Worcestershire Acute Hospitals NHS Trust

Trust Board
There will be a meeting of the Trust Board on Thursday 10 September 2020 at 10:00. It will be held virtually and live streamed on YouTube.

Sir David Nicholson
Chairman

Agenda			Enclosure Page no
1	**Welcome and apologies for absence**		
2	**Patient Story**		
3	**Items of Any Other Business** *To declare any business to be taken under this agenda item.*		
4	**Declarations of Interest**		
5	**Minutes of the previous meeting** *To approve the Minutes of the meeting held on **9 July 2020** as a true and accurate record of discussions.*	*For approval*	**Enc A 1**
6	**Action Log**	*For noting*	**Enc B 12**
7	**Chairman's Report**	*For assurance*	**Enc C 14**
8	**Chief Executive's Report**	*For noting*	**Enc D 16**
9	**STRATEGY**		
9.1	**Recovery and Restoration** Director of Strategy and Planning	*For assurance*	**Enc E1 19**
9.2	**People and Culture update: COVID-19 – Safety and welfare of the workforce** Director of People and Culture	*For assurance*	**Enc E2 25**
	BREAK		
10	**Performance**		
10.1 **10.1.1**	**Integrated Performance Report** **Executive Summary/SPC Charts** Chief Digital Officer/Executive Directors	*For assurance*	**Enc F1 31**
10.1.2	**Committee Assurance Reports** Committee Chairs		

11	**Governance**		
11.1	**Infection Control Board Assurance Framework** Chief Nurse	*For approval*	**Enc G1** **109**
11.2	**Trust Management Executive Report** Chief Executive	*For assurance*	**Enc G2** **113**
11.3	**Audit and Assurance Committee report** Committee Chairman	*For assurance*	**Enc G3** **116**
11.4	**Blood and Blood Products Supply Contract** Chief Finance Officer	*For approval*	**Enc G4** **128**
11.5	**Standing Financial Instructions and Scheme of Delegation** Chief Finance Officer	*For approval*	**Enc G5** **130**
11.6	**Standing Orders** Company Secretary	*For approval*	**Enc G6** **226**

Any Other Business *as previously notified*

Date of Next Meeting
The next public Trust Board meeting will be held on 15 October 2020 virtually.

Exclusion of the press and public
The Board is asked to resolve that - **pursuant to the Public Bodies (Admission to Meetings) Act 1960 'representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest'** (Section 1(2) Public Bodies (Admission to Meetings) Act 1960).

Enc A

Worcestershire Acute Hospitals NHS Trust

MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON THURSDAY 9 JULY 2020 AT 10:00 hours VIRTUALLY

Present:		
Chairman:	Sir David Nicholson	
Board members: (voting)	Anita Day	Non-Executive Director
	Mike Hallissey	Chief Medical Officer
	Matthew Hopkins	Chief Executive
	Dame Julie Moore	Non-Executive Director
	Vicky Morris	Chief Nursing Officer
	Robert Toole	Chief Finance Officer
	Bill Tunnicliffe	Non-Executive Director
	Mark Yates	Non-Executive Director
Board members: (non-voting)	Richard Haynes	Director of Communications and Engagement
	Colin Horwath	Associate Non-Executive Director
	Vikki Lewis	Chief Digital Officer
	Jo Newton	Director of Strategy and Planning
	Richard Oosterom	Associate Non-Executive Director
	Tina Ricketts	Director of People and Culture
	Kimara Sharpe	Company Secretary
	Robin Snead	Deputy Chief Operating Officer
Healthwatch	Peter Pinfield	Chair
Public	6	(via YouTube)
Apologies	Paul Brennan	Deputy Chief Executive/Chief Operating Officer
	Stephen Williams	Non-Executive Director
	Fleur Blakeman	NHS Intensive Support Director

031/20 **WELCOME**

Sir David welcomed everyone to the meeting, especially Mr Snead who was covering for Mr Brennan. He thanked Mr Snead for his work at the Alexandra Hospital on patient flow. He also welcomed those viewing the meeting on YouTube.

032/20 **PATIENT STORY**

Sir David reiterated the importance of the Patient Story and welcomed PD, who was treated early on with COVID-19 and is now back at work. He invited Mrs Morris to introduce the story.

Mrs Morris explained that PD had some profound experiences to share and there was important learning for the Trust, particularly in respect of support for the family. She has already spoken to the matrons about this aspect of the story.

PD expressed his thanks for being able to share his story with the Trust Board.

PD explained that he became ill at end of March and after one week became worse. He contacted 111 who sent a paramedic. Initially he was reluctant to go to hospital, but his wife (an ex-nurse) persuaded him and he went to hospital on his daughter's 15th birthday. He then was in a cubicle but cannot remember anything else until he woke up being extubated some weeks later. He then went to a step down ward after a further 2 days on ITU.

He described some of the mental health experiences in respect of dreams. He also lost two stone in weight and he could not walk properly. He stated that the experience was strange and scary.

He was desperate to see his family but it was the height of the COVID-19 pandemic and he was unable to do so except through a window. He reflected that the experience was very hard on his family and their mental health.

Mrs Morris thanked PD for his story and asked him to expand on support for the family. PD stated that the staff were extremely busy and as a result, did not have time to spend with the family when they phoned. This was particularly hard on his wife. He suggested that a family liaison officer would be one way of ensuring families were kept informed of their loved one's condition.

Dr Tunnicliffe thanked PD for his story. As an ITU consultant, he was aware of the challenging situation in ITU. He wondered whether PD had had access to the mental and physical support needed. PD stated that the follow up has bene marvellous and he has had equipment installed as required. Mentally, his GP has been excellent and has maintained contact with him and his family.

Mr Hopkins also thanked PD for his story. He wondered whether PD had heard staff utter concerns about the PPE available to them. PD stated that he was very conscious of the PPE situation as he managed it within his job. Only cleaning staff had occasional concerns.

Sir David thanked PD. He was aware that Mrs Morris was going to pursue the family liaison role. He hoped that PD had not returned to work too soon and wished him well.

PD thanked the Board for their interest and stated that he was willing to become involved with the Trust. He felt a big loyalty to the hospital.

PD left the meeting

Sir David asked members to remember the story as the meeting progressed. It was particularly relevant to the COVID-19 update later on the agenda.

033/20 **ANY OTHER BUSINESS**

There were no items of any other business.

034/20 **DECLARATIONS OF INTERESTS**

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

035/20 **MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON 11 June 2020**

RESOLVED THAT the Minutes of the public meeting held on 11 June 2020 be confirmed as a correct record and signed by the Chairman.

036/20 **MATTERS ARISING/ACTION SCHEDULE**

Mrs Sharpe reported that there no outstanding actions and all other actions had been completed.

037/20 **CHAIRMAN'S REPORT**

Sir David reported that he has been invited to be a member of the Local Engagement Board. This Board was managed by the local authority and predominately had councillors from the County Council and District Councils as members. He attended the first meeting the day before and had been impressed with the level of knowledge within the Council. Public Health have a significant amount of data in respect of the situation within Worcestershire. Currently there are approximately two new cases a day. This is a considerable decrease in numbers. Public Health have undertaken spot checks on businesses to ensure social distancing was in place. There is a huge amount of communication to be undertaken with the population of Worcestershire – they are determined to ensure that the population are well briefed. Currently activity concentrated on areas which have experienced a high level of cases such as care homes and meat processing plants.

The meeting takes place once a fortnight and he will ensure that the Board is kept informed.

Sir David then turned to BAME staff and emphasised the importance of ensuring that all staff were treated equitably and had fair treatment. He was pleased to appoint a sponsor for the new BAME network, Mark Yates, deputy Chairman and chair of the People and Culture Committee.

RESOLVED THAT The Board noted the appointment of Mark Yates as network sponsor for the Black, Asian and Minority Ethnic (BAME) staff network

038/20 **CHIEF EXECUTIVE'S REPORT**

Mr Hopkins drew the Board's attention to the future plans for the current CNO post. He confirmed that succession planning had commenced.

Mr Hopkins asked whether the Board supported the stance of not recommending staff for honours for COVID-19. He felt that all staff had been involved and it was not right to single out one or two people. This was supported.

Finally he asked the Board to note a minor change to the ASR business case in respect of capital. The business case remained within the cost envelope previously agreed.

RESOLVED THAT the Board

- **Noted the additional £187k capital costs associated with the ASR business case**
- **Supported the stance of not nominating individual staff for honours for COVID-19 work.**

039/20 **STRATEGY**

039/20/1 **People and Culture Update**

Sir David invited Ms Ricketts to present her update.

Ms Ricketts explained that her report was in three parts. Firstly she outlined the work being undertaken to increase Black and Minority Ethnic (BAME) staff representation. A significant amount of work has been undertaken to set up a meaningful network for BAME staff and she was pleased to report that two meetings have been held with 25

members of staff. The terms of reference are being developed and staff are agreeing the lead, backfill funded through charitable funds, for one day per week. The network will be called the Inclusion Diversity Action network for BAME colleagues. She committed to invited board members to the meetings which were being held at 3pm every Wednesday.

Sir David welcomed the setting up of the network and stated that that the Trust would be judged on the action being taken. It was crucial to review the systems and processes in place. On attending the network meetings, he was struck by the conversations being held and the deeply felt and emotional.

Mr Yates also welcomed the development. He stated that he was invited members of the network to the People and Culture Committee in early August to hear first-hand from members.

Mr Hopkins gave a commitment to ensure that the network was meaningful and would make a difference to the work of the Trust.

Ms Ricketts stated that the network has been asked for the top three things that would improve the workplace for BAME staff. She would feed these back at the next Board meeting.

Ms Ricketts then turned to the workforce risk assessments which had three components; the workplace (i.e. environmental risk assessment), overarching risk assessment for high risk individuals and individual risk assessments. The Occupational Health department are currently reviewing the risk assessments and an assurance framework is being developed for completion by each department.

The third key piece of work was to ensure that the Trust was aware of the key risks to individuals. By the end of June, there was an 83% compliance rate with 78% of BAME staff. There continues to be a focus on the completion of the risk assessments. Ms Ricketts drew members' attention to page 6 of the report (page 24 of the pack) and initial findings show that there are disparities between the wider workforce and BAME staff. More non-BAME staff are working from home or redeployed. She will give an update to the next Board meeting on this work.

ACTION: Feedback the three issues identified by the Inclusion Diversity Action network and provide an update on the findings of the risk assessments to the next Board meeting (Ms Ricketts)

Mr Yates congratulated Ms Ricketts on her work He expressed concern that the medical and dental workforce was an outlier and he asked Mr Hallissey how this was being tackled. Mr Hallissey confirmed that all medical and dental staff would have an assessment at their next attendance in the Trust. Mr Hopkins added that there had been extensive engagement with the local medical staff committees which were very positive in supporting the process.

Dr Tunnicliffe added his thanks to Ms Ricketts and Mr Yates for their work. He wondered what the wider strategy was for this work for the entire workforce. Mr Hopkins confirmed that the Gold command was reviewing the strategy for all staff during week commencing 13 July. This would also be covered in a future People and Culture Committee meeting.

Sir David thanked Ms Ricketts for her work in this area. He commended the recent email to 4ward advocates which outlined several articles and books for reading to

increase understanding of this area.

RESOLVED THAT the Board noted

- The actions that have been taken to improve representation of Black, Asian and Minority Ethnic colleagues within the Trust, which is the first step in our journey to improving equality of opportunity
- The findings of the latest COVID-19 workforce risk assessment which identifies three additional groups of staff that are at increased risk
- The actions that have been taken to reduce the risk of potential COVID-19 related work hazards for all colleagues

039/20/2 **Board Assurance Framework**

Mr Hopkins thanked Mrs Sharpe for her work in updating the Board Assurance Framework (BAF). He drew members' attention to the front sheet which outlined the suggested changes and the process that the BAF has been through.

Mr Horwath confirmed that the document has been reviewed by the Governance Working Group and it was concluded that the document was fit for purpose. The Group would be reviewing how the BAF can become more meaningful within the Board and Committee agendas.

Mr Horwath wondered whether the issues in relation to BAME staff should be reflected within the document. He also expressed concern that BAME staff were not mentioned in the annual plan.

Sir David agreed. He was encouraged by the document and stated that it reflected the work that the Board and committees undertook.

ACTION: Review the content of the BAF and Annual Plan and reflect the work being undertaken with respect to BAME staff (Ms Ricketts and Mrs Newton)

RESOLVED that the report be approved.

039/20/3/1 **COVID-19 – Recovery and Reset**

Mrs Newton reported that the Clinical Services Strategy (CSS) refresh workshops were now underway. She will bring the results back to the Board.

She was continuing the discussions across the system in respect of the 10 high impact changes and the COVID-19 experiences. A dashboard was being developed to enable progress to be monitored. She was expecting further guidance with respect to STP and regional/national working later in the month.

Mr Oosterom thanked Mrs Newton for her work, in particular with respect to the STP.

Dr Tunnicliffe also commended the paper and asked for digital to be more integrated within the goals. He reflected that a huge amount of work had been undertaken in a short period of time.

Ms Day asked for clarification in the trajectories for improvements in services. She also asked that behavioural changes be captured.

Mrs Morris thanked Mrs Newton for attending the professional forum where it was evident that, despite the exhaustion shown in relation to the COVID-19 work, staff were energised to move forward and sustain the improvements made. She was also pleased

with the engagement of the Patient and Public Forum and HealthWatch.

Mr Yates asked whether the engagement of medical staff could be clarified.

Mrs Newton thanked members for their feedback. She confirmed that the whole clinical fraternity was engaged and in particular the Divisional Directors who were key. There had been medical engagement in the virtual workshops. The main gap had been with junior doctors as well as estates and facilities staff.

Sir David thanked Mrs Newton for her work. He was pleased with the progress and the engagement with staff. He asked for assurance that there was collaboration between divisions and organisations. Mrs Newton confirmed that there was but the picture was complex.

Mr Hopkins acknowledged that there was more work to be undertaken by the executives to ensure better collaboration between the divisions and the command and control structure, which was overseeing this, would ensure clear oversight.

Sir David urged the executives to ensure that the annual plan objective of undertaking half the outpatient consultations remotely was realised immediately and he also observed that not all the non-clinical accommodation was required with more staff working remotely more often.

Sir David finally thanked Mrs Newton for her clear paper which showed the progress being made.

RESOLVED THAT the Board:

- Endorsed the status of the recovery and reset programmes of work, particularly the progress made since the June 2020 Trust Board report
- Noted the risks and mitigations relating to recovery and reset
- Affirmed the proposed direction of travel, particularly for refresh of the Trust's Clinical Services Strategy.

039/20/3/2 **COVID-19 – Update**

Mr Snead stated that the command and control structure would remain in place for the foreseeable future. There was increasing attention being given to the non-COVID-19 patients. All wards were now open on the Worcestershire Royal site and there were plans in place for a possible second wave in relating to intensive care capacity. Bed occupancy remained under 92% for both main sites and patient flow was good.

Currently there were five COVID-19 positive patients. The Trust continued to use the private sector for cancer surgery. Demand modelling was being undertaken to ascertain any impact of the opening of the hospitality sector on the 4 July. This was, as yet, an unknown impact.

Sir David asked whether the Trust had modelled the closure of A&E which had happened recently in two trusts where there had been a localised COVID-19 outbreak within the staff. Mr Hopkins confirmed that this modelling had not yet taken place and he would action this.

ACTION: Consider the implications of a localised COVID-19 outbreak amongst staff and the necessity to close A&E (Mr Snead/Mr Brennan)

Ms Day asked about the plan for the Alexandra Hospital bed capacity. Mr Snead

confirmed that the plan was to increase elective capacity by realigning theatres with green surgical activity. He explained how this would work by utilising the two floors differently.

Mr Oosterom asked about how the bed capacity was tracked. Mr Snead stated that the available beds were tracked on a daily basis and decisions were made through the command and control structure. There continued to be a significant number of empty beds across both sites and he acknowledged that activity needed to be restarted in a safe way. Sir David asked for bed capacity modelling to be considered in depth at a future meeting.

ACTION: Consider bed modelling at a future meeting (Mr Brennan)

Dame Julie asked for more detail on the antigen testing. Mr Snead stated that 5632 out of 6500 staff had undergone an antigen test. He would supply the detailed data outside the meeting.

ACTION: Mr Snead to supply detail in relation to antigen testing

Mrs Morris informed members that a balanced scorecard was in development in relation to restoration and restart to give a more holistic view.

RESOLVED THAT the report be noted for assurance.

There followed a break from 11:25-11:35

040/20 **PERFORMANCE**

040/20/1 **HomeFirst Worcestershire**

Mr Snead explained that HomeFirst Worcestershire drives the programmes as outlined within the paper. The new acute medical model was being piloted at the Alexandra Hospital and was planned to be rolled out to the Worcestershire Royal (the business case was being considered by the Trust Management Executive on 22 July). Patients who needed a specialist assessment bypassed the A&E department and staff have the mind-set to discharge patients not to admit.

He was pleased to announce that seven staff were recruited for the clinical site management team and this team should be fully formed by 30 September.

There has been a huge amount of work to reduce the number of patients staying over 21 days and this has decreased from 114 in April 2019 to 30 as the current date. There will now be more focus on those patients waiting over 7 and 14 days.

Mr Horwath recognised the complexity of the work. He wondered whether it was possible to measure whether the work was progressing despite the COVID-19 pandemic. He was also concerned that new ways of working would be lost with the restart of services. Mr Snead stated that the metrics continued to improve and there was focus on all the work streams. He was keen to emphasise the necessity and importance of partnership working, particularly in respect of early discharges and the development of the onward care team (OCT).

Mrs Newton added that the workshops she was running to review the Clinical Services Strategy were discussing how to maintain the new ways of working.

Ms Day stated that several of the graphs showed a ‘weekend effect’. She wanted to understand what was happening to ensure that there was no effect from the weekend.

She also wished to understand why criteria-led discharge had not yet had an impact.

Dr Tunnicliffe added that it was disappointing that the data showed the Trust was not adhering to the internal professional standards. He wondered what was in place to ensure that behaviours remained appropriate. He echoed Ms Day's comments about criteria-led discharge and he also asked for clarification in relation to SPC chart 7. His view was that the data showed that the issues were not about an overcrowded emergency department but showed inherent behavioural issues that needed to be tackled. Dame Julie echoed the sentiments of Ms Day and Dr Tunnicliffe.

Mr Hopkins acknowledged that the paper as written could have been clearer and he referred members to the next paper, the Integrated Performance Report (pages 127-128 of the pack) which showed the headline performance indicators. He also acknowledged that the current situation with the number of beds available was exposing process issues that are being addressed. He stated that in the previous week, he had instigated two serious incident investigations when ED performance at Worcestershire Royal was below 85%. The investigations highlighted cultural and other issues which were being addressed. He was pleased that the ED performance had improved. Generally, however, the IPR showed better performance with for example, reduced ambulance delays. He stated that he was still not satisfied that the Trust had the right attitude to delays for patients and he was keen to ensure that there was a clear grip on the issues.

Sir David acknowledged that the headline numbers showed an improving position. However once the data was probed, underlying issues were evident.

Mr Hallissey reminded members that the A&E activity was back to pre-COVID-19 levels. The new model at the Alexandra Hospital had been implemented with very good initial results. Significant changes have already been made and he was confident that other issues had been identified.

Mr Oosterom expressed frustration that some areas of work e.g. red to green had been on the Trust's agenda for some time and yet progress had been patchy.

Sir David expressed concern that work needed to be progressed as the winter effect would soon be present. He asked for a more detailed report to the next Board meeting focussing on areas that can be controlled by the Trust.

ACTION: Detailed report on metrics showing actions being undertaken at the next Board meeting in preparation for winter (Mr Brennan)

Sir David asked whether there was detailed bed modelling to ensure that the right beds were in the right place at the right time. Mr Hopkins confirmed that this was being overseen by the restoration phase. He was pleased with the progress made at the Alexandra Hospital with the new ways of working and was keen to see these embedded at the Worcestershire Royal.

RESOLVED THAT the report be received for assurance.

040/20/2 **Integrated Performance Report**

040/20/2/1 **Executive Summary/SPC Charts**

Mrs Lewis summarised the IPR which showed validated data as at May 2020. The IPR had been presented to the Finance and Performance Committee, Quality Governance and Trust Management Executive. The paper covered a number of the Board Assurance Framework risks.

Mr Hopkins added that the IPR should show clear alignment with the BAF risks and showed progress against the controls in place. It also shows the links to the annual plan and priorities. He explained that the executive team meeting prior to the Board to determine the three key areas of focus for the Board and he acknowledged that those three areas should be clearer within the executive summary.

Sir David asked for a better assessment in the document to show whether there had been true progress with various metrics.

Mrs Lewis the outlined the three areas of focus as identified by the Executive Team. These were:

- Elective and diagnostic programme and the numbers of patients now waiting for treatment, particularly those waiting over 40 weeks
- Cancer – whilst this had been prioritised during COVID-19, the number of 2 week referrals remained low
- Sepsis and the sepsis bundle.

Mr Snead explained the challenges with the number of patients waiting. Some patients were now not taking up the offer of treatment was they remained concerned about contacting COVID-19 whilst attending hospital. Performance had decreased in May due to the guidance issued by the Royal Colleges in respect of diagnostics. A mobile CT scanner has now been obtained and he was confident that diagnostic activity would increase in the coming weeks. The Trust continued to work with the independent sector to utilise the facilities as much as possible. Mr Snead concluded by stating that the STP had a coordinated approach for bidding for extra resources to reduce the waiting list.

Mr Hallissey explained that the critical care team, who lead the Trust's approach to sepsis, have been engaged in the front line work for COVID-19. This work has now reduced so the team can now refocus on sepsis. There is a new intake of junior doctors in the next few weeks and sepsis will be a key focus for them. He assured members that all patients except one had antibiotics within one hour and he was confident that patients had the treatment as needed. Finally he stated that sepsis will be monitored through the divisional performance management meetings.

Dr Tunnicliffe asked about endoscopy and wondered why these services could not be re-opened sooner. Mr Hallissey explained that the constraint is the guidance from the Royal Colleges. He described what was needed in order for the service to be recommenced.

Sir David thanked everyone for their contributions and turned to finance. He asked Mr Toole to outline the current position and explain whether the Trust was performing well financially.

Mr Toole explained that the situation was extremely complex. The spend profiles were better than expecting, despite the lack of activity. With respect to pay, the spend is lower than pre-COVID-19. This is due to the reduced us of agency staff. There is still work to be undertaken on productivity and a meeting has been set up to discuss this further with the non-executive directors. He then stated that the Trust has enough capital and there is a positive cash balance.

Finally, Mr Toole stated that the Trust was in a reasonably good position but the situation is complex.

Mr Oosterom, as Chair of the Finance and Performance Committee, stated that Mr Toole had explained the financial situation very well. He also welcomed the meeting to look at productivity in more detail.

Sir David, whilst acknowledging the financial performance, he asked whether the Trust continued to have an underlying problem.

Mr Hopkins confirmed that the Trust was in a good position but there needed to be more confidence on productivity and a need to drive down overall expenditure. In summary, in relation to quality, Mr Hopkins acknowledged that the Trust was an outlier in sepsis, but performed well in other areas; workforce metrics were showing continued performance and with performance, there were problems with the long waiters as well as other performance indicators.

Sir David complimented the Trust on its response to COVID-19. This was an opportunity for the Trust to move forward and he wished to see these improvements in place by the September meeting.

040/20/2/2 **Committee Assurance Reports**

Dr Tunnicliffe drew members' attention to the excellent COVID-19 performance within ITU. There continued to be a focus on harm reviews. Sir David added the Board's congratulations to the ITU team.

RESOLVED THAT the reports be noted for assurance.

041/20 **GOVERNANCE**

041/20/1 **Stakeholder report**

Mr Haynes stated that his report highlights key areas of work which have already been discussed within the meeting. He thanked Chris Parks and team for the work involved in lighting up the Trust's hospitals in blue for the NHS Birthday. He highlighted the significant number of achievements made by the Charitable team and he thanked the Head of Charitable Funds.

Mr Haynes concluded by stating that he was looking forward to having a wider conversation with patients and the public about the complex restart programme.

Mr Yates voiced concern about the significant number of people who do not have access to social media and urged the communications team to have alternative methods of engagement. Mr Haynes agreed and reassured Mr Yates that many channels were used for communication.

RESOLVED THAT the report be noted

041/20/4 **Trust Management Executive**

Mr Hopkins presented the report which gave a summary of the items discussed at the recent Trust Management Executive meeting. Sir David commented that he was pleased to see the way reports flowed through the Trust.

RESOLVED THAT the report be received for assurance

042/20 **HealthWatch**

Mr Pinfield thanked the Board for an interesting few hours. He confirmed that the issues raised triangulated with the soft intelligence gleaned through HealthWatch. The public are aware of the growing waiting list and also aware of the problems in accessing diagnostics. He stated that there are issues with mental health services as well. He

thanked the Board for their continued work and open dialogue in difficult times.

DATE OF NEXT MEETING

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

The meeting closed at 12:37 hours .

Signed _____ **Date** _____

Sir David Nicholson, Chairman

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WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

PUBLIC TRUST BOARD ACTION SCHEDULE – SEPTEMBER 2020

RAG Rating Key:

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

Meeting Date	Agenda Item	Minute Number (Ref)	Action Point	Owner	Agreed Due Date	Revised Due Date	Comments/Update	RAG rating
12-9-19	Patient Story	63/19	Arrange dementia training for Trust Board members.	CNO (VM)	Oct 2019		To be programmed into a Board seminar. Dementia lead has requested face to face training. To be taken up by CNO.	
9-7-20	People and Culture Update	039/20/1	Feedback the three issues identified by the Inclusion Diversity Action network and provide an update on the findings of the risk assessments to the next Board meeting	Dir P&C (TR)	Sept 2020		Recruitment, Selection & Career advancement, Support & Advocacy, Education More detail within report enc E2. Action closed	
9-7-20	COVID-19 – Update	039/20/3 /2	Consider the implications of a localised COVID-19 outbreak amongst staff and the necessity to close A&E	COO (PB/ RS)	Sept 2020		Work not undertaken as staff would be redeployed from other areas. Action closed.	
9-7-20	COVID-19 – Update	039/20/3 /2	Consider bed modelling at a future meeting	COO (PB)			Modellng undertaken. To be presented to the F&P committee. Action closed.	
9-7-20	HomeFirst Worcestershire	040/20/1	Detailed report on metrics showing actions being undertaken at the next Board meeting in preparation for winter	COO (PB)	Sept 2020		Winter plan being presented through the governance process in September. Action closed.	

9-7-20	Board Assurance Framework	039/20/2	Review the content of the BAF and Annual Plan and reflect the work being undertaken with respect to BAME	Dir P&C/ Dir P&S (TR/ JN)	Sept 2020		BAME was added to the Annual Plan as part of the refresh approved by the June board. BAF refresh being undertaken during September and will be included in the refresh. Action closed.	
9-7-20	COVID-19 – Update	039/20/3 /2	Mr Snead to supply detail in relation to antigen testing	Deputy COO (RS)	Jul 2020		Results sent to Board member 28-7-20. Action closed.	

NHS
Worcestershire Acute Hospitals NHS Trust

Putting patients first May 2019

Meeting	Trust Board
Date of meeting	10 September 2020
Paper number	C

Chairman's Report

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

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

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

Report previously reviewed by		
Committee/Group	Date	Outcome

Recommendations	The Trust Board is requested to • Approve the allocation of non-executive directors to committees • Note the recruitment to NED positions

Executive summary	I would like to thank Steve Williams for his contribution in the last three year. His term of office comes to an end on 31 December. I am working with NHS E/I to recruit for a replacement, who will have a strong focus on community engagement. I am also recruiting to another associate NED at the same time. I am pleased to report that Anita Day has been reappointed for a four year term of office form 1 August 2020. I am recommending changes to the NED membership of Committees, with effect from 1 January 2021. The membership is shown on attached. This membership will ensure that all Committees have an overlap of members to enable triangulation to take place. If we are successful in our recruitment, I will review the membership of the Committees again.

Meeting	Trust Board
Date of meeting	10 September 2020
Paper number	C

COMMITTEE	NON-EXECUTIVE DIRECTOR
Audit and Assurance Committee	**Anita Day, Chair** Colin Horwath Mark Yates
Charitable Funds Committee	**Mark Yates, Chair** Julie Moore Anita Day
Finance and Performance Committee	**Richard Oosterom, Chair** Julie Moore Colin Horwath
People and Culture Committee	**Mark Yates, Chair** Anita Day Colin Horwath Bill Tunnicliffe
Quality Governance Committee	**Bill Tunnicliffe , Chair** Richard Oosterom Julie Moore
Remuneration Committee	**Sir David Nicholson, Chair** Anita Day Mark Yates

NHS
Worcestershire Acute Hospitals NHS Trust

Putting patients first May 2019

Meeting	Trust Board
Date of meeting	10 September 2020
Paper number	D

Chief Executive's Report

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

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

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

Report previously reviewed by		
Committee/Group	Date	Outcome

Recommendations	The Trust Board is requested to • Note this report

Executive summary	This report is to brief the board on various local and national issues. Items within this report are as follows: • Update on single improvement methodology • System Improvement Director • National awards • Ophthalmology • National Institute for Health Protection • NHS Race and Health Observatory • Medical Student places

Risk								
Key Risks	N/A							
Assurance	N/A							
Assurance level	**Significant**		**Moderate**		**Limited**		**None**	
Financial Risk	N/A							

Meeting	Trust Board
Date of meeting	10 September 2020
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Introduction/Background

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

Issues and options

Update on Single Improvement Methodology

As part of our strategic objectives, a case for change has been developed for the introduction of a Single Improvement Methodology which will provide a systematic approach to building a culture of continuous incremental improvement, using recognised improvement tools and techniques which will be deployed across the organisation. The case for change was presented and supported at TME on 19th August which describes the current state, imperative for change and future state in relation to the implementation of a Single Improvement Methodology, supported by a number of options. A full options appraisal and business case will now be developed. Next steps include:

- Development of options appraisal and business case by mid September
- Undertaking an organisational readiness assessment in late September/early October
- Board review of outputs of the readiness assessment to develop an action plan to maximise chances of success
- Full business case developed by late October
- Making a decision on the preferred option for a Single Improvement Methodology in late October/early November and commence procurement.

Further information is available in the document section of VBR.

System Improvement Director: David Hill has been appointed by Worcestershire system leaders with the support of NHS England/Improvement, to this newly created role which will see him working closely with NHS and social care leaders from across the county.

A highly experienced public sector leader, David Hill's career includes Chief Executive roles in NHS organisations and local authorities. As System Improvement Director he will act as an independent 'critical friend' to NHS leadership teams across Worcestershire, to help drive system-wide improvements in quality, safety, operational performance and efficiency.

He will also act as a link between local NHS and care leaders and their key external partners, including NHS England/NHS Improvement, local authorities and regulators including the Care Quality Commission (CQC).

Shortlisted for awards: I am delighted to be able to share with you the news that three of our teams have made the shortlist for the prestigious 2020 Nursing Times awards. Our Neonatal Community Outreach team have been shortlisted under the category of Nursing in the Community while our Frailty Service is shortlisted for the Care of Older People Award. Infection, Prevention and Control have also been shortlisted for a custom made on line learning course (jointly with Bangor University). Congratulations to all involved in these services – and good luck!

Digital system transforms Ophthalmology services in Worcestershire: A new web based electronic patient record system is now in use across the Trust, reducing the need for patients to visit hospital for their procedures. The new digital system OpenEyes is a secure open source electronic patient record system that allows health professionals to share

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information electronically across health care providers across the county.

National Institute for Health Protection: The new National Institute for Health Protection (NIHP) has started work to advance the country's response to the coronavirus pandemic. Under the new organisation, Public Health England and NHS Test and Trace will be brought together, as well as the analytical capability of the Joint Biosecurity Centre (JBC) under a single leadership team. It represents the first step towards becoming a single organisation, focused on tackling Covid-19 and protecting the nation's health. As an effort to minimise disruption to the vital work dealing with the pandemic, the organisation will be formalised and operating from Spring 2021.

NHS Race and Health Observatory (RHO): Marie Gabriel CBE will lead this new work programme, which has been tasked with identifying and tackling the specific health challenges facing people from black, Asian and ethnic minority (BAME) backgrounds in England today. The RHO is hosted by the NHS Confederation. Ms Gabriel is currently Chair of North East London STP, and Norfolk and Suffolk Foundation Trust, and has previously chaired East London NHS Foundation Trust, NHS North East London, and the City and Newham Primary Care Trust, following over two decades in senior executive roles within local government, housing and the third sector.

Medical Student places: Ministers have scrapped a cap on the number of medical student places this year. Similar limits on undergraduate teaching, dentistry and veterinary courses will also be dropped and universities will be given extra money to teach expensive subjects. The government has also agreed with universities that every student with the required grades will be offered a place at their first choice institution either this year or next. A separate cap on the number of medical students, who require clinical placements as part of their training, remained in place.

Recommendations

The Trust Board is requested to

- Note this report

Appendices

NHS
Worcestershire Acute Hospitals NHS Trust

Putting patients first May 2019

Meeting	Trust Board
Date of meeting	10 September 2020
Paper number	E1

COVID-19 Restoration & Recovery Plan Phase 3 - Recovery

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

Accountable Director	Jo Newton, Director of Strategy & Planning		
Presented by	Jo Newton, Director of Strategy & Planning	**Author /s**	Lisa Peaty, Deputy Director of Strategy and Planning Nikki O'Brien, Associate Director of Business Intelligence, Performance and Digital Felicity Davies, Deputy Director of People & Culture Jo Kirwan, Assistant Director of Finance Katie Osmond, Deputy Director of Finance

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

Report previously reviewed by		
Committee/Group	Date	Outcome
TME	19/8/20	Noted risk around timeline requirements and dependency on demand & capacity modelling to inform workforce and financial returns
Finance & performance Committee	26/8/20	Noted and agreed sign off for Phase 3 submission via TME

Recommendations	The board is recommended to *Part 1* - Note the guidance, timelines and proposed approach to and timeline for the Phase 3 planning submission *Part 2* – Note the progress made on Phase 3 as part of the STP submission and potential risks and dependencies. *This is within the private section of the Board as the contents are draft. The final document will be presented to the Board in public at the October meeting.*

Executive summary	Our WAHT Restoration and Recovery plan continues to be dynamic, with capacity and restoration flexing in line with changes in demand and to reflect government policy. Phase 3 guidance issued during July / August outlined the need to restore service activity to prior year levels by October 2020.

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	Our Restoration and Recovery framework focuses on 3 key principles: • Safer services – to both patients and staff • Sustainable services – embedding learning and innovation • System first – working collaboratively with partners This report details the approach and requirements for Phase 3, whilst Part 2 outlines progress to date, including any emergent delivery gaps and risks as part of the STP submission. Work via divisions and the Restoration Oversight group continues to further iterate and devise mitigations prior to final STP submission on 21st September. Detailed work on finance and workforce will form a key part of the work through this month.

Risk								
Key Risks	BAF 4: If we do not achieve safe and efficient patient flow and improve our processes and capacity and demand planning, then we will fail the national quality and performance standards, resulting in a negative patient experience and a possible compromise to patient safety. BAF 5: If there is a lack of a county wide operational plan which balances demand and capacity across the county, then there will be delays to patient treatment, resulting in a significant impact on the trust's ability to deliver safe, effective and efficient care to patients. BAF 6: If we are unable to resolve the structural imbalance in the trust's income and expenditure position, then we will not be able to fulfil our financial duties, resulting in the potential inability to invest in services to meet the needs of our patients. BAF 9: If we are unable to sustain our clinical services, then the trust will become unviable, resulting in inequity of access for our patients. BAF 11: If we are unable to recruit, retain and develop sufficient numbers of skilled, competent and trained staff, including those from the EU, then there is a risk to the sustainability of some clinical services, resulting in lower quality care for our patients and higher staffing costs.							
Assurance	Restoration Oversight group continue to iterate and test assumptions against known and projected activity. The annual planning process contributes to the mitigation of the risks above.							
Assurance level	**Significant**		**Moderate**	*x*	**Limited**		**None**	
Financial Risk	*N/A*							

NHS
Worcestershire Acute Hospitals NHS Trust

Putting patients first May 2019

Meeting	Trust Board
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Introduction/Background

On 31st July, NHSE/I wrote to all providers and Clinical Commissioning Groups (CCGs) outlining the approach and actions required for the third phase of the NHS response to COVID-19 which was followed by more detailed guidance[1] on 7th August 2020. The letter and guidance set out the priorities for the third phase which commences 1st August 2020:

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

The development of Phase 3 plans will be led by systems, supported by organisational level detail.

The guidance sets out the Phase 3 planning requirements and assumptions for organisations and systems for the remainder of 2020/21 (activity, performance, workforce). The planning submission will consist of a narrative supported by technical templates which, together, will describe how the system plans to deliver the goals set out for Phase 3. The narrative will articulate how the system will restore service delivery to pre-pandemic levels to March 2021, including the risks to restoration and how and system partners will to collaborate to mitigate them. The narrative will also describe how the system will:

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

The national timetable is:

Key Tasks	**Date**
Phase 3 letter issued	31st July
Guidance and template issued	7th August
Draft submission of technical templates and narrative	1st September
Final submission of technical templates, narrative and people plan	21st September

As the policy shifts in Phase 3 from crisis to ongoing management, National Voices, a coalition of health and care charities in England, have called for decision makers to engage with citizens and most affected by both the virus and lockdown restrictions, to adopt five principles which put people and their rights at the centre. These principles will be integral to the STP/ICS response and will be form the basis in patient/public engagement in the trust's programme of high impact changes.

[1] Implementing Phase 3 of the NHS response to the COVID-19 pandemic

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Actively engage with those impacted by the change	Need for consultation, policy based on needs, proper coproduction
Make everyone matter	Leave no-one behind
Confront inequality head-on	Confront the determinants of health head on
Recognise people, not categories	By strengthening personalised care
Value health, care and support equally	Dismantle barriers between sectors

Issues and options

i) Activity and performance

Forecasts of activity and performance measures to cover the last 7 months of the financial year are required. Although the usual set of annual planning performance metrics has been reduced for the purpose of the Phase 3 submission, there are additional requirements to capture face to face / non face to face outpatient appointments; split of COVID/Non-COVID 1+ day non elective attendances; and count of cancer activity rather than waiting times. The activity return includes weekly activity commissioned by the CCG in the independent sector and activity that will be delivered by the independent sector under a re-procured Phase 3 national framework. These technical templates will be supported by a commentary on the key strategic actions and assumptions that underpin the activity and performance metrics.

There has also been a further request on 12th August from the region which requires demand and capacity scenarios to be completed for 'reasonable worst-case scenario' and 'reasonable best-case scenario', which includes winter pressures and an assumed Covid peak later in the financial year.

ii) Workforce

A People Plan for 2020/21 was published alongside the NHSE/I letter on 31st July 2020. The People Plan sets out practical actions for employers and systems over the remainder of 2020/21. It includes commitments on:

- Actions all NHS employers should take to keep staff safe, healthy and well.
- Specific requirements to offer staff flexible working.
- Urgent action to address systemic inequality experienced by some staff, particularly BAME staff.
- New ways of working and delivering care.
- Growing the workforce, including through supporting former staff to return to the NHS and retaining staff longer.
- Workforce planning and transformation to be undertaken by systems

Robust Workforce Planning underpins restoration and recovery. This includes the workforce needed to return to near-normal levels of non-Covid health services and the workforce needed in preparation for winter demand pressures, alongside further probable Covid spikes. The narrative returned with the technical templates will draw out what assumptions

have been included for restoration and recovery work.

All STP/ICS systems are required to develop a local people plan in response to these commitments, covering expansion of staff numbers, support for staff, improving retention and flexible working opportunities, and new initiatives for development and upskilling of staff. This is in addition to completion of a technical template for workforce which aligns to the people plan and ICS narrative. The technical template will forecast the monthly workforce (substantive, bank & agency WTE) plan for all staff categories during the last seven months of 2020/21.

iii) Finance

To support restoration, current financial arrangements for trusts will be extended until September with the intention to implement a revised financial framework in the latter part of 2020/21. The current arrangements comprise nationally block-set contracts between providers and commissions and top up funding to support delivery of breakeven positions against reasonable expenditure. The revised framework will retain simplified arrangements for payment and contracting but with a greater focus on system partnership and restoration of elective services. Details for the latter part of 2020/21 have yet to be agreed nationally but the following is expected:

- A block contract with prospective top-up uplifted for the full year effect of inflation.
- A Covid-19 fixed funding envelope which assumes current levels of Covid-19 claims adjusted for one-off items, exclusion of items which are subject to national procurements and any suspended services. However, specific items will be outside of the scope of the issued fixed envelopes (e.g. PPE, Covid-19 testing services).
- An expectation for systems to provide financial bridges which reflect the delivery of activity and performance targets as outlined within the plan submissions. Activity and supporting financial bridges will explain best and worst case scenarios for 2020/21.

Systems will be expected to achieve financial balance within these envelopes, although organisations within them will be permitted by mutual agreement across the partners to deliver surplus and deficit positions.

iv) Implications of the guidance for Virtual Patient Management High Impact Changes (HIC)

The NHSE/I letter of 31st July states the trusts are expected to re-establish services to deliver 100% of last year's activity for first and face to face outpatient attendances from September through the balance of the year, aiming for 90% in August. The e-referral system should be fully open to referrals from primary care and clinicians should consider avoiding asking patients to attend a physical outpatients appointment where clinically appropriate alternatives exist. The guidance states that advice and guidance should be used where possible and a patient-initiated follow up (PIFU) approach should be adopted. Where an outpatient appointment is clinically necessary, the national benchmark is that at least 25% of all outpatient appointments (new and follow ups) could be conducted by telephone or video, including 60% of all follow up appointments. Section 4 of the more detailed guidance provides the conditions for PIFU, lists clinical specialties most suited for PIFU and provides example implementation checklists. Individual services are now expected to develop their own criteria and protocols on when to use PIFU, provides practical information on implemented PIFU.

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WAHT's virtual patient management (VPM) HICs encompass the aspirations of the NHSE/I letter and guidance. Work is already underway on the following HICs:

- Electronic referral and triage, including advice and guidance
- Minimising face to face outpatients appointments
- PIFU
- Remote monitoring of long term conditions

However, if the national timescales are to be met, the work needs to be accelerated across all specialties. The clinical lead for VPM has scheduled two virtual workshops for clinical leads from all specialties (12th and 19th August). The workshops focus on the VPM programme of work, national expectations and what specialties need to do next. However, resources to support implementation of such changes in the timescale requires, particularly digital implementation, is limited.

v) The Trust's approach

WAHT began preparing for the provider technical templates week commencing 10th August. This work will progress in parallel with the system-wide approach and once triangulated, the templates will contribute to the aggregated STP/ICS return. WAHT will also contribute to the development of the system-wide narrative, providing an explanation of the key elements of the delivery plans that drive patient activity and performance. The STP/ICS approach was discussed at the STP Directors of Strategy Group Meeting on 13th August 2020.

Demand and capacity submission work is being reviewed by the Restoration oversight group. A short life steering group of Corporate leads from Strategy & Planning, Finance, HR and Informatics has been convened to oversee the overall work, and will meet fortnightly until submission on 21st September 2020. These leads will ensure that clinical divisions are engaged in the exercise.

Conclusion

The national guidance provides the context for the trust's response to COVID Phase 3 which is outlined above. The proposed approach to and timeline for the planning submission associated with the third phase of the response to COVID-19 is ambitious, but is never the less crucial for operational and financial delivery and stability for the remainder of 2020/21.

Recommendations

The board is recommended to

Part 1 - Note the guidance, timelines and proposed approach to and timeline for the Phase 3 planning submission

Part 2 – Note the progress made on Phase 3 as part of the STP submission and potential risks and dependencies. *This is within the private section of the Board as the contents are draft. The final document will be presented to the Board in public at the October meeting.*

Appendices

NHS
Worcestershire Acute Hospitals NHS Trust

Putting patients first May 2019

Meeting	Board
Date of meeting	10 September 2020
Paper number	E2

People & Culture Update
COVID-19 – Safety and welfare of the workforce

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

Accountable Director	Tina Ricketts, Director of People and Culture		
Presented by	Tina Ricketts	**Author /s**	Tina Ricketts

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

Report previously reviewed by		
Committee/Group	Date	Outcome

Recommendations	The Board is asked to note: 1. The actions that have been taken to reduce the risk of potential COVID-19 related work hazards for all colleagues 2. The wellbeing support that has been put in place to support colleagues with both their physical and mental health

Executive summary	Regular workplace and workforce risk assessments have been undertaken to ensure effective risk management and risk reduction of potential COVID-19 work hazards and a comprehensive wellbeing package is in place to support colleagues with both their physical and mental health. As at 31st August 2020, 94% (5,839 headcount) of staff have been supported by their line manager to complete an individual occupational health risk assessment. Compliance for black, Asian and minority ethnic colleagues is currently at 92%. A number of adjustments have been made in response to the risks identified and these include: • Strict adherence to social distancing • Enhanced Personal Protective Equipment • Adjusted working hours to avoid rush hour on public transport • Redeployment to lower risk areas or non-patient facing areas • Remote working • Limit duration of close interactions with patients A wellbeing task and finish group was set up at the beginning of the COVID-19 pandemic with representatives from each of the key staff groups. The group meets regularly to evaluate our wellbeing offer and has overseen the implementation of a comprehensive package for

	staff. We have been working with Kalidescope a local mental health charity who will be running mental health first aid training for colleagues commencing in October 2020. The next steps are to introduce wellbeing conversations for every member of staff, and we are exploring the clinical restorative supervision approach which has been successful in other organisations. Furthermore, we are working with the Point of Care Foundation to pilot the Team Time intervention which provides support to selected teams that have been affected in particular ways by the COVID-19 crisis. An important part of wellbeing is for staff to feel engaged and supported by the Trust. Engagement through staff networks is being strengthened and prioritised to enable us to hear and learn from colleague's lived experience. We have been successful in setting up a BAME network and we are in the process of setting up networks to strengthen the voice of LGBT and disabled colleagues. A number of staff deaths, three of which were Covid related, have occurred in the last six months. Understandably these deaths and the increase in deaths in general due to COVID-19, have had and may have a profound impact on colleague's wellbeing. We have received good feedback from colleagues who have accessed the wellbeing support. However, to ensure our offer is fit for purpose we are undertaking a peer review with the University Hospitals of Derby & Burton NHS Foundation Trust. The findings of this review will be shared with the People & Culture Committee in October.

Risk									
Key Risks	BAF 10: If we do not deliver a cultural change programme, then we may fail to attract and retain staff with the values and behaviours required for putting patients first, resulting in lower quality care BAF 11: If we are unable to recruit, retain and develop sufficient numbers of skilled, competent and trained staff, including those from the EU, then there is a risk to the sustainability of some clinical services. resulting in lower quality care for our patients and higher staffing costs								
Assurance	All elements of this report will be reviewed by the Trust Management Executive.								
Assurance level	**Significant**		**Moderate**	*x*	**Limited**		**None**		
Financial Risk	None identified								

Meeting	Board
Date of meeting	10 September 2020
Paper number	E2

1.0 Introduction/Background

We have a duty of care that requires us, as far as reasonably practical, to secure the health, safety and welfare of our workforce. This includes an equitable approach to effective risk management and risk reduction of potential work hazards, for all staff which requires:

A. A workplace assessment – taking into consideration the healthcare setting, the review of air generating procedures and the potential exposure to COVID-19 in the workplace

B. A workforce assessment – identifying individuals with increased vulnerability to infection or poorer outcomes to COVID-19. In March 2020, three categories of vulnerability were identified by Public Health England – specific long term health conditions, older age and pregnancy. More recent evidence confirms that ethnicity of a Black, Asian or Minority Ethnic (BAME) background are associated with increased vulnerability. There is also evidence of males over 50 being at greater risk and colleagues aged over 60.

C. Individual assessment – six factors should be considered when assessing the risk for individual members of staff (1) *age* with those aged over 70 being identified as clinically vulnerable (2) *sex* (3) *Clinically vulnerable people* (those with underlying health conditions or co-morbidities) (4) *Ethnicity* with BAME aged above 55 or having co-morbidities being at increased risk (5) *Pregnancy* in particular those are over 28 weeks or have underlying conditions (6) *Disabilities*

2.0 Issues

2.1 Workforce Risk Assessment

The following groups of staff have been identified as being at increased risk of COVID-19

- Those with specific underlying health conditions as defined by Public Health England
- Pregnant workers
- Those from a Black, Asian or Minority Ethnic background
- Those aged over 60
- Males aged over 55

Whilst the completion of an occupational health risk assessment has been mandated for all staff, managers have prioritised colleagues in the above categories.

Compliance as at 31st August 2020 is as follows:

By division:	Count of Employee Number	Staff in post	Compliance
365 Corporate	524	596	88%
365 Digital	72	72	100%
365 Estates & Facilities	355	364	98%
365 Specialised Clinical Services	1799	1851	97%
365 Specialty Medicine	1166	1311	89%
365 Surgery	752	775	97%
365 Urgent Care	479	532	90%
365 Women & Children	692	718	96%
Grand Total	**5839**	**6219**	**94%**

By staff group:	Count of Employee Number	Staff in post	Compliance
Add Prof Scientific and Technic	194	205	94%
Additional Clinical Services	1112	1174	94%
Administrative and Clerical	1129	1189	95%
Allied Health Professionals	420	439	96%
Estates and Ancillary	393	403	98%
Healthcare Scientists	176	183	96%
Medical and Dental	541	646	84%
Nursing and Midwifery	1874	1978	95%
Grand Total	**5839**	**6219**	**94%**

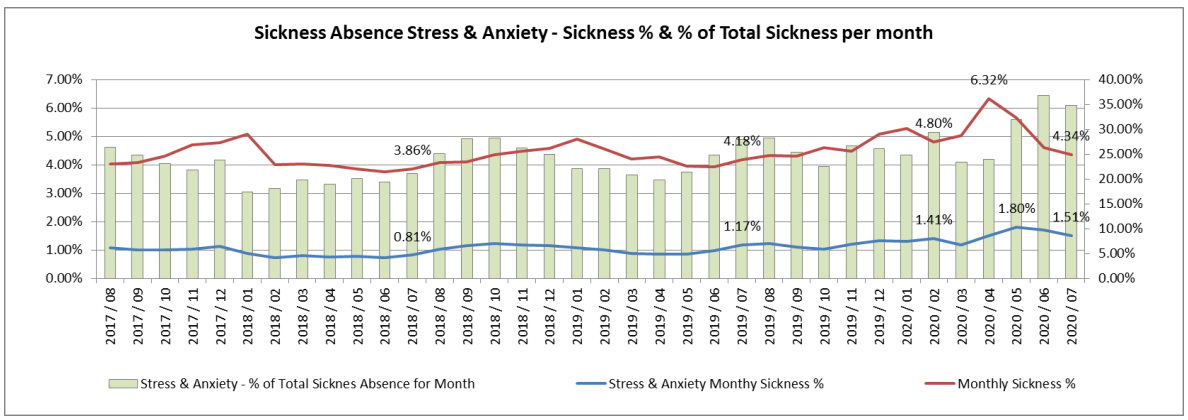
Overall compliance is at 94% with those in black, Asian and minority ethnic groups being at 92%.

The mitigation we have put in place for those with an identified risk include:

- Strict adherence to social distancing
- Enhanced personal protective equipment
- Adjustment in working hours to avoid rush hour on public transport
- Redeployment to lower risk areas or non-patient facing areas
- Remote working
- Limit duration of close interactions with patients

2.2 Employee Wellbeing

A number of staff deaths, three of which were Covid related, have occurred in the last six months. Understandably these deaths and the increase in deaths in general due to COVID-19, have had and may have a profound impact on colleague's wellbeing. From the graph below it can be seen that the percentage of staff absent due to stress, anxiety and depression has increased during the pandemic from a normal run rate of around 1% (70 headcount) to a peak of 1.8% (126 headcount) during May 2020. Feedback from occupational health confirms that in general the increase in absence is linked to bereavement.



In anticipation of an increase in mental health related absence due to COVID-19, a wellbeing

task and finish group was set up at the beginning of the pandemic to oversee the implementation and evaluation of the support package offered to staff. The group has representation from each of the key staff groups, staff side, chaplaincy, occupational health, health psychology and the bereavement services.

The group have implemented a wide range of support for colleagues which includes:

- Occupational health self or management referral
- Free 24hr Counselling – on line, telephone or face to face
- Project wingman/ wellbeing rooms across the 3 main sites
- Health psychology webinars for managers
- Mindfulness sessions
- Individual and team debriefs
- Free wellbeing Apps
- Free refreshments/ lunches for staff on COVID-19 wards
- Bereavement support through Chaplaincy and the bereavement office
- Wellbeing programmes for managers and staff
- On line wellbeing webinar held in conjunction with the BMA

To promote the above offer the group have developed the following resource:

- Dedicated wellbeing section on intranet
- Posters distributed across all sites
- Regular features in staff newsletter
- Comprehensive set of managers guidance (developed in conjunction with staff side)
- Managers toolkit (issued July 2020)

We have been working with the local mental health charity Kalidescope to explore a range of welfare support for colleagues and have contracted them to run mental health first aid training commencing October 2020. This training has been supported by charitable funds. The next steps are to introduce wellbeing conversations for every member of staff, and we are exploring the clinical restorative supervision approach which has been successful in other organisations. Furthermore, we are working with the Point of Care Foundation to pilot the Team Time intervention which provides support to selected teams that have been affected in particular ways by the COVID-19 crisis.

2.3 Staff networks

An important part of wellbeing is for staff to feel engaged and supported by the Trust. Engagement through staff networks is being strengthened and prioritised to enable us to hear and learn from colleague's lived experience.

The Black, Asian and Minority Ethnic (BAME) network has been created by colleagues from across the Trust and has full sponsorship from the Trust Board. At the People & Culture Committee in August, colleagues from the network were invited to update the committee on progress to date. The network has created a clear mission to support Black, Asian and Minority Ethnic colleagues, creating the opportunity to discuss race-related issues in an inclusive and 'safe' space, to have their concerns heard and then for the network to hold the Trust Board accountable. The network is attended by the freedom to speak up guardian and a number of network members have been recruited to become freedom to speak up champions. At the same time network members are being encouraged to join the 4ward advocates network.

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The network is electing its first Chair in September. The chairperson will play a key role in representing the network at the new Inclusion, Diversity, Equality and Action (IDEA) committee which replaces the Equality and Diversity Committee.

The network has committed to creating 3 task and finish groups that focus on areas for improvement.

- Recruitment, Selection & Career advancement
- Support & Advocacy
- Education

We are in the process of setting up a LGBT network and Disability network and will be following the same format as the BAME network.

2.4 Summary

We have received good feedback from colleagues who have accessed the wellbeing support. However, to ensure our offer is fit for purpose we are undertaking a peer review with the University Hospitals of Derby & Burton NHS Foundation Trust. The findings of this review will be shared with the People & Culture Committee in October.

3.0 Recommendations

The Board is asked to note:

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

NHS
Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	10 September 2020
Paper number	

Integrated Performance Report – Month 4 – 2020/21

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

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

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

Report previously reviewed by		
Committee/Group	**Date**	**Outcome**
TME	19th August 2020	Approved
Finance & Performance	26th August 2020	Assured
Quality Governance	27th August 2020	Assured

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

Executive summary	This paper provides the Trust Board with a validated overview of July 2020 against the trajectories, specifically for the NHS constitutional standards, key operational, quality and safety and workforce key metrics. Please note the format of the papers is in transition and all the sections will be transferring to the same format as the operational performance in the coming month.

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

Background

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

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

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NHS Trust

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Issues and options

The papers provided for the Finance and Performance Committee, Quality Governance Committee and People and Culture Committee are attached as Appendices.

The top three areas of challenge are:

- **Recovery of services following the Covid-19 pandemic, and ensuring patients are safely managed in the right place of care for their needs. Failure to comply with target activity levels will attract a financial consequence in the forms of an incentive payment risk from month 7 onwards.**
  All Trusts received a letter on 31 July from Simon Stevens to inform them of the level of expected activity required from September onwards. The level of activity is challenging and we are modelling whether it is achievable for Worcestershire Acute Hospitals Trust to deliver this level of activity without placing any staff member or patient 'at risk' of infection.
  We are working to triangulate patient experience and care, physical space and workforce requirements to identify what the activity gap may be to the national expectations. This has to be completed by 21 September for a final national submission.
- **Meeting our emergency access standard during winter through implementation of the Home First Programme. Emergency activity is almost at pre-COVID-19 levels, and the bed base is affected because Trust must maintain ring-fenced beds for infection control reasons.**
  In July we have experienced the same level of emergency activity as last year and still have approximately 10% of our beds unused (ring fenced - to enable us to comply with infection control restrictions). (Please note: 10% is the latest August position). Our urgent care and patient flow programme – Home First Worcestershire has had a positive impact on our performance, but we still need to ensure that we have contingency plans in place and enacted upon, on days when performance is above the expected level.
  These days of peak activity are compromising what is otherwise improved performance across Urgent Care and Patient Flow.
- **Minimise the harm to patients waiting for care who have been impacted by extended waits due to COVID-19.**
  Following 5 months of limited elective activity we have increasing waiting lists for RTT and some Cancer patients. The Harm review process has been made more robust internally, but it is highly likely that some patients are decompensating in the Community. Although we have an internal process we need to strengthen and be assured that there is a system wide approach to harm reviews for patients awaiting or on treatment pathways.

Recommendations

The Board is asked to note this report for assurance.

Appendices

1. IPR - Operational Performance
2. IPR – Quality & Safety
3. IPR – People and Culture
4. IPR - Finance
5. Home First Programme (Cover Report - 5a and Project Update - 5b)
6. Committee Assurance Statements

IPR - Operational Performance Report

Trust Board

10th September 2020

July 2020

Month 4

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

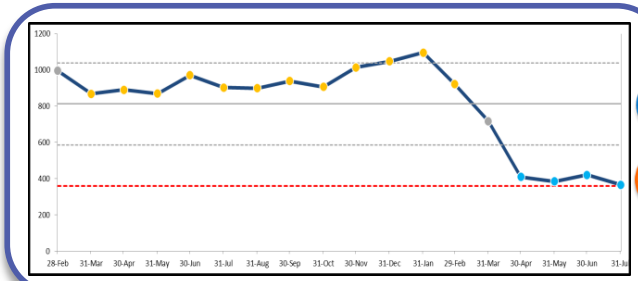
Month 4 [July] 2020-21 Operational Performance Summary

Responsible Director: Chief Operating Officer | Validated for July-20 as 14th August 2020

NHS Worcestershire Acute Hospitals NHS Trust

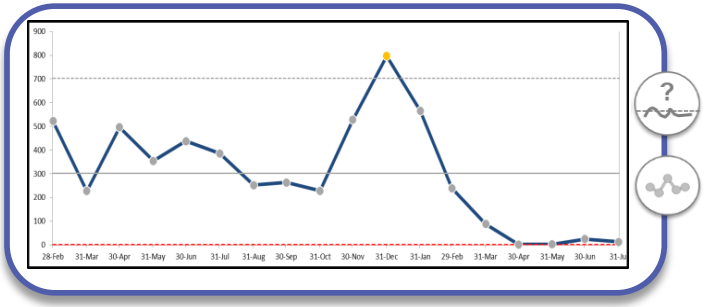
Total time spent in A&E (95th Percentile)

366 mins



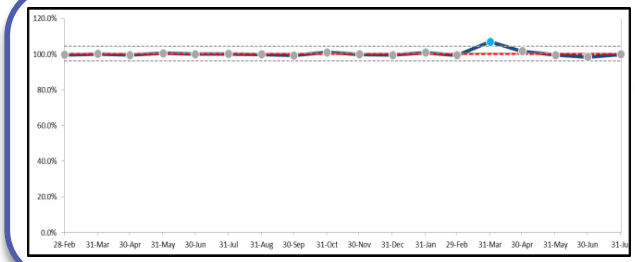
60 minute Ambulance Handover Delays

13



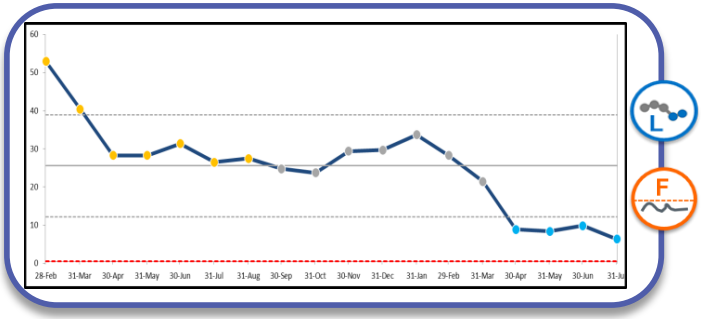
Discharge as a percentage of admissions

99.86%



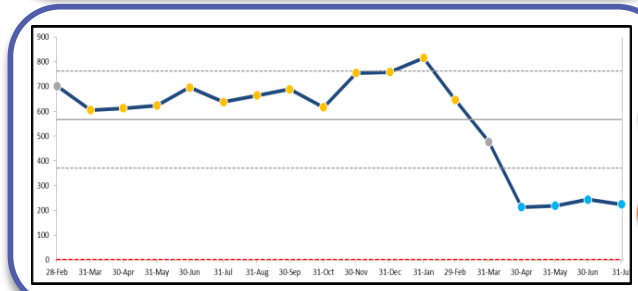
Capacity Gap (Daily avg. excl. EL)

5.8



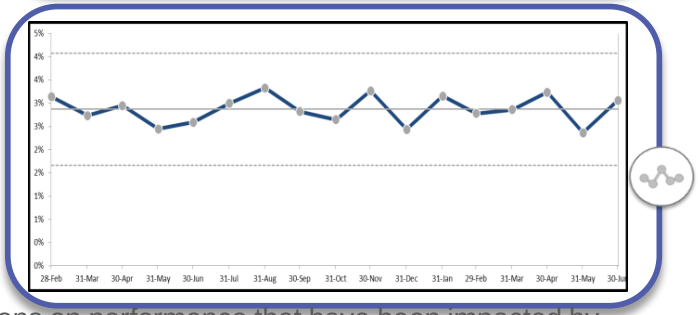
Aggregated Patient Delay (APD)

223



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

3.55%



Please note: These SPC charts are basing the icons on performance that have been impacted by Covid, when we have a few more data points these graphs will be re-based.

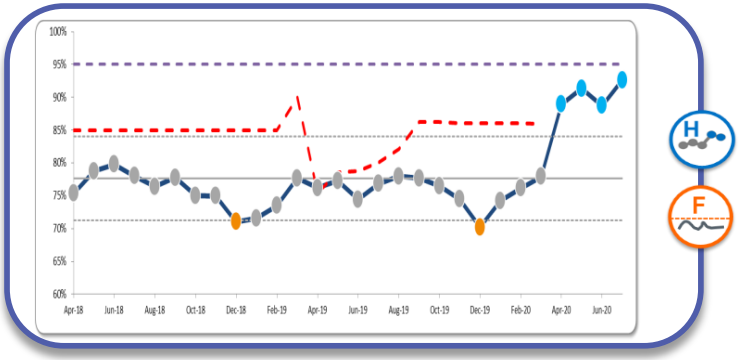
Month 4 [July] 2020-21 Operational Performance Summary

Responsible Director: Chief Operating Officer | Validated for July-20 as 14th August 2020

NHS Worcestershire Acute Hospitals NHS Trust

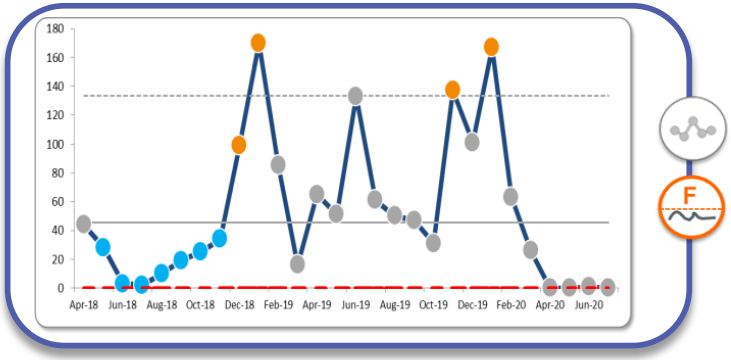
4 Hour EAS (all)

92.60%



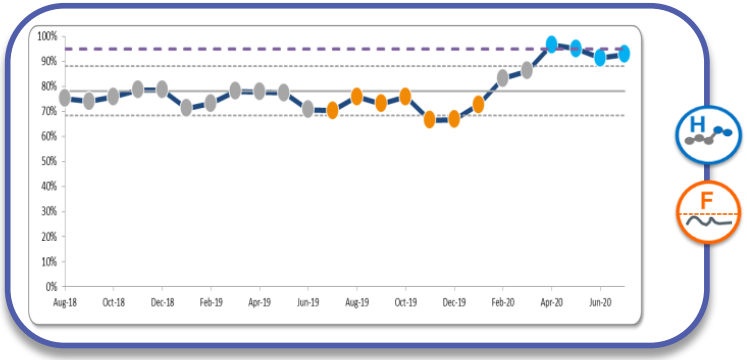
12 Hour Trolley Breaches

0



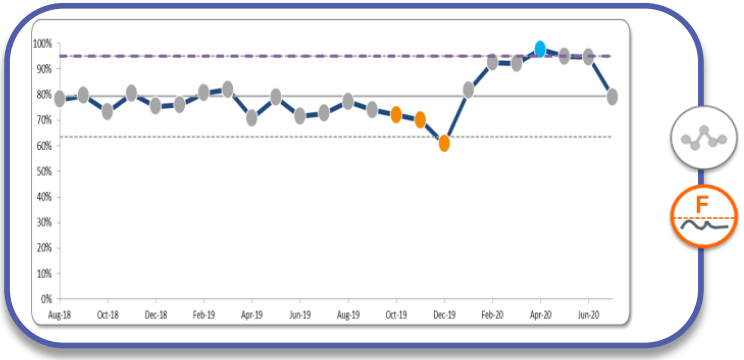
TTIA - % within 15 minutes WRH

92.72%



TTIA - % within 15 minutes ALX

78.95%



Please note: These SPC charts are basing the icons on performance that have been impacted by Covid, when we have a few more data points these graphs will be re-based.

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

12 Hour Breaches	Ambulance Handover Delays (Home First Programme metric)			Occupancy
	15-30 mins	30-60 mins	60+ mins	
0	818	97	13	64.12%

What does the data tell us?

- **EAS** - The EAS performance at Trust level which includes KTC MIU improved to 92.60% in Jul-20, compared to 88.71% in Jun-20. The EAS performance at WRH increased by 5.73%, there had been 449 more ED attendances than June and 294 fewer 4 hour breaches (July breaches – 835). The ALX EAS increased 3.19% and it had 500 more attendance than in June and had 97 fewer 4 hour breaches (July breaches – 242). Total Type 1 attendances across ALX and WRH was 10,982. The activity at WRH did not result in any 12 hour trolley breaches and there was a reduction in 60 minute ambulance handover delays.
- **15 minute time to triage –** The Trust performance is 92.72%, the target is 95%. With the exception of July at the ALX, both sites had been sustaining improved performance.
- **Conversion rates** - 3,015 Type 1 patients were admitted which is a conversion rate of 28.03%. The conversion rate at WRH was 31.36% and the ALX was 23.23%. The conversion rate at WRH in Jul-20 compared to Jun-19 is 5.6% higher highlighting the change in patient acuity for people requiring urgent care. There has been a stepped change increase in the number of patients being admitted from both ambulance conveyance and walk ins (at WRH). There has been a stepped decrease at the ALX.
- **Specialty Review times** – Data provided as part of the Internal Professional standards shows that Specialty Review times for the Trust are consistently around 40-50% of all patients who need a specialty review being seen within 30 minutes. This is being investigated as consistency and lack of clarity regarding who should capture the arrival times are causing data quality issues.
- **Bed Capacity** - G&A bed occupancy averaged at 64.12% across the Trust, with the WRH increasing week on week in July to 77.59% at month end and the ALX increasing week on week in July to 44.75% at month end. The G & A bed stock across both sites is 761, however that has reduced to 660 due to COVID-19, and there are c150 beds unused also each day in order to meet Infection safety requirements and due to having 2.1% of the workforce unavailable due to COVID-19 absences.
- **Discharges –** The % of discharges compared to admissions at the WRH has been between 79% and 149% and fluctuates significantly from day to day – the target is 100%. The ALX has a similar profile with the range between 53% and 168%. Before midday discharges are on an increasing trajectory, however there is still a lower performance on weekends. Every ward is now monitored on identifying patients who can have criteria led discharge, this metric is new and progress updates will be included in the Home First Programme updates going forward.

National Benchmarking (July 2020) - EAS:
The Trust was one of 5 of 13 of the West Midlands Trusts which saw a increase in performance between June and July. This Trust was ranked 5th of 13; where we were 9th previous month. The peer group performance ranged from 81.31% to 96.95% with a peer group average of 92.07%; increasing from 90.12% the previous month. The England average for July was 91.10%, a 1.7 percentage point decrease from 92.80%, in June

Operational Performance: Patient Flow

Home First Overarching metrics (*Ambulance H/O's earlier slide)				Selected key supporting metrics		
Capacity Gap (Target – 0)	95th percentile - longest time within ED (Target 360 mins)	Readmissions (No target)	Discharges as % of admissions (Target - >100%)	Patients with a LOS >=21 days	Before Midday Discharges (Target – 33%)	Number / % of patients streamed to Primary Care
5.8	366	3.52%	99.88%	23	25.4%	8.0% (End of July)

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

How have we been doing?

Please see separate Home First Programme papers for detailed update. Included below are business as usual updates.

- An action plan for immediate delivery has been put in place as a result of completing seven investigations into why performance at the WRH fell below the internal 85% Emergency Access Standard minimum. Updates on the completion of these actions will be to the Home First Board.
- Specialty reviews are being investigated to improve the data quality following a challenge from NHSE/I.
- Think 111 (First 111) which is a national programme aimed at reducing 'unhearalded' patients (those who have no and very minor treatment in ED) by 20% has commenced within the H&W STP. We are currently identifying what pathways could be targeted and what demand could be moved away from the ED departments. These patients will have to call NHS 111 to obtain an appointment time for attendance at the Emergency Department. H&W STP is the first to adopt this in the West Midlands.

What improvements will we make?

- A review of the diagnostic turnaround times for CT is taking place and results will be shared in August.
- Digital – Information are completing a three phased approach to ratify the data and information received by Urgent Care. This will be completed by December.
- Think 111 draft implementation plans are to be completed by August 28th.
- AMU business case is being re-written to take into account national funding.
- Demand and Capacity modelling to establish bed capacity during the winter months will be reviewed following the Phase 3 letter sent from Simon Stevens.

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

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

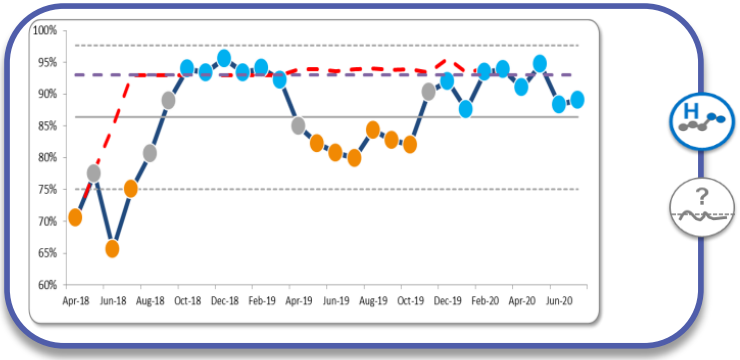
Month 4 [July] 2020-21 Operational Performance: Cancer

Responsible Director: Chief Operating Officer | Unvalidated for July-20 as 28th August 2020

NHS Worcestershire Acute Hospitals NHS Trust

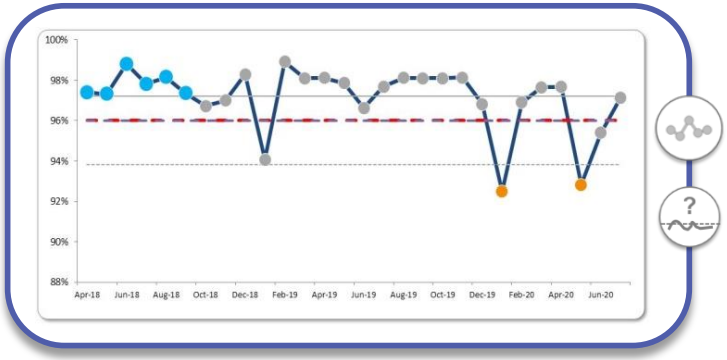
Cancer 2WW All

89.04%



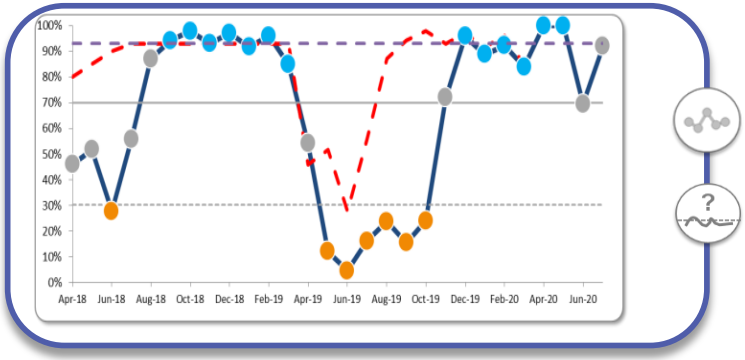
Cancer 31 Day All

97.14%



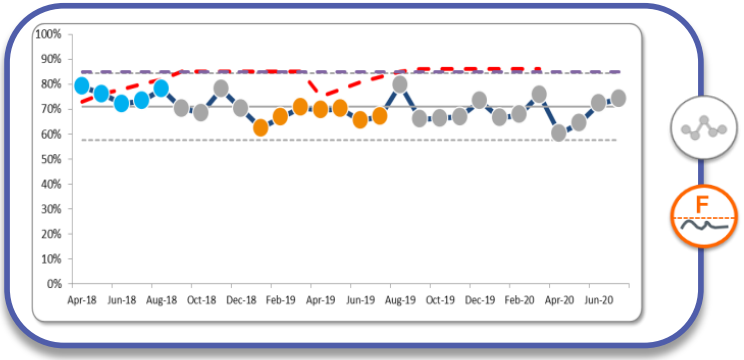
Cancer 2WW Breast Symptomatic

91.95%



Cancer 62 Day All

74.10%



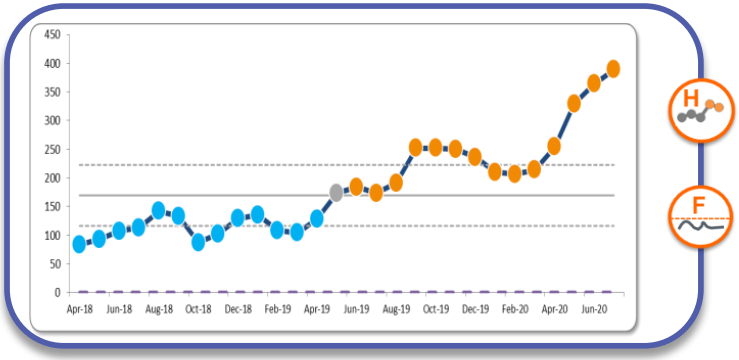
Month 4 [July] 2020-21 Operational Performance: Cancer

Responsible Director: Chief Operating Officer | Unvalidated for July-20 as 28th August 2020

NHS Worcestershire Acute Hospitals NHS Trust

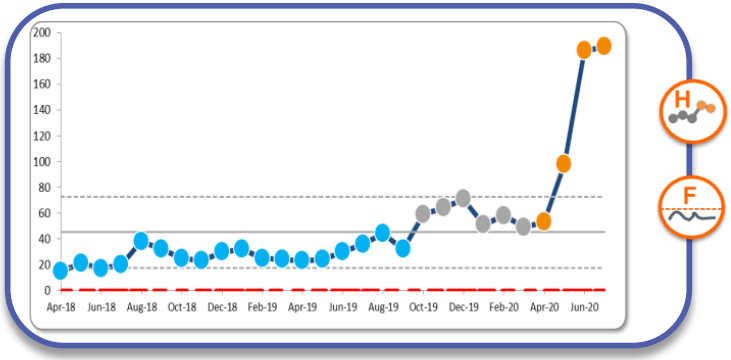
Backlog 62+ Day Waiters

389



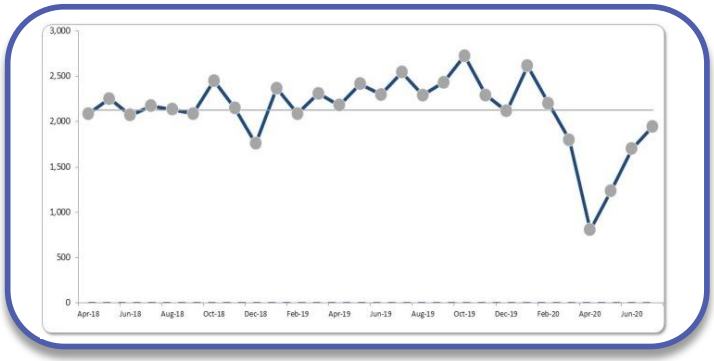
Backlog 104+ Day Waiters

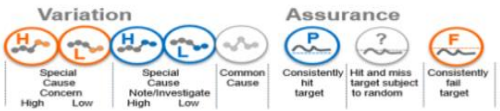
189



2WW Referrals

1,947





Operational Performance: Cancer

Cancer Referrals	Patients seen within 14 days (2WW) (All Cancers)	Patients seen within 14 days (2WW) Breast Symptomatic	Patients treated within 31 days	Patients treated within 62 days	Back log of patients waiting 62+ days	Back log of patients waiting 104+ days
1,947	89.04% 1,600 (total seen)	91.95% 87 (total seen)	97.10% 245 (total treated)	74.10% 152.5 (total treated)	389	189

What does the data tells us?

- **Referrals:** We have seen a month on month increase in 2WW referrals of 14%, with skin, colorectal and breast showing the biggest increases. Although at Trust level we are not yet at historic volumes (between 2,100 and 2,700 a month), we are planning for any increase in referrals through monitoring more recent trends rather than against historic, seasonal variation.
- **2WW:** The Trust saw 21% more patients in Jul-20 and 89.04% were within 14 days, in-line with Jun-20 performance of 88.32%. Three specialties were below the 93% standard, these were breast, Upper GI and urology. Of the 178 breaches, 25 were due to patient choice, with capacity issues impacting breast and urology and the diagnostic pathway impacting Upper GI.
- **2WW Breast Symptomatic:** The Trust saw 22% more patients referred for breast symptoms and waiting times performance improved to 91.95% in Jul-20 from 70.42% in Jun-20
- **31 Day:** 238 patients waited less than 31 days for their first definitive treatment from receiving their diagnosis with 7 patients breaching.
- **62 Day:** There have been 152.5 recorded treatments in Jul-20 to date and 74.10% were within 62 days. This is currently 19.5 more treatments than in Jun-20 but 54.0 fewer than Jul-19.
- **Backlog:** The number of patients waiting 62+ days for their diagnosis and, if necessary, treatment was 389, with 189 of those patients waiting 104 days or more. Colorectal, upper GI and urology are contributing the most patients to this waiting list.

What have we been doing?

- The majority of cancer pathways have continued and the independent sector has provided additional capacity for diagnostic and surgery although not enough to manage demand.
- Tertiary capacity (upper GI and lung) remains a concern for our patients although patients are now being dated.
- Divisions continue to prioritise cancer patients whilst seeking approval to undertake urgent work. Some specialties have requested routine work to commence due to the high percentage of Cancer patients that are converted from these clinics i.e. ENT.

What are we doing next?

- The upcoming increase in diagnostic capacity will support the pathways where it is needed; however, Endoscopy remains a challenge due to the restrictions placed on the service during COVID and the lack of capacity to meet the demand from the UGI and colorectal cancer pathways
- A Demand and Capacity tool has been provided to the Divisions by Digital – Information to support the planning of 2WW appointments – this will need to be included in the mapping of demand to capacity as we look to undertake more urgent and routine activity; and identify the gaps to the Phase 3 letter requirements.

National Benchmarking (June 2020)

2WW: The Trust was 6 of the 13 West Midlands Trusts that saw a decrease in performance between May and June. This Trust ranking changed from 5th to 12th out of 13. The peer group performance ranged from 67.74% to 98.62% with a peer group average of 94.10%; decreasing from 94.46% the previous month. The England average for June 2020 was 92.50%, a 1.6 percentage point decrease from 94.19% in May.

2WW BS: The Trust was one of 11 of the 13 West Midlands Trusts that saw a decrease in performance between May and June. This Trust was ranked 12 of 11. The peer group performance ranged from 65.56% to 100% with a peer group average of 97.33%; decreasing from 100% the previous month. The England average for June 2020 was 90.59 %, a 3.15 percentage point decrease from 93.74%, in May.

62 Days: The Trust was one of 12 of the 13 West Midlands Trusts that saw an in increase in performance between May and June. This Trust its position at 5 of 11. The peer group performance ranged from 58.84% to 82.12% with a peer group average of 69.28%; decreasing from 71.53% the previous month. The England average for June 2020 was 75.21%, a 5.35 percentage point increase from 69.86% in May.

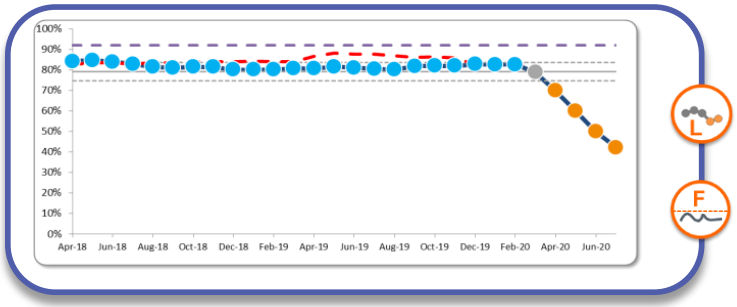
Month 4 [July] 2020-21 Operational Performance: RTT

Responsible Director: Chief Operating Officer | Validated for July-20 as 28th August 2020

NHS Worcestershire Acute Hospitals NHS Trust

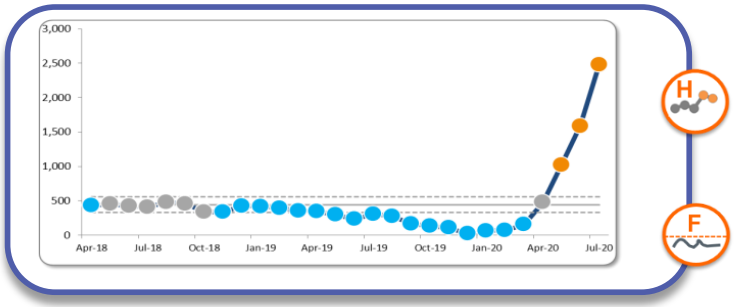
RTT % within 18 weeks

42.70%



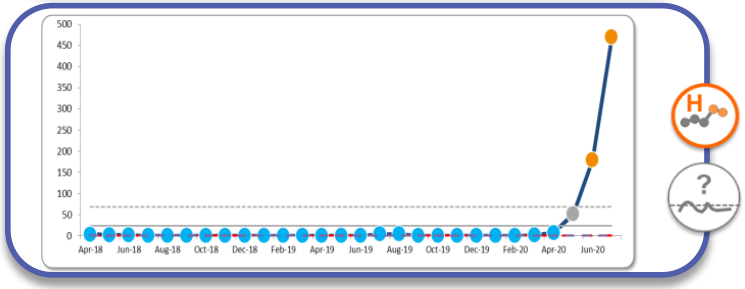
40-52 week waits

2,457



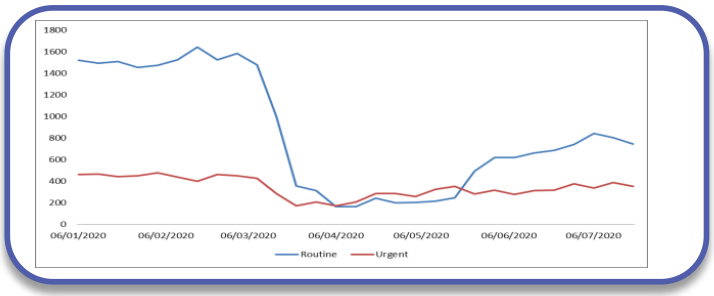
52+ week waits

483

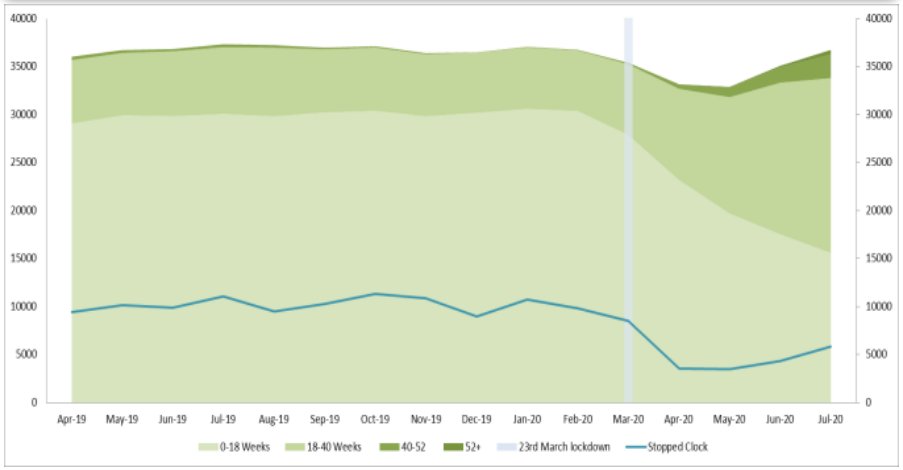


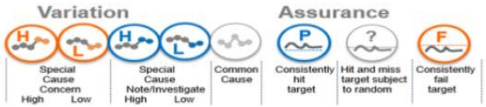
RTT Referrals

5,290



RTT Waiting list profile





Operational Performance: RTT

Percentage of patients on a consultant led pathway waiting less than 18 weeks for their first definitive treatment	Total Waiting List	Number of patients waiting over 18 weeks	Number of patients waiting 40 to 52 weeks or more for their first definitive treatment	52+ weeks	RTT Referrals (Routine and Urgent) received
42.70%	36,384	20,848	2,457	483	5,290

What does the data tells us?

- July 2020 continues to reflect the consequences of COVID-19 and the national mandate to stand down routine activity and referrals. The Trust has seen a 4.12% increase in the overall wait list size in Jul-20 compared to Jun-20; from 35,086 to 36,384.
- The number of patients over 18 weeks who were unable to be treated has reached 20,848, a further rise of 3,434 from June. The number of patients waiting over 18 weeks has almost tripled since pre-COVID-19.
- The Trust is reporting 2,457 patients waiting over 40 weeks for treatment, and 483 of those patients waiting over 52 weeks
- Although patients will be booked as activity/capacity increases are agreed, and therefore the following numbers are expected to reduce, there are currently (as at 14th August) 912 patients predicted to be breaching 52 weeks in August and 1,762 in September.
- The unvalidated RTT PTL for Jul-20 has 42.70% of the patients under the 18 weeks threshold up from 42.45% in Jun-20.
- Surgical specialties contribute 69% of all breached patients with ophthalmology, general surgery, urology, ENT, oral surgery, T&O, and gynaecology all having more than 1,000 patients over 18 weeks.
- RTT referrals (urgent and routine) have increased by 24.9% from Jun-20 to Jul-20.

What have we been doing?

- The Trust's governance process is being followed to ensure that for any restored service it is safe for both patients and staff. At the moment, this is focussed on restoring urgent activity; this will be followed by reviewing what capacity remains to undertake routine activity as well.

What are we doing next?

- The Trust has a significant number of patients categorised as urgent who need to be treated ahead of routines so performance will deteriorate further as those waiting are not treated.
- Risk stratification of the inpatient waiting list is required to ensure there is aligned capacity to theatres and beds.
- Demand and Capacity modelling is being completed between the operational leads and Digital –Information to understand the level of gap between the current capacity and Phase 3 letter requirements.

National Benchmarking (June 2020)

All 13 West Midlands Trusts saw a decrease in RTT performance between May and June. This Trust is now ranked at 8 of 13 where the previous month we were ranked 7th. The peer group performance ranged from 39.13% to 62.67% with a peer group average of 51.30%; decreasing from 61.48% the previous month. The England average for June 2020 was 52.00%, a 10.20 percentage point decrease from 62.20%, in May. There were 50,536 patients recorded as waiting 52+ weeks; this Trust was contributing 0.35% of those.

Month 4 [July] 2020-21 Operational Performance – Theatre Utilisation and Outpatients

Responsible Director: Chief Operating Officer | Unvalidated for July-20 as 14th August 2020

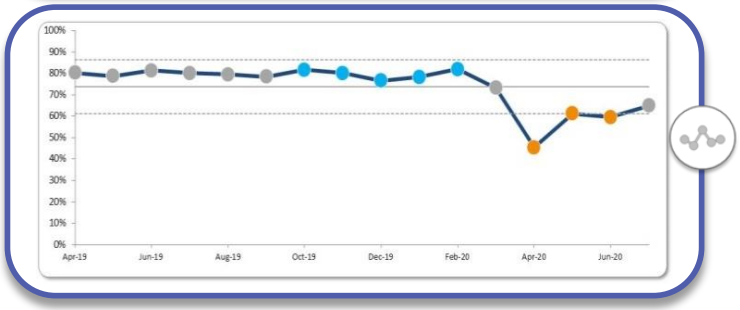
Worcestershire Acute Hospitals NHS Trust

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

6.10

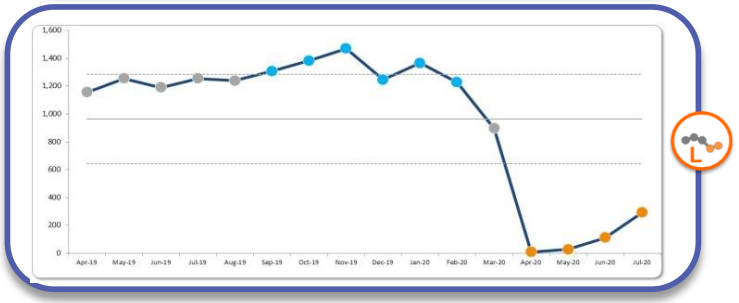
Actual session utilisation (%)

65.00 %



Day cases on elective theatre sessions (n)

293



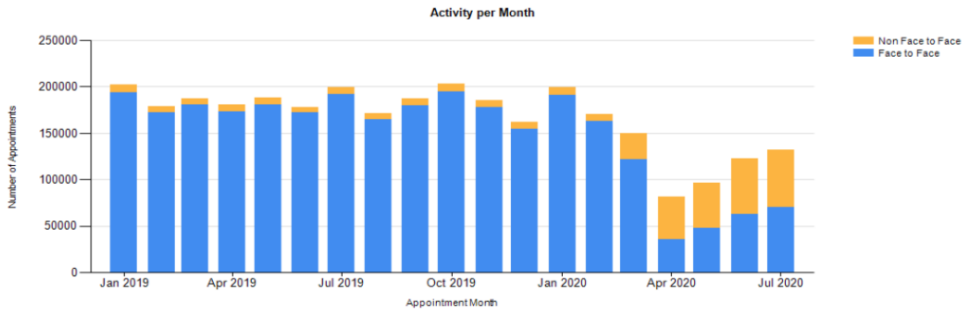
Electives on elective theatre sessions (n)

124

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

14

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



Operational Performance: Outpatients and Planned Admissions

Outpatients

News Face to Face	News Non Face to Face	News % Non Face to Face	Follow ups Face to Face	Follow ups Non Face to Face	Follow ups % Non Face to Face	Total % Non Face to Face
7,884	2,492	24.02%	9,551	13,152	57.93%	47.29%

What does the data tell us?

- The Trust undertook 33,079 outpatient appointments in Jul-20. Although this is 16,801 fewer appointments than Jul-19, there has been a significant shift in the number of non-face to face appointments.
- In Jul-19 1,924 non-face to face appointment took place which has increased to 15,644 in Jul-20. That is 13,720 more appointments, an increase of 713.10% and represents 47.29% of all appointments in the month.
- 17,428 appointment that were scheduled for Jul-20 have been cancelled. 14,591 appointments were cancelled by the Trust and 2,837 were patient cancellations.
- As at 6th August the outpatient backlog for new outpatients was over 42,000 with ~17,000 on an RTT pathway and ~25,000 on a non-RTT pathway. Just over 8,000 patients had been dated but that does leave almost 34,000 not yet dated. Just over 33,000 patients, of the total new outpatient waiting list are deemed to be routine.

What have we been doing?

- Through the Outpatients Restart Group, Restoration Forum and Restoration Oversight Group, 15 service restarts have been approved. This is predominantly urgent work, or work that was originally deemed routine but has become urgent due to the delay in patients being seen and the risk of harm this represents.

What are we doing next?

- In order to achieve the NSHEI phase 3 ambition of 100% of the previous years activity (from October), the Trust will need to plan how it can best prioritise, and then undertake, routine work whilst ensuring patient and staff safety.

Planned Admissions

On the day cancellations	Theatre Utilisation	DC on EL theatre sessions (n)	EL on EL theatre sessions (n)	NEL on EL theatre sessions (n)
6.10%	65.00%	293	124	14

What does the data tell us?

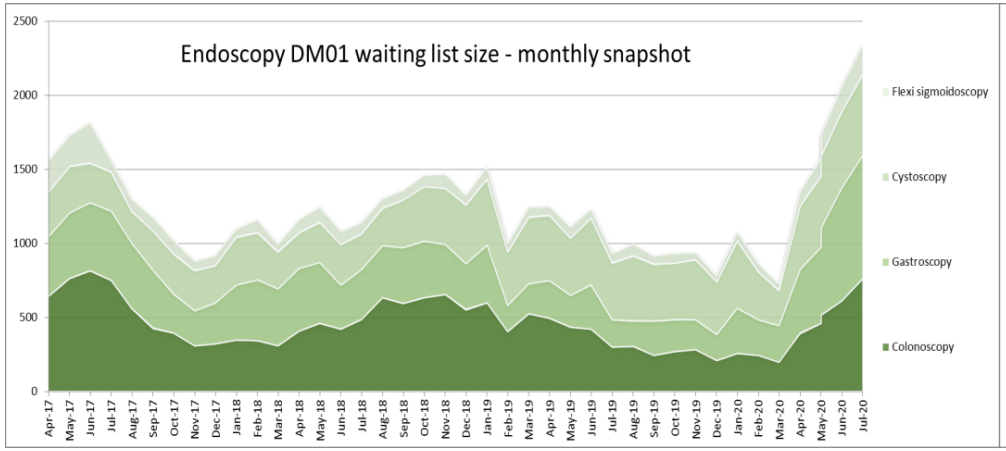
- On the day cancellations are showing normal variation having been statistically lower for April and May.
- Theatre utilisation has improved in July to be back within normal variation but it is clear that we have yet to achieve pre-COVID utilisation. Areas that are doing well as far as utilisation are Obstetrics and Gynaecology, Breast and Vascular. These are all areas that fill lists at short notice with MDT patients and urgent cases.
- 750 planned admissions that were scheduled for Jul-20 were cancelled. 443 were cancelled by the Trust and 307were patient cancellations.

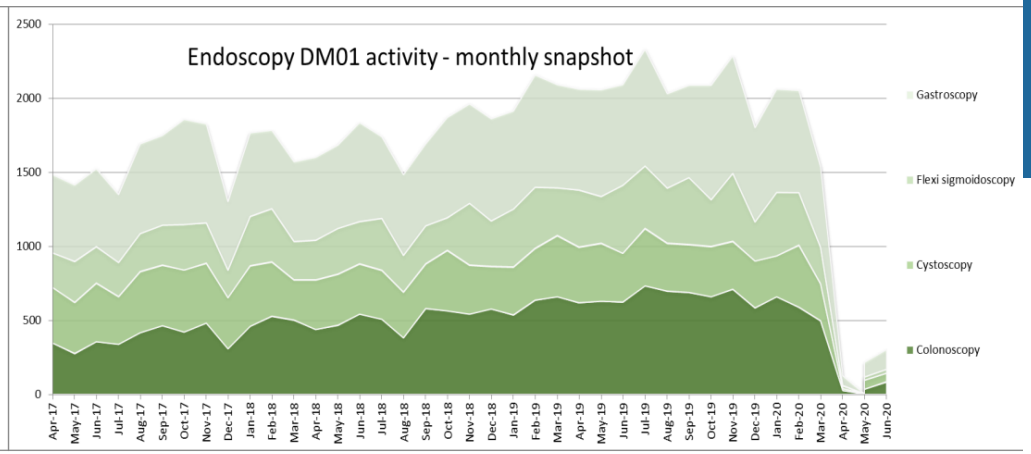
What are we doing next?

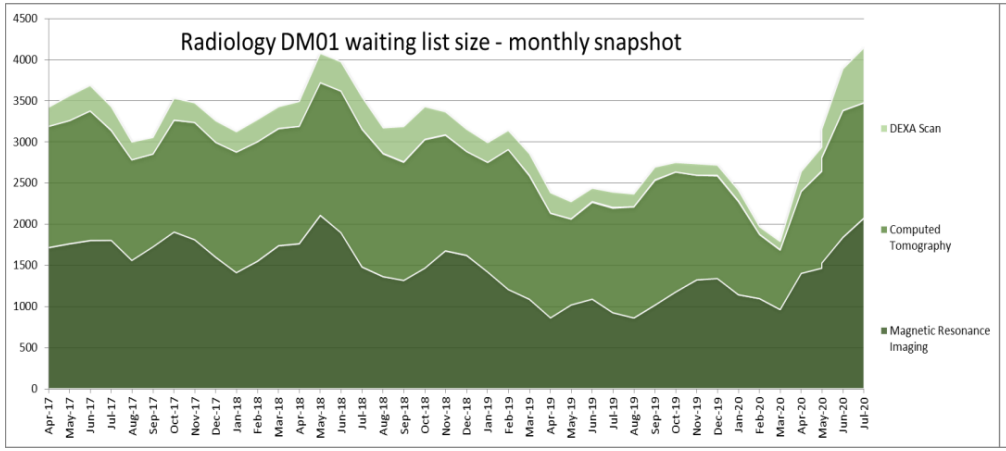
- The 6-4-2 meeting continues to meet to ensure we maximise all available capacity and plan for how we can open up additional theatre capacity

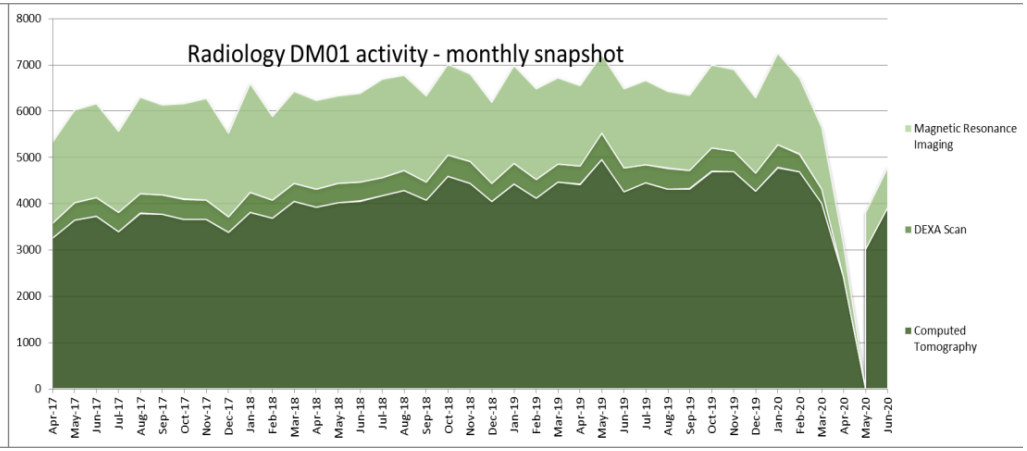
Month 4 [July] 2020-21 Operational Performance: DM01 Diagnostics

Responsible Director: Chief Operating Officer | Unvalidated for July-20 as 14th August 2020









Note the different scaled axis on this Radiology graph compared to the adjacent waiting list size graph

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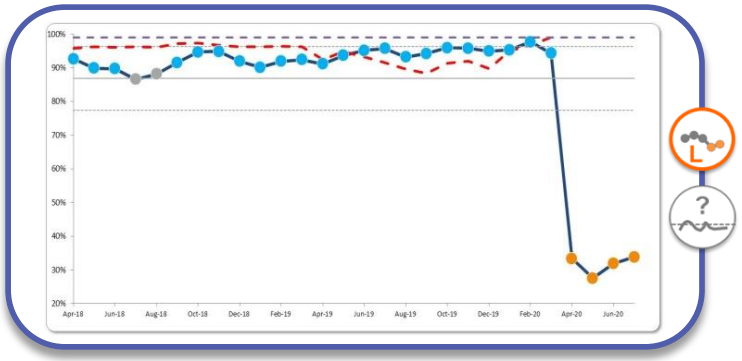
Operational Performance: DM01 Diagnostics

Number of patients waiting less than 6 weeks for a diagnostic test, the total waiting list and % waiting less than 6 weeks											
Trust Total			Radiology			Physiology			Endoscopy		
7,988	12,206	34.56%	5,181	7,874	34.20%	1,199	1,875	36.05%	1,608	2,457	34.55%

Diagnostics % within 6 weeks

34.56%



What does the data tell us?

- The Diagnostic performance is unvalidated at 34.56%. This is a direct result of the national mandate to cease elective activity, where patients were referred for tests and added to the waiting list but the Trust was unable to offer an appointment.
- The diagnostic waiting list is significantly growing as patients are added. The waiting list size is currently 12,206 , an increase of 1,140 (10.3%) from the previous month and the total number of patients waiting 6+ weeks has increased by 446 patients (5.9%).
- Radiology has the largest number of patients waiting at 7,874 but has been able to restart more activity compared to Endoscopy, particularly CT scans.
- The Trust continues to utilise the independent sector to undertake endoscopies. Although the requirement to self-isolate has reduced to 7 days from 14, this does not always alleviate fears or make it any more manageable for some of our patients.

National Benchmarking (June 2020)

The latest published national data is for June 2020. All West Midlands Trusts saw a decrease in performance. This Trust was ranked 12 of 13 in June 2020. The peer group performance ranged from 4.35 % to 68.15% with a peer group average of 48.45%; decreasing from 63.64% the previous month. The England average for June 2020 was 47.80%, a 10.70 percentage point decrease from 58.50% in May.

Operational Performance: DM01 Diagnostics

What have we been doing?	What are we doing next?
ENDOSCOPY (inc Gynae & urology) • Utilising available capacity IS- BMI and Spire • Continued provision of 2WW and urgent patients as prioritised by MDT • Re-establishment of WLI at weekends at KTC/ALX • Re-established activity at ECH • Recommenced endoscopy at KTC as W&C have vacated department. • Diagnostics for Urodynamics / Cystoscopy are both considered routine activity and ceased during COVID	• Reintroduce 18 week support insourcing team. • Within 4 week period 18 week will run 2 rooms at ECH • Increase patient numbers on urology sessions at ALX • Gradually increase patient numbers on sessions at ECH for Colonoscopy • Commence Cystoscopy on 7th August approx. 7 sessions per month giving capacity for 42 slots. • A draft document has been produced for Urodynamic studies to restart. The plan will be to run clinics from both KTC and AGH.
RADIOLOGY • Continued provision of all 2WW and urgent referrals • Reinstated routine activity on community sites for Ultrasound (no CT or MRI equipment on community sites) • Reinstated 5pm-8pm for MRI Routine referrals on KTC site • Utilising CT mobile on KTC site for routine and planned referrals (back log only) • Utilising Independent sector capacity at BMI (CT) and SPIRE (CT) • Utilising SPIRE CT Cardiac capacity	• On approval of QIA reinstate routine examinations on WRH and Alex • Extension to CT mobile contract to maintain current capacity • Reduce back log as per trajectory • Work in collaboration with other Divisions/Directorates to support strategy re-start and 12 months.
NEUROPHYSIOLOGY • All services suspended in March 2020 • Restart of services in June 2020 up to around 75% capacity due to infection control and social distancing measures • Approx. 12 – 15 week wait	• Continue to aim for 80% capacity by September • Waiting for additional rooms at ALX and KTC to allow additional clinics to re-start.
CARDIOLOGY - ECHO • Currently seeing urgent patients only • In process of gaining authorisation for restoration of service	• When services have been resumed the backlog will be managed in priority order.

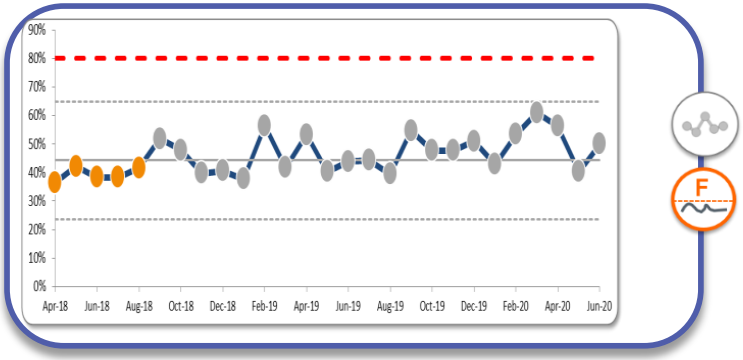
Month 3 [June] 2020-21 Operational Performance: Stroke

Responsible Director: Chief Operating Officer | Validated for June-20 as 14th August 2020

NHS Worcestershire Acute Hospitals NHS Trust

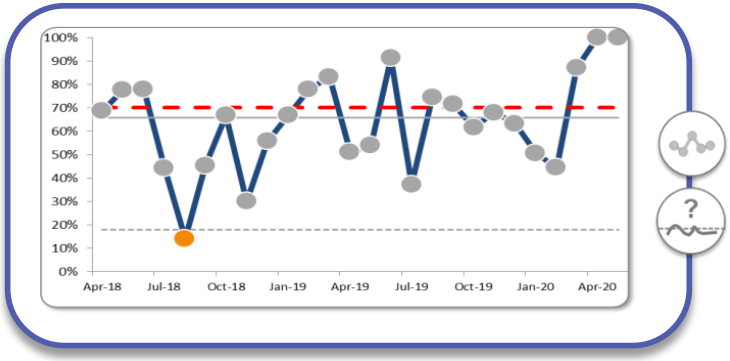
Stroke : % CT scan within 60 minutes

50.7%



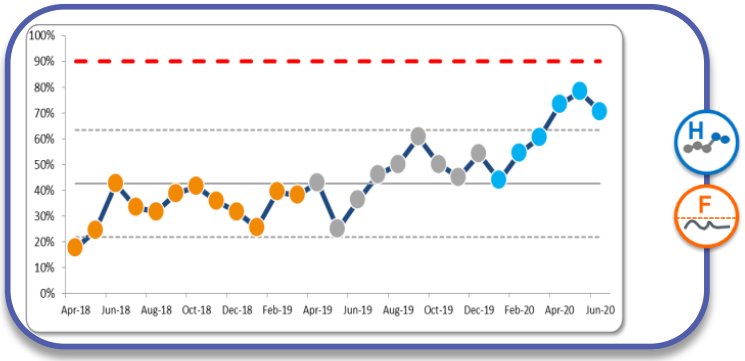
Stroke: % seen in TIA clinic within 24 hours (May)

100%



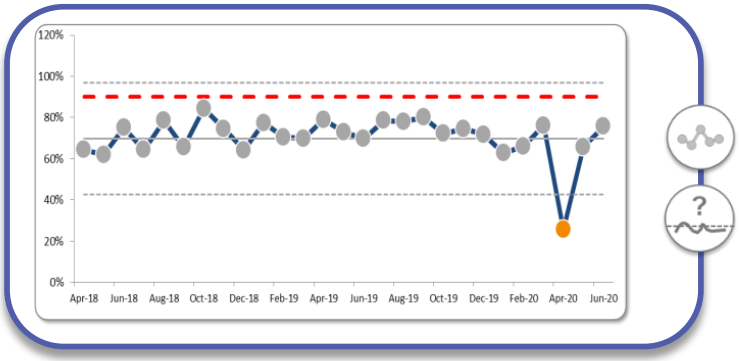
Stroke : % Direct Admission to Stroke ward

71.1%



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

74.6%



Operational Performance: Stroke

% of patients spending 90% of time on a Stroke Ward	% of patients who had Direct Admission (via A&E) to a Stroke Ward	% patients seen in TIA clinic within 24 hours	% of patients who had a CT within 60 minutes of arrival	SSNAP Q4 Jan-20 to Mar-20			
74.6%	71.1%	100%	50.7%	Score	69.3	Grade	C

What does the data tell us?

- There has been, as a result of a 0.7 decrease in our SSNAP score between quarter 3 to quarter 4, a change in grade from B to C. This is driven by the reduction in the case ascertainment score to between 80-89% and therefore a 5% reduction in overall score is applied.
- Three stroke metrics have maintained their common cause variation. The direct admission metric has maintained it's special cause improvement.
- The SPC chart for patients seen in TIA clinic within 24 hours masks the sustained improvement of 100%. This has been achieved by a change in process which means that, following triage by a consultant, the appointment is held non face-to-face.

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

We relocated the Stroke Unit in January to a smaller bed base and ring-fenced of all Stroke beds to ensure their efficient use. Since then we have updated the SOP to reflect the current changes with regards to ring-fencing, role & responsibilities of both CNS's and Consultants supporting front door activity. This was provisionally agreed in our directorate meeting in July and will be presented to Divisional Management Board in September.

We have been working closely with the information team to enhance performance reporting. This now provides up to date performance information to the team, allowing data to be compared/reconciled both at local and national level. The expectation is that this should drive improvement in range of measures on a weekly/monthly basis and contribute greatly in overall improvement. From this work we now have a live Stroke dashboard which was made available in June and a weekly report that predicts future SSNAP gradings. We understand the value of ensuring activity/performance is monitored regularly and support from the Information Team is facilitating this.

Previously the team have also established a detailed list of expected duties to be carried out by each doctor when covering ward, front door and TIA. This is anticipated to improve consistency in approach and behaviour, which should result in improvement against each of the key indicators. Similarly, the role and responsibilities of Stroke CNS has also been clearly defined and aligned to the role of front door consultant, which should also support. The SOP does need to be updated and agreed by the division. We aim to have a final version ready for next DMB meeting in September.

We have develop a 24/7 CNS model, which should contribute to overall improvement in all key indicators. We are currently waiting on HR to agree to the proposed changes of the contract. We aim for this to be in place November/ December.

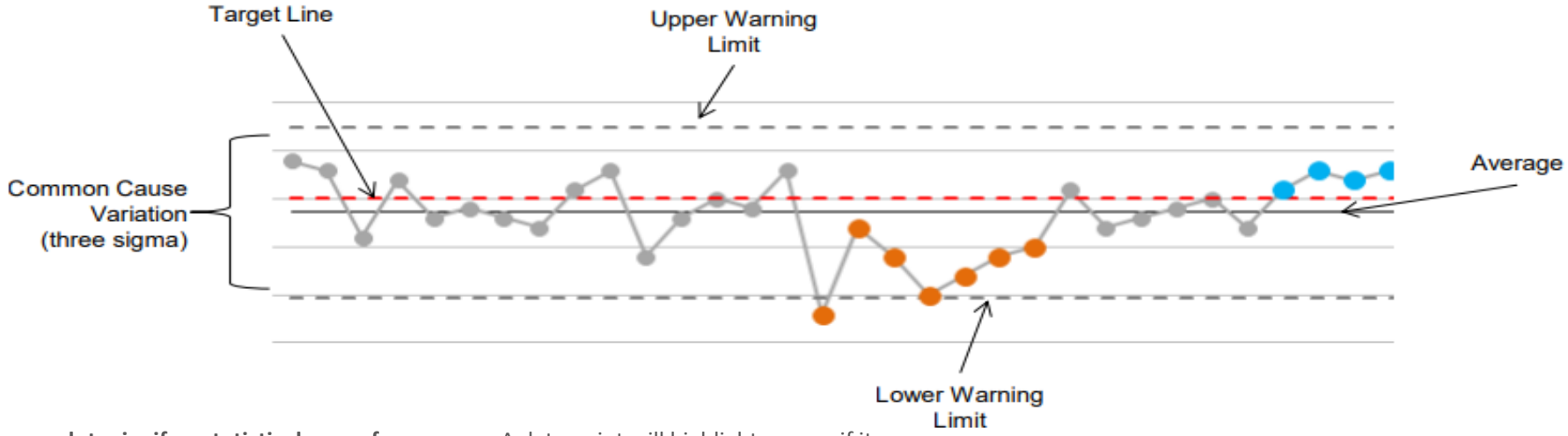
STP model of stroke services – discussions have restarted but nothing has been agreed yet.

Operational Performance Table | Month 4 [July] 2020-21

NHS Worcestershire Acute Hospitals NHS Trust

	Performance Metrics	Operational Standard		Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20
EAS	4 Hours (all)	95%	Actual	76.82% ✗	77.98% ✗	77.68% ✗	76.49% ✗	74.47% ✗	70.17% ✗	74.23% ✗	76.15% ✗	77.90% ✗	88.92%	91.33%	88.71%	92.61%
			Trajectory	80.10%	82.10%	86.21%	86.24%	86.00%	86.00%	86.00%	86.00%	86.00%				
	15-30 minute Amb. Delays	-	Actual	1,925 ✗	1,828 ✗	1,624 ✗	1,940 ✗	1,826 ✗	1,946 ✗	1735 ✗	1788 ✗	1992 ✗	1,443	1,148	1,119	818
			Trajectory	1112	855	831	673	655	704	706	642	470				
	30-60 minute Amb. Delays	-	Actual	751 ✗	646 ✗	578 ✗	705 ✗	813 ✗	1,004 ✗	647 ✗	458 ✗	413 ✓	145	82	150	97
			Trajectory	445	428	416	292	284	376	377	428	470				
	60+ minutes Amb. Delays	0	Actual	386 ✗	252 ✗	264 ✗	228 ✓	528 ✗	797 ✗	566 ✗	239 ✗	88 ✗	2	3	25	13
			Trajectory	222	214	208	269	262	329	330	107	0				
RTT	Incomplete (<18 wks)	92%	Actual	80.53% ✗	80.10% ✗	81.75% ✗	81.88% ✗	81.94% ✗	82.72% ✓	82.56% ✗	82.66% ✗	78.75% ✗	69.92%	59.89%	49.95%	42.70%
			Trajectory	87.69%	86.93%	86.01%	86.25%	85.81%	82.59%	83.06%	82.95%	82.43%				
	52+ WW	0	Actual	4 ✗	4 ✗	0 ✓	0 ✓	0 ✓	0 ✓	0 ✓	0 ✓	1 ✗	7	52	179	483
			Trajectory	0	0	0	0	0	0	0	0	0				
CANCER	2WW All	93%	Actual	79.91% ✗	84.32% ✗	82.76% ✗	82.03% ✗	90.30% ✗	91.99% ✗	87.53% ✗	93.44% ✗	93.83% ✓	90.97%	94.69%	88.30%	89.04%
			Trajectory	93.94%	94.02%	93.83%	93.96%	93.37%	95.58%	93.34%	94.05%	93.10%				
	2WW Breast Symptomatic	93%	Actual	16.07% ✗	23.77% ✗	15.52% ✗	24.06% ✗	71.96% ✗	95.92% ✗	88.82% ✗	92.25% ✗	83.94% ✗	100.00%	100.00%	70.42%	91.95%
			Trajectory	55.68%	87.01%	94.20%	97.81%	93.02%	97.04%	91.72%	96.00%	84.80%				
	62 Day All	85%	Actual	67.07% ✗	79.70% ✗	65.86% ✗	66.37% ✗	66.87% ✗	73.25% ✗	66.50% ✗	67.75% ✗	75.82% ✗	60.14%	64.31%	72.18%	74.10%
			Trajectory	82.91%	84.90%	86.04%	86.04%	86.04%	86.04%	86.04%	86.04%	86.04%				
	104 day waits	0	Actual	36 ✗	44 ✗	32 ✗	59 ✗	64 ✗	71 ✗	51 ✗	58 ✗	49 ✗	53	98	186	189
			Trajectory	0	0	0	0	0	0	0	0	0				
	31 Day First Treatment	96%	Actual	97.69% ✗	98.11% ✗	98.10% ✓	98.09% ✓	98.13% ✓	96.81% ✗	92.48% ✗	96.90% ✗	97.65% ✓	97.67%	92.82%	95.39%	97.14%
			Trajectory	97.82%	98.15%	97.35%	96.73%	96.99%	98.30%	94.07%	98.91%	97.22%				
	31 Day Surgery	94%	Actual	75.0 % ✗	85.2 % ✗	88.0 % ✗	76.0 % ✗	85.3 % ✗	76.2 % ✗	59.3 % ✗	63.3 % ✗	90.9 % ✗	97.2 %	76.9 %	81.8 %	62.5 %
			Trajectory	100.00%	100.00%	95.00%	100.00%	100.00%	100.00%	92.68%	93.33%	95.83%				
	31 Day Drugs	98%	Actual	100.0 % ✓	100.0 % ✓	90.9 % ✗	100.0 % ✓	97.6 % ✗	96.8 % ✗	90.9 % ✗	100.0 % ✓	97.8 % ✗	100.0 %	97.8 %	99.2 %	100.0 %
			Trajectory	100%	100%	100%	100%	100%	100%	100%	100%	100%				
	31 Day Radiotherapy	94%	Actual	100.0 % ✓	100.0 % ✓	100.0 % ✓	100.0 % ✓	100.0 % ✓	98.8 % ✗	98.0 % ✗	98.9 % ✗	100.0 % ✓	96.4 %	97.2 %	95.6 %	91.7 %
			Trajectory	100%	100%	100%	100%	100%	100%	100%	100%	100%				
	62 Day Screening	90%	Actual	100.0 % ✓	94.4 % ✓	82.5 % ✓	85.7 % ✓	72.2 % ✗	80.0 % ✗	73.5 % ✓	72.2 % ✗	73.9 % ✗	70.6 %	88.2 %	0.0 %	0.0 %
			Trajectory	90.70%	76.60%	73.21%	65.38%	78.26%	93.55%	63.41%	86.96%	81.25%				
	62 Day Upgrade	-	Actual	52.4 % ✗	73.3 % ✗	46.7 % ✗	76.9 % ✓	80.0 % ✓	73.1 % ✓	85.7 % ✓	85.3 % ✓	92.4 % ✓	95.5 %	89.4 %	92.0 %	82.6 %
			Trajectory	83.33%	80.00%	90.91%	60.00%	75.00%	55.00%	62.50%	84.21%	65.38%				
	Diagnostics (DM01 only)	99%	Actual	95.68% ✓	93.17% ✓	94.21% ✓	95.96% ✓	95.78% ✓	94.94% ✓	95.28% ✓	97.64% ✓	94.29% ✗	33.37%	27.52%	31.85%	34.56%
			Trajectory	91.42%	89.52%	88.25%	91.28%	91.91%	89.77%	94.99%	96.71%	99.03%				
STROKE	CT Scan within 60 minutes	-	Actual	44.30% ✗	39.50% ✗	54.70% ✗	47.70% ✗	47.70% ✗	51.00% ✗	42.90% ✗	53.40% ✗	60.90% ✗	56.30%	40.30%	50.70%	-
			Trajectory	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%				
	Seen in TIA clinic within 24hrs	-	Actual	37.10% ✗	74.40% ✓	71.60% ✓	61.60% ✗	67.90% ✗	63.10% ✗	50.50% ✗	44.40% ✗	87.00% ✓	100.00%	100.00%	100.00%	-
			Trajectory	70.00%	70.00%	70.00%	70.00%	70.00%	70.00%	70.00%	70.00%	70.00%				
	Direct Admission	-	Actual	46.00% ✗	50.00% ✗	60.70% ✗	50.00% ✗	45.10% ✗	54.10% ✗	43.90% ✗	54.40% ✗	60.40% ✗	73.30%	78.30%	71.10%	-
			Trajectory	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%				
	90% time on a Stroke Ward	-	Actual	78.50% ✗	78.00% ✗	80.00% ✗	72.10% ✗	74.60% ✗	71.70% ✗	62.70% ✗	66.00% ✗	76.11% ✗	25.50%	65.70%	74.60%	-
			Trajectory	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%	80.00%				

Statistical Process Charts (SPC) Guidance



Orange dots signify a statistical cause for concern. A data point will highlight orange if it:
A) Breaches the lower warning limit (special cause variation) when low reflects underperformance or breaches the upper control limit when high reflects underperformance.
B) Runs for 7 consecutive points below the average when low reflects underperformance or runs for 7 consecutive points above the average when high reflects underperformance.
C) Runs in a descending or ascending pattern for 7 consecutive points depending on what direction reflects a deteriorating trend.

Blue dots signify a statistical improvement. A data point will highlight blue if it:
A) Breaches the upper warning limit (special cause variation) when high reflects good performance or breaches the lower warning limit when low reflects good performance.
B) Runs for 7 consecutive points above the average when high reflects good performance or runs for 7 consecutive points below the average when low reflects good performance.
C) Runs in an ascending or descending pattern for 7 consecutive points depending on what direction reflects an improving trend.

Special cause variation is unlikely to have happened by chance and is usually the result of a process change. If a process change has happened, after a period, warning limits can be recalculated and a step change will be observed. A process change can be identified by a consistent and consecutive pattern of orange or blue dots.