Worcestershire Acute Hospitals NHS Trust

Trust Board
There will be a meeting of the Trust Board on Thursday 11 June 2020 at 10:00. It will be held virtually and live streamed on You Tube.

Sir David Nicholson
Chairman

Agenda			Enclosure
1	**Welcome and apologies for absence**		
2	**Items of Any Other Business** *To declare any business to be taken under this agenda item.*		
3	**Minutes of the previous meeting** *To approve the Minutes of the meeting held on **14 May 2020** as a true and accurate record of discussions.*	*For approval*	**Enc A**
4	**Action Log**	*For noting*	**Enc B**
5	**COVID-19: Restoration, Recovery & Reset**		
5.1	**COVID-19: Restoration, Recovery & Reset** Chief Operating Officer Director of Strategy and Planning	*For assurance*	**Enc C**
6	**STRATEGY**		
6.1	**2020/21 Annual Plan Priorities** Director of Strategy and Planning	*For approval*	**Enc D**
	BREAK		
7	**Performance**		
7.1 **7.1.1**	**Integrated Performance Report** **Executive Summary/SPC charts** Chief Executive/Executive Directors	*For assurance*	**Enc E**
7.2.2	**Committee Assurance Reports** Committee Chairs		**Appendix 2**
7.2.3	**Finance summary** Chief Finance Officer		**Appendix 3**
8	**Governance**		
8.1	**Safe Staffing Paper** Chief Nursing Officer	*For assurance*	**Enc F**
9	**Assurance Reports**		
9.1	**Audit and Assurance Committee Report** Audit and Assurance Committee Chairman	*For assurance*	**Enc G**

Any Other Business *as previously notified*

Date of Next Meeting
The next public Trust Board meeting will be held on 9 July 2020, Board Room 1 and 2, Alexandra Hospital, Redditch/virtually.

Enc A

Worcestershire Acute Hospitals NHS Trust

MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON THURSDAY 14 MAY 2020 AT 10:00 hours VIRTUALLY

Present:

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

(The minutes reflect the order in which the items were considered)

010/20 **WELCOME**

Sir David welcomed everyone to the meeting. In particular he welcomed Jo Newton to her first meeting following her appointment to the post of Director of Strategy and Planning.

011/20 **ANY OTHER BUSINESS**

There were no items of any other business.

012/20 **DECLARATIONS OF INTERESTS**

Sir David introduced the report setting out the annual review of declarations of interest for Board members which are available on our Trust's website.

RESOLVED THAT The report be noted.

013/20 **MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON 23 APRIL 2020**

RESOLVED THAT the Minutes of the public meeting held on 23 April 2020 be confirmed as a correct record and signed by the Chairman.

014/20 **MATTERS ARISING/ACTION SCHEDULE**

Mr Wood reported that the log contained updates on the three overdue actions. One action was for a future meeting and two actions had been completed.

015/20 **CHAIRMAN'S REPORT**

The Chair had no matters upon which he wished to report.

016/20 **CHIEF EXECUTIVE'S REPORT**

Mr Hopkins invited the Board to reflect on the death of those members of staff during the pandemic; Julie Omar, Karen Perrygrove and Jordon Gait. He had written to family members offering our Trust's condolences and staff had been informed.

Mr Hopkins then presented his report. At the Provider Oversight Committee meeting earlier in the week there was positive feedback on the progress made since the CQC's visit to the Emergency Departments in December 2019 and the well-managed response to the COVID-19 pandemic under Mr Brennan's leadership was acknowledged. NHSE/I will be seeking assurance that there has been sustained improvement in performance before consideration is given to the Trust exiting quality special measures as previously recommended by the CQC.

Mr Hopkins paid tribute to the incredible generosity of the people of Worcestershire, local businesses and organisations, to the charity appeal launched to support our staff and patients during the COVID-19 outbreak which raised more than £100,000 in just four weeks.

On restoration and recovery, Mr Hopkins said that earlier in the week he had met the Chairs of the Health Overview and Scrutiny Committee and the Health and Wellbeing Board to discuss our approach to restoration and recovery to work alongside those organisations. Discussions which he and Sir David had with local MPs had been positive. We will also be working with the STP and ICS to ensure that we develop services innovatively with no return to the former ways of working. We need to ensure that we are able to manage a likely second surge in COVID-19 patients, continue to have empty trolleys in Assessment Units, treat elective patients as scheduled, reduce agency spend, reduce expenditure, develop workforce plans to deliver cost effective services which do not compromise staff and patient safety and continue our cultural journey. We are considering how to implement a gateway process to ensure we meet the CQC's domains. We need to perform better than before services were suspended as part of the COVID-19 response. We will work with system partners to consider services which we would no longer wish to continue, how services re-start and amplify the benefits from the pandemic. We will consult staff and, with the support of Healthwatch, our patients. Details will be developed with Non-Executive Directors, TME, Board Committees and presented to the Trust Board at the June 2020 meeting. Our Annual Plan will be refreshed with the Integrated Performance Report aligned to those new priorities. This is an opportunity not to be missed.

During the course of the discussion, the following were the main points raised:

- Mr Williams asked whether the current flexible staff working arrangements will form part of the transformation work, who will fund the spare capacity for a second wave of COVID-19 patients and dealing with both COVIV-19 and non-COVID-19 patients which will increase our costs. In response, Mr Hopkins said

that flexible and remote staff working will continue where it is beneficial for individual services and we will look at ceasing to occupy rented office accommodation. Block funding including the cost of unused capacity will be provided to the end of October 2020. There are currently no plans for the position thereafter. Staff savings will be realise with a reduction in agency spend. Despite the block funding arrangement we will need to drive productivity and efficiencies and reset our budget.

(Dr Tunnicliffe and Ms Ricketts join the meeting)

- Ms Day asked for information on the learning from the three staff deaths. In response, Mrs Morris said that staff understand the issues with BAME staff and risk assessments are being undertaken. BAME staff are able to raise any health concerns confidentially. Ms Ricketts added that Occupational Health are reviewing the records of all BAME and positive COVID-19 staff to ensure that any health issues since appointment are captured. In response to Mr Horwath, Mr Hopkins said that discussions are taking place with Divisions so that future QIAs are not too bureaucratic.

RESOLVED THAT the report be noted.

017/20 **COVID-19**

017/20/1 **Response to NHS CEO/COO Letter of 29 April 2020 and Restoration of Services**

Mr Brennan presented the report outlining the actions we have taken and progress made to date and our future plans to meet the expectations outlined within the letter dated 29 April 2020 received from the Chief Executive and Chief Operating Officer of the NHS commending the NHS response to the Coronavirus and outlining expectations on NHS organisations in phase 2 of the incident response. The key points are the resumption of services and increasing activity whilst maintaining sufficient ITU capacity to treat COVID-19 positive patients and a second wave of patients. During the pandemic there has been good flexible and responsive system working with Social Services, CCG, Health and Care Trust which we will seek to maintain. System discussions are taking place early next week on patient flow and discharges. Emergency Department attendances and admissions are rising together with an increase in emergency surgical activity which can be linked to patients not attending to hospital during the pandemic peak. Cancer activity has continued being undertaken in the independent sector in Droitwich and Worcester and patients have been booked to the end of June 2020 when the current contract ends. Bowel cancer screening for high risk patients is to resume in the independent sector in Worcester. Dolan Park Hospital is to be used from the end of May 2020 for routine surgery. We remain at level 4 and the Incident Command structure will continue in its present from until the end of the month when this will be reviewed.

During the course of the discussion, the following were the main points raised:-

- Ms Day enquired about the impact of social distancing on bed capacity and our plans to deal with this. In response, Mr Brennan said that guidance is awaited and the issue has been raised with the Region. Modelling work is underway which may set an upper threshold on bed occupancy. Given our ways of working, this could reduce our bed capacity by 60% necessitating the ceasing of elective activity which is being re-started.
- In response to Mr Yates, Mr Brennan said that Radiologists undertaking home reporting will be considered in the next phase and undertaken if clinically justified.
- Ms Day said that our governance arrangements during transformation need to be sufficiently agile to enable staff to deliver. Sir David added that a level of

bureaucracy is inherent in regulation. Mr Hopkins and Dame Julie commented that we need to see which governance arrangements can be managed internally to become governance lite.

- Dr Tunnicliffe acknowledged the use of Kidderminster as a "clean" site for elective activity and asked how this could be undertaken in the longer term. Mr Brennan said in response that the plan is to use Kidderminster in the short term as a "clean" site and the wider strategic intention is to use the site for activity not previously undertaken there.

RESOLVED THAT the Trust's response to the letter from the Chief Executive and Chief Operating Officer of the NHS dated 29 April 2020, the actions taken to maintain cancer services and the Phase 2 restoration of services plan be endorsed.

018/21 **PERFORMANCE**

018/21/1 **Home First Worcestershire**

Mr Brennan presented the report saying that the positive indicators needed to be treated with caution given the current level of reduced demand. He drew attention to the capacity gap and the impact of COVID-19 which reflected the reduction in the overnight bed capacity. Lower ED attendances and ambulance conveyances, with new ways of working to expedite same day discharges, has reduced patients length of stay and delayed transfer of care numbers. Thereby, generating capacity to cope which then result in no corridor care and/or ambulance handover breaches. We achieved our long length of stay target at 31 March 2020. However, there is concern over the increase in long length of stay patients during the last ten days which he is addressing with the health system early next week. Home First Worcestershire is being used to influence clinical pathways.

During the course of the discussion, the following were the main points raised:-

- Ms Day enquired as to the cause of the poor discharges before mid-day performance. In response, Mr Brennan said this was mainly as a result of the effect of the changeover of the non-urgent ambulance service from WMAS to a provide provider which is managed by the CCG. To a lesser extent this was caused by legitimate coding issues regarding when patients are transferred from wards to the Discharge Lounge. This has now been resolved.

RESOLVED that the report be received for assurance.

018/21/2 **Integrated Performance Report**

Mr Brennan presented the report providing an overview of April 2020 performance against the trajectories, specifically for the NHS constitutional standards and the key operational metrics. The Quality metrics and the Workforce metrics are not available at the time of writing this report and performance up to mid-April was reported to the last Trust Board. The finance report was not available due to timings and will be presented to the May Finance and Performance Committee and subsequent Trust Board. Overall performance is improving; however the main issue is the number of long wait patients. Mr Hopkins stressed that long waits is a key issue and system discussions are needed to revisit expectation to reduce the size of the increased waiting list based on demand and capacity and potential harm. Mr Brennan said that there has been a reduction in 2 week wait cancer referrals; however the cancer detection range has not reduced.

Mr Toole drew attention to the Finance and Performance Committee Assurance Report that the financial position at the end of month 12 (March 2020) was a deficit of £(81.5)m (subject to audit), £1.3m positive to the submitted plan and £1.3m better than the

operational forecast. Against the profiled internal stretch target of £(73.7)m, this position would be £(7.8)m adverse.

(Mrs Morris and Mr Hallissey left the meeting)

Our Trust is block funded to October 2020 based on the average monthly expenditure between November 2019 and January 2020. Post January 2020 we had opened additional bed capacity which has increased our costs. Currently we are ahead of plan by approximately £1.3m but lower levels of activity might affect our income.

Mr Hopkins reported that the last meeting of the Quality Governance Committee had noted that we have not achieved 3 of the 4 key infection year end trajectories; namely, C-Diff, MSSA and MRSA which is disappointing. A detailed review involving Divisions has been undertaken of all C-Diff cases to understand the issues and identify learning. Addressing anti microbiological stewardship will be crucial to improving C-Diff performance. Learning from deaths reviews have been paused and are about to recommence with job plans being amended for certain self-isolating Consultants to undertake this work with some becoming medical examiners so that real time death reviews can be undertaken in the near future.

During the course of the discussion, the following were the main points raised:-

- Mr Williams said that as part of our transformation work it is necessary that we fully understand our costs and that we do not continue with the previous level of costs. Processes are in place to control bank and agency spend and whilst there is a slight those controls seem overly bureaucratic and have not been effective. We need a strategic workforce plan to manage headcount and bank and agency spend. Mr Hopkins said that as part of the gateway process we will look at the cost per unit of delivery and Service Level Report will be considered.
- Ms Day commented that costs for virtual activity are paid at a lower level than for face to face activity and how this is to be managed in the future. In response, Mr Toole said that the payment by results method needs to be looked at nationally. Mr Hallissey added that work is underway to amend consultant job plans so that emergency activity becomes the main priority followed by other areas of activity. This will provide support to the Emergency Department where space could be better utilised to improve the way in which services are delivered. Mrs Newton said that this is also a system issue. Sir David said that the short term focus is cost control and looking at the way in which services are locally paid.

RESOLVED THAT the report be noted for assurance.

019/20 **GOVERNANCE**

019/20/1 **Self-Certification – Conditions FT4 and G6 of the Provider Licence**

Mr Hopkins introduced the report saying that each year, the Trust has to declare against two provider licence provisions, FT4 and G6. The declaration has to be placed on the Trust website by 31 May. There is no requirement for the declaration to be returned to the centre. The Trust has been in special quality measures for the whole year 2019/20 with conditions placed on the CQC licence in December 2019 following an unannounced visit by the CQC to the Emergency Departments at the Alexandra Hospital and Worcestershire Royal. Nonetheless the position was an improvement on last year. The report had been presented to members of the Audit and Assurance Committee and no observations were made. Mrs Blakeman added that she had provided input into the self-declarations.

RESOLVED THAT the self-certification be approved for publication.

019/20/2 **Trust Management Executive Report**

Mr Hopkins presented his report on the meeting of the Trust Management Executive (TME) held in April 2020. He highlighted the remote monitoring of COPD designed to support the wider STP clinical transformation and new models of care for COPD. The pilot provides increased capacity to manage more patients and reduce length of stay. It has also prevented home visits. Positive patient feedback has been received. It provides a structured discharge process to the community. If successful the pilot will be rolled out to shape other services.

RESOLVED THAT the report be received for assurance.

(Mrs Morris and Mr Hallissey rejoin the meeting)

019/20/3 **Managing Charitable Donations During the COVID-19 Pandemic**

Sir David reminded members to consider this report in their separate capacity as Corporate Trustee of the Charity and not as a Trust Board member.

Mr Haynes presented the report saying that the COVID-19 outbreak has prompted a huge up swell of good will from individuals, organisations and businesses across our community towards the Trust and Charity. We have received a wide range of donations in kind (goods and services) as well as cash donations, including significant amounts of national funding from NHS Charities Together. It is crucial that we maximise the benefits of this generosity, and ensure that the donations are used in a timely and well-co-ordinated way to deliver the best outcomes for our patients and staff. We must also maintain robust financial and charity governance and transparency to demonstrate effective use of charitable funds. It is also important to align decisions made with the Trust's incident management governance (including the Bronze/Silver/Gold incident management structures) with appropriate oversight from Charitable Funds Committee on behalf of the Trust Board as Corporate Trustees.

Mr Yates stressed that the Charitable Funds Committee wish to have robust governance arrangements in place to demonstrate publicly how the donations and cash have been spent given the substantial amounts likely to be received from NHS Charities Together.

Mr Toole said from a finance perspective that the right level of governance is being provided with the Deputy Director of Finance and the Director of Communications and Engagement acting as fund managers.

During the course of the discussion, the following were the main points raised:

- Sir David reiterated the importance of demonstrating publicly how the donations and cash has been allocated.
- Mr Haynes said that COVID-19 has raised the profile of the Charity more quickly than originally anticipated. It is important not to lose that momentum and a further report will be presented to support that work.

RESOLVED THAT the interim COVID-19 charitable funds process and governance as described in the report be endorsed.

020/20 **ANY OTHER BUSINESS**

None.

021/20 **DATE OF NEXT MEETING**

The next Public Trust Board meeting will be held on Thursday 11 June 2020 at 10:00.

The meeting will be held virtually.

The meeting closed at 11.34 am.

Signed _____ **Date** _____

Sir David Nicholson, Chairman

Enc C

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

PUBLIC TRUST BOARD ACTION SCHEDULE – JUNE 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
13-2-20	IPR	166/19/3	Draft a report for the ICS executive on the roles and expectations of partners in respect of HFW	PB/ SS	Feb 2020	Mar 2020 April 2020 May 2020	PB/SS will discuss this with DN/MH. This remains to be undertaken.	
12-3-20	Home First Worcestershire	181/19/1	Write to the Chair of the System Improvement Board	DN	April 2020	TBD	The System Improvement Board has not met since the last Trust Board meeting and this remains to be undertaken when meetings of the System Improvement Board resume.	
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.	
12-3-20	Annual Plan 2020/21	180/19/1	Restructure appendix 2	TR	April 2020	May 2020	Detailed information was presented to the People and Culture Committee on 312 March 2020. The Plan remains to be completed.	

							Revised annual priorities on agenda. Action closed.	

NHS
Worcestershire Acute Hospitals NHS Trust

Putting patients first May 2019

Meeting	Trust Board
Date of meeting	11 June 2020
Paper number	C

COVID-19: Restoration, Recovery & Reset

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

Accountable Director	Paul Brennan, Deputy CEO and COO Jo Newton, Director of Strategy & Planning		
Presented by	Paul Brennan/ Jo Newton	**Author /s**	Paul Brennan / Jo Newton / Lisa Peaty

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	20/5/20	Approved in principle
Finance & Performance	27/5/20	Noted
Quality & Safety	28/5/20	Noted
JNCC	28/5/20	Noted for information

Recommendations	• To receive the significant achievement in response and recovery to COVID-19 by trust and partners for assurance • To note the requirement to build a framework with flexibility to respond to continued COVID impact and risk to patients, staff and the public • To endorse the direction of travel

Executive summary	This report summarises the Trust position regarding Restoration and Recovery of services and corporate activity in line with national guidance. The paper supersedes that presented to May board. The report seeks to outline current activity and progress to **Restore** services, outlining challenges and risks presented by the trajectory of COVID-19 and the response by the public and wider system. In addition the paper outlines an approach to both capture the innovations, set against a refresh of the Clinical Service and enabling strategies, to take the trust through Phase 2 and 3 **Recovery & Reset**. The paper should be read in the context of developing refreshed ICS priorities, underpinned by the 2 key principles of getting flow right, and system first.

Risk	
Key Risks	The development of this report supports five of the Trust's BAF risks: **BAF 12 COVID-19**: IF COVID -19 manifests itself as is modelled by the

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	Government, then there is a serious risk that the safety of patients will be compromised due to the lack of medical and nursing staff and equipment to enable treatment of the most seriously ill resulting in excess deaths **BAF 3 Clinical strategy:** If we do not implement the Clinical Services Strategy then we will not be able to realise the benefits of the proposed service changes in full, causing reputational damage and impacting on patient experience and patient outcomes. **BAF 1 Patient flow:** If the System Improvement Board is not able to resolve the mismatch between demand and capacity, 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 7 Finance:** If we fail to address the drivers of the underlying deficit then we will not achieve financial sustainability (as measured through achievement as a minimum of the structural level of deficit) resulting in the potential inability to transform the way in which services operate, and putting the Trust at risk of being placed into financial special measures. **BAF 10: Organisational culture**: If we fail to sustain the positive change in organisational culture, then we may fail to attract and retain sufficiently qualified, skilled and experienced staff to sustain the delivery of safe, effective high quality compassionate treatment and care.
Assurance	Trust Gold Command have approved a Gateway Process for Restoration and Recovery of Services, with separate cells created at Bronze for Response, Restoration and Reset elements. The CEO and Deputy CEO link to the STP Gold and Silver Command for NHSE/I communication

Assurance level	**Significant**		**Moderate**	*x*	**Limited**		**None**	

Financial Risk	COVID-19 expenditure is covered by the guidance as set out in the NHSE/I and reported through Finance and Performance Committee

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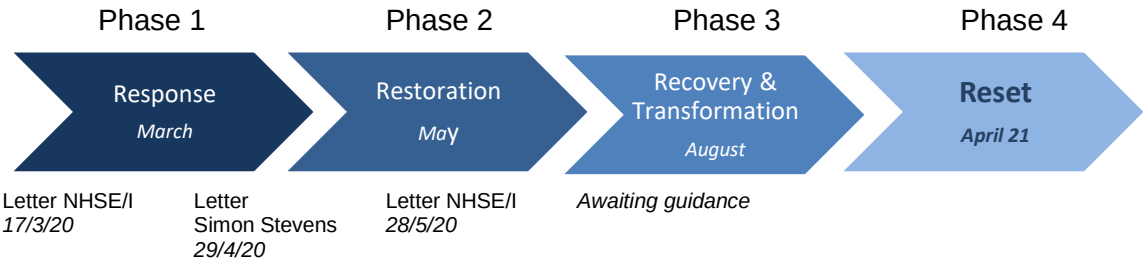
Introduction/Background

On 17 March, NHSE/I notified NHS bodies asking them to invoke a number of measures to free up capacity to cope with the unprecedented demand caused by COVID-19, such as postponing core services, including non-urgent elective care, in order to look after critically ill patients and avoid the NHS becoming overwhelmed.



Urgent and emergency care, including cancer referrals, continued to be available, with many outpatient appointments conducted online or over the phone. Amid evidence that fewer people were accessing care in medical emergencies, and concerns of the impact of lockdown on people's physical and mental health, NHSE/I wrote to NHS bodies to set out its response to the second phase of COVID-19 asking them to assess their capacity for "at least" some services which had been deprioritised to be reintroduced.

The next phase of managing COVID-19 will involve careful consideration of how trusts can return to delivering more of the services people need and remain responsive to the potential ongoing threat of coronavirus. Demand and capacity planning at system level is identifying the trajectory towards a 'new normal'. This will involve tackling a backlog created by cancelled and postponed elective care, a potential rise in additional demand created by the effects of isolation and economic downturn, and a spike in presentations from people who have developed health concerns at home but either chosen not to seek help, or not known what services were available, during the lockdown.

Whilst the response phase evoked massive innovation which needs to be captured, there is an inevitable toll of the pandemic response on the workforce and supporting through the next phase of change whilst maintaining momentum is a key challenge.

The remaining paper summarises key actions and outcomes of Phase 2 (Restoration & Recovery) and preparation for Phase 3 (Recovery & Reset) in line with ICS objectives (appendix 1).

Issues and options

The following key themes have been identified for **Restoration & Recovery**, drawn from learnings at regional and STP level and in line with ICS objectives. Delivery will focus at trust or system level, or both as identified in the table below:

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Changing needs of our Population	Elective Backlog (Restoration)	Staff Wellbeing	Innovation and transformation	Structures and Processes
Identify the changing needs and develop plans that ensure services meet these needs *System focus*	Identify the current backlog of patients waiting for treatment and develop plans to restore services in priority order *WAHT focus*	Identify the current and future requirements *WAHT & system focus*	Capture the innovations *Reset Programme* to amplify / restart / let go/ end high impact changes Align Homefirst with ICS objectives *WAHT & system focus*	Gateway QIA process to review structures or processes. Presumption of no reinstatement & let go of old practices *WAHT & system focus*

Phase 2 – Restoration and Restart

The Trust maintained all emergency medical services and Level 1a (surgery required within 24 hours) and 1b (surgery required within 72 hours) emergency surgical services at Worcestershire Royal Hospital and the Alexandra Hospital throughout the period. Oncology, Haematology, Chemotherapy and Radiotherapy services were also maintained at Worcestershire Royal Hospital and a range of services, including cancer 2 week wait clinics, women health and maternity and outpatient chemotherapy services were transferred from both Worcestershire Royal and the Alexandra Hospitals to Kidderminster Treatment Centre.

In order to preserve cancer services and more complex elective Level 2 surgery (surgery that should be undertaken within 28 days of decision to treat) the Trust worked in partnership with the Independent Sector to enable surgery to continue in a safe environment. The relationship with colleagues at Spire South Bank and BMI Droitwich has enabled a rapid response to the situation and by the week commencing the 30th March 2020 arrangements were in place to commence cancer surgery and complex elective surgery. Cancer surgery being undertaken includes colorectal, breast, gynaecology, urology and head and neck. During the period of the 30th March 2020 to 29th May 2020 we have undertaken 339 operations at the two hospitals and we also commenced limited diagnostic GI endoscopy services on both sites on the 20th April and have now undertaken 231 procedures. In addition the Trust commenced TRUS biopsies at Spire South Bank on the 25th May 2020 and we have now completed 7 biopsies.

The activity at Spire South Bank and BMI Droitwich has been undertaken within the framework of the national contract between the NHS and Independent Sector. This contract is due to expire on the 30th June 2020; however Trusts have been invited to develop proposals to apply for a three month extension to the contract. The Trust, under the umbrella of the STP/ICS submitted its proposal to continue the arrangements until the 30th September 2020 with the two hospitals on the 2nd June 2020 and are confident this will be supported given the extensive use we have made of the Independent Sector and the excellent working relationships between the hospitals.

It should be noted that the recent changes regarding social isolation prior to surgery has led to a reduction in cases during the weeks commencing the 25th May and 1st June 2020

though we expect to be back to previous levels from the 8th June 2020.

In addition to the work with BMI Droitwich and Spire South Bank the Trust has also commenced working with Dolan Park, an Independent Hospital close to Redditch, and from the 1st June 2020 will be undertaking Oral Max Fax, skin and orthopaedic procedures; again under the national framework contract and the submission referred to above to extend our working relationship with the Independent Sector includes Dolan Park.

At Worcestershire Royal Hospital we designated Aconbury 4 as a super clean ward with HDU capabilities during the week commencing the 18th May 2020 to enable the Trust to offer the more complex cancer and Level 2 surgery that could not be undertaken in the Independent Sector due to co morbidities and/or the need for post-operative HDU care. To support this activity two additional theatres have been brought in to use at the Hospital. In addition we opened two theatres and Ward 1 at Kidderminster Treatment Centre on the 25th May 2020 to enable the Trust to offer an enhanced range of Level 3 surgical activity (surgery that should be undertaken within 10 to 12 weeks of the decision to treat) though the full benefit of this has been affected by the social isolation requirements referred to above. We will be fully operational from the 8th June 2020.

As Trust Board members are aware a mobile CT Scanner was in use on the Kidderminster site and this was removed as part of the national takeover of all mobile units. I am pleased to report that with the support of regional colleagues we have been allocated a released scanner from the Nightingale Hospital and this is expected to be on site on Friday 5th June 2020.

In order to maintain flow on the emergency pathway a ‘pull’ Acute Medical Unit approach has been implemented at the Alexandra Hospital and we are currently developing a proposal to create a fully integrated Acute Medical Unit incorporating ambulatory (8 hours maximum stay), assessment (14 hours maximum stay) and short stay (72 hours maximum stay) at Worcestershire Royal Hospital by reconfiguring services at the hospital.

Proposals are also being implemented to restart Cardiac CT services using the facilities at Spire South Bank and a range of level 2/3 elective medical services at Kidderminster Treatment Centre.

Board members may be aware a number of Trusts have moved to implement a range of temporary service changes aimed at separating as much as possible services caring for COVID-19 and non-COVID-19 patients to limit the risk of transmission, to enable more services to be restored to increase elective activity and potentially improve productivity by changes to Infection and Prevention Control on a ‘Green’ site. To date our use of the Independent Sector and the increasing use of the Kidderminster Treatment Centre has enabled the Trust to provide cancer, complex elective and a degree of Level 3 services however this is an option for consideration as part of the next stage of the recovery and transformation phase of the programme.

1. Phase 2-3

3.1 Approach for **Recovery & Reset**

Work has been underway over the last few weeks to scope the Trust’s **Reset Programme**. The focus is to capture and embed the positive changes that have been implemented in

response to COVID-19 and reset against the Clinical Services and enabling strategies. Core to Recovery & Reset is the importance of establishing proper flow through the system under the auspices of the HOMEFIRST programme.

3.2 **Progress to date**
Clinical divisions have evaluated the service changes which they introduced in response to COVID-19 phase one using a four quadrant model (**end, let go, amplify and restart**) (appendix 2). The Reset Programme focuses on the **amplify** quadrant (i.e. **those things that we have been able to try which show some signs of promise for the future**). The divisional 'amplify' lists have been collated, analysed and key themes which we propose are referred to as 'high impact changes' have been identified.

The proposed initial ten **high impact changes** are set out in appendix 3. These have been drawn from common themes emerging from the divisional lists and are those which will have significant impact on **patient flow**. These proposed high impact changes have been discussed and refined through CETM, TME, Strategy & Planning Group and with Divisional Directors and Directors of Operations. As each high impact change is delivered, they will be replaced by new ones to create an ongoing, rolling programme of work. However, **not all high impact changes are equally applicable to all specialties or pathways.** The Strategy and Planning Team are currently undertaking a comprehensive **staff engagement** exercise to capture further ideas on positive service changes that have resulted from COVID-19 and to further test whether the initial ten high impact changes are the right ones. The feedback will help to refine the focus of the Reset Programme.

The **principles** underlying the Reset Programme and how it contributes to key outcomes the Trust wishes to achieve have been discussed at CETM and TME. These can be encapsulated as:

Aligned with ICS and Trust Clinical Services Strategy;
Transformed by capturing innovations and implementing agile methodologies
Delivered adopting 4ward principles of Putting Patients First
Embedded using cross divisional and system engagement with staff and patients

3.3 **Proposed approach**
It is proposed that an **agile** approach is taken, dividing each high impact change into a series of short tasks and phases of work which are frequently reassessed and adapted in light of progress and learning. This iterative approach is a departure from the more traditional project management styles adopted by the Trust. Support for delivering this new methodology will be provided by the Strategy & Planning Team.

All high impact change teams will have representatives from digital, finance, HR and estates as well as an ICS system representative as appropriate. A co-design approach will be adopted through patient and staff engagement in work associated with each of the high impact changes.

It is important to note that the Trust will continue to implement other transformational workstreams as part of restart and recovery in parallel to delivery of the ten initial high impact changes. These include, for example, HomeFirst Worcestershire, implementation of an Acute Medical Unit and site configuration.

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3.4 **Prioritisation/ Quick wins**
Given the current restoration of elective services it is proposed that priority is given to the high impact changes associated with Virtual Management of Outpatients and Flow and Discharge. This is because quick wins can be achieved in selected specialties/pathways and by embedding the work already undertaken on discharge to assess/onward care. This will enable immediate impacts to be achieved and provide a strong platform for rolling out further work.

4 Governance

Reporting will be to Bronze Command. In line with agile methodology, each high impact change team will hold a daily virtual 'stand up' meeting 20-30 minutes in length to report on progress.

A monthly summary report for the Reset Programme will provided for TME and the Finance and Service Improvement Group.

5 Risks & dependencies

Risk	Mitigation
Return to old ways of working & behaviours	• Use of staff engagement to define common purpose • Tailored approach for different specialties and pathways • Implement and show case quick wins • Clear communication of purpose and benefits • Iterative improvement approaches implemented
New ways of working layered on old	• Introduce gateway approval process & strong controls • Review and revise/remove redundant governance structures
Trusts works independently of system/STP	• Agree priorities with STP • Ensure Trust representation and participation in STP structures and programmes of work
New surge of Covid-19	• Nurture and empower staff to sustain changes • Maintain operational focus
Lack of staff engagement / staff fatigue	• Ensure variety of engagement channels • Ensure ongoing programme of engagement • Identification of staff champions to support • Provide wellbeing and stratified staff support • Implement quick wins
Perception of programme / project management approaches as being bureaucratic	• Implementation of and training in Agile approach • Show case quick wins • Clear communication of purpose and benefits

6 Transformation agenda

It is important that the Reset Programme is seen within in the context of the Trust's **Clinical Service Strategy and Annual Plan 2020/21**. The approach will identify and celebrate the sections of the 42 specialty clinical service strategies and the parts of the 2020/21 annual plan that have already been delivered, and will enable a **refresh** of the Trust's Clinical Service Strategy and supporting strategies during Phase 3 in preparation for Phase 4. A refreshed approach to PEP (Productivity & Efficiency) programmes will be recommended to

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realign accountability and realise resource efficiencies in line with the Model Hospital approach.

A roadmap outlining key milestones is shown below (and Appendix 4).

Conclusion

The Restoration and Recovery of services necessitated by the COVID-19 pandemic represents an unprecedented challenge for NHS trusts and health and care systems. Yet the experience of accelerated change during Phase 1 presents a unique opportunity to embed sustainable change.

This work provides an opportunity to establish a new 'business as usual' for the Trust based on some of the changes introduced during the COVID-19 incident. It will also accelerate transformation and strengthen its position within the local Sustainability and Transformation Partnership/Integrated Care System.

Recommendations

- To receive the significant achievement in response and recovery to COVID-19 by trust and partners for assurance
- To note the requirement to build a framework with flexibility to respond to continued COVID impact and risk to patients, staff and the public
- To endorse the direction of travel

Appendices

Appendix 1 – H& W ICS
Appendix 2 - Quadrant model
Appendix 3 – Initial high impact changes
Appendix 4 – Reset programme roadmap

Restoration and Recovery

Herefordshire and Worcestershire ICS

May 2020

Introduction

Prior to the COVID 19 pandemic our system faced substantial challenges, notably in terms of workforce sustainability and the quality and performance of services, particularly urgent care, RTT and cancer targets.

This was in the context of a significant financial deficit with challenging savings targets across the system, compounded by ongoing demographic growth and predicted rising demand for services.

We had already set out our commitment to shift to a new way of working. We had analysed our populations health and care needs and set out our detailed plans to meet them through our Long term Plan submission, and we had started our journey towards a mature Integrated Care System (ICS), working collectively to drive service transformation and improved performance across care settings and across organisational boundaries.

Through our system wide response to the COVID 19 pandemic we delivered unprecedented levels and pace of transformational change. This was not only in the type of services that we delivered, but also in the way we worked collectively across health, social care, local government, public sector and voluntary/community services to achieve the common aim of keeping our communities, citizens and workforce safe.

As we move forward through restoration and recovery we know that COVID 19 will continue to circulate in our communities. This will bring new challenges to health, care, pubic sector and voluntary and community services as we work to control its spread, ensure we have sufficient capacity to meet our populations health and care needs, and limit its impact on wider wellbeing and inequalities.

To address these challenges we need to continue driving the shift in the way we deliver services and care, as well as embedding our learning from the COVID 19 response and consolidating and embedding the transformation we have already delivered. This will need to be based on our ICS collaborative approach, working with our citizens and communities and with strong clinical and professional leadership to give our workforce the backing they need.

Sir David Nicholson, Chair of Herefordshire and Worcestershire ICS

What Will Success Look Like: Our Aims and Objectives

Our Aims

- Improve outcomes for our citizens and communities
- Improve wellbeing
- Reduce inequalities
- Reduce the costs of delivery
- Embed the building blocks of our new ICS

Our Objectives

- Appropriate capacity with surge capability:
  - Covid treatment
  - Non-Covid unplanned care
  - Non-Covid planned care
- Infection prevention and control
- Pathway/care model redesign – commissioning and delivering around patients needs not organisations/services
- Wider wellbeing, inequalities & economic impacts – work across health, local government, VCS, public sector
- Staff and carer wellbeing
- Innovation and digital solutions
- Embed delivery of LTP objectives through our Covid 19 learning
- Empowering front line clinicians and professionals to continue to transform services and care model delivery
- Streamlined decision making by evolving our ICS governance and collective approach

Our System Framework for Restoration and Recovery 3

Framework	Rationale
This is about adaptation rather than recovery	COVID 19 is not a short term issue and we need to respond and adapt as the pandemic shifts and our learning evolves
Our ICS response is a collective endeavour	We recognise we are all in this together, moving forward through: • A 'bottom up' approach, with clinicians embedded in the development and delivery of priorities, pathways and processes • Balanced by a whole system approach, ensuring a coherent and comprehensive response without gaps or duplication
Our response will continue to be built upon detailed understanding of our patients/population needs and system capacity	Through this approach we will ensure capacity is matched to those with greatest clinical need in order to: • Deliver national must do's • Deliver local priorities • Address inequalities
We will build on our learning from the COVID response	Keeping what worked well and stopping what didn't Recognising this is about 'how' we achieved transformation as well as about 'what' we transformed
We will continue to focus on patient centred approaches	We will commission, organise and deliver around patients/citizens/communities needs, rather than around organisations or service boundaries
We will incentivise delivery and live within our financial allocations/budgets	Developing a financial framework to incentivise the delivery of improved outcomes, productivity and efficiency – within and across providers and sectors
We will streamline our ICS governance	Increasing autonomy and empowerment to enable ongoing: • Decision making as close to the point of delivery as possible • Clinically driven transformation and change 'at pace'
We will recognise and work collectively to mitigate the risks in our system	Resilient capacity with sufficient surge capability Impacts on wider wellbeing and inequalities, children and all age mental health Funding settlements and the impacts on local government and social care

Our Design Principles for Restoration and Recovery 5

We will apply the following design principles to all our restoration and recovery plans and work programms:

- We will focus on delivering the national must do's and local priorities
- We will commission, organise and deliver care around patients needs across the whole patient pathway – through a collective approach that works across organisational and service boundaries
- For each of our work programmes we will organise ourselves to deliver:
  - COVID activity with surge capability
  - Non COVID planned activity
  - Non-COVID unplanned activity
- We will align available capacity to those with the greatest clinical need – embedding robust and transparent process's to identify and prioritise those with greatest clinical need
- We will seek to manage demand by providing robust alternatives to care, promoted by clinicians across the whole pathway to ensure a 'common message'. This approach will be underpinned by:
  - Selfcare and online/virtual resources
  - Non-surgical options e.g. physiotherapy and psychological support
  - The use of 'advice and guidance'
- We will ensure informed decision making with patients – providing clear information so they understand the risks and benefits of health and care interventions as we live with COVID-19
- We will continue the shift to digitally enabled care – but:
  - We recognise the potential for digital exclusion to widen inequalities – we will provide alternatives when needed
  - We recognise virtual care only adds value when it can be used 'instead of' face to face care, rather than 'as well as'
- We will ensure we understand the impact of our plans, work programms and interventions, to understand
  - How well we addressed our populations needs
  - How we have impacted on inequalities

Our Phases of Restoration and Recovery

Phase 2 Restoration
Now until August

- Understand need and demand
- Agree local priorities
- Understand what worked/didn't work
- Agree key transformational activities and 'what we will keep'
- Plan for national must do's and local priorities

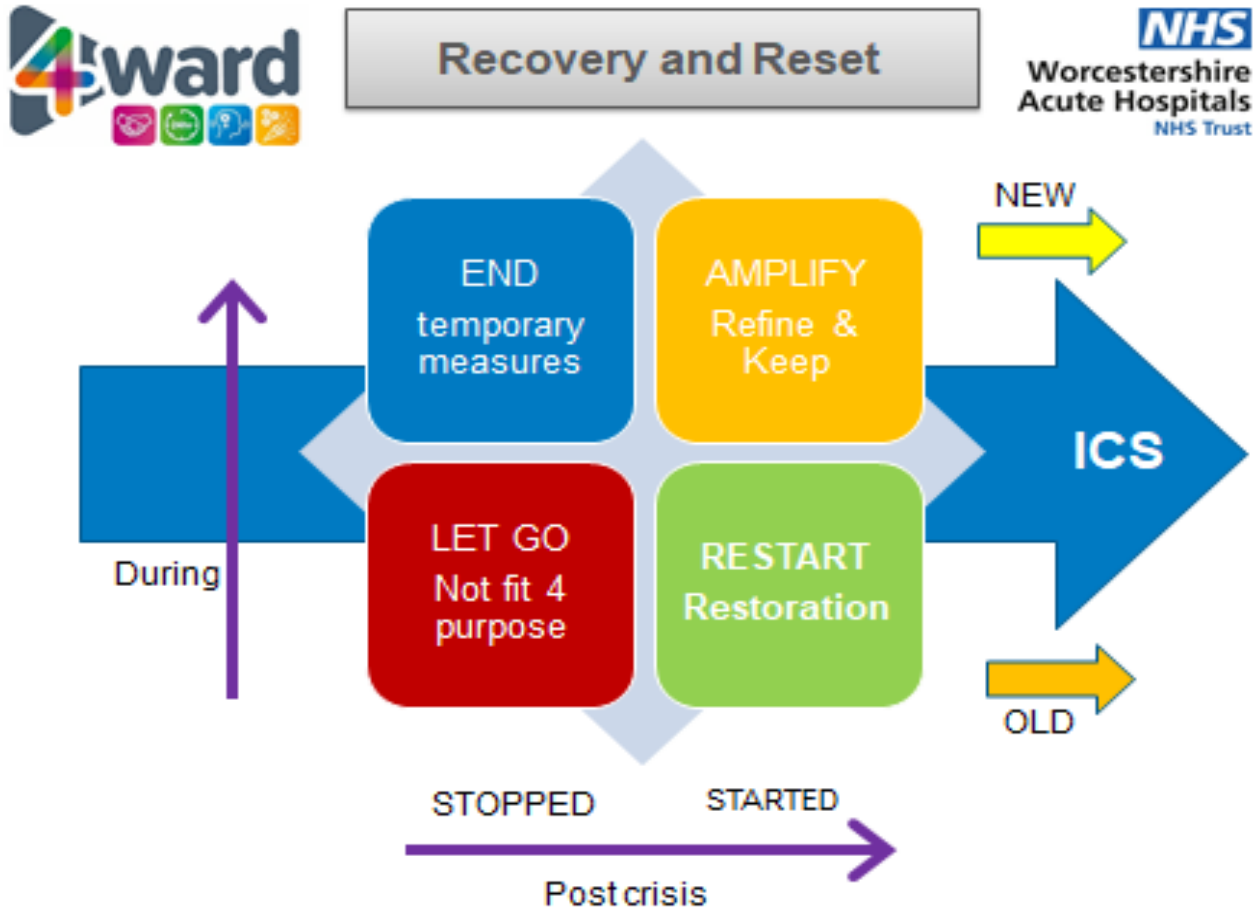
Phase 3 Recovery
August to April

- Evaluate and evolve our plans and delivery
- Embed a monitoring and outcomes framework so we can understand the impacts and evolve our priorities
- Assess and develop our ability to mitigate risks
- Engage with patients, citizens and stakeholders
- Evolve the governance needed for system reset

System Reset
April Onwards

- Deliver national must-do's and local priorities
- Implement new steady state governance frameworks
- Ongoing engagement of citizens, patients and stakeholders
- Continue to evaluate and evolve our system working

Appendix 2


4ward
Recovery and Reset
NHS
Worcestershire
Acute Hospitals
NHS Trust
NEW
END
temporary
measures
AMPLIFY
Refine &
Keep
ICS
During
LET GO
Not fit 4
purpose
RESTART
Restoration
OLD
STOPPED
STARTED
Post crisis

Appendix 3: Reset Programme - Initial COVID High Impact Changes to Embed and Amplify

Worcestershire Acute Hospitals NHS Trust

Cross-cutting Themes

Digital I Estates I Finance

Workforce & culture: Covid ***"we do this by"***

Quality improvement

Communications & engagement

Other existing / new workstreams for implementation to support restart and recovery (e.g. Site Configuration, Acute Medical Unit, divisional management restructure, Homefirst Worcestershire etc)

High Impact Change Goals

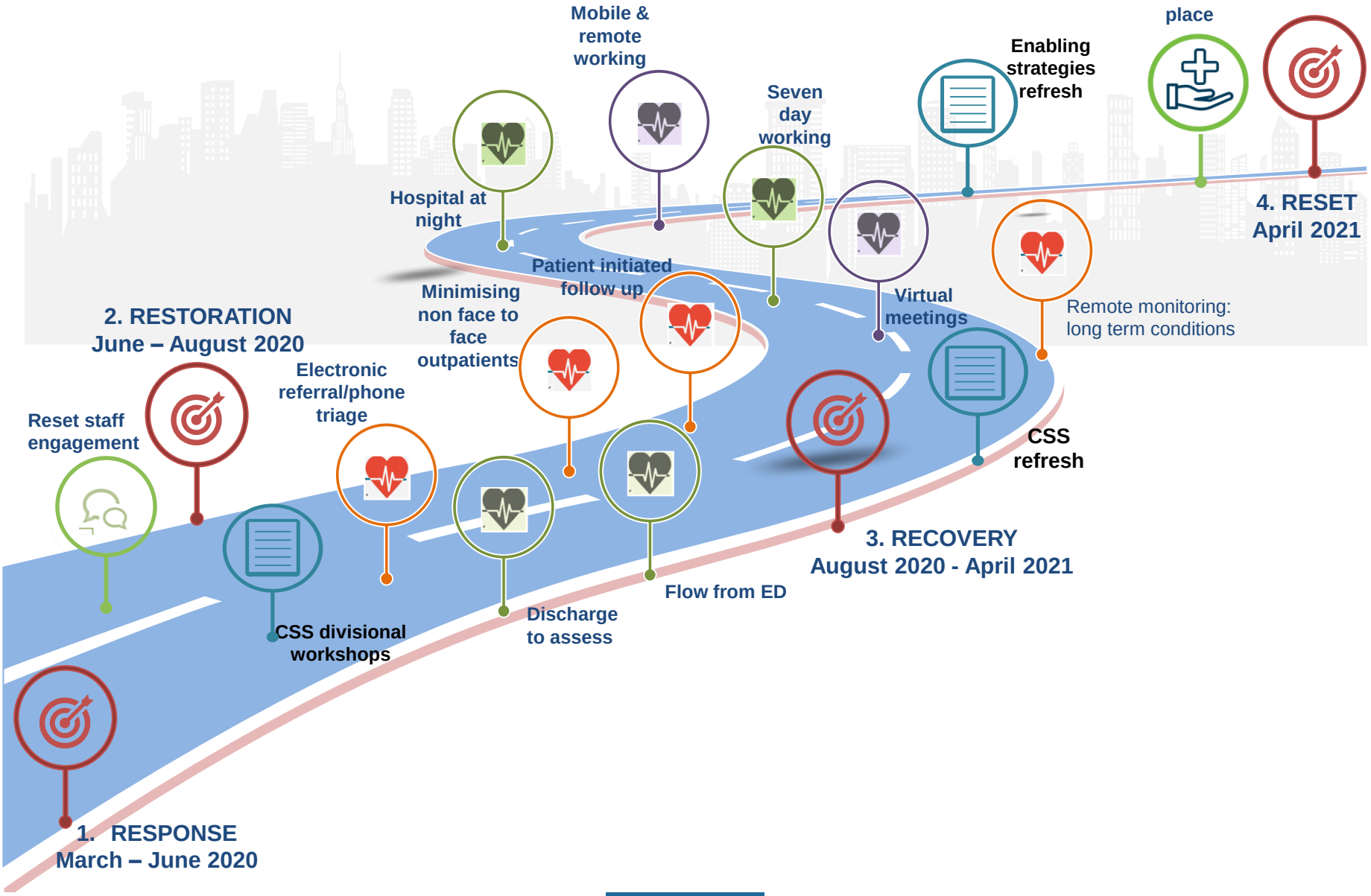
1. All referrals into the organisation will be received / managed electronically (including GP advice & guidance) & triaged by a clinician virtually
2. Face to face outpatients will be minimised and the use of one stop clinics will be optimised
3. All follow up appointments will be patient initiated unless clinically necessary
4. Long term conditions will be monitored remotely to reduce outpatient appointments, support early discharge and support admission avoidance
5. Flow from ED will be improved by functioning clinical assessment areas
6. Seven day working will be implemented by all divisions
7. Hospital at night will be implemented
8. Improvements in bed capacity will be sustained through an improved system approach to discharge processes
9. All team meetings, including MDTs, should take place virtually where appropriate
10. Staff will be enabled to work remotely when role and task make this possible

NB – not every high impact change is equally applicable to every specialty or pathway

Putting patients first through agile transformation

Appendix 4

Reset Programme



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Worcestershire Acute Hospitals NHS Trust

Putting patients first May 2019

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2020/21 Annual Plan Priorities

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

Accountable Director	Jo Newton, Director of Strategy and Planning		
Presented by	Jo Newton, Director of Strategy and Planning	**Author /s**	Jo Newton, Director of Strategy and Planning Sarah Smith, Director of Strategy and Planning

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

Report previously reviewed by		
Committee/Group	Date	Outcome
TME	20TH May 2020	Approved
Finance & Performance	27th May 2020	Agreed with comments
Quality & Safety	28th May 2020	Agreed with comments
People & Culture	2nd June 2020	Request to consider BAME risk assessment objective

Recommendations	It is recommended that the Board: • Approve the refresh of Annual Plan objectives in line with the changed business environment post COVID • Identify and agree any risks consistent with recommended changes

Executive summary	The purpose of this report is to set out a revised annual plan for 2020/21. It outlines our refreshed priorities and actions for the year ahead as a consequence of the COVID-19 pandemic. The plan remains aimed at further improving the quality, safety and sustainability of the services our staff provide to patients and our overall financial and operational performance as a Trust. It has been developed in line with the key strategic risks outlined in the refreshed board assurance framework. The plan is set within the context of the trust's key strategies and in concert with the annual delivery plan for the Herefordshire and Worcestershire Integrated Care System which itself has been developed in the context of the NHS Long Term Plan implementation framework and national planning guidance. The Trust remains challenged in key areas such as the emergency pathway and financial performance and there is more to in these areas

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	in 2020/21 to build on the green shoots of success we saw in other areas of the Trust in 2019/20 in terms of quality of services and staff satisfaction. The Annual plan was first submitted to the board and approved in February 2020. Consideration has been given to feedback from Committees at CETM with SMART KPI's agreed as part of implementation within directorates.

Risk									
Key Risks	BAF 1: If the System Improvement Board is not able to resolve the mismatch between demand and capacity, then there will be delays to patient treatment, resulting in a significant impact on the Trust's ability to deliver safe, effective and efficient care to patients. BAF 3: If we do not implement the Clinical Services Strategy then we will not be able to realise the benefits of the proposed service changes in full, causing reputational damage and impacting on patient experience and patient outcomes. BAF 4: If we do not have in place robust systems and processes to ensure improvement of quality and safety, then we may fail to deliver high quality safe care resulting in negative impact on patient experience and outcomes. BAF5: If we fail to implement Home First Worcestershire as scheduled then there will be an impact on our ability to see, treat and discharge patients in a timely way which may result in patient harm and curtails urgent elective activity. BAF6: If we do not implement year one of the digital care record business case in a timely coordinated way, then we may not be able to utilise the system for the benefit of patients, resulting in delayed and poorly coordinated care for patients and a poor patient experience. BAF9: If we do not have a sustainable fit for purpose diverse and flexible workforce, we will not be able to provide safe and effective services resulting in a poor patient experience.								
Assurance	The annual planning process contributes to the mitigation of the risks above. It will continue to be reviewed in light of the continued impact of COVID-19 on the Restoration & Recovery & Transformation of services.								
Assurance level	**Significant**		**Moderate**	*x*	**Limited**		**None**		
Financial Risk	*N/A*								

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Introduction/Background

- The trust's annual plan for 2020/21 was adopted by the board in February 2020. This followed guidance from NHSE/I which sets out the requirements and planning assumptions for organisations and systems, aligned to the NHS Long Term Plan. The guidance is clear that 2020/21 is critical in the development of system working, and we need to adopt a "system by default" approach.
- In March 2020 NHSE/I guidance changed in response to the COVID-19 declaration as a pandemic. In light of the Response phase annual plan priorities and the underpinning clinical service strategy is being reviewed as part of the Restoration, Recovery and Reset phases communicated under NHSE/I guidance

Issues and options

- It is recognised that whilst the trajectory of the pandemic and possibility of surge remains fluid, delivery of the full Annual Plan is unachievable.
- The refresh seeks to prioritise clinical service changes and reflect slippage due to the Response phase.
- Further confirmation with the STP is required to ensure alignment of the key priorities within the pl
- The Herefordshire and Worcestershire STP system plan requires further review in line with national guidance and local implementation post COVID.
- The plan triangulation process across the Herefordshire and Worcestershire STP system to ensure all partners have a shared view of operational performance may need to be revisited.

Conclusion

- The COVID-19 pandemic has accelerated some annual plan deliverables, and elements of the clinical services strategy
- Suspension of normal operational delivery necessitates a reset of clinical services and priorities highlighted in the attachment
- Strategic planning will be reviewed with a refreshed Clinical Service Strategy by end Q2

Recommendations

It is recommended that the Board:

- Approve the refresh of Annual Plan objectives in line with the changed business environment post COVID
- Identify and agree any risks consistent with recommended changes

Appendices

Annual Plan priorities – 2020/21

Worcestershire Acute Hospitals NHS Trust

OUR STRATEGIC OBJECTIVES, ONE YEAR GOALS & IMPROVEMENT PRIORITIES IN 2020/21 – REFRESH JUNE 2020

STRATEGIC OBJECTIVE ONE: *BEST SERVICES FOR LOCAL PEOPLE*			
CLINICAL SERVICES STRATEGY			
Exec Lead	**Refreshed Improvement Priorities 2020/21**	**Exec Lead / Delivery Lead**	**Measured by**
D of S&P	**1.1 INTEGRATED CARE**		
	• System wide integrated service model for older people incorporating: ○ Geriatric Emergency Medicine Service ○ Frailty management and avoidance of hospital acquired functional decline (HAFD)	D of S&P / DD Spec Med	• Increase by 15% the proportion of patients > 75 years discharged prior to first midnight on SDEC pathway by end Mar 21 compared to 19/20 baseline
	• More out of hospital care for long term conditions: diabetes; respiratory, cardiovascular disease: ○ Build on the work from the COVID experience to deliver more care integrated with primary and community services and more digitally enabled care for patients	CMO/DD Spec Med	• Successful evaluation of Respiratory Medicene pilot on remote monitoring, and rollout to minimum further service with agreed KPIs developed by end Sep 20
	• Deliver more acute /community pathway / service integration: ○ Focus on Onward Care team/processes, Frailty Stroke, Rehabilitation , Outpatient Parenteral Antibiotic Therapy (OPAT) Service, Fractured Neck of Femur	COO/ DD Spec Med/DD Surgery	Achievement of Homefirst objectives for OCT and discharge • Agreement to frailty business case by Q1, service implementation by Q3; positive feedback from system and service users
	• H&W Local Pathology Network development	COO / DD SCSD	• Self - sufficiency across the H&W STP in COVID antigen and antibody testing capacity from Q2 20/21 • Integrated Pathology Management Strategy agreed with MoU and delivery plan between WVT and WHAT by Dec20

Worcestershire Acute Hospitals NHS Trust

STRATEGIC OBJECTIVE ONE: *BEST SERVICES FOR LOCAL PEOPLE*			
CLINICAL SERVICES STRATEGY			
Exec Lead	**Refreshed Improvement Priorities 2020/21**	**Exec Lead / Delivery Lead**	**Measured by**
	• Local Maternity and Neonatal Service (H&W LMNS) development	COO / DD W&C	• Achieve milestones in LMNS plan
	• End of Life Care Strategy	COO / DD SCSD	System-wide strategy agreed by end Dec 20; evidence of co-production with patients
D of S&P	**1.2 URGENT AND EMERGENCY CARE**		
	• <u>Countywide service/pathway development for urgent and emergency care.</u> ○ Further development of acute medicine speciality and increased capacity and coverage to support acute take ○ Increase in same day emergency care ○ Improvement in assessment unit capacity and flow ○ Extensive internal pathway development to support rapid flow of specialty patients from ED	DS&P/ COO /DD UC/ All DDs	• Trust level achievement of EAS (85% by end Mar 2021) • Increase proportion of patients with LoS = 0 midnights by 10% by end Mar 21 in line with HomeFirst performance indicators
	1.3 ACUTE AND SPECIALIST PLANNED CARE		
	• <u>Blueprint for Surgical Centres of Excellence at KTC and AGH</u> ○ Increase the utilisation of KTC in 20/21 ○ Refurbish the AGH theatres in preparation for elective centre development in 21/22	COO/ DDs Surgery, W&C/ SCSD	• Review of clinical site strategy by Q2 • Subject to business case approval, increase utilisation for day case activity at KTC by 10 % by end Mar 21 compared to 19/20 outturn
	• <u>Strategic Partnership</u> ○ Joint service model for oncology, urology & head and neck cancer developed with preferred partner	DS&P/CMO COO/ DDs Surgery, SCSD	<u>By end Mar 21:</u> • Review partner options by end Q2 • MOU agreed by end Q3

			• Seek opportunities for joint appointments in oncology and urology • Adopt host oncology prescribing system

	• NHS Long Term Plan - Outpatient Transformation:
	  ○ Reduction in follow up appointments
	  ○ Adopt virtual outpatient appointments
		COO/DDs (All)	• Review channels by speciality end Q2
			• Increase the # OP virtual consultations by 50%; trial, test and roll out patient requested follow ups in 75% OP clinics

STRATEGIC OBJECTIVE TWO: *BEST EXPERIENCE OF CARE AND BEST OUTCOMES FOR OUR PATIENTS*			
QUALITY			
Exec Lead	**Refreshed Improvement Priorities 2020/21**	**Exec Lead / Delivery Lead**	**Measured by**
CNO	**2.1 CARE THAT IS SAFE**		

	• Infection Prevention and Control
	  ○ Embed our current infection prevention and control policies and practices
	  ○ Continuously monitor the effectiveness of our enhanced infection control policies and practices in preventing in - hospital transmission of COVID- 19
		CNO / Deputy DIPC	• 95% compliance with IPC mandatory training by end Mar 21
			• Full compliance with our *Key Standards to Prevent Infection*, ie Hand Hygiene 97%, Cleanliness in line with national standards, ongoing care of invasive devices 97%

CMO	**2.2 CARE THAT IS EFFECTIVE**		
	• Undertake review of poor performance to develop action plan • Improve delivery in respect of the Sepsis Six	CMO / Sepsis Clinical Lead	• 25% improvement across all six measures (and specifically IV fluid resuscitation and catheterisation / urine output measurement) by end Mar 21 compared to 19/20 outturn
	• Implement clinical standards for seven day hospital services and agreed Internal Professional Standards (IPS) consistent with Homefirst principles	CMO / DDs	• 95 % compliance with the 4 priority clinical standards by end Dec 20 • 100% compliance with IPS by end Dec 20
	• Improve our *Learning from deaths* process	CMO / DCMO	• 95% primary mortality reviews completed within 30 days by end Aug 20

STRATEGIC OBJECTIVE TWO: *BEST EXPERIENCE OF CARE AND BEST OUTCOMES FOR OUR PATIENTS*			
QUALITY			
Exec Lead	**Refreshed Improvement Priorities 2020/21**	**Exec Lead / Delivery Lead**	**Measured by**
CNO	**2.3 CARE THAT IS A POSITIVE EXPERIENCE FOR PATIENTS AND THEIR CARERS**		
	• Launch and implement real time patient and carer feedback through a focussed "you said….we did" approach utilising FFT/ WREN data at ward and department level	CNO / Head of Patient, Carer and Public Engagement	• Adopted by 100% of all wards/ departments (adults, children, maternity, theatre and outpatients) as measured through ward accreditation programme April 2021 • Evidence of patient involvement in improvement strategies

	• Re-launch the Dementia strategy with a clinical co-production of a "fundamentals of care" programme	CNO / Dementia Lead Nurse	• 100% of adult wards achieving compliance with fundamentals of care programme as measured through ward accreditation programme April 2021
	• Review Volunteering strategy in post COVID environment • Launch and implement our Volunteers Strategy #WeAreVolunteering	CNO / Head of Patient, Carer and Public Engagement	• Review by Q2 2020 • Strategy launched and implementation commenced by end Q3 2020 • By year end maintain 90% of current volunteer numbers
COO	**2.4 OPERATIONAL PERFORMANCE STANDARDS**		
	• Complete the implementation of Home First Worcestershire to eradicate corridor care and minimise ambulance handover and admission delays	COO / DCOO	• Eradicate corridor care & reduce ambulance delays and > 12 hours waits for admission by 50% in 2020/21 v prior year

STRATEGIC OBJECTIVE TWO: *BEST EXPERIENCE OF CARE AND BEST OUTCOMES FOR OUR PATIENTS*			
QUALITY			
Exec Lead	**Refreshed Improvement Priorities 2020/21**	**Exec Lead / Delivery Lead**	**Measured by**
COO	• Ensure timely access to diagnostics and treatment for all urgent cancer care	COO /DOps	• 62 day diagnosis to treatment target by Dec 2020
	• Maintain access to all emergency surgery (inc trauma) and triage elective waiting list to prioritise access for those at greatest risk of harm from delay.	COO/ DOps	• Maintain standards in line with national guidance as part of Restoration Phase 2
CEO	**2.5 IMPROVEMENT**		
	• Single Improvement Methodology	**CEO / D**	• Review requirement by end June 20

	○ Increase capacity and capability of service improvement function	**S&P**	• Secure agreed resource end Q2 • Roll out Q3
	• Reset and Transformation ○ Identify and deliver the 10 high impact changes from COVID 19 ways of working ○ Reviewed and delivered KLOE improvements as required by CQC ○ Reset the workforce model to meet the needs of the new service model	CEO / D S&P	By end Mar 21: • Patient Friends and Family Test scores improve by 5% • Our average length of stay is <5 days • NHSI have exited us from Special Measures • Agency spend is reduced to 6% of total pay

STRATEGIC OBJECTIVE THREE: *BEST USE OF RESOURCES*			
ENABLERS			
Exec Lead	**Refreshed Improvement Priorities 2020/21**	**Exec Lead / Delivery Lead**	**Measured by**
CDO	**3.1 DIGITAL STRATEGY**		
	• Deliver year one of our digital strategy ○ Digital care record implementation plan ○ Digital Infrastructure development ○ Digital innovation programme to support new ways of working	CDO / Deputy CDO	By end Mar 21: • improved internet connections across all three sites and robust remote working solutions for staff and clinical teams. • an digital infrastructure development plan in place underpinned by a 3 year capital programme • adoption of video consultations and remote monitoring rolled out to Cardiology teams • Chief Digital Nurse Officer and Chief Clinical Digital Officer in post • create space for a digital campus to include innovation spaces and model ward and

			clinic environments •
CFO	**3.2 FINANCE**		
	• <u>Deliver year one of our medium term financial plan linked to the delivery of system wide financial improvement</u> ○ Specific focus on opportunity to remove reliance on temporary staffing ○ Further develop the productivity and efficiency programme in line with refreshed Model Hospital /Use of Resources opportunities and internal Reset	CFO / Deputy Directors of Finance/ PMO	<u>By end Mar 21:</u> • reduce our agency spend below the £17m cap by March 2021. • minimum PEP savings/efficiencies - £15m in 2020/21

STRATEGIC OBJECTIVE THREE: *BEST USE OF RESOURCES*			
ENABLERS			
Exec Lead	**Refreshed Improvement Priorities 2020/21**	**Exec Lead / Delivery Lead**	**Measured by**
COO	**3.3 ESTATES**		
	• <u>Estates strategy</u> ○ Develop interim strategy for more efficient utilisation of Trust sites in support of social distancing measures for staff and site designation (COVID/Non-COVID) ○ Ensure appropriate resources and arrangements for the project management of the remaining ASR construction programmes	COO / Director of Estates and Facilities	<u>By Mar 21:</u> • reduce the amount of empty and under – utilised space (6.7% and 1.0% respectively) to align more closely with the Model Hospital benchmark values (1.1% and 0.7%) • ASR programmes delivered on time and on budget (COVID 19 permitting)

STRATEGIC OBJECTIVE FOUR: *BEST PEOPLE*			
WORKFORCE AND CULTURE			
Exec Lead	**Refreshed Improvement Priorities 2020/21**	**Exec Lead / Delivery Lead**	**Measured by**
D of P&C	**4.1 WORKFORCE**		
	• Organisation development ○ Implement our new operational management structure	COO/DDs	• New structure fully in place with supporting leadership development offer by Dec 20 •
	• Strategic workforce plan ○ Introduce new roles and staffing models to support the delivery of our clinical services strategy ○ Accelerate new ways of working from the COVID experience	D of P&C /Deputy D of P&C	By Mar 21: • new roles and staffing models implemented in line with workforce transformation plan on a page milestones: ○ Physician Associates, Clinical Fellows, Associate Nurses, Virtual Ward, Hospital @ Night, Skill Mix Reviews (SCSD) • 50% increase in staff work remotely for more of the time v prior year • further reduction in substantive vacancies (baseline 7.50% Mar 20) towards national average
	• BAME workforce ○ Undertake COVID risk management assessments for all BAME staff	D of P&C/ CNO	• 75% completed by end Q1 • 100% by end Q2

STRATEGIC OBJECTIVE FOUR: *BEST PEOPLE*			
WORKFORCE AND CULTURE			
Exec Lead	**Refreshed Improvement Priorities 2020/21**	**Exec Lead / Delivery Lead**	**Measured by**
	4.2 CULTURE		
	• 4ward ○ Continue to develop our culture and improve staff engagement through 4ward phase 2 – Step Forward	D of C&E / Lead Advocate	By end Mar 21: • increase in number of 4ward advocates of at least 200 (to a total of at least 600) by end Mar 21. • improvement in Staff F&F scores to better than national average by end Mar 2021 • improvement in 2020/21 staff survey response rate in line with national average for acute trusts

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

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Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	11th June 2020
Paper number	Enc

Integrated Performance Report – Month 1 – 2020/21

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

Accountable Director	Paul Brennan – Chief Operating Officer / Deputy Chief Executive		
Presented by	Paul Brennan – Deputy Chief Executive & Chief Operating Officer	**Author /s**	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

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

Executive summary	This paper provides the Trust Board with a validated overview of April 2020 against the trajectories, specifically for the NHS constitutional standards, key operational, quality and safety and workforce key metrics. (Cancer data will be validated the end of June.) Please note that this paper is a transitional paper between 19/20 and 20/21 priorities. Some of the content of this paper has been presented to Trust Board previously, however where validated data has become available we have included this.

Risk

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

NHS
Worcestershire
Acute Hospitals
NHS Trust

Meeting	Trust Board
Date of meeting	11th June 2020
Paper number	Enc

Introduction/Background

This paper provides the Board with an overview of April 2020 against the trajectories, specifically for the NHS constitutional standards and the key operational, quality and workforce metrics.

In April 2020, the performance of several key measures has continued to be impacted by the Trust's rapid implementation of emergency planning protocols to manage the Covid 19 incident; particularly in relation to Referral to Treatment Time and Diagnostics. However, we are now assured that we are over the initial peak of Covid 19 and thankfully we did not experience the levels of demand that was modelled for this county. We are now moving towards a restoration plan that will enable us to start to rebuild some of the services for the most in need patients and re-focus on ensuring we do not revert back to previous ways of working that created 'exit block'. This will be a focus of the integrated performance report for the forthcoming months.

Issues and options

OPERATIONAL PERFORMANCE STANDARDS (BAF 1 / Annual Plan Priority – 2.4 Exec Lead: COO)

4-hour emergency standard and patient flow

- We did achieve the April-20 provisional trajectory of 80.84% for the 4 hour emergency standard. Our performance was 88.92%. This equates to 921 breaches from 8,308 emergency attendances.
- In April 2020, whilst in COVID 19 lockdown our emergency demand has decreased significantly with 50% less attendances at our Emergency Department than April last year. However, this profile was changing towards the end of April with 420 more attendances in the last ten days than the previous ten days.
- Many of the patients that have attended have been acuity ill and required admission, we have seen 5.6% more people admitted than the same month last year.
- There were 2 ambulance 60 minute handover breaches for April-20, and statistical significant improvement in both the 15 minute and the 30 minute ambulance handovers at both sites. The Trust performance for 30 minute ambulance handovers was 95.7%, and the 15 minute ambulance handovers at 53.8%.
- There were no 12 hour breaches for April-20.
- Across both sites we have had some Ward closures and significant numbers of beds empty. At the end of April we had a total of 198 beds unused (101 beds on unused wards and 97 beds empty on open wards) at the Worcestershire Royal site and a total of 143 beds unused at the Alexandra Hospital (59 beds on unused wards and 84 empty beds on open wards). A total of 341 unused beds across both sites. This number has significantly reduced in early May to 264 unused beds across both sites.
- The occupancy level as at the end of April was 61% at the Worcestershire Royal and 45% at the Alexandra Hospital.
- On average our patients have been staying less days in the hospital during April, with Surgery reducing from 8.9 to 5.8 days at the Alexandra Hospital and from 6.4 to 5.2 days on the Worcestershire Royal site. Medicine has decreased from 7.7 to 6.3 days at the Alexandra Hospital and from 7.7 to 5.9 days at the Worcestershire Royal site.

As expected the overnight bed capacity gap during the Covid incident had reduced

significantly. The volume of emergency attendances had been increasing steadily since mid-April and increased significantly on April 27th (following the Governments message that the 'NHS is open for business, and for people to seek emergency support as soon as they need it'). On April 27th we had over 100 more patients attend the Emergency Departments (both sites) than we had seen in the previous days. The capacity gap increased on this day and took a number of days to recover. One point of learning for us is to ensure that we have the ability to react quickly to increasing demands and monitor triggers that are indicating potential stresses on the open capacity.

Throughout the Covid 19 incident we have continued to:

- Sustain a low volume of patients with a length of stay over 21 days. At the end of April we had 21 patients. We are now looking to set an aspirational target for the end of March 2021 to build on this improvement.
- Focus on criteria led discharge in the pilot wards and we have recruited the clinical leads needed to take this forward as this will be crucial in the next phase of the Covid - 19 incident, especially as we start to increase the volume of non-covid related patients in the hospital with a continued reduced bed base.
- Work with our GP federation colleagues to provide a front door primary streaming service at the Worcestershire Royal, that can be stepped up as more patients return to seek emergency treatment through the Emergency Department, thus releasing some of the previous pressures experienced by the Emergency Departments.
- Although before midday discharge volumes at the Worcestershire Royal have declined slightly in the non-covid wards which is due to the temporary closure of the Discharge Lounge, we are still seeing a focus from several wards on the earlier discharge processes.

The focus for the forthcoming months will be to continue to create flow and build upon the change in culture that has enabled us to discharge patients as soon as it is clinically safe to do so during the Covid 19 incident so far.
We will be:

- Completing case studies on one patient per ward for two weeks in May, to identify any barriers to timely discharge, specifically where criteria led discharge may have facilitated earlier discharge.
- Completing a deep dive analysis into Monday discharges to identify what improvements could be made during the weekends to increase the weekend discharges.
- Completing a review of the CT service that supports the Emergency Department to identify any changes in pathway needed to improve faster decision making.
- Re-starting the Frailty front door service at the Worcestershire Royal Hospital.

Referral to treatment (RTT)
The RTT waiting list was validated at 33,162 with 9,967 patients waiting more than 18 weeks for their first definitive treatment. Our performance in April was submitted as 69.92%. There were 7 patients who were waiting over 52 weeks and 477 patients waiting between 40 and 52 weeks.

Predictions show that if we did not re-start some services before the start of August we will have 18,835 patients waiting longer than 18 weeks for definitive treatment.

- The consultant–led referral rate has reduced significantly from the levels seen in last April from 4,073 referrals (exc 2WW) to 511 referrals in April 2020.

Please note: In the last report we misreported the volume of telephone consultations that had taken place during March, this should have read 6,500 telephone/virtual consultations from a total of 39,000, not 33,000 telephone consultations as stated.

In April, the volume of telephone/virtual outpatient consultations was 10,311, which is 50% of all outpatient appointments that occurred in April.

Cancer – please note the data for April is unvalidated at the time of writing this report (it will be validated by the end of June).

- There is no submitted trajectory for 2ww cancer for April-20; unvalidated performance is 88.89%.
- During April our 2WW referrals from primary care have reduced by 61% (1,352) compared to the previous April and 53% (990) compared to March 2020.
- Although Breast symptomatic performance is 100% for April-20, this is in context of 14 patients being seen since a change in referral criteria agreed with GPs.
- Our 62 day performance is 'unvalidated' for April-20 at 60.13% with 150.5 patients treated, of which 61 has already breached 62 days.
- We had 53 patients who had been waiting over 104 day waits for treatment at the end of April.

In order to manage the COVID-19 incident we have had to implement changes to referral criteria and services delivered to some patients, whilst maintaining the clinical oversight of those who are most vulnerable and delivering critical surgery using the independent sector. Some clinical management changes we have made are as below:

- Expanded telephone triage for some 2WW referrals (examples in Colorectal and Haematology, Head and Neck)
- 2WW - Transferred some FIT testing to our primary care colleagues (Colorectal)
- Suspended all routine and non-urgent diagnostics to provide the capacity for urgent diagnostics (such as MRI scans in Breast)
- In most specialties cancer follow ups have been transferred to telephone consultations.

The independent sector (Spire, BMI Droitwich, BMI Edgbaston/The Priory) have undertaken 167 cancer treatments, 12 non-cancer treatments and 58 scopes between 30th March and 3rd April.

Diagnostics

- Our total waiting list was validated at 7,527 with 5,015 patients waiting longer than 6 weeks, therefore performance was submitted as 39.87% (with 60.13% patients breaching 6+ weeks).
- During April we have completed 4,971 diagnostics, and of these 26% was unscheduled CT scans.

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BEST EXPERIENCE OF CARE AND BEST OUTCOMES FOR OUR PATIENTS
During April 2020 the Trust has continued a specific response to managing the COVID 19 outbreak with the strategy of command and control whilst maintaining and ensuring quality and safety for our patients and staff.

CARE THAT IS SAFE (BAF 4 / Annual Priority 2.1, Exec Lead - CMO)
The focus on infection control lead by DIPCE has and remains a key priority.

The Serious incident meetings have continued, these are led by The Chief Medical Officer.

The quality audits were paused in March 2020 and replaced by a tool (Dynamic Trigger Tool). This tool was beneficial for ward staff to use at handover and safety huddles. This tool has provided a focus on areas of quality and safety for patients and staff and when and where to escalate concerns. No concerns were escalated during April.

CARE THAT IS EFFECTIVE (BAF 2 & 4 / Annual Priority 2.2, Exec Lead - CNO)
There has been a continued focus through the daily Silver command structures lead by Chief Medical/Nursing officers with Divisional Directors on clinical leadership of Quality and safety. This has provided clinical oversight of daily standards of care/treatments and responses required to specific COVID related patient issues and operational changes in patient care pathways as well as sight on staff health and wellbeing.

CARE THAT IS A POSITIVE EXPERIENCE FOR PATIENTS AND THEIR CARERS (BAF 2 / Annual Priority 2.3, Exec Lead - CNO)
The national timescales for complaints has been abated during COVID 19, however the Divisions have been investigating concerns where they have had sufficient capacity. The focus in the initial stages of COVID reflected in this report has been to recognise and respond to the difficulties for our patients and their relatives with admissions during the COVID 19 pandemic and a number of key initiatives have been implemented. New initiatives being: Letters from home, hearts in hand, patient and relative helpline.

BEST PEOPLE (BAF 9 / Annual Priority – 4, Exec Lead – D of P&C)
Workforce and Culture
The Director of People & Culture is pleased to report that the significant reduction in bank and agency spend in month 1 has continued in to month 2. This correlates with a reduction in hours worked. The reduction in spend has been achieved by the internal redeployment of staff due to some services being paused. The incident management module of Allocate has been utilised which allows the tracking of staff to support accurate costing and enables colleagues to be easily moved from one rota to another.

Due to the focus on COVID-19 we have seen deterioration in a number of workforce metrics with job plans seeing the biggest drop in compliance from 89% to 63%. Temporary job plans will be adopted to support our continued response to COVID-19 whilst ensuring urgent care is prioritised.

Mandatory training and appraisals were paused during the early weeks of COVID-19 but have been reinstated for some staff groups from May 2020.

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BEST USE OF RESOURCES (BAF 7 & 8 / Annual Plan Priority – 3.2, Exec Lead – CFO)

Finance
Please see appendix 3.

Recommendations

The Board is asked to note this report for assurance.

Appendices

1. Committee Assurance Reports
2. SPC Charts
3. Finance summary slides

Trust Board

Worcestershire Acute Hospitals NHS Trust

Integrated Performance Report

SPC Charts

April 2020
Month 1

11th June 2020

Best Services for Local People

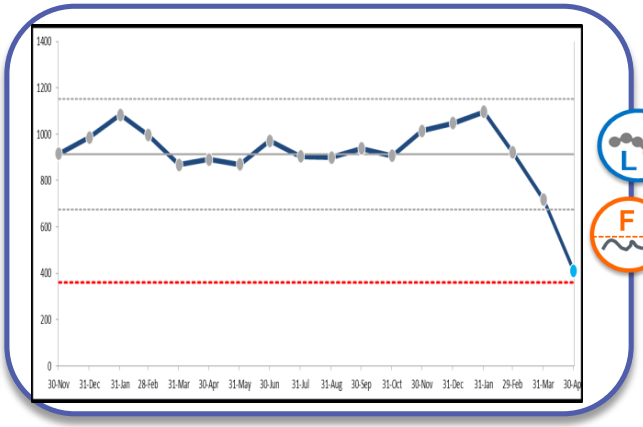
NHS Worcestershire Acute Hospitals NHS Trust

Month 1 [April] 2020-21 | Home First Programme Summary

Responsible Director: Chief Operating Officer | Validated for April-20 at 18th May 2020

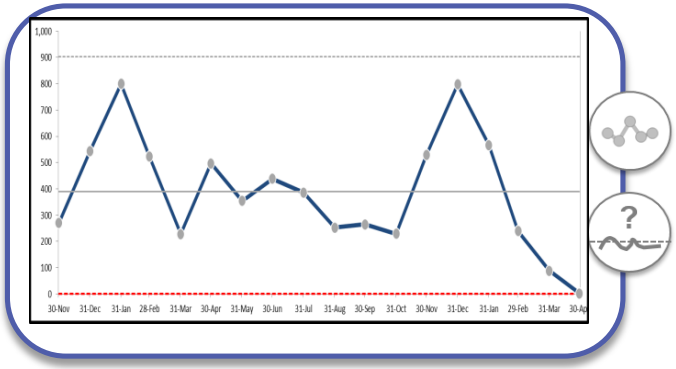
Total time spent in A&E

410



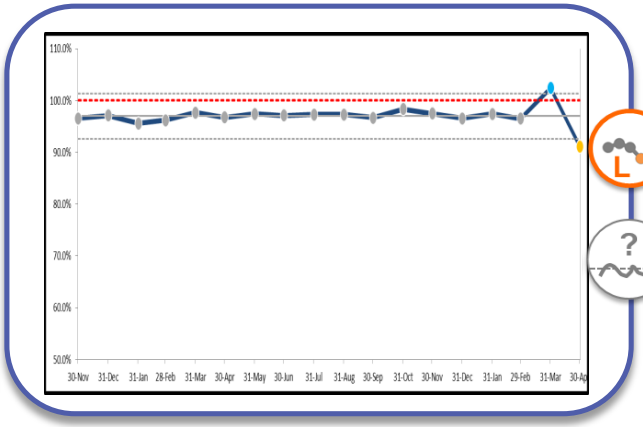
60 minute Ambulance Handover Delays

2



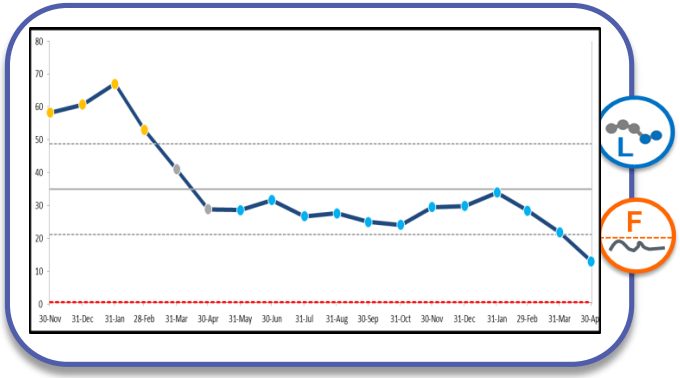
Discharge as a percentage of admissions

91.14%



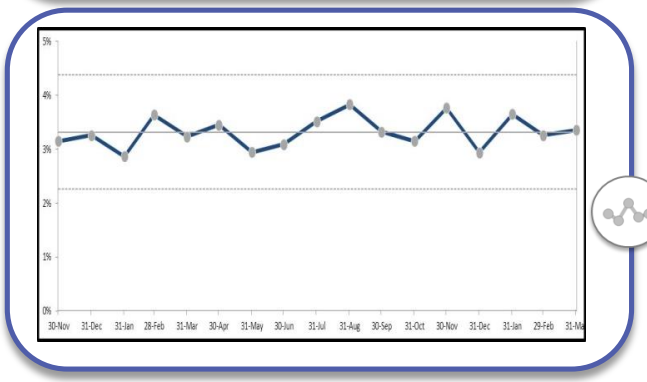
Capacity Gap (Daily Average)

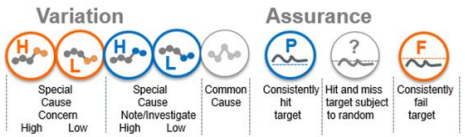
12.5



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

3.35%





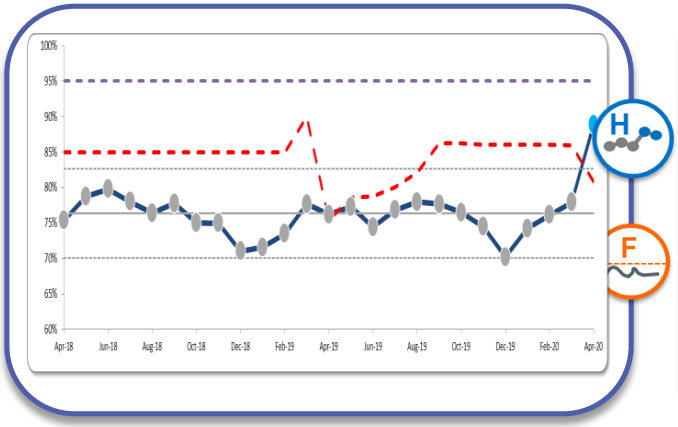
Month 1 [April] 2020-21 Operational Performance Summary

Responsible Director: Chief Operating Officer | Validated for April-20 at 18th May 2020

NHS Worcestershire Acute Hospitals NHS Trust

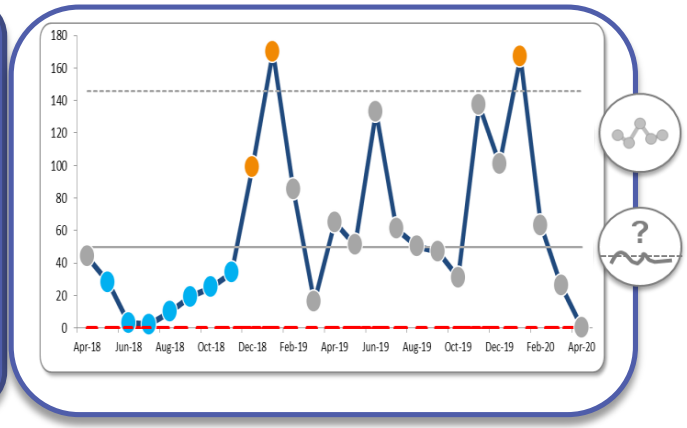
4 Hour EAS (all)

88.92%



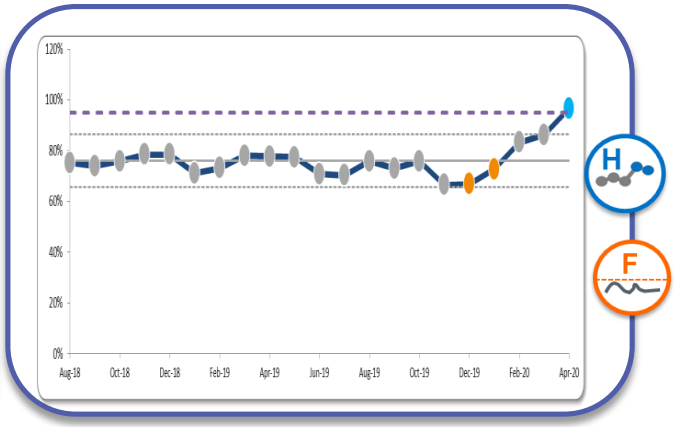
12 Hour Trolley Breaches

0



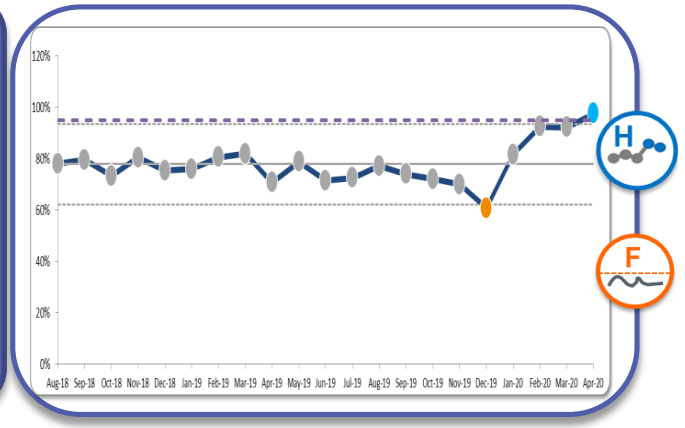
TTIA - % within 15 minutes WRH

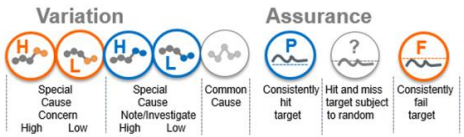
96.58%



TTIA - % within 15 minutes ALX

97.69%





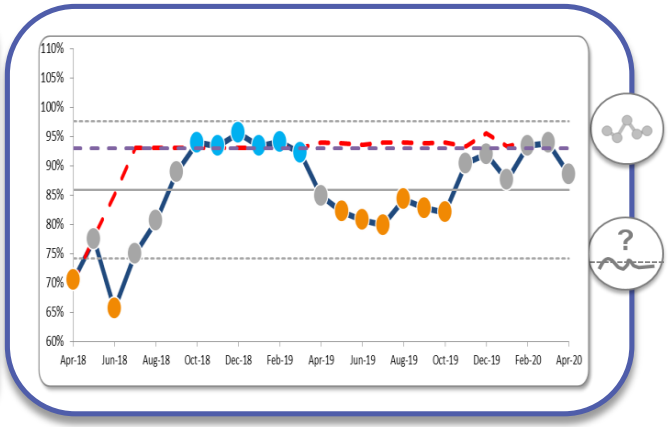
Month 1 [April] 2020-21 Operational Performance Summary

Responsible Director: Chief Operating Officer | Unvalidated for April-20 at 18th May 2020

NHS Worcestershire Acute Hospitals NHS Trust

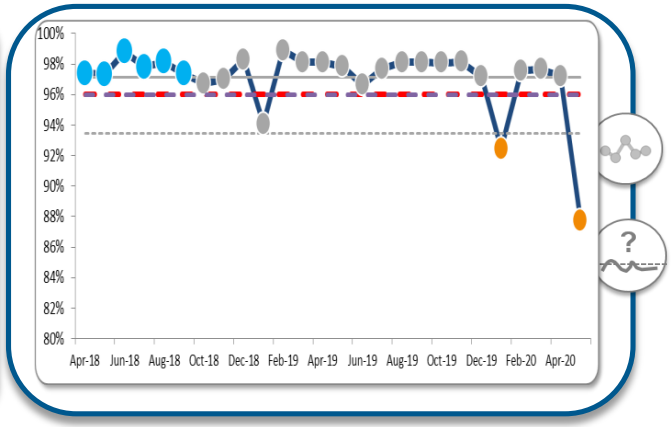
Cancer 2WW All

88.89%



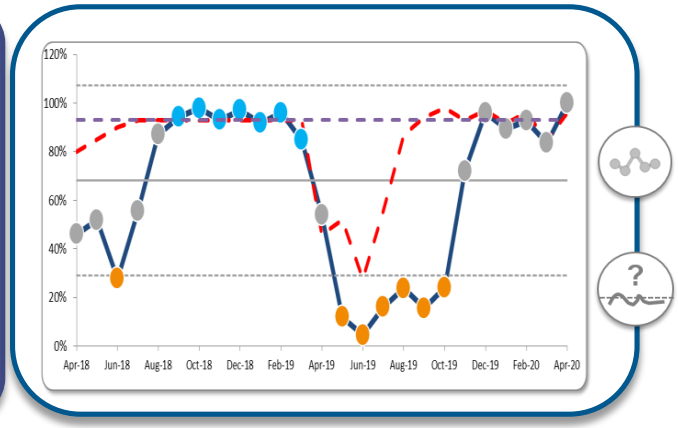
Cancer 31 Day All

97.20%



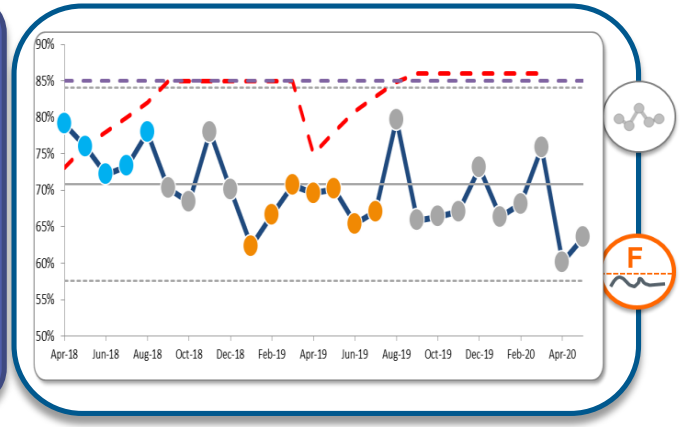
Cancer 2WW Breast Symptomatic

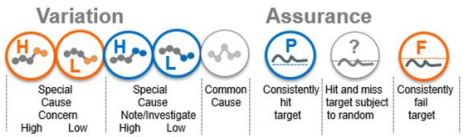
100%



Cancer 62 Day All

60.13%





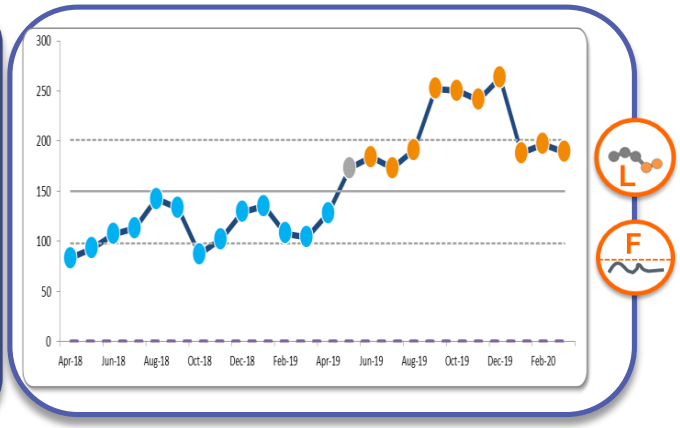
Month 1 [April] 2020-21 Operational Performance Summary

Responsible Director: Chief Operating Officer |Validated for April-20 at 18th May 2020

Worcestershire Acute Hospitals NHS Trust

62+ Day Waiters

189



104+ Day Waiters

53