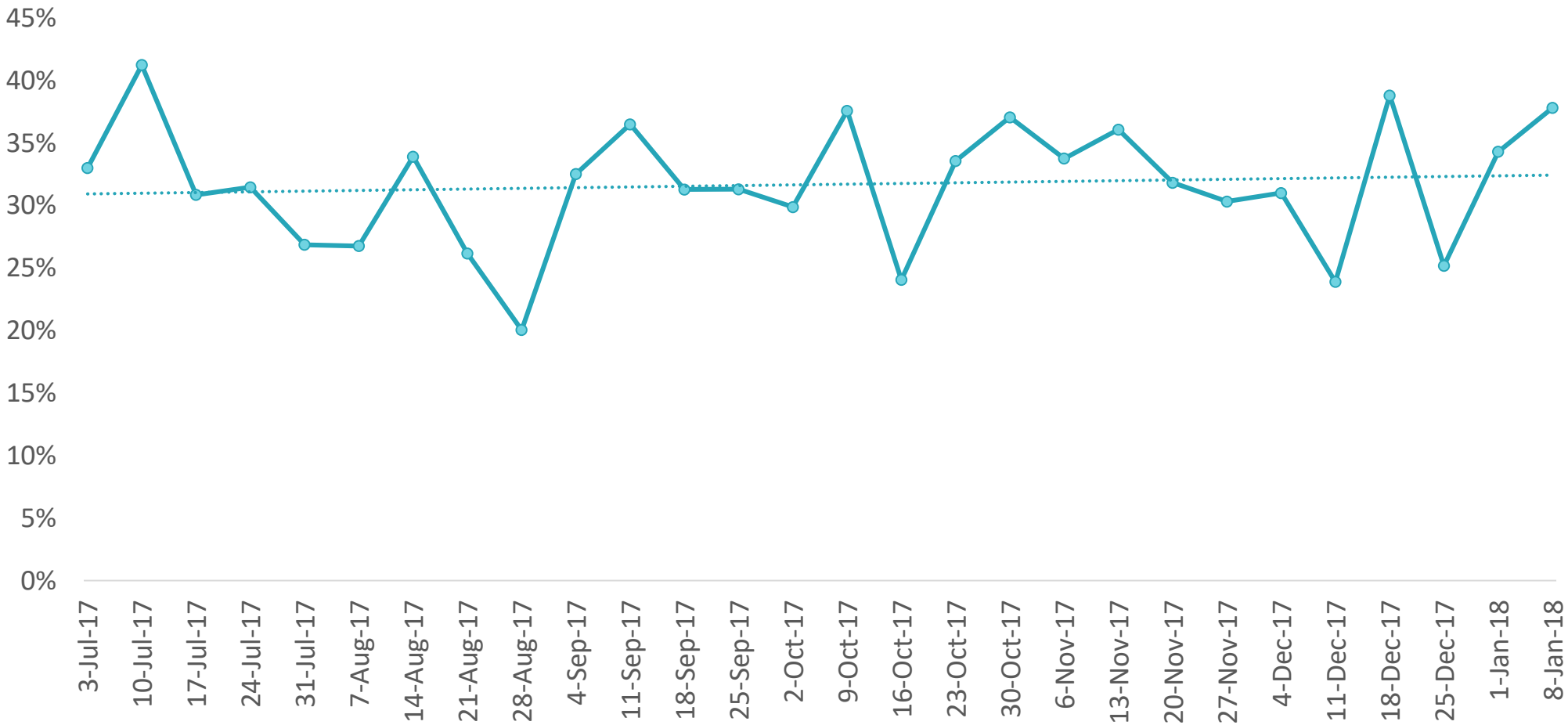


Source: Trust data, Carnall Farrar analysis

Across the Trust, the average proportion of patients who are MFFD is 32%

Worcestershire Acute Hospitals NHS Trust

Average proportion of patients who are medically fit for discharge

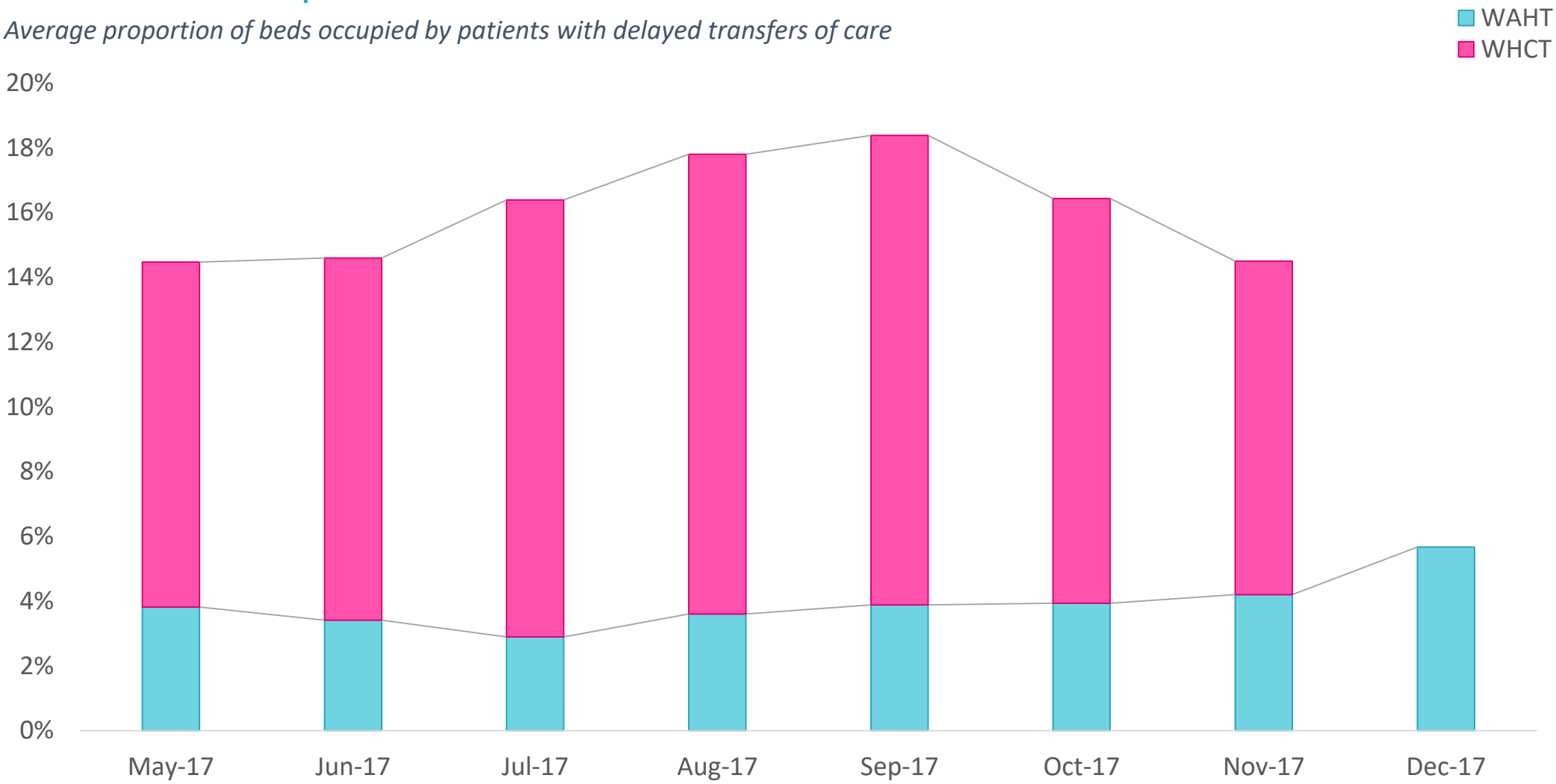


Source: AEDB dashboard, Carnall Farrar analysis

On average, 16% of beds across the system are occupied by patients with delayed transfers of care with 3.7% of these at WAHT

Worcestershire Acute Hospitals NHS Trust and Worcester Health and Care NHS Trust

Average proportion of beds occupied by patients with delayed transfers of care

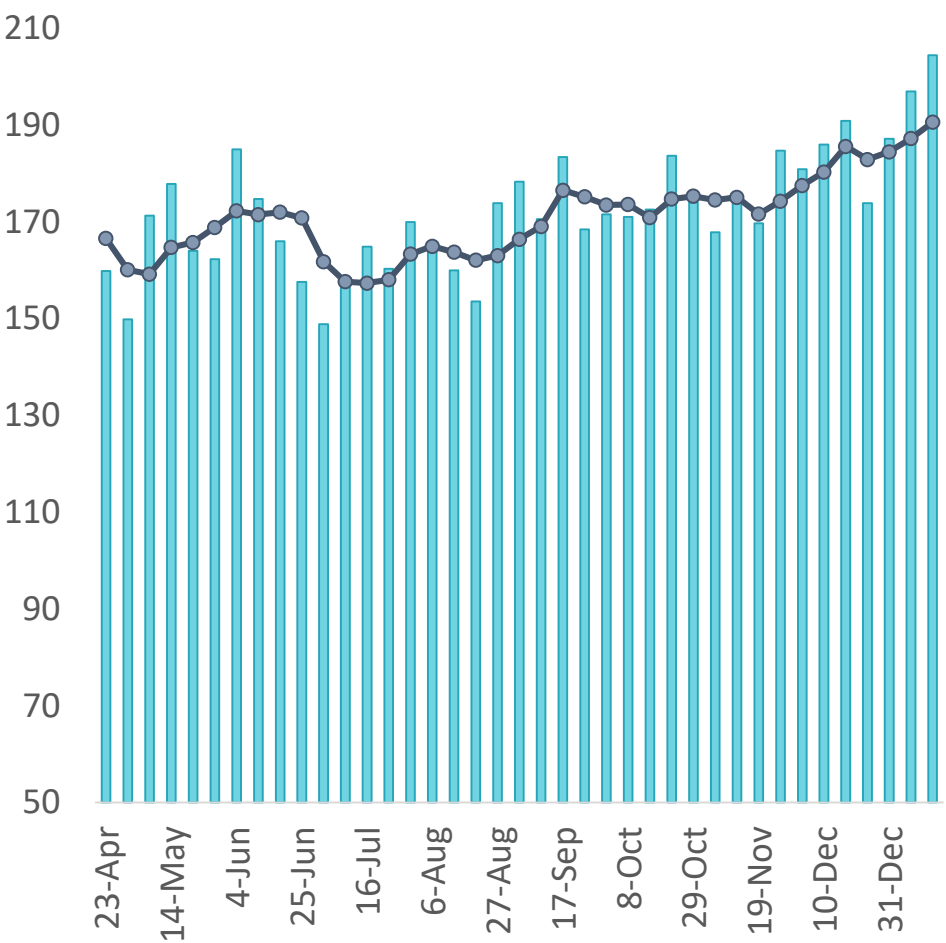


Note: Dec data for Community Trust not available
Source: AEDB dashboard, Carnall Farrar

Absolute numbers of stranded patients is variable week by week on both sites, however the 4 week running average remains static

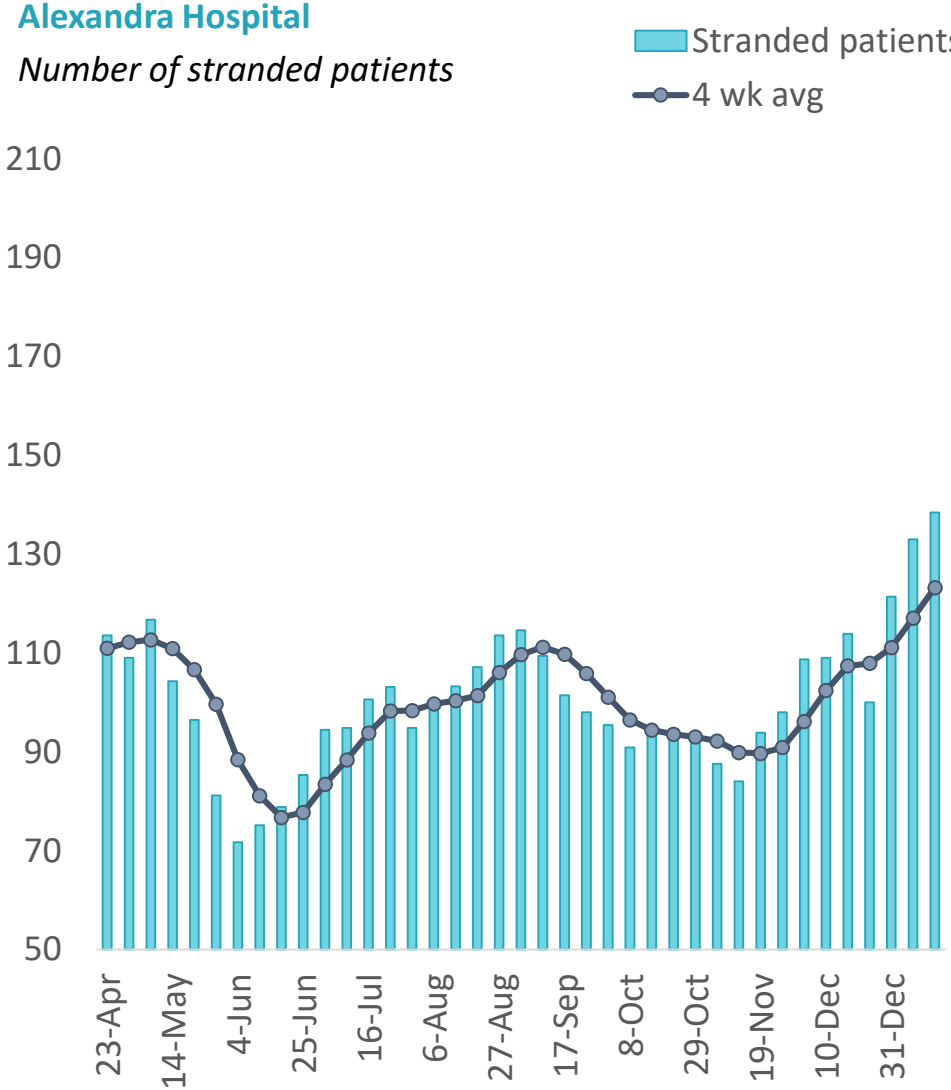
Worcester Royal Hospital

Number of stranded patients



Alexandra Hospital

Number of stranded patients

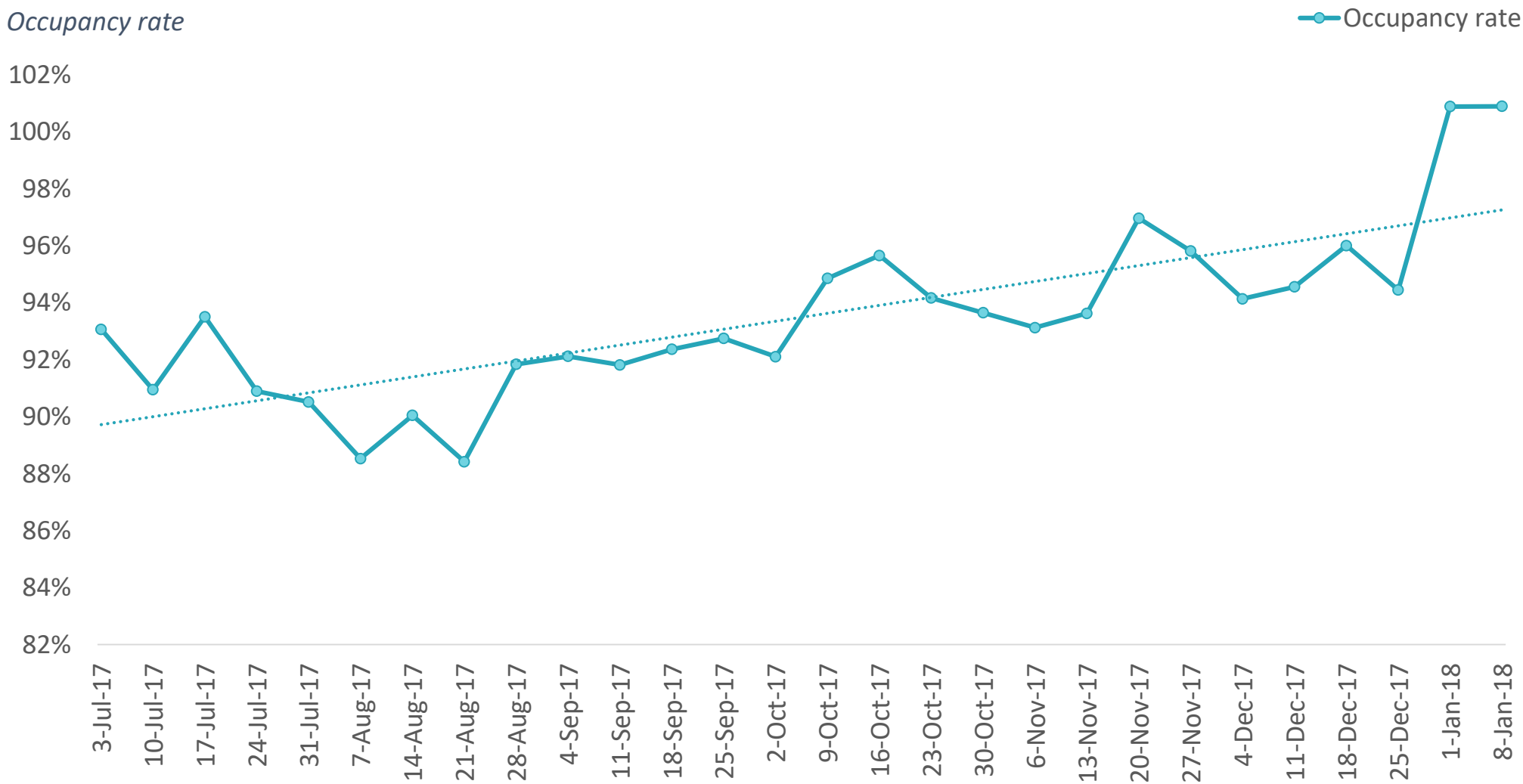


Source: Trust data, Carnall Farrar analysis

Occupancy at the community trust, Worcestershire Health and Care Trust is also on the rise, exceeding 100% in January

Worcester Health and Care NHS Trust

Occupancy rate

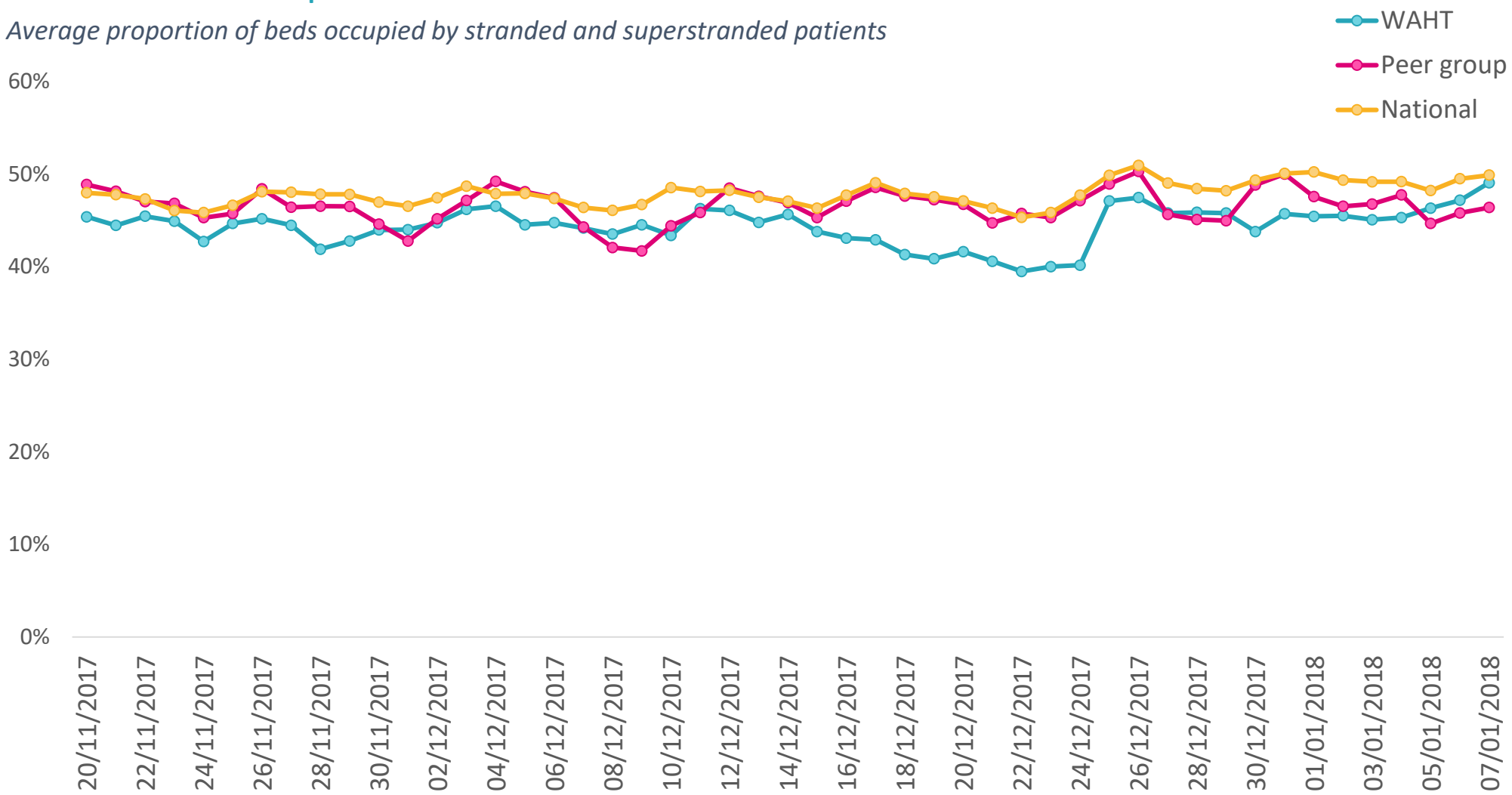


Source: AEDB dashboard, Carnall Farrar analysis

Across the Trust, an average of 44% of beds are occupied by stranded and superstranded patients, which is consistently below the national average

Worcestershire Acute Hospitals NHS Trust

Average proportion of beds occupied by stranded and superstranded patients

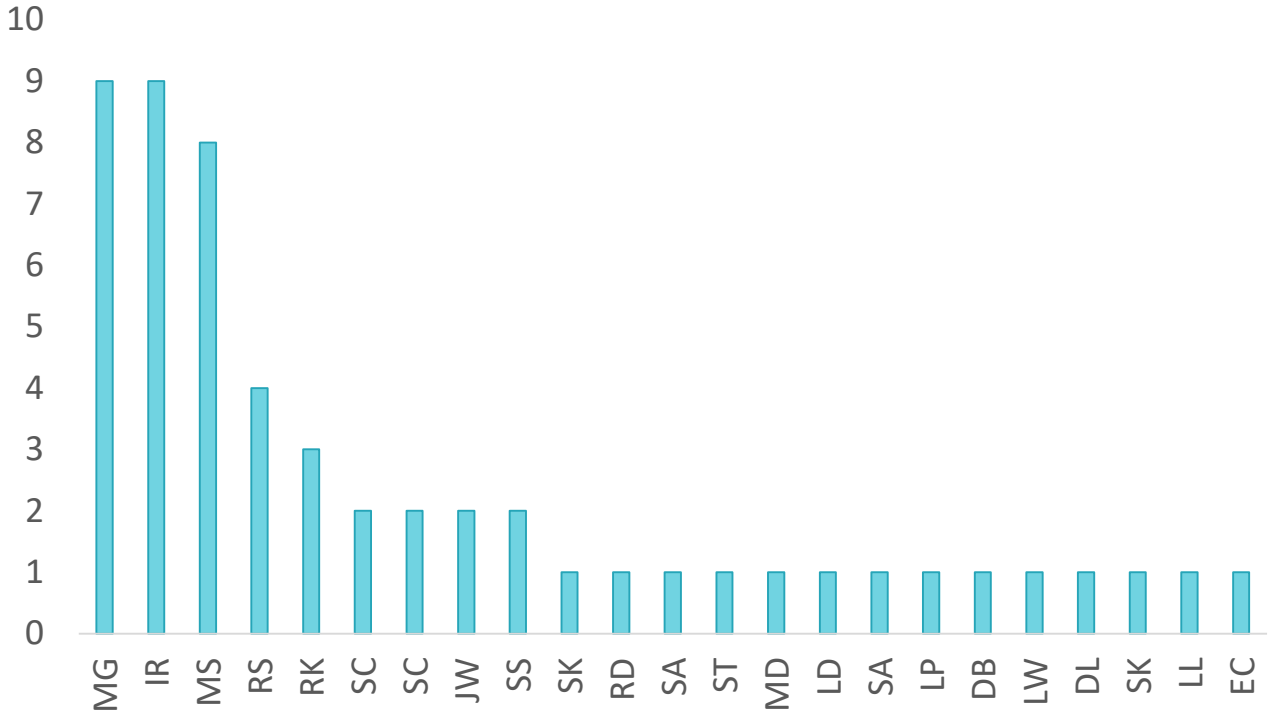


Source: NHS E Winter Sitrep, Carnall Farrar analysis

Winter Plan: Delivery leadership is highly distributed with a heavy focus on ”Discharge” and “ED Front Door”

Worcestershire System Winter Plan

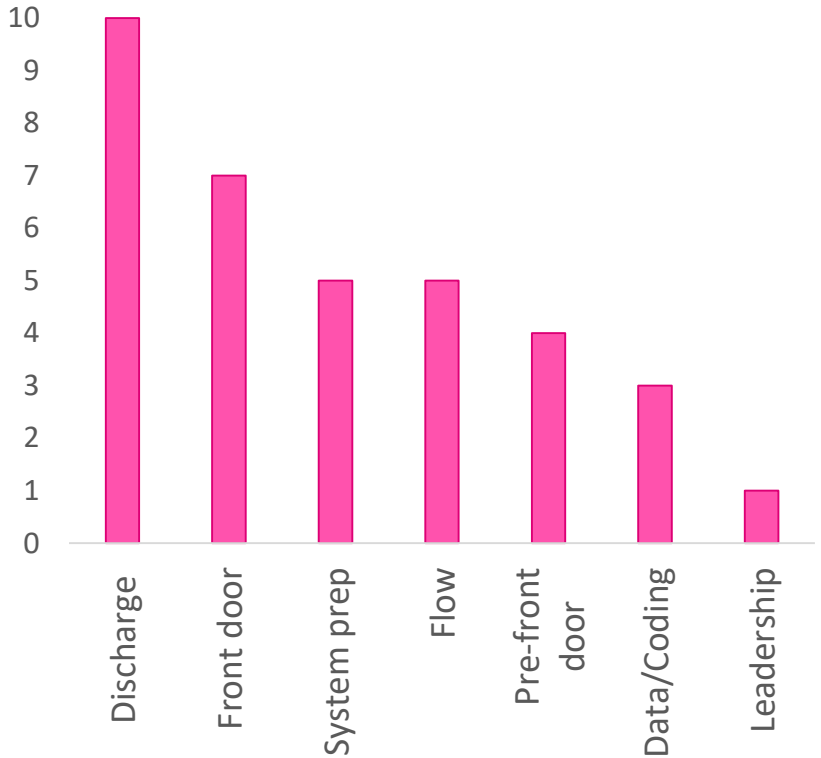
Number of initiatives per named lead



- There a total of 35 initiatives in the System Winter Plan, of which 5 have no specified named lead. There are 24 named leads covering the remaining 30 projects
- Mari Gay and Inese Robotham have oversight of 9 projects each, representing 30% of the initiatives

Worcestershire System Winter Plan

Number of initiatives by area of focus



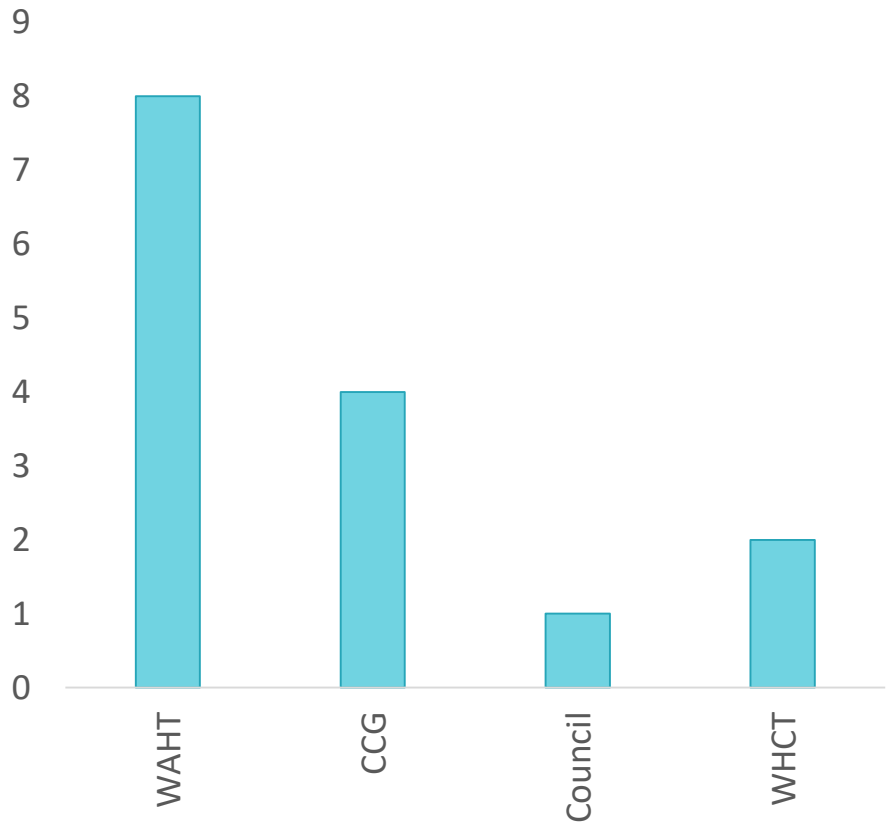
- Of the 35 initiatives, 29% are related to ”Discharge”
- A further 20% are related to “ED Front Door”

Source: System Winter Plan, Carnall Farrar

Winter Plan: 56% of the Winter Monies has been allocated to three initiatives, of which all three relate to the purchasing of extra beds across the system

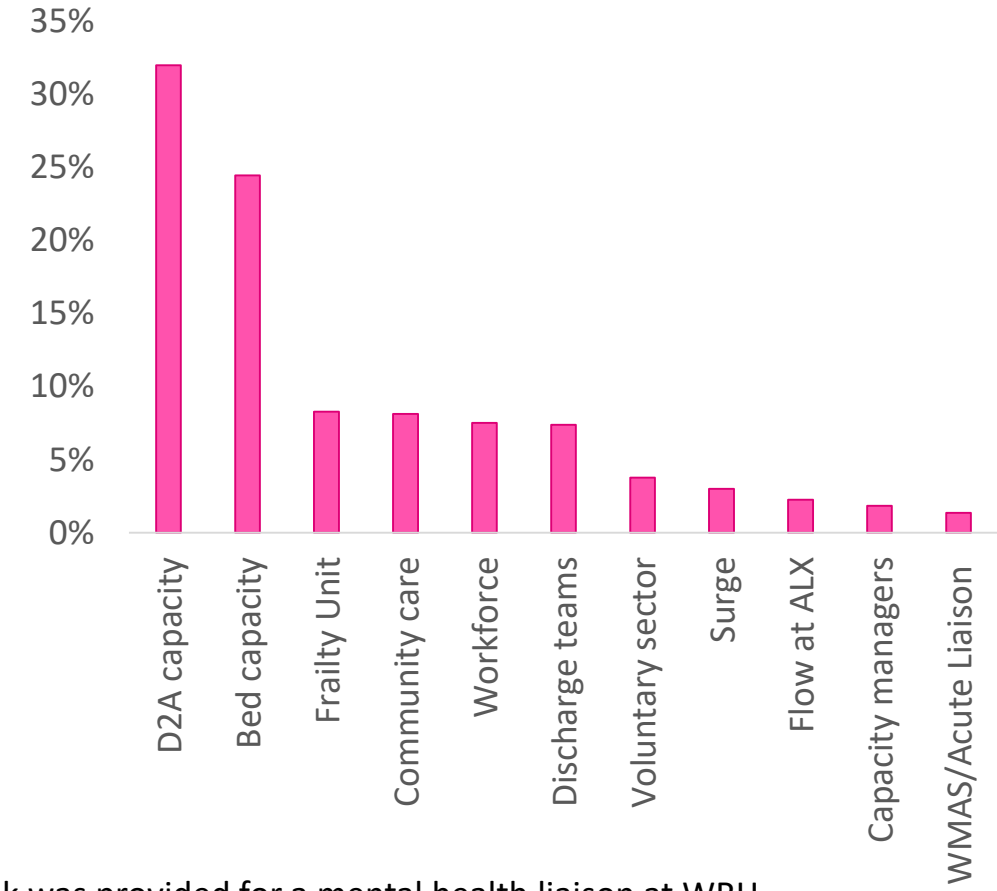
Worcestershire Winter Monies Tranche 2

Number of initiatives overseen by organisation



Worcestershire Winter Monies Tranche 2

Percentage of money allocated for initiatives



- Tranche 2 of the Winter Monies was £2.657m, an additional £135k was provided for a mental health liaison at WRH
- This funding is being used for 13 initiatives, of which, 8 are overseen by Worcestershire Acute Hospitals NHS Trust
- 56% of the winter monies has been allocated to three initiatives: D2A capacity x2 and bed capacity at WAHT
- A further £200k of funding has been made available from the STP to focus on UEC related projects and this has been allocated via the CCG to 5 projects

Source: Trust data, Carnall Farrar analysis

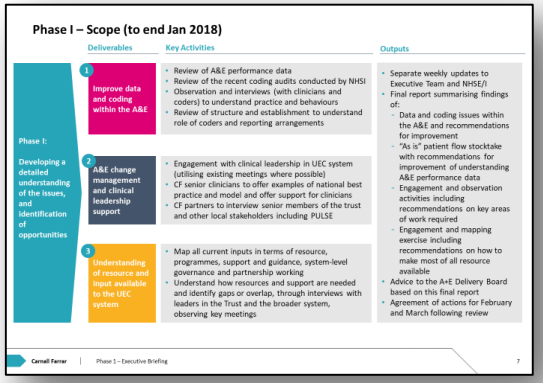
Appendix 2: Engagement Overview

The Journey so far…

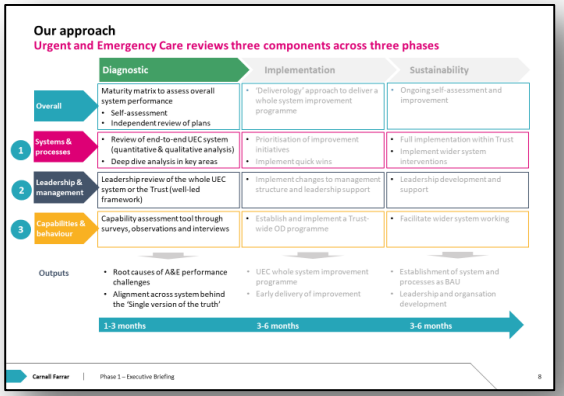
A rapid diagnostic review of UEC at Worcester Acute Hospitals NHS Trust

Scope → **Diagnostic** → **Recommendations & Roadmap**

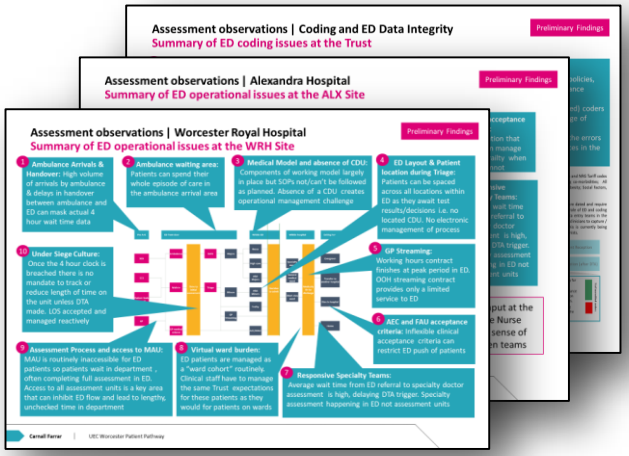
1 Phase 1 Scope confirmation



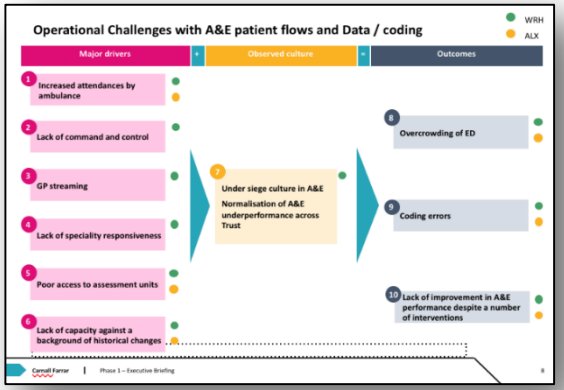
2 Rapid ED diagnostic assessment



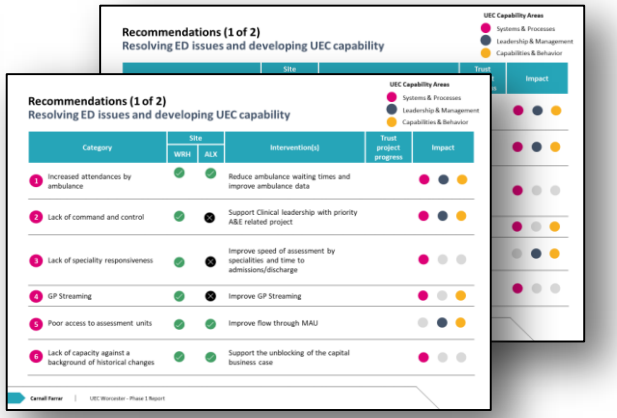
3 Identified operational challenges



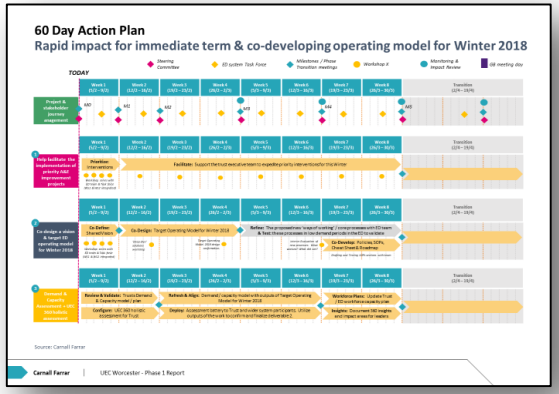
4 Conducted 'root cause' analysis



5 Defined a set of critical recommendations



6 60 day action plan to deliver impact



Source: Carnall Farrar

Engagement Highlights

Comprehensive consultation of ED administrative, corporate and clinical staff

1 Trust

4 sites

4 weeks
Diagnostic Review

3
Emergency Department 'Walk Throughs' – including:

Ambulance waiting areas, AEC, FAU, Minor Injuries, GP streaming, A&E majors

1 HALO (WMAS) interviewed

18 ED clinicians interviewed

8 Trust Executives inc. Board Chairman interviewed

Informatics and Coding departments interviews

2 MADE events

1
A&E Operational Group meeting attended

4 system leadership team members interviewed

Validation of findings

3 interviews with Operations Managers

c.130 sources of information and data reviewed

2 Winter Room System Assurance calls attended

2 month
Rapid Implementation Program

Source: Carnall Farrar

Interviews conducted

Trust board	
Caragh Merrick	Chairman
Michelle McKay	Chief Executive
Inese Robotham	Interim Chief Operating Officer
Dr Suneil Kapadia	Chief Medical Officer
Sarah Smith	Director of Strategy, Planning and Improvement
Jill Robinson	Director of Finance
Vicky Morris	Chief Nursing Officer
Mike Murphy	Improvement Director
Cathy Geddes	Improvement Director
Mark Taylor	Improvement Director for Finance
Trust stakeholders	
Jules Walton	Divisional Medical Director
Steph Beasley	Divisional Director of Operations - Urgent Care
Clare Bush	Matron A&E (WRH)
Marc Tarrant	Matron A&E (Alex)
Emma Welch	Matron - Frailty Assessment Unit
Jo Adams	Matron - Medical Assessment Unit (WRH)
James France	Clinical Lead - A&E at WRH
Beth Williams	A&E consultant
Rebecca Brown	Deputy Director of Informatics
Simon Dale	PMO Director
System stakeholders	
Mari Gay	Chief Operating Officer – Worcestershire Clinical Commissioning Groups
Simon Trickett	Accountable Officer – Worcestershire Clinical Commissioning Groups
Stephen Collman	Director of Operations – Worcestershire Health and Care NHS Trust
Robin Snead	Worcestershire Clinical Commissioning Groups
Jane Gordijn	Worcestershire Clinical Commissioning Groups

UEC Systems Review Worcester Update (Phase 2 - Implementation)

Steering Committee 1:

Project Charter & Kick Off

20th February 2018

Agenda

Objectives, Deliverables & Dashboard	Project Objectives Scope of Work: Phase 2 - Deliverables, Activities & Outputs Executive Dashboard: Tracking & Reporting	**10 min**
Roadmap, Implementation & Final Report	60 Day Roadmap & Intervention leads Stakeholder Engagement & Communications Plan Final Report	**10 min**
Our 'One Team' Approach	One Team Approach & Shared Responsibilities Governance & Weekly meeting schedule Risk & Issues Management	**10 min**
Emerging Insights, Planned activity & Next Steps	WS1: Emerging insights for ED Interventions WS2 & WS3: Vision for ED & UEC 360 Deployment Plan Decisions summary & Next steps	**30 min**

Objectives, Deliverables & Dashboard

Project Objectives

Delivering rapid impact and designing Worcester ED for the future

Project Objectives

- Help facilitate the implementation of 10 priority A&E improvement projects identified in Phase 1
- Co-design a vision & target operating model for Worcester Trust's ED
- Deploy CF's Demand & Capacity Assessment + UEC 360 holistic assessment to enable systemwide discussions on how to better manage regional capacity

Target Outcomes

1. Rapidly implement PIDs 1 - 10
2. De-bottleneck Trusts ED
3. Improve UEC System connectivity
4. Impact agreed metrics for intervention (TBC)

Scope of work

Phase 2 - Deliverables, activities and outputs

Scope item	Key Activities	Deliverables
1 **Help facilitate the implementation of priority A&E improvement projects**	Facilitate the implementation of priority A&E improvement projects, by: (1) developing high level PIDs, (2) tracking progress against agreed trajectories with the PMO team, (3) escalating risks / issues as required to the CEO, (4) Integrating effectively with PMO and other consulting teams where needed. The areas of focus for the Trust's ED & NHS England and Improvement are listed on the following slide.	• ED delivery working group • High level PIDs for 10 agreed priority initiative areas • Weekly progress reports against agreed trajectory for operational leads and trust management • Final Phase 2 progress report
2 **Co-design a vision and target ED operating model**	• Agree guiding design principles & model Trust stretch performance targets for improved performance • Respecting financial & physical constraints (ie. current building / access etc.), co-design an optimal operating model for the Department – covering the following layers: Patient flow & process, Trust escalation protocol, Organisation & people, Technology, Operational capacity planning, Governance (and controls). • Roadmap to test, validate & transition new processes with ED team	• Vision statement for ED 2018 • Target Operating Model (TOM) for ED by Winter 2018 approved by Staff and wider System • Org design, Workforce plan, JDs & performance management system for ED. • Updated Trust ED escalation protocol (inc. "Safety Matrix") • Build roadmap to Winter 2018
3 **Demand and Capacity assessment + UEC 360 holistic assessment**	Design a robust capacity planning tool (2018 – 2023) to improve the Trust's ability to respond to surge a) Review & validate Trust current demand plans for FY18/19 b) Assess scheduling and workforce plans for A&E c) Sign off forecasts for winter 18/19 UEC 360 holistic assessment – covering: Leadership, capability, behavior; MI; Systems and processes	• Demand, Capacity & Flow trajectories 2018 - 2023 • Validate the A&E workforce / capacity plans from Deliverable 2 • UEC360 holistic assessment report

Phase 2 - Implementation Dashboard

Monitoring & reporting the impact from interventions

% Complete	RAG rating at 75%
Not started	On track
50% complete	Minor issues/ delays
Complete	Major issues/ delays

Workstream	Initiatives	Design	Build / Test	Implement	Monitor	Metric	Target	Performance 14/01/18	Trend
0. Mobilization	Project Charter & Kick off	◔	→			N/A	N/A	N/A	N/A
1. Help facilitate the implementation of priority A&E improvement projects	1.1 Reduce ambulance waiting times and improve ambulance data	◔				TBC			
	1.2 Support Clinical leadership with this priority A&E related project	●	●	✓	N/A	N/A			
	1.3 Improve speed of assessment by specialities and time to admission / discharge	◑				TBC			
	1.4 Improve GP and other service streaming at the Emergency Department front door	◑	◑	✓		TBC			
	1.5 Improve flow through MAU and all assessment units	◑				TBC			
	1.6 Capital business case delivers acute capacity	◔				TBC			
	1.7 Work with Pulse team to help embed culture change programme with ED & Trust leadership team	◔				TBC			
	1.8 Develop a Demand and Capacity Planning tool	◔				TBC			
	1.9 Improve A&E operational data and recording	◔				TBC			
	1.10 Design and Implement A&E Performance Management System	◔				TBC			
2. Co-design a vision & target ED operating model	2.1. Vision Statement	○		N/A		N/A	N/A	N/A	N/A
	2.2 Target Operating Model (TOM) for ED	○		N/A		N/A	N/A	N/A	N/A
	2.3 Org design, Workforce plan, JDs & performance management system for ED	○		N/A		N/A	N/A	N/A	N/A
	2.4 Trust ED escalation protocol (inc. "Safety Matrix")	◑		N/A		N/A	N/A	N/A	N/A
	2.5 Roadmap to Winter 2018	○		N/A		N/A	N/A	N/A	N/A
3. Demand & Capacity + UEC 360	3.1 Demand / Capacity Model	○		N/A		N/A	N/A	N/A	N/A
	3.2 UEC 360 Holistic Assessment	○		N/A		N/A	N/A	N/A	N/A
4. Final Report	Drafting and Finalisation	○		N/A		N/A	N/A	N/A	N/A

We are working with the intervention leads to confirm the KPI and incremental improvement targets over the course of this week (c. 19/2)

Worcestershire Acute Hospitals NHS Trust

Date of meeting	15 March 2018
Paper number	E3

Cancer Waiting Times

For approval:		For assurance:	x	To note:	

Accountable Director	Inese Robotham, Interim Chief Operating Officer		
Presented by	Inese Robotham, Interim Chief Operating Officer	**Author**	David Burrell, Deputy Chief Operating Officer (Planned care)

Alignment to the Trust's strategic priorities					
Deliver safe, high quality, compassionate patient care	x	Design healthcare around the needs of our patients, with our partners	x	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	x		

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

Report previously reviewed by		
Committee/Group	Date	Outcome

Assurance: *Does this report provide assurance in respect of the Board Assurance Framework strategic risks?*	Y	BAF number(s)	P2.2

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

Recommendations	To receive the update for assurance regarding current cancer performance, initiatives to improve performance and the external support provided to the Trust.

Date of meeting	15 March 2018
Paper number	E3

Executive Summary

Improving performance against the cancer standards is a strategic priority for the Trust.

There have been improvements in cancer performance within the Trust over the last 8 months evidenced by reducing number of patients waiting over 62 days for treatment and improvements against the other cancer waiting time standards.

Whilst there have been improvements in a number of stages of the 62 day referral to treatment pathways, these improvements have not yet translated into meeting the 62 day operational standard.

Emergency care pressures and equipment failure have detrimentally impacted performance since November 2017.

There are on-going internal and externally supported work streams and improvement work to rapidly improve performance against the cancer waiting time standards.

Background

Trust cancer performance has been improving consistently and the number of patients waiting over 62 days for treatment since July 2017 has reduced from 203 to 73 (as at 05/03/18). The backlog reduction has been mainly in colorectal where following a collective focus of the MDT team and strong clinical leadership the number of patients waiting over 62 days has reduced from 105 to 5. During the same period performance against the 2 week wait to first appointment also improved up to November 2017.

An increased operational focus on the cancer standards combined with improvements in diagnostic waiting times, particularly in endoscopy and histopathology and the implementation of enhanced pathways in lung, colorectal and prostate has driven improvements in performance.

The performance during November was the best seen in the Trust for 8 months with the Trust achieving 6 of the 8 cancer standards, and coming close to achieving the 2week wait standard (92.75%) for the first time in 8 months. The 2 week wait breast symptomatic standard was achieved for 3 consecutive months (September – November 2017). There was significant deterioration in January 2018 (63.6%) due to failure of mammography equipment at the Alexandra Hospital. Performance was recovered in February at 89.2% (unvalidated).

Performance against the 62 day standard remains challenging and it is clear that this standard will not be achieved until the current backlog of patients over 62 days is reduced further to below 50.

During December and into beginning of 2018 performance has deteriorated against all standards due to a combined impact of:

- loss of diagnostic capacity due to using recovery beds in endoscopy as in patient surge beds
- patient choice during Christmas period and during episodes of inclement weather.
- frequent failure of a mammography unit at Alexandra Hospital resulting in multiple cancellations.

Date of meeting	15 March 2018
Paper number	E3

Issues and options

A cancer recovery plan has been developed with support from the Trust project management office (PMO). The plan has 4 main strands:

- Collaborative working with CCGs to ensure General Practitioners inform patients that they are being referred on a cancer pathway and ensure that they are available to attend appointments.
- Reducing the time to first appointment to reduce time to diagnosis.
- Work streams to improve diagnostic phase including carve out of radiology capacity for cancer patients
- Pathway specific initiatives to reduce time to diagnosis and treatment including:
    - Colorectal patients: nurse triage and straight to test for patients from south of county with plan to roll out for all patients over a 12 month period
    - Lung patient pathway straight to CT scan. Currently implemented and will improve once diagnostic carve out is achieved
    - Prostate optimal pathway linking MRI diagnostic scan and biopsy to reduce time to diagnosis
    - Head and neck: one stop clinic will commence in March to reduce time to diagnosis and failed fine needle aspiration rated.

The plan is monitored at weekly scrutiny meetings chaired by the Chief Operating Officer.

The Trust has recently approved a new post of cancer manager and recruitment to this post has been successful with an experienced cancer manager joining the organisation beginning of June 2018.

There is agreement that the newly appointed deputy Chief Medical Officer will provide senior leadership for cancer.

A paper was approved at Trust Leadership Group in February mandating the carve out of radiology capacity for cancer patients. This will commence from 26th March 2018 and will ensure that time to report for patients on a cancer pathway is 7 days.

A short term transfer of endoscopy work to other sites is taking place to reduce the impact of cancellations and delays to test for endoscopy patients.

Improvements in histopathology turnaround times have been achieved by implementing a new role of a biomedical scientist to undertake sample dissection previously done by a consultant histopathologist, voice recognition for reporting and new techniques for processing tissue samples.

The Trust has actively participated in the Midlands and East Cancer Collaborative Programme which has provided the opportunity to work with other Trusts that are challenged with performance. As part of this work a senior quality improvement manger from NHS I has been working to support the Trust.

The West Midlands Cancer alliance is providing the following support:

- Funding to support improved operational performance on the lung and prostate cancer pathways in Q4 2017/18.

Date of meeting	15 March 2018
Paper number	E3

- Support for the implementation and embedding of 'straight to MRI' for prostate cancer pathway
- Coordination and liaison of external support from NHS I, Cancer Alliance and the Intensive Support Team (IST)
- Clinical input and advice from Alliance clinical representatives towards improving effectiveness of MDT working
- Communication and support to cancer services until the newly appointed cancer manager commences at the Trust.

The intensive support team from NHS I will be starting a 6 week engagement with the Trust in mid March to focus on further improvements particularly:

- Implement the IST cancer sustainability tool to provide a baseline assessment of key areas.
- Capacity and demand analysis of the front end of the pathway (2WW) including diagnostics (radiology)
- Breach analysis-identifying common breach reasons.
- Operational management of 62 day pathway including PTL meeting format, escalation, governance arrangements, and delivery of cancer strategy.
- Informatics – dashboard development/ enhancement of reporting functions.

Recommendations

To receive the update for assurance regarding current cancer performance, initiatives to improve performance and the external support provided to the Trust.

Appendices None

NHS
Worcestershire
Acute Hospitals
NHS Trust

Date of meeting	15 March 2018
Paper number	Enc E4

FINANCE & PERFORMANCE COMMITTEE ASSURANCE REPORT

For approval:	✓	For assurance:	✓	To note:	

Accountable Director	Phil Mayhew – Chairman of FPC/Non-Executive Director		
Presented by	Steve Williams, Member, FPC/Non-Executive Director	**Author**	Jill Robinson – Chief Finance Officer Thekla Goodman – FPC Committee Administrator

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

Assurance: *Does this report provide assurance in respect of the Board Assurance Framework strategic risks?*	Y	BAF number(s)	R4.1

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

Recommendations	The Board is asked to confirm it is assured that: - The Trust continues to put actions in place to optimise operational performance - The additional measures put in place to grip and maintain financial control are effective. - A robust financial recovery plan is in place for 2017/18 and is being closely monitored by the Executive Team.

	- The Trust is managing the Capital Programme to ensure the Capital Resource Limit is met. - The Finance Team continues to actively pursue an outcome on the bids for capital loans. The Board is also asked to: - Approve the revised Terms of Reference - Approve the recommendation that R4.2 of the BAF is re-assigned to the People & Culture Committee - Approve the March Revenue Loan (Interim cash support)

NHS
Worcestershire
Acute Hospitals
NHS Trust

Date of meeting	15 March 2018
Paper number	Enc E4

Executive Summary

The Finance & Performance Committee (FPC) focuses the agenda on three main priorities:

- Flow
- Cancer Performance
- Financial Performance

Background

The Finance & Performance Committee (FPC) meets on a monthly basis to gain assurance that plans are in place to achieve the Trust's agreed Operational Performance Targets, Financial Control Total, its Cost Improvement and Financial Recovery Plans.

The Committee met on 29 January 2018 (Month 9) and 26 February 2018 (Month 10).

Highlights from the Meetings

PERFORMANCE, WINTER & FLOW

The Trust has been particularly challenged during the winter months having seen an increase in patient attendance and ambulance conveyances to the Emergency Department compared to the same period the previous year but despite these pressures the Trust recorded 8 x 12 hour breaches in month which is 163 less than the same month the previous year.

Carnall Farrar who have been assisting the Trust with developing a detailed understanding of the issues and identification of opportunities with A & E/flow have completed their Phase 1 diagnostic, their findings/proposal had been shared with NHS England. This report is elsewhere on the Trust Board agenda.

The Trust's performance would have been in a worse position had it not been for the additional plans in place to mitigate against the winter pressures, for example the move to a countywide frailty model at the Alexandra Hospital, expansion of the Ambulatory Care Model at the Worcestershire Royal Hospital (WRH) and additional bed capacity on Evergreen 2 ward at WRH whilst also utilising a number of surge areas at both the Alexandra Hospital and Worcestershire Royal Hospital; it must be noted that whilst the impact of emergency pressures have been supported by additional investment, there has been a knock on effect on patient flow.

Flow within the Trust remains a concern and discussions with health economy partners continue in respect of the transfer of patients that no longer require acute care to a more appropriate environment and thereby release bed capacity.

The Committee was pleased to note that the RTT backlog was at its lowest since February 2016 despite the continuous challenges and that the 52+ week waiters had now stabilised.

The Integrated Performance Report elsewhere on the agenda provides fuller detail of the Trust's operational performance.

CANCER PERFORMANCE

Three out of 8 operational standards for cancer waiting times were achieved in Month 10, the five that are not being achieved are (1) first treatment within 62 days, (2) two week wait, (3) two week wait breast symptomatic, (4) 31 days and (5) 62 screening.

The Trust has been successful in receiving some cancer funding some of which will support a review of

cancer pathways.

FINANCIAL PERFORMANCE

For the third consecutive month the Trust has achieved its CIP and FRP targets and is on track to deliver the revised forecast deficit of £57.9m albeit there remain significant challenges for the remaining two months. The Trust continues to operate under enhanced oversight with NHS Improvement.

Confirm & challenge meetings with the Divisional triumvirates are continuing to ensure plans remain on track and all opportunities are explored that will contribute to the bottom line such as the standardisation of prosthetic items within theatres.

The Committee considered the risks in some degree of detail which are articulated within the Financial Performance Report elsewhere on the agenda.

As part of the 4ward programme the Trust has refreshed a number of schemes including an improvement in theatre productivity to ensure a better rate of utilisation, this will improve efficiency and consequently financial benefit.

The Committee supported the recommendation that the Board approve the March Interim revenue Support Loan to ensure sufficient cash is available to meet the March obligations.

Medium Term Financial Plan

The Committee received an update on the development of the Medium Term Financial Plan to improve the Trust's deficit position and the progress against the financial plans and budgets for 2018/19.

The Committee noted that the Trust is required to submit its first draft operating plan to the NHSI on 8 March which needs to include Income & Expenditure, Capital, Recovery programme, activity plan and workforce plans.

Capital

The Trust is forecasting a breakeven position following mitigation of capital schemes and a depreciation revaluation, the Trust is expecting its CRL to be re-set to match the revision in depreciation.

The Capital Prioritisation Group meets on a monthly basis to ensure the Trust meets its CRL and more recent discussions have centred around the programme prioritisation for 2018/19. The Trust available capital after pre-commitments are £1.5m, it has been agreed that these funds will be ring-fenced for urgent works required during the financial year and a submission will be submitted early April to cover the remaining schemes deemed to be urgent.

To date the Trust has not received any monies from its bid for a loan of £16.7m. Following discussion with NHSI the Trust submitted a loan bid for £5m at the end of January to cover the most urgent and highest risk schemes that could be progressed quickly, to date the Trust has yet to receive a response.

OTHER COMMITTEE BUSINESS

Standing Financial Instructions

The Committee noted that upon completion, the Standing Financial Instructions and Scheme of Delegation would be circulated to key stakeholders for comment and presented to the Board for final

approval.

The Standing Financial Instructions and Scheme of Delegation will be considered elsewhere on the agenda.

Board Assurance Framework (BAF)

The Committee agreed with the recommendations i.e. (a) Endorse proposal to maintain the current risk rating for BAF R4.1 at 20 and change the direction of travel to stable, (b) the corporate risks linked to the BAF have been updated or closed off as applicable and (c) FPC is recommending that R4.2 is reassigned to the People & Culture Committee.

Reference Cost Update

The Trust has received a formal update on its Reference Cost performance for 2016/17 compared to 237 other NHS providers, the outcome of which is that the Trust's costs are 6% higher than the national average which equates to £22m higher than expected cost. This information used with the Model Hospital will steer the Trust to potential productivity opportunities supporting delivery of the CIP programme.

As part of the Costing Transformation Programme (CTP) for which the Trust is an early implementer, there will be a national shift toward Patient Level costing data as opposed to Reference costing. CTP will become live by 2019.

PFI working group (task and finish)

At the January meeting, there was a commitment to set up a task and finish group to review and negotiate with the PFI partner on medical equipment. The Director of Asset Management and IT will be taking this forward.

Terms of Reference

The Committee considered and agreed the suggested revisions to the Terms of Reference that are attached as appendix 1 for Trust Board approval.

Recommendations

The Board is asked to confirm it is assured that:

- The Trust continues put actions in place to optimise operational performance.
- The additional measures put in place to grip and maintain financial control are effective.
- A robust financial recovery plan is in place and is being closely monitored by the Executive Team.
- The Trust is managing the Capital Programme to ensure the Capital Resource Limit is met.
- The Finance Team continues to actively pursue an outcome on the bids for capital loans.

The Board is also asked to:

- Approve the revised Terms of Reference
- Approve the recommendation that R4.2 of the BAF is re-assigned to the People & Culture Committee
- Approve the March Revenue Loan (Interim cash support)

Appendices

- Appendix 1 – Terms of Reference

Date of meeting	15 M
Paper number	Enc

Terms of Reference

FINANCE AND PERFORMANCE COMMITTEE

Version: **2.0**

Terms of Reference approved by: **Trust Board**

Date approved: ~~January 2017~~ February 2018

Author: **Company Secretary**

Responsible directorate: **Finance**

Review date: February 2019

Date of meeting	15 March 2018
Paper number	Enc E4

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

FINANCE AND PERFORMANCE COMMITTEE

Terms of Reference

1. Introduction

The purpose of the Finance and Performance Committee (F&P) is to act as a sub-committee of the Trust Board to give the Board assurance on the management of the financial and operational performance of the Trust and to monitor and support the financial planning and budget setting process. The Committee will also review business cases with a significant financial impact or those referred by the Service Development Group and oversee developments in financial systems and reporting, e.g. SLR/PLICS.

The Committee will also review the performance strategy of the Trust and hold the Trust to account on national and local targets.

2. Membership

- Three non-executive directors
- Chief Executive
- Chief Operating Officer
- Director of Finance
- Chief Nursing Officer and/or Chief Medical Officer (or their nominated Deputy)
- Director of Strategy, Planning & Development

In attendance:

- Assistant Directors of Finance/Performance
- Company Secretary
- Other senior finance staff as required
- Director of Asset Management &ICT as required
- Divisional representatives and other staff as appropriate

2.1 The Chair of the Committee is appointed by the Trust Board.

3 Arrangements for the conduct of business

3.1 Chairing the meetings

A non-executive director will chair the meetings. In the absence of the Chair, another non-executive director will chair the meeting.

3.2 Quorum

The Committee will be quorate when two non-executive directors and two executive directors are present.

3.3 Frequency of meetings

The Committee will meet monthly.

3.4 Frequency of attendance by members

Members are expected to attend each meeting, unless there are exceptional circumstances.

3.5 Declaration of interests

If any member has an interest, pecuniary or otherwise, in any matter and is present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible and shall not participate in the discussions. The Chair will have the power to request that member to withdraw until the subject consideration has been completed. All declarations of interest will be minuted.

3.6 Urgent matters arising between meetings

If there is a need for an emergency meeting, the Chair will call one in liaison with the Director of Finance and Chief Operating Officer

3.7 Secretariat support

Secretarial support will be through the Finance Directorate.

4 Authority

The Committee is authorised by the Trust Board.

5 Purpose and Functions

5.1 Purpose

To act as a sub-committee of the Trust Board to:

- Give the Board assurance on the management of the financial and operational performance of the Trust
- Monitor and support the financial planning and budget setting process
- Review business cases with a significant financial impact.
- Oversee developments in financial systems and reporting, e.g. SLR/PLICS
- To conduct post implementation reviews of all major business cases approved by the Committee
- To review procurement Strategy Development
- The following sub-groups will report to the F & P Committee on a frequency determined by their business cycle:
    - Capital Prioritisation Group
    - To be confirmed pending finalisation of Governance Structure
    - ~~Sustainable Expert Forum~~

- ~~PFI Expert Forum~~
- ~~Performance Review Meetings~~

5.2 Duties

In discharging the purpose above, the specific duties of the F&P Committee are as follows:

5.2.1 Financial Management

To provide key assurances on the financial governance of the Trust through a programme of review work incorporating the following:

- To oversee and evaluate the development of the Trust's financial strategy to deliver its integrated business plan.
- ~~To oversee the financial part of the FT application process~~
- To regularly review the financial standing of the Trust
- Review and endorsement of the annual revenue and capital budgets before they are presented to the Board for approval.
- Monitor income and expenditure against planned levels and make recommendations for corrective action should excess variances occur.
- Review expenditure against the agreed capital plan.
- To review the key financial risks facing the Trust
- To review financial aspects of key policy areas
- To review the Trust's and, as appropriate, CCG QIPP programmes.
- To review the financial impact on quality of the financial strategy
- To receive reports relating to the financial recovery plan
- To commission work as needed to enhance the work of the Committee

5.2.2 Performance Management

To provide key assurances on the Trust's performance management framework through a programme of review work incorporating the following:

- To oversee and evaluate the development of the Trust's performance strategy to performance manage against strategy and against plan.
- Review the performance report and dashboards against local/national targets
- Review performance against the CQUIN targets
- Review areas of underperformance and agree corrective actions
- Horizon scan regarding new targets
- Develop performance dashboards for reporting to the Board

5.2.3 Other Duties

- To scrutinise the financial aspects of business cases/investment proposals as necessary.
- Receive updates on the contract negotiations giving direction as necessary.
- Periodically review financial policies and procedures including the SFIs, scheme of delegation, etc. to ensure that they are still relevant and appropriate.
- Review the outputs of benchmarking exercises and consider appropriate actions.
- To identify any training needs for Committee members and to ensure that all members are competent in ensuring they can undertake their duties as members of the Committee.

6. Relationships and reporting

6.1 The F&P Committee is accountable to the Trust Board and will report monthly to the Board.

6.2 Through the linkage of common NED membership, the F&P Committee will retain a close relationship with the Quality Governance Committee, People & Culture Committee and the Audit and Assurance Committee. This will include referring matters to those committees and receiving referrals from those committees.

7 Review of the Terms of Reference

These Terms of reference will be reviewed by ~~March 2018~~ February 2019 or earlier if deemed appropriate by the Chair.