Worcestershire NHS
Acute Hospitals NHS Trust

There will be a meeting of the **Worcestershire Acute Hospitals NHS Trust Board** on
**Wednesday 11 January 2017**
at 09:30 – 11:30 in **Alexandra Hospital Board Room, Redditch**

From 11:45 to 12:45, the Chairman and Trust Board will discuss topics with the Public
Topics should be emailed to kimara.sharpe@nhs.net by
Tuesday 10 January 12 noon

Caragh Merrick
Chairman

***Please take papers as read***

## AGENDA

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| 1 | **Welcome and apologies for absence** | Chairman | |
| 2 | **Patient Story** | Interim CNO | |
| 3 | **Items of Any Other Business**<br>*To declare any business to be taken under this agenda item.* | | |
| 4 | **Declarations of Interest**<br>*To declare any interest members may have in connection with the agenda and any further interest(s) acquired since the previous meeting.*<br>To note the following declarations of interest:<br>Chris Swan (Non-Executive Director) – Cobalt Development Ltd<br>Philip Mayhew (Non-Executive Director)<br>• Associate Director – Koru Consulting Limited<br>• Director of Midlands School of Social Enterprise<br>• Director of the Institute for Continuous Improvement in Public Services<br>• Member of Loughborough University's School of Service Operations Management Advisory Board<br>• Trustee of Colebridge Trust<br>• Governor at Solihull College and Summerfield Pupil Referral Unit | | |
| 5 | **Minutes of the previous meeting**<br>*To approve the Minutes of the meeting held on **2 November 2016** as a true and accurate record of discussions.* | Chairman | **Enc A** |
| 6 | **Matters Arising** | Chairman | **Enc B** |
| 7 | **Chairman's Update Report**<br>*For information* | Chairman | **Enc C1** |
| 8 | **Chief Executive's Report**<br>*For assurance* | Interim Chief Executive | **Enc C2** |

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| **STRATEGY** | | | |
| 9.1 | **Emergency care pressures**<br>*For assurance* | Interim CEO | **Presentation** |
| 9.2 | **Herefordshire and Worcestershire Sustainability and Transformation Plan**<br>*For assurance* | Director of Planning and Development | **Enc D1** |
| 9.3 | **Trust Management Group**<br>*For assurance* | Interim CEO | **Enc D2** |
| **QUALITY AND PATIENT SAFETY** | | | |
| 10.1 | **Quality Governance Committee report**<br>*For assurance* | Committee Chair | **Enc E1** |
| 10.2 | **Trust Improvement Plan**<br>*For approval* | Director of Planning and Development | **Enc E2** |
| **FINANCE AND PERFORMANCE** | | | |
| 12.1 | **Finance and Performance Committee**<br>*For assurance* | Committee Chair | **Enc F1**<br>***To follow (mtg 6-1-17)*** |
| 12.2 | **Integrated Performance Report**<br>*For assurance* | Director of Planning and Development | **Enc F2** |
| 12.3 | **Financial Performance Report**<br>*For assurance* | Interim Director of Finance | **Enc F3** |
| **RISK MANAGEMENT/GOVERNANCE** | | | |
| 13.1 | **Audit and Assurance Committee report**<br>*For assurance* | Committee Chairman | **Enc G1** |
| **ITEMS FOR INFORMATION** | | | |
| 11.2 | **Nursing and Midwifery Workforce**<br>*For noting* | Interim CNO | **Enc H1** |
| 14.1 | **Charitable Funds committee report**<br>*For assurance* | Committee Chairman | **Enc H2** |
| 15 | **Any Other Business** | | |
| | Date of Next Meeting The next public Trust Board meeting will be held on **Wednesday, 1 March 2017, Alexandra Hospital Board Room** | | |

**11:45 – 12:45**
**Topic discussion – topics determined by the Public**
**Please email your topic to kimara.sharpe@nhs.net by Tuesday 1 November, 12 noon**

**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).

Worcestershire NHS
Acute Hospitals NHS Trust

**MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON**

**WEDNESDAY 7 SEPTEMBER AT 09:30 hours**

**Present:**

| | | |
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| **Chairman of the Trust:** | Caragh Merrick | Chairman |
| **Board members: (voting)** | John Burbeck | Vice Chairman |
| | Stephen Howarth | Non-Executive Director |
| | Bryan McGinity | Non-Executive Director |
| | Jill Robinson | Interim Director of Finance |
| | Andrew Short | Acting Chief Medical Officer |
| | Andrew Sleigh | Non-Executive Director |
| | Jan Stevens | Interim Chief Nursing Officer |
| | Chris Tidman | Interim Chief Executive |
| **Board members: (non-voting)** | Denise Harnin | Director of HR & Organisational Development |
| | Sarah Smith | Director of Planning and Development |
| | Lisa Thomson | Director of Communications |
| | Bill Tunnicliffe | Associate Non-Executive Director |
| **In attendance:** | Kimara Sharpe | Company Secretary (minutes) |
| | Paul Crawford | Patient Representative |
| | Inese Robotham | Interim Chief Operating Officer |
| | Rob Cooper | Director of Financial Improvement |
| **Public Gallery:** | Press | 1 |
| | Public | 8 |
| **Apologies**: | Stewart Messer | Chief Operating Officer |
| | Alan Harrison | Non-Executive Director |
| | Marie-Noelle Orzel | Improvement Director |
| | Gareth Robinson | Interim Chief Operating Officer |

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114/16 **WELCOME**

Mrs Merrick welcomed members of the public to the meeting. She outlined the Trust's new approach to the public board meeting which was to have one hour at the end of the meeting to discuss topics raised in advance and answer questions from the public.

Mrs Merrick welcomed Jill Robinson, Interim Director of Finance to her first meeting.

115/16 **PATIENT STORY**

Ms Stevens introduced Ms Rosanne Dunkley, Specialist Community Diabetes Dietician. She explained that Ms Dunkley whilst based in Redditch, works across the county and her team has won several national awards for the work that they undertake.

Ms Dunkley explained that she organises and runs educational courses for diabetics. There are 35000 diabetics with 80-90% diagnosed with type 2 diabetes within Worcestershire with over 100 people diagnosed every month. There is evidence that education supports people with the coping with the diagnosis and if lifestyle is managed then this will save the NHS costs in the future.

She went onto outline the courses run, X-PERT diabetes, X-PERT insulin, DAFNE, First Steps and annual update courses. The team has won national awards for the greatest participation in courses (2016, 2015, 2014 and 2013) and two additional prizes in 2015 for impact on risk factors.

In 2014, the waiting time for attending courses was 12 months. The Team introduced a half day course, First Steps which was a launched in 2015. The waiting time is now 2-4 weeks.

She outlined the partners involved in delivering the programme, an on line provider, Diabetes UK, the Acute Trust and Primary Care.

Ms Dunkley then gave details of the course content. Over 50 courses are now being run a year, across the county, daytime and evening. The age profile of attendees matches the prevalence of type 2 diabetes. The evaluation from participants was excellent and their blood results also showed an improvement. A number of people had blood results which moved them out of being a diabetic.

She was pleased that Diabetes UK has highlighted the work being undertaken and she has recently made education videos for the website.

Ms Stevens thanked Ms Dunkley for her inspirational presentation. She was delighted with the outcomes and the real difference the education was making, both with immediate effect and for the future.

Mr Tidman reminded members that the Consultant lead for ophthalmology had described a similar programme. He stated that he would like to see the expert patient approach spread over more disciplines.

Mr McGinity asked whether celebrities were used to ensure people understood the necessity of education. Ms Dunkley confirmed that they were.

Mrs Merrick thanked Ms Dunkley for an inspirational presentation. She was particularly impressed with the partnership approach and she felt that elements of the service should be an exemplar for 21st century healthcare.

**Resolved: that**
**The Board**

- Noted the content of the story

116/16 **ANY OTHER BUSINESS**

No other items of business were raised.

117/16 **DECLARATIONS OF INTERESTS**

**Resolved that**
**The Board**

- Noted the revised declaration of interests with the addition of interests for Mr Robinson as an employee of Price Waterhouse Cooper and a governor of Queen Alexandra College, Edgbaston.

Mrs Merrick stated that dialogue had taken place with Mr Robinson prior to his appointment in relation to his employment with PWC and the necessity for him to withdraw from some discussions.

118/16 **MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON 7 SEPTEMBER 2016**

**Resolved that:-**

- The Minutes of the public meeting held on 7 September 2016 be confirmed as a correct record and be signed.

118/16/1 **MATTERS ARISING/ACTION SCHEDULE**

Mrs Sharpe confirmed that all the actions had been completed or not yet due.

119/16 **Chairman's Report**

Mrs Merrick asked the Board to formally receive the Chairman's Action undertaken at the meeting of directors. This enabled Evergreen Ward to be opened. She also asked for approval for the revised remuneration committee membership.

She went onto confirm that the interviews for the permanent chief executive were to be held on 9 November. The announcement would be made at the end of the month in relation to the successful appointee. She was also interviewing for non-executive directors on 14 November. She was hopeful that she would be able to appoint a non-executive director from North Worcestershire and Kidderminster.

She thanked partners for their support and involvement with the recruitment, in particular the Chair of the Health and Care Trust and the HR support from 2gether NHS Foundation Trust.

**Resolved that:-**

**The Board**

- Noted the Chairman's action taken on 28 September
- Approved the revised remuneration committee membership
- Received the update in respect of the board membership
- Noted the report

120/16 **Interim Chief Executive's Report**

Mr Tidman reported that the representatives from the Health Community including the Acute Trust, GPs and CCGs had attended a meeting with NHS England in the final phase of the assurance process prior to consultation on the Future of Acute Hospital Services in Worcestershire. There was a final NHS E capital meeting on 21 November and he hoped to hear after that date confirmation of the dates of consultation.

He was delighted that he was able, with the Chairman, to recognise staff at the recent long service awards and he was looking forward to the staff award ceremony at Chateau Impney on 18 November where the key note speaker will be Olympian Colin Jackson. Additionally, a number of staff were recognised by the University in recent mentor awards ceremony.

He then turned to the work of the A&E Delivery Board, which he chairs. He described the five work streams including NHS 111 and the ambulance service. He stated that there remained a number of actions the Trust could take internally as well as working externally with partners to improve patient flow. Discussions had also taken place about how to ensure people attended the appropriate service for their needs.

Mrs Merrick asked how the objectives of the Delivery Board would be shown in the metrics. Mr Tidman assured her that the work of the board was reflected in a range of high level (e.g. 4 hour waits) and more detailed metrics. The QGC was monitoring the quality of the performance.

Dr Tunnicliffe stated that it was important to understand the quality of care received and welcomed the development of a quality dashboard.

Ms Stevens stated that any person delayed over 15 minutes had a harm review which was reported internally as well as externally to the CQC. Protocols are in place for care and comfort rounds and extra staff are deployed when necessary.

Mr Howarth asked whether there were unintended consequences for the Trust if the Ambulance Service constantly strived to meet targets. Mr Tidman confirmed that the Health Economy together managed risk and there was no evidence that the risk was being transferred. There has been a 10% rise in ambulance conveyances and there has been a corresponding increase in 999 calls. This situation is not sustainable and he was working to reverse the trend. The Ambulance Service was integral to proactively managing demand.

Mr McGinity was pleased to see the good results in the national patient cancer survey and asked how much influence the Oncology Centre had on these results. Mr Tidman stated that it was fundamental to the service and had ensured that 95% of cancer patients were now treated in Worcestershire rather than having to travel across the West Midlands for their treatment. He stated that the presentation on the 9 November was a summary of the results and he urged people to attend if they could.

Mrs Merrick asked how the Trust was responding to the national requirement for monthly returns on agency spend. Mr Cooper confirmed that he was chairing a task group. He reminded the board that the Trust was successful in reducing agency spend by a third in 2015/16. The Finance and Performance Committee would be monitoring this in future.

Mrs Merrick thanked Mr Tidman for his report. She was pleased to see the staff achievements and was looking forward to the embedding of the new governance arrangements.

**Resolved that:-**
**The Board**

- Delegated to the Finance and Performance committee to sign off the monthly return on agency staff
- Received the assurance within the report.

121/16 **STRATEGY**

121/16/1 **Winter Plan**

Ms Robotham summarised the Trust's Winter Plan. The Ambulatory Emergency Care Centre (AEC) would support the Trust's stance of admission avoidance and she was looking to expand this service on both sites. The Older Person's Assessment and Liaison Service (OPAL) was proving a success on the Worcestershire Royal site and she was looking forward to implementing it at the Alexandra Hospital. There was now a dedicated theatre admissions unit at Worcester.

Evergreen Ward was now open. It was led by the physiotherapists and the outcomes were so far very good. Some patients, who had been waiting for pathway 2, were now

home with additional support. She was working with the Health and Care Trust to replicate the service in the North of the County at the Princes of Wales Community Hospital. The GP Unit in Kidderminster was reopening on 12 Nov under the management of the Health and Care Trust.

The Health Economy had implemented a single call to the patient flow centre to speed up discharge and was now working with commissioners for access to discharge to assess beds within the community. She was pleased that the stroke rehabilitation beds would be centralised at Evesham.

Ms Robotham stated that the actions she had outlined were being supplemented by preventative measures - administration of the flu jab, communications and transport.

Mrs Merrick invited Ms Stevens to comment on the Winter Plan. Ms Stevens confirmed that Evergreen was proving successful with more patients being discharged home.

Mrs Thomson outlined the communications plan which involved all the health economy partners. The messages were aimed at keeping well, staying warm add keeping fit with messages such as not going out in slippers during very cold weather, look after yourselves and your neighbours. She was also working on literature to raise awareness of the patient's journey through hospital and what to expect in relation to discharge.

Dr Short welcomed the work undertaken and planned in preparation for Winter but wondered whether it was sufficient. He outlined the steady rise in the A&E attendances, particularly in the over 75 age group and in ambulance conveyances. The Trust continues to have challenges with patient flow and the community needs to support with earlier discharge. He wondered whether the Trust ought to consider turning people away who should not be attending A&E and advising them on an alternative route to access health care.

Ms Robotham stated that streaming at the front door would mitigate some risk and she acknowledged that more work needed to be undertaken with partners. The A&E delivery board would hold partners to account.

Mr Howarth asked when the Trust would be able to utilise the discharge to assess beds. Mr Tidman confirmed that market testing was being undertaken and within the next 4 weeks, the beds would be operational.

Mr Burbeck was pleased to hear of the partnership working and the recognition that the issues were not just for the acute trust to solve. He also welcomed more education for the public. Mrs Merrick echoed this and suggested that the Trust could develop a strategy for public education.

Mr Sleigh welcomed the discharge to assess beds but stated that 50 beds were needed, not 10. Mrs Merrick reminded Mr Sleigh that it was essential to evaluate new approaches to delivering care before expanding the service.

Dr Tunnicliffe expressed concern that the cold weather had not yet arrived but the hospital continued to be full. He wondered whether the Trust had considered the Nuffield Report which stated that spare capacity was needed. Mr Tidman agreed and reflected that Birmingham had identified that 430 beds were needed in the future. Currently there are 105 people in the Acute trust who do not need an acute bed. The health community needs approximately 50-70 extra beds to cope with the case mix of patients. Commissioners will go to the market if the 10 extra beds evaluate well.

Ms Robotham confirmed that there will be 48 extra beds if Evergreen is counted. Mr Tidman stated that if with an additional 48 beds, and the Trust has challenges with patient flow, then elective cases will be cancelled, waiting lists will increase. Currently the plan is to continue with elective work as well as manage emergencies. He reaffirmed the importance of public consultation to secure the future for the hospitals. Having a clear vision about how the hospitals will work and the public supporting the reconfiguration, will enable the Trust to recruit permanent staff.

Mrs Merrick thanked the Board for their contribution to a critical strategic piece of work. She stated that there were a number of risks but they were currently mitigated. The Trust needed to remain vigilant to continue to identify the risks and any escalation. The most important issue was safe high quality patient care.

**Resolved that:-**
**The Board:-**

- Approved the Winter Plan
- Noted the report

121/16/2 **Trust Management Group (TMG)**

Mr Tidman thanked the staff from Oxford Hospitals Foundation Trust for working with the Board in separating out management from assurance work. He stated that the Clinical Governance Group reviews all aspects of clinical governance to give assurance to the QGC. TMG will have the overarching role to manage risk. He acknowledged that the Trust was not yet in the same position as Oxford in assurance, but had come a long way. He recommended that the terms of reference be approved and stated that they would be reviewed with to view to increasing responsibility in the next few months.

Ms Stevens confirmed that the governance processes had been strengthened. She described some of the detailed work undertaken including the revision of the terms of reference and guiding and coaching people. Within the Governance Assessment tool used by Oxford, the Trust was rated 2 out of 5 and she was positive that the Trust would progress to the next level. The Trust understood the risks and where support was needed.

Mrs Merrick was pleased to see the terms of reference and acknowledged the crucial role TMG had within the governance processes. She confirmed that the board and subcommittees would be reviewed early in the next financial year.

Mr Burbeck supported the terms of reference. However he asked for more detail on the outcomes of the discussions held. This was agreed.

Ms Smith described the governance around the performance framework which has been agreed by the executives and Finance and Performance Committee. The monthly performance meetings will be supplemented by quarterly meetings which will focus on business objectives. This will commence in November. The reporting will be developed. Mr Tidman emphasised the importance of the assurance that the new cycle of meetings would give to the executives.

Mrs Merrick welcomed the development of the governance around the performance framework and requested clear milestones with deliverables.

Ms Stevens also welcomed the approach and reminded members that this gives a clearer line of sight from ward to board with respect to performance management.

**Resolved that:-**
**The Board**

- Approved the Terms of Reference
- Noted the work being undertaken on medical vacancies
- Noted the progress on out of hours care
- Noted the report

122/16 **QUALITY AND PATIENT SAFETY**

122/16/1 **Quality Governance Committee**

The Chair of the Committee, Dr Bill Tunnicliffe presented the report from the Quality Governance Committee (Enclosure E1). The Report covered both September and October meetings.

Dr Tunnicliffe emphasised the benefits now being seen at QGC with the revised governance structure. The Clinical Governance Group has made a positive difference to the debate at QGC. He thanked Ms Stevens for her considerable work.

Dr Tunnicliffe then turned to the items discussed at the last two meetings of the QGC.

He reported that members were impressed with the Dementia lead who spoke about the improvements being made for people with dementia. These included dementia friendly clocks and reminiscent therapy. He urged all board members to review and understand the developments.

He then turned to avoidable mortality. Members were not assured with the progress being made with primary mortality reviews but he was able to report that there were now firm trajectories in place and he understood that there was a grip on the issues. He reported a similar picture with fractured neck of femur pathway and he was able to report that the executives were confident that the metrics would improve.

Dr Tunnicliffe explained to Mr McGinity that the QGC were concerned that the same quality standards were not present when workforce information was presented as for other information. Mrs Harnin confirmed that workforce information and analysis would transfer to the information department to ensure that there was consistency. Mr Tidman reminded members that the Audit and Assurance Committee regularly received reports on data quality and would be able to assure the board on this area of work in the future.

**Resolved that:-**
**The Board**

- Noted the never event
- Received assurance in respect of the management of VTE prevention
- Noted the lack of assurance in respect of the time to theatre for patients who had suffered a fracture neck of femur and primary mortality reviews
- Noted the lack of assurance in relation to the workforce information governance processes
- Received the Dementia update and note the amount of work being undertaken
- Noted the report

122/16/2 **Patient Care Improvement Plan**

Ms Smith presented the summary report. Patient Safety was now the umbrella programme for urgent care, patient flow and avoidable mortality. She was pleased that the dedicated project managers were ensuring a robust governance process.

The urgent care and patient flow work stream has a strong focus on the emergency department and crowding. She was pleased that the outpatients' programme, organisational development programme and high dependency are all making good progress. She confirmed that the TMG oversaw the detail of the programmes. She confirmed to Mrs Merrick that there was real progress being made.

Mr Burbeck was pleased to see the progress and wondered how the Board would be able to know those areas which were not making progress. Ms Smith confirmed that the progress would be reported through to TMG and QGC for Caring Safely. Mr Tidman stated that TMG would hold the organisation's senior managers to account. Finance and performance also had a role within performance management. There was no single route for Board reporting.

Mrs Merrick stated that progress needed to be more rapid. She was concerned that some areas of the PCIP did not appear to be moving forward quickly to ensure that care for patients was improving.

**Resolved that:-**
**The Board**

- Received the latest published PCIP report and to support the further actions described to ensure that satisfactory progress is being made.

**123/16 WORKFORCE**

123/16/1 **Medical Workforce Report**

Dr Short reported that there were still a significant number of medical vacancies, 40 of which were caused by Health Education West Midlands not being able to fill all the training posts. There were consultant vacancies in all the divisions with medicine having the highest number at 25. He outlined a revised approach for Consultant recruitment.

He went onto confirm that the new junior doctor contract would be implemented from December and he then outlined the proposal to strengthen senior clinical leadership which included a formal deputy CMO role.

Mrs Harnin confirmed that all the divisions were engaged in the medical workforce challenges and there had been a strong and robust discussion at the last TMG.

Mr McGinity outlined an approach by one trust to reduce the number of applications which are withdrawn. Mrs Harnin agreed that a number of approaches were needed and that the women and children division had recently been successful with a buddying arrangement for applicants.

Mrs Merrick welcomed the paper and stated that the board would undertake a deep dive on the issues at its December Board of Directors meeting.

**Resolved that:-**
**The Board**

- Noted the current situation regarding medical vacancies and work being undertaken to reduce vacancies across the Trust.
- Noted the salary issues in relation to the impact of the introduction of the new Junior Doctor Contract.
- Noted the costs associated with the UKVI CoS price changes in April 2017 and the impact on the Trust's recruitment plans.

- Noted the establishment of the Central Temporary Medical Staffing service and associated benefits.
- Supported the introduction of the revised Senior Clinical Leadership arrangements

123/16/2 **Nursing and Midwifery Workforce**

Ms Stevens stated that there is a national shortage of nurses and the Trust, along with many others, has challenges around nursing numbers. The targeting of students at Worcester University was beginning to reap benefits.

She then turned to fill rates. She reminded members that the fill rates were a snapshot in time and each day staffing levels were reviewed by matrons, taking into account the acuity of patients. She confirmed that the Trust was working to try to convert agency staff to permanent.

Mrs Merrick welcomed the report and confirmed that the deep dive in December would also cover nursing workforce.

**Resolved that:-**
**The Board received assurance in relation to**

- Nursing and Midwifery Workforce metrics and associated actions

124/16 **FINANCE AND PERFORMANCE**

124/16/1 **Finance and Performance Committee Report**

Mr Sleigh spoke to the tabled report. There was a significant improvement from the previous year with respect to grip and controls in place. He confirmed that the Trust would meet the control total for 2016/17 as long as everyone was able to manage the risks.

However he was disappointed with the operational performance. There is an immediate effect of poor performance on obtaining funding under the banner of the Sustainability and Transformation Fund (STF).

There was improvement with the performance of theatres but he was concerned with the role of the patient flow centre and with the implementation of some programme such as the SAFER bundle.

**Resolved that:-**
**The Board**

- Noted that Income & Expenditure is on plan year to date (before STF payments).
- Noted that operational performance continues to be significantly behind plan and the STF improvement trajectories. Additional support and review machinery has been introduced, but capacity planning, recruitment and bed availability remain driving factors.
- Noted that the full year planned deficit is achievable and within the control of the Trust provided the risks are mitigated.
- Noted the recommendation to approve the business cases for the Winter Plan and Endoscopy.
- Considered the approach proposed for the submission of the Financial Plan Paper 17/18-18/19.

124/16/2 **Integrated Performance Report**

Ms Smith presented the report. She reminded members that the Quality Governance Committee and the Finance and Performance Committee scrutinise the respective performance.

She confirmed that the full report had been considered at the Finance and Performance Committee. She presented a summary with the corrective action statement for the key performance metrics. She invited Ms Robotham to comment on the operational performance.

Ms Robotham stated that the Trust's biggest challenges were for referral to treatment (RTT) and the emergency access standard (EAS). She highlighted the specialities of dermatology and oral surgery which had had significant improvement recently. However some specialities were deteriorating – general surgery and trauma and orthopaedics. The total waiting list has reduced by 1400 and she was pleased that data quality was starting to improve. She was in the process of scrutinising the trajectories that the divisions had submitted.

She was disappointed that there was no improvement in the emergency department performance, but stated that the Trust had improved the quality and safety of patients by only using areas designated for inpatient use. Mr Tidman described the grip that he has on the performance. Overall waiting time is reducing. He was pleased that the Theatre Admission Unit was operational so elective care is still being undertaken, despite the emergency pressures.

Mr Tidman was concerned with RTT and he has allocated additional resource for T&O to ensure that more orthopaedic scheduling can take place.

Mr McGinity was disappointed that complaints performance has deteriorated and the Friends and Family test was not improving. Ms Stevens reminded Mr McGinity that the complaints data showed a one month deterioration and extra support had been given to medicine. She explained that she would be relaunching F&F in the New Year. Mr Tidman reminded members that the F&F data showed the response rate, not whether people would recommend the Trust as a place to be treated.

**Resolved that:-**
**The Board**

- Reviewed the Integrated Performance Report for July 2016; the key performance issues and the mitigating actions.

124/16/3 **Financial Performance Report**

Mr Cooper confirmed that the control total for 2016/17 was £34.6m deficit. The deficit for 2015/6 had been £59.9m. Month 6 data showed that the Trust was on plan to deliver the control total. He went onto describe the key risks to the achievement of the control total.

There was a decrease in income in September caused by a decrease in activity. He was working with the divisions to ensure that the trajectories were met.

The contracting round was about the start and he was hopeful that the conclusion of this in December would ensure less risk to the Trust.

There continued to be cost pressures such as agency usage. Other cost pressures were beginning to emerge such as stroke services. He described the actions being taken to monitor agency spend on a week by week basis.

The next two to three months would be crucial in determining the year end position. This position needed to be sustainable going into 2017/18.

In response to Mr Howarth, Mr Cooper stated that of the £28m cost improvement needed in 2016/17, £24m was expected to be delivered. The CIP needed for 2016/17 was less at 5%. Mr Howarth complimented the Trust in the delivery of the CIP and urged Mr Cooper to ensure that the public were aware of the efficiency gains made.

Ms Stevens commented that it was crucial to have a permanent workforce which would not only reduce the Trust's costs by also improve quality.

Mrs Merrick expressed confidence that the Trust would meet its control total for 2016/17 and urged all staff to be vigilant.

**Resolved that:-**
**The Board**

- Noted the Trust's financial position

*At this point, Mrs Merrick apologised for overrunning. She asked members of the public whether the Board should break and hold the public session or whether to continue to finish the main agenda. It was agreed to finish the main agenda.*

125/16 **GOVERNANCE**

125/16/1 **Board Assurance Framework (BAF) and Corporate Risk Register (CRR)**

Mrs Merrick welcomed the report and reminded members that the Board would undertake a deep dive into the Board Assurance Framework and other risk areas in February.

Ms Stevens stated that more work needed to be undertaken on the Board Assurance Framework. She stated that the main report showed the changes to the BAF since the previous report.

Mr Tidman confirmed that there was a review being undertaken of stroke information. He was pleased that the health economy was working together on the stroke pathway to ensure seamless transition from the Acute Trust to the Community setting. Stroke consultant jobs would be advertised shortly encompassing the whole stroke pathway.

**Resolved that:-**
**The Board**

- Note the changes to the BAF & CRR
- Review risk ratings, controls, assurance and mitigating actions and consider if sufficient progress has been made

125/16/2 **Audit and Assurance Committee report**

Mr McGinity spoke to the previously circulated report. He asked for approval for the Auditor Panel terms of reference and confirmed that the first meeting was on the 21 November. He also reported that he has requested attendance from key personnel in relation to the RTT and Discharge audits. He referred the issue of venous thrombolytic prevention (VTE) to QGC and reported that concern had been expressed about the number of outstanding actions in relation to the audit reports.

Dr Short confirmed that recruitment has been successful to the medical revalidation post.

In response to Mrs Merrick, Mr McGinity confirmed that the internal audit report into director expenses was being presented to the next Audit and Assurance Committee on 10 November. There were no concerns expressed by Internal Audit. The primary issue

was that the data could have been presented better.

**Resolved that:-**
**The Board**

- Approved the terms of reference for the Auditor Panel
- Noted the lack of assurance in relation to
    - Discharge policy
    - RTT and training
    - VTE recording
- Noted the report.

125/16/3 **Security Annual Report**

**Resolved that:-**
**The Board**

- Received the Annual Report

126/16 **Charitable Funds Committee report**
Mrs Merrick expressed concern that the meeting had not been quorate.

**Resolved that:-**
**The Board**

- Noted that the meeting was not quorate
- Noted that the Committee expressed concern at the slow pace of spend for some funds.
- Noted the Investment report from CCLA which indicated that the Trust's return on its investment was slightly ahead of market comparators.
- Noted the decision to transfer £200k from £500K cash from the Trust's Charitable Funds account to the Trust's investor (CCLA) to gain a better return, whist anticipating increased future rate of commitment.

**DATE OF NEXT MEETING**
The next Trust Board meeting will be held on Wednesday 11 January 2017 at 09:30 in the Alexandra Hospital board room, Redditch.

The meeting closed at 11:54 hours.

At the end of the Public Session, Mrs Merrick thanked Mr Sleigh and Mr Howarth for their support during their tenure as non-executive directors. She wished them well in the future.

**Signed** _____ **Date** _____
**Caragh Merrick, Chairman**

**WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST**

**PUBLIC TRUST BOARD ACTION SCHEDULE – AS AT 11 JANUARY 2017**

**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 |
|---|---|---|---|---|---|---|---|---|
| 7-7-16 | BAF | 76/16/1 | Review CRR in relation to emergency surgery | RM | Sept 2016 | Oct 2016 | Completed | |
| 7-7-16 | WAG | 74/16/1 | OD strategy to be presented to TB in September | DH | Sept 2016 | | Deferred. For discussion with the Chairman for way forward<br>Planned for December BoD meeting. Deferred.<br>Awaiting a further date for discussion | |

Worcestershire NHS
Acute Hospitals NHS Trust

**Date of Trust Board: 11 January 2017** **Enc C1**

**Report to Trust Board**

| | |
|---|---|
| **Title** | **Chairman's Report** |
| **Sponsoring Director** | **Caragh Merrick, Chairman** |
| **Author** | **Kimara Sharpe, Company Secretary** |
| **Action Required** | The Board is requested to:<br>• Note the Chairman's Action taken on 5 December<br>• Approve the revised committee membership and governance structure<br>• To approve the appointment of John Burbeck as the Whistleblowing Champion and as the health and safety NED lead<br>• Receive the update with respect to the Board appointments |
| | |
| **Previously considered by** | Not applicable |

**Priorities (√)**

| | |
|---|---|
| *Investing in staff* | |
| *Delivering better performance and flow* | √ |
| *Improving safety* | √ |
| *Stabilising our finances* | |

| | |
|---|---|
| **Related Board Assurance Framework Entries** | 2932 Turnover of Trust Board members adversely affecting business continuity and impairing the ability to operate services<br>3038 If the Trust does not address concerns raised by the CQC inspection the Trust will fail to improve patient care |
| **Legal Implications or Regulatory requirements** | |

**Key Messages**

This paper details the Chairman's Action taken on 28 September, recruitment to Board posts and changes to the membership of the Committees.

**Date of Trust Board: 11 January 2017** **Enc C1**

**REPORT TO TRUST BOARD – 11 JANUARY 2017**

## 1 Chief Executive

I am delighted to formally announce to the Board that Michelle McKay will be starting as the permanent Chief Executive on 27 March 2017. Michelle is an emergency nurse practitioner by background and joins us from Australia where she is currently Director Regional and Remote Services, Blue Care and is based in Brisbane. Michelle will be relocating to Worcestershire.

I should like to take this opportunity for thanking Chris Tidman for his work as Interim CEO and would like to wish him every success as he moves forward with his career.

Rob Cooper will be the Interim CEO until Michelle commences at the Trust. I have agreed priorities with him which are explained in more detail in his report.

## 2 Non-Executive Director appointments

I should like to welcome Chris Swan and Philip Mayhew to the Trust Board. Both have been appointed for a two year term of office commencing 1 January 2017. Philip is from Redditch and has a background in local government and Chris lives in Stratford but has strong business connections into North Worcestershire. John Burbeck has had his appointment extended for a six month period and Bryan McGinity for a 12 month period.

## 3 Committee membership

I would like to propose the following as membership of the Trust Board Committees:

| Committee | Chair | Vice chair | NED |
|---|---|---|---|
| **Audit and Assurance** | Bryan McGinity | Chris Swan | Philip Mayhew |
| **Finance and Performance** | John Burbeck | Philip Mayhew | Bryan McGinity |
| **Quality Governance** | Bill Tunnicliffe | Chris Swan | John Burbeck |
| **Charitable Funds** | Chris Swan | Bryan McGinity | Philip Mayhew |
| **Remuneration** | Caragh Merrick | John Burbeck | Bryan McGinity |

The revised governance structure is attached for approval.

## 4 Chairman's Action

On 5 December 2016, I took a Chairman's Action to approve the MPS Business case. This had already been approved by the F & P Committee on 2 December and required sign off by the Chairman as the total contract value was above £1m. In addition to the request from the F&P Committee that a post

implementation review is completed after 12 months (April 2018), I have requested that the executive team receive assurance concerning the implementation plan prior to the start of the project. The Interim DF has spoken to the Director of Asset Management and he is aware of the request which he has in hand.

I made this decision in conjunction with Andrew Sleigh (Non-Executive Director Chair of F&P) and after discussion with the Interim Director of Finance, Jill Robinson.

**5 Whistleblowing Champion/Health and Safety NED lead**

I would like to propose that John Burbeck takes on these roles.

**6 Recommendations**

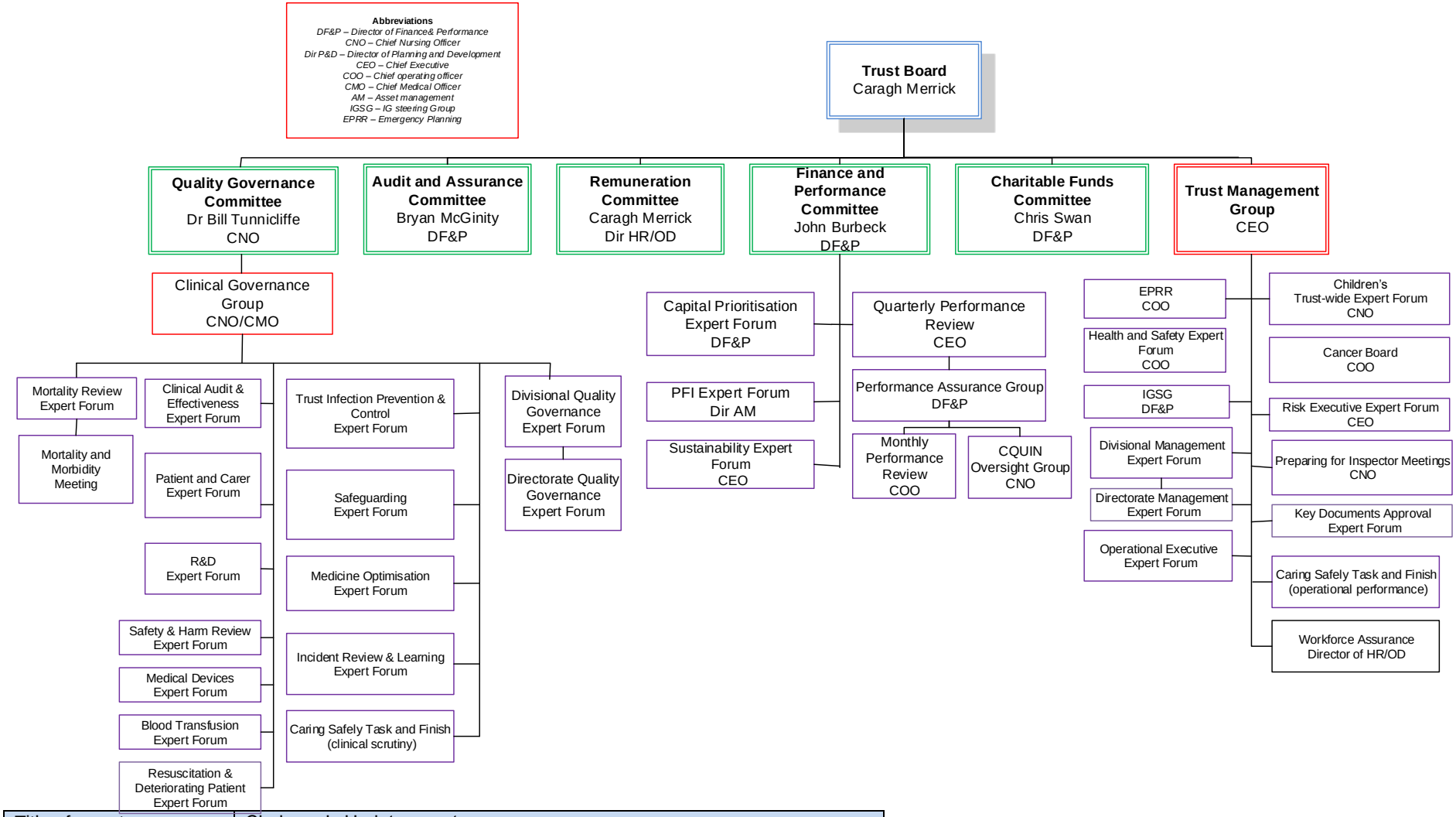
The Board is requested to:

- Note the Chairman's Action taken on 5 December
- Approve the revised committee membership and governance structure
- To approve the appointment of John Burbeck as the Whistleblowing Champion and as the health and safety NED lead
- Receive the update with respect to the Board appointments

Caragh Merrick
Chairman

Worcestershire NHS
Acute Hospitals NHS Trust

**Date of Trust Board: 11 January 2017** **Enc C1**




| | |
|---|---|
| Title of report | Chairman's Update report |
| Name of director | Caragh Merrick |

Worcestershire NHS
Acute Hospitals NHS Trust

**Date of meeting: 11 January 2017** **Enc C2**

**Report to Trust Board**

| | |
|---|---|
| **Title** | **Interim Chief Executive's Report** |
| **Sponsoring Director** | **Rob Cooper, Interim Chief Executive** |
| **Author** | **Kimara Sharpe, Company Secretary** |
| **Action Required** | The Board is asked to<br>• Note the items covered in the report<br>• Receive the assurance contained within the report |
| | |
| **Previously considered by** | Not applicable |

**Priorities (√)**

| | |
|---|---|
| *Investing in staff* | √ |
| *Delivering better performance and flow* | √ |
| *Improving safety* | √ |
| *Stabilising our finances* | √ |

| | |
|---|---|
| **Related Board Assurance Framework Entries** | All BAF risks are covered. |
| **Legal Implications or Regulatory requirements** | None |
| | |
| **Glossary** | Sustainability and transformation plan (STP)<br>Emergency Care Improvement Programme (ECIP)<br>RTT – referral to treatment time |

**Key Messages**

This report is provided to inform the Board on issues relating to the activity of the Trust and national policy that the Board needs to be aware of but which do not themselves warrant a full Board paper.

**Date of meeting: 11 January 2017** **Enc C2**

**WORCESTERSHIRE ACUTE HOSPITAL NHS TRUST**

**REPORT TO PUBLIC TRUST BOARD – 11 JANUARY 2017**

## 1 Situation

This report aims to brief Board members on various issues.

## 2 Background

The Chief Executive's report is provided to inform the Board on issues relating to the activity of the Trust and national policy that the Board needs to be aware of but which do not themselves warrant a full Board paper.

## 3 Board membership

Interviews for the substantive posts of Chief Nursing Officer, Chief Medical Officer and Director of Finance will be held during week commencing 23 January 2017.

I am delighted that Jill Robinson has agreed to manage the Performance function for the Trust. Her title will now be Director of Finance and Performance.

## 4 Future of Acute Hospitals in Worcestershire (FOAHSW) Programme

I am pleased that the consultation for this Programme commenced on 3 January 2017. I would urge members to attend the events which are being held throughout the County and the current dates are appended to this report.

## 5 Objectives for the next 3-6 months

I have confirmed the following objectives with Directors for the next 3-6 months.

| |
|---|
| **Medical Recruitment**: The Director of HR and OD has redefined the process for recruitment to the consultant vacancies and recruitment plans will be monitored through the performance review process with divisions. Senior medical staff are actively engaged in the process. I would expect a difference to be seen within six to nine months. |
| **Performance**: I have asked the Director of Finance and Performance to prioritise the Executive approach to performance management of the divisions. A Head of Performance is in post who is developing the performance management framework. |
| **Improvement Plan:** The Trust's Improvement Plan will focus on the 30, 60 and 90 day actions, the enabling plans and resources required to rapidly turnaround Trust performance in a number of key areas, with greater accountability and improved governance through the Chief Executive as SRO and a dedicated Trust Improvement Lead managed by the Director of Planning and Development. |
| **Sustainability and Transformation Plan:** The Director of Planning and Development will continue to engage with Future of Acute Hospital Services in Worcestershire (FoAHSW) programme including plans for public consultation and finalising the Trust Outline Business Case**.** The Director will also directly support partners in the central co-ordination of the Herefordshire and Worcestershire Sustainability and Transformation Plan, and will ensure that the work streams that the Trust is leading (Clinical Support Services, Specialised Acute Elective Care and services for Women and the Newborn) are properly constituted and led with clinical engagement at the core, as well as ensuring that the Trust is effectively engaged with the other programmes being developed and led by STP partners. |
| **Communications**: The Director of Communications is working across the health economy to ensure messages about the use of appropriate health services are communicated to the |

| |
|---|
| population. She will be also supporting the consultation on the future of Acute Hospital Services |
| **Quality**: The Chief Nursing Officer will continue to strengthen the Governance function. She is also working with the nursing staff to develop a skills and competency framework for bands 7 and 8+ to inform the development needed for those staff. She will identify nursing leads for the following areas and agree plans to address deficiencies in quality:<br>• Infection control<br>• Pain management<br>• Understanding the Mental Capacity Act/deprivation of liberty standards (DOLS)<br>• Medicines management<br><br>She will be working with the Director of HR and OD to strengthen nurse recruitment practices and processes. |
| **Patient Flow**: The Chief Operating Officer will be ensuring actions are embedded in relation to the safety of patients within A&E. He will be continuing to work with the health economy on actively discharging patients to a more appropriate setting once they are medically fit. I am continuing to chair the A&E Delivery Board which all health partners work to manage the flow issues. This includes working with the Ambulance Service to ensure patients who come by Ambulance are taken to the most appropriate place for their needs. |
| **RTT/Cancer**: The Chief Operating Officer continues to work towards stabilising the RTT standard and improving the delivery of the 2 week and 62 days cancer waiting targets. |
| **Agency spend**: I have asked that the Director of Finance and Performance and the Chief Nurse and Chief Medical officers hold senior staff to account on agency spend. This is through a weekly task group and review of individual spends. Considerable work has already been undertaken on non-clinical agency staff. |
| **Avoidable Mortality**: Following the CQC's recent report into avoidable deaths, the Chief Medical Officer will be continuing to work with consultants to ensure primary and secondary mortality reviews are undertaken and to work to publish avoidable deaths from the end of March 2017. The CQC report is on the agenda to discuss at the next QGC being held later this month. |

## 6 Operational pressures

I should like to thank all the staff who worked over the recent bank holidays. The Trust has been exceptionally busy with unprecedented levels of patients arriving at the A&E departments. For two days the Health and Care Trust closed their Minor Injury Units and staff were supporting the A&Es. The number of ambulances arriving continues to be exceeding predictions. These issues will be discussed at the Finance and Performance Committee. There is a presentation on today's agenda which addresses these issues.

## 7 Risk Summit

Board members will be aware that a risk summit was held on 22 December with all health economy partners. This was called due to the demand on the Trust A&E departments. Agreements have been reached with partners in respect of mutual aid.

## 8 Workforce Assurance Group

Given the large agenda in relation to workforce, it was agreed to recommend to the Board that WAG would not be disestablished, but would be reviewed to give a more strategic emphasis. The Director of HR/OD presented a revised meeting structure for Workforce Assurance at the December Workforce Assurance Group and will be developing terms of reference for each meeting to be implemented from January 2017.

- Strategic Workforce Committee/Board – meeting annually setting direction.
- Workforce Operational Assurance Group (WOAG) – meeting quarterly, development of policies, strategies and implementation plans reporting to TMG.
- Operational Workforce Group – meeting monthly, monitoring performance against integrated HR KPI's reporting to F & P Committee.

**9 Stroke Service - update**

From the end of January the Worcestershire Health and Care Trust will be centralising all stroke rehabilitation beds into a 32 bedded unit at Evesham hospital. It is hoped that this will prevent long delays for specific units across the County and will free up general rehabilitation beds for patients closer to home. There is a current stroke workforce task and finish group and stroke strategy group that meet on a monthly basis to deliver the county wide strategy for Stroke and will include future working with Hereford for delivery of services against the STP programme.

**10 NHS Improvement Segmentation**

NHS I have confirmed that the Trust is in segment 4. This is the segment for providers in special measures.

**11 Chief Inspector of Hospitals planned inspection**

Since the last Trust Board meeting, the trust has undergone a planned inspection by the Chief Inspector of Hospitals. In addition, there were unannounced inspections in the weeks following the planned inspection plus many requests for additional data. The Trust is now awaiting the report which will be sent to us for accuracy checking early in 2017. We are as yet unsure of the date of publication.

I should like to thank all the staff involved in coordinating the inspection.

**12 Director of Urgent Care**

Lisa Miruszenko has been seconded to a new role of Director of Urgent Care for a four month period. Lisa will be reporting to the Acting Chief Executive Rob Cooper and working alongside Gareth Robinson, the Interim Chief Operating Officer. The aim is to further strengthen the focus needed on emergency patient flow and to trial this new approach as we enter the very busy winter period.

Lisa has over 33 years' experience in the NHS, where she has held senior operational roles. It is critical over the coming months that we have someone who knows the organisation with a strong clinical background who can lead, influence and support the changes we need to make in our very complex organisation. Part of Lisa's new role will be to support and co-ordinate the processes and systems around urgent care within the trust linking in with external partners.

**13 Equality and Diversity Annual Report**

The Trust Equality and Diversity Annual Information Report 2015/16 was presented at Workforce Assurance Group on 8th December 2016. The report demonstrates our progress in 2015/16 and identifies key priorities for 2016/17 as

- Eliminating discrimination, harassment and victimisation.
- Advancing equality of opportunity.

- Fostering good relationships

The report was approved at WAG and also was presented at TMG in November and was approved for publication on the Trust website. Compliance against objectives in the report for 2016/17 will be monitored at future (WOAG).

**14 Refurbishment of Ward 12**

The newly refurbished Ward 12 at the Alexandra Hospital opened on 29 November. Ward 12 is a 28 bed in-patients unit providing a mix of care of the elderly and gastroenterology care to patients.

**15 Business Administration apprentices – regional awards**

Megan Lloyd, who works in the Ophthalmology and Rheumatology departments at WRH and KTC, picked up a special award for 'Commerce Apprentice of the Year' for her work over the past 12 months. Megan received her award from the Herefordshire and Worcestershire Group Training Associate (HWGTA) at their annual apprentice awards evening on Monday 7 November at Sixways, Worcester Rugby Club and included special guest Andrew Triggs-Hodge MBE, Olympic Gold Medal winning rower who presented the awards. The judges' comments noted the significant development shown by Megan throughout the 12 month programme and said: "Megan's confidence has increased significantly over the year, and she has taken on additional duties with increased responsibility, due to being such an efficient worker".

**16 Flu vaccination**

The Trust exceeded the target of 75% of staff vaccinated by 31 December. I should like to express my thanks to the Interim Chief Nursing Officer and her staff for the effective campaign that was run.

**17 Staff Awards Ceremony**

The annual staff awards ceremony was held at the Chateau Impney Hotel on 18 November. A glittering evening was had by all. I should like to express my thanks to the organisers, specifically Sandra Berry, Caroline Edwards and Jo Chant. The winners are featured within the recent edition of Worcestershire News.

**18 Consultants**

Please see the attached starters and leavers.

**19 National Update**

**19.1 CQC report - avoidable deaths, *Learning, candour and accountability***

The CQC released a report in December after an investigation into how Trusts review deaths. From 31 March 2017, all trusts will be expected to publish statistics on preventable deaths quarterly and appoint a Director of Patient Safety. The Report's findings included:

- Families and carers often have a poor experience of mortality investigations; are sometimes not treated with kindness, respect and sensitivity; can feel their involvement is tokenistic; and often question the independence of the reports.
- The NHS does not prioritise learning from deaths and misses countless opportunities to learn and improve as a result.
- There is no single framework which sets out how local NHS organisations

should identify, analyse and learn from deaths of patients in their care or who have recently been in their care.
- As a result there is inconsistency. Some NHS Trusts get some elements of mortality reporting right, but not one gets all elements right.

In particular, the leaders of NHS organisations, their doctors, nurses and other staff simply do not have access to the full picture of how many patients die in their care, which deaths were preventable and what needs to be learned. There will be national guidelines produced on reviewing and learning from care provided to people who die and Health Education England has been asked to review the training of doctors and nurses in this area.

**19.2 New minister joins Department of Health**

Lord O'Shaughnessy, a former Downing Street aide and policy advisor to David Cameron, has been made Parliamentary Undersecretary of State, replacing Lord Prior who has moved to the Department of Business, Energy and Industrial Strategy. His portfolio will include drugs spending, life sciences, NHS Commercial issues and blood and transplant.

**19.3 Sepsis – National Campaign**

A national campaign is being launched this month aimed at parents, raising awareness of the dangers of sepsis in young children.

**20 Recommendation**

The Board is asked to

- Note the items covered in the report
- Receive the assurance contained within the report

**Rob Cooper**
**Interim Chief Executive**

**Date of meeting: 11 January 2017** **Enc C2**

## Current dates for consultation meetings

| | | | |
|---|---|---|---|
| 10/10/2017 | | R&B GP Advisory Forum | 12.30pm |
| 11/01/2017 | tbc | Redditch BC Health Commission | 6pm |
| 12/01/2017 | | LMC | 7.30pm |
| | tbc | Redditch BC Health Commission | 6pm |
| 13/01/2017 | | HealthWatch Worcs | 10.30am |
| 17/01/2017 | | R&B PPF Forum | 4.30pm |
| | | Drop in at the Alex | all day |
| | | SW PPG Network | 5.00pm |
| 18/01/2017 | | WF PPI Forum | 6.00pm |
| | | Drop in at KTC | all day |
| 19/01/2017 | | Drop in at WRH | all day |
| 26/01/2017 | | R&B CCG Governing Body | 9.00am to 12.30pm |
| | | SW CCG Governing Body | 2.00pm to 4.30pm |
| 07/02/2017 | | WF CCG Governing Body | 9am to 1pm |
| | | HOSC | 10am |
| 16/02/2017 | | SW PSAG | 10.00am |
| 21/02/2017 | | R&B PPI Forum | |

**Date of meeting: 11 January 2017** **Enc C2**

**Consultant Starters**

Dr Weng Chin Oh, Consultant in Renal & Acute Medicine, 3rd October 2016
Dr Catherine Hillman-Cooper, Consultant in Obstetrics & Gynaecology, 7th November 2016
Dr Olivia Kelsall, Consultant in Anaesthetics and Intensive Care Medicine, 20th December 2016

**Leavers**

Dr Philemon Sanmuganathan, Consultant in Stroke Medicine, last day of service 30th November 2016

Worcestershire NHS
Acute Hospitals NHS Trust

**Date of Trust Board: 11 January 2017** **Enc D1**

**Report to Trust Board**

| | |
|---|---|
| **Title** | **Herefordshire and Worcestershire Sustainability and Transformation Plan (STP)** |
| **Sponsoring Director** | **Sarah Smith, Director of Planning and Development** |
| **Author** | **H&W STP Programme Office** |
| **Action Required** | The Board is requested to:<br>• Receive the Herefordshire and Worcestershire Sustainability and Transformation Plan (STP) that was published on Tuesday 22 November 2016.<br>• Note that the document is intended for discussion and public engagement – it is not a final plan at this stage.<br>• Note that formal approval of the final plan will be sought at the end of the public engagement and discussion process. |
| | |
| **Previously considered by** | Not applicable |

**Priorities (√)**

| | |
|---|---|
| *Investing in staff* | |
| *Delivering better performance and flow* | √ |
| *Improving safety* | √ |
| *Stabilising our finances* | √ |

| | |
|---|---|
| **Related Board Assurance Framework Entries** | This item relates to all the current BAF risks |
| **Legal Implications or Regulatory requirements** | |

**Key Messages**

On 22nd December 2015, NHS England issued shared planning guidance. This guidance called for the development of whole system Sustainability and Transformation Plans (STP) covering defined planning footprints, to be submitted by October 2016.

The Herefordshire and Worcestershire Sustainability and Transformation Plan (STP) was published on Tuesday 22 November 2016, as a document intended for discussion and public engagement around the ideas and proposals prior to development and publication of the final plan.

The period of public engagement runs from November 2016 to March 2017.

| | |
|---|---|
| Title of report | Herefordshire and Worcestershire Sustainability and Transformation Plan (STP) |
| Name of director | Sarah Smith |

**Date of Trust Board: 11 January 2017** **Enc D1**

**REPORT TO TRUST BOARD – 11 JANUARY 2017**

## 1. Situation

The Herefordshire and Worcestershire Sustainability and Transformation Plan (STP) as published on November 22nd 2016, is presented to the Trust Board.

## 2. Background

On 22nd December 2015, NHS England issued shared planning guidance. This guidance called for the development of whole system Sustainability and Transformation Plans (STP) covering defined planning footprints.

The STP planning footprint agreed for this area was Herefordshire and Worcestershire – a footprint covering a population of approximately 780,000 people.

There are 44 footprints nationally, with the average sized footprint covering 1.3m people and the largest footprints covering 2.8m people.

A subsequent requirement for individual organisations to create two year operational plans for 2017/18 to 2018/19 (linked to the STP) was captured in guidance issued in September 2016.

## 3. Assessment

**3.1 Purpose of the STP.** The STP builds upon local transformation work already in progress through the 'One Herefordshire' programme, Worcestershire 'Well Connected' and the Future of Acute Hospital Services in Worcestershire programme and other local transformation schemes. The purpose of the STP is to develop the opportunities for local bodies to work on a more sustainable planning footprint in order to address local gaps in terms of the 'Triple Aim' described in the NHS England Five Year Forward View:

- **Health and Well Being** - The main focus being on achieving a radical upgrade in illness prevention to reduce the long term burden of ill health – both from a quality of life perspective for individuals and a financial perspective for the health and care system.

- **Care and Quality** - The main focus being on securing changes to enable local provider trusts to exit from the CQC special measures regime and to reduce avoidable mortality through more effective health interventions in areas such as cancer, stroke, dementia, mental health and improved maternity services.

- **Finance and Efficiency** - The main focus being on reducing unwarranted variation in the demand and use of services and securing provider efficiencies through implementing new approaches to care provision.

**3.2 Work undertaken to date.** There have been four main phases to the STP development work to date:

| | |
|---|---|
| Title of report | Herefordshire and Worcestershire Sustainability and Transformation Plan (STP) |
| Name of director | Sarah Smith |

- **Phase 1** – Undertake an initial gap analysis to identify the biggest areas of concern across the triple aim areas – This phase of work was undertaken during March and April 2016.

- **Phase 2** – Define and understand the challenge arising from this gap analysis – This phase of work was undertaken during April, May and June 2016.

- **Phase 3** – Consolidate existing ideas and develop new ideas and themes to address the challenge – This phase was undertaken during July to October 2016.

- **Phase 4** – National review and assurance to assess how well the local ideas and themes meet national priorities – This phase was undertaken during October and November 2016

**3.3** **Publication of the plan.** The STP for Herefordshire and Worcestershire was published on Tuesday 22nd November 2016, with two documents published – the full STP and a public summary version.

These are available on the following websites, with a link from individual organisations websites within the STP footprint:

http://www.yourconversationhw.nhs.uk

**3.4** **Engagement and discussion on the STP.** The plan itself outlines in detail the proposed communication and engagement process.

It is important to emphasise that this is not a final plan. It is a proposed plan for engagement and discussion. This period of engagement and discussion will take place between November 2016 and March 2017. At the Board meeting in April 2017, there will be an updated plan that takes account of the discussions that have taken place.

Equally it is important to note that the engagement process is not a formal consultation on the plan. This is because the plan sets out the challenges we face and some of the ideas and themes we have identified to address those challenges. It does not set out specific service changes. Any specific service changes will be developed through engagement with patients and the public and will be subject to the formal legislative consultation process as appropriate to the scale of the change.

**3.5** **Next steps.** The NHS planning process requires NHS organisations to produce annual operational plans. This year, the process requires that organisations set out a two year operating plan using the STP as the basis for developing this plan.

The normal NHS planning cycle requires these plans to be produced during the fourth quarter of each financial year for sign off in March and

implementation from the beginning of the next financial year in April.

This year the process was brought forward by 3 months and operational plans were expected to be finalised by 23rd December 2016. A single STP system operational plan was developed across the four CCGs in Herefordshire and Worcestershire with providers developing individual operational plans reflecting the relevant parts of the STP delivery plans for 17/18 and 18/19.

## 4 Recommendation

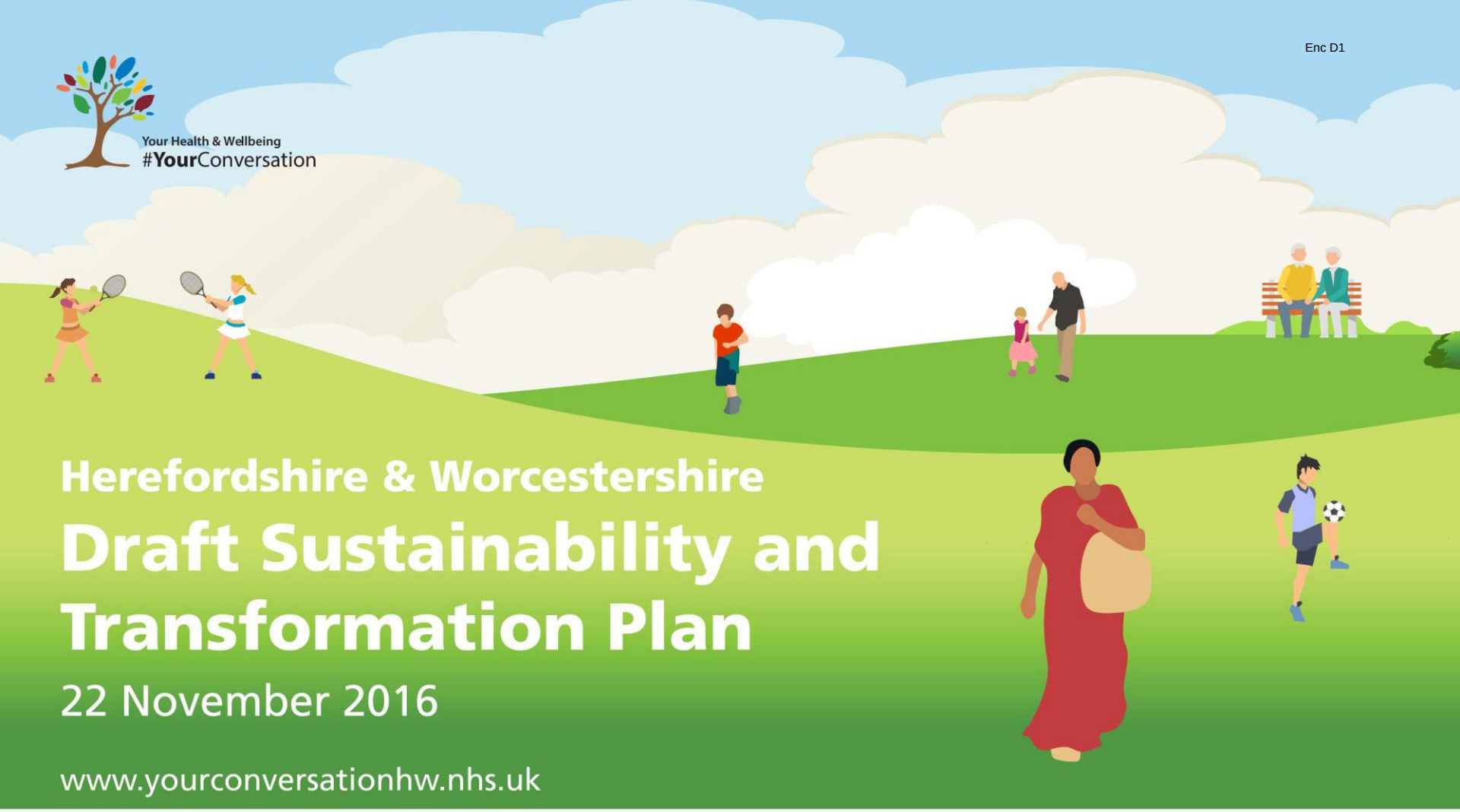
The Board is requested to:

- Receive the Herefordshire and Worcestershire Sustainability and Transformation Plan (STP) that was published on Tuesday 22 November 2016.
- Note that the document is intended for discussion and public engagement – it is not a final plan at this stage.
- Note that formal approval of the final plan will be sought at the end of the public engagement and discussion process.

**Sarah Smith**
**Director of Planning and Development**

| | |
|---|---|
| Title of report | Herefordshire and Worcestershire Sustainability and Transformation Plan (STP) |
| Name of director | Sarah Smith |

Your Health & Wellbeing
#YourConversation



# Herefordshire & Worcestershire

# Draft Sustainability and Transformation Plan

## 22 November 2016

www.yourconversationhw.nhs.uk

Worcestershire Acute Hospitals NHS Trust
NHS Herefordshire Clinical Commissioning Group
NHS Redditch and Bromsgrove Clinical Commissioning Group
NHS South Worcestershire Clinical Commissioning Group
NHS Wyre Forest Clinical Commissioning Group
Wye Valley NHS Trust
Worcestershire Health and Care NHS
2gether NHS Foundation Trust
Taurus Healthcare
worcestershire county council
Herefordshire Council

| | |
|---|---|
| **Name of footprint** | Herefordshire and Worcestershire |
| **Region** | Midlands and East |
| **Nominated Lead** | Sarah Dugan, Chief Executive<br>Worcestershire Health and Care NHS Trust |
| **Contact Email** | whcnhs.yourconversationhw@nhs.uk |

| Partners involved | |
|---|---|
| **GP Practices** | 90 |
| **CCGs** | 4 |
| **Acute Trusts** | 1 |
| **Combined Acute and Community Trusts** | 1 |
| **Combined Community and Mental Health Trusts** | 1 |
| **Mental Health Trusts** | 1 |
| **HealthWatch bodies** | 2 |
| **District and Borough Councils** | 6 |
| **Councils with Health & Well Being Boards** | 2 |

| Key Statistics | |
|---|---|
| **Population** | 780,000 |
| **Area** | 1,500sq m |
| **Annual NHS Allocation – 2016/17** | £1.168bn |
| **Annual NHS Allocation – 2020/21** | £1.327bn |
| **STF allocation in 2020/21** | £50m |
| **NHS "Do Nothing" financial gap to 2020/21** | £229.6m |
| **NHS Residual Gap after applying national planning assumptions** | £61.5m |

# Herefordshire and Worcestershire

## Sustainability and Transformation Plan

## *(22nd November 2016 Draft)*


Redditch and Bromsgrove CCG
South Worcestershire CCG
Wyre Forest CCG
Worcestershire Acute Hospitals NHS Trust
Worcestershire Health and Care NHS Trust
4 Primary Care Collaborations (covering 66 practices)
Worcestershire County Council

Herefordshire CCG
Wye Valley NHS Trust
2gether NHS Foundation Trust
Taurus GP Federation (representing 24 practices)
Herefordshire Council

#yourconversationHW

# Contents and foreword



**Foreword by Mark Yates, Independent STP Chair**

Our STP footprint has some unusual challenges compared to many of the other footprints. Our footprint is one of the largest in terms of geography – covering 1,500 sq miles, but one of the smallest in terms of population – covering about 780,000 people. By way of example the distance between Hereford County Hospital and Worcestershire Royal Hospital is more than 30 miles and typically takes more than an hour to drive on single carriageway roads.

Our STP footprint is also unusual in that it provides hospital services for 40,000 people from the Welsh health system who are external to the footprint. Powys has no district general hospitals and the people of mid-Powys rely on the County Hospital in Hereford and with Powys being even more sparsely populated than Herefordshire, for some residents, the nearest acute hospital after Hereford is some considerable distance away in Aberystwyth. Service provision in this area is characterised by long travel times for patients and staff and we have the challenge of achieving a balance of what can be provided locally in Wales and centrally in England.

Partners across the footprint recognise that the solution to the sustainability and efficiency challenges facing health and social care cannot be dealt with by partners nor organisations working alone. Individuals, families, local communities, Voluntary and Community Sector Partners all have a core role to play in developing solutions. We need to place equal if not greater focus on helping communities and individuals to live healthily, be resilient and avoid the need to access organised services for things that many people are able to deal with themselves. Carers play a vital role in this vision and are a hugely important asset to the NHS and social care system. We need to do more to help identify, support and recognise their vital roles. We will do this by working towards achieving system wide agreement to implement the "Commitment to Carers – Carers Toolkit". Helping carers to provide better care and to stay well themselves will contribute to better lives for those needing care and more effective use of NHS and social care resources.

These a just a few of the many challenges faced by our STP footprint, but all partners continue to be equally committed to providing the best and most cost effective services to our communities and patients. We've been working very closely together throughout 2016 and this commitment to the STP process will see our collective journey forge well into the future. However, partners also recognise the magnitude of the difficulty of providing health and social care services to a very diverse and widespread population within a very tight cost envelope. We recognise that this submission is not an end point – it is merely a stage in our collective journey towards a better health and social care system for the population of Herefordshire and Worcestershire and we are committed to engaging with our communities to ensure this is the case going forward.

# Our vision for 2020/21

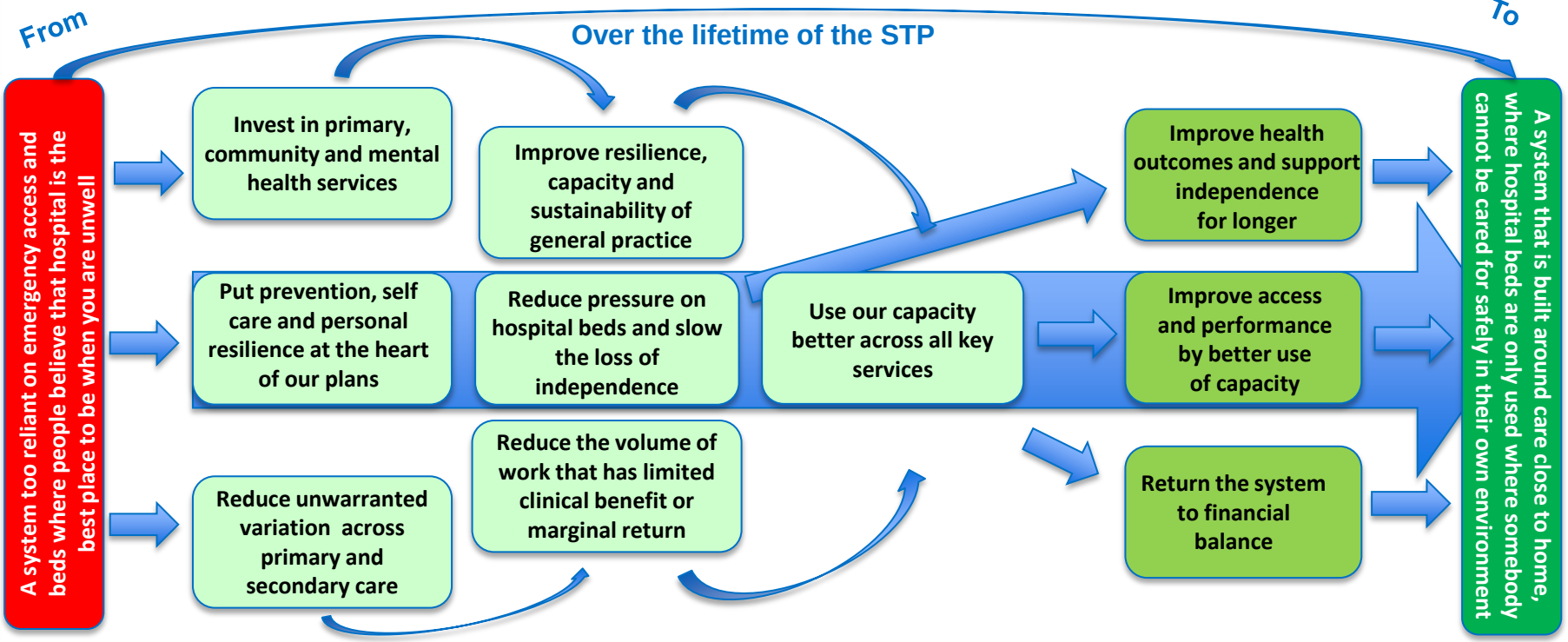
***"Local people will live well in a supportive community with joined up care underpinned by specialist expertise and delivered in the best place by the most appropriate people".***

| | What we mean |
|---|---|
| Live well in a supportive community… | There is collective agreement across the wider public and voluntary/community sector that one of the most effective ways to improve health is for people to live well within supportive resilient communities taking ownership of their own health and well-being. We will be better at helping residents to draw on the support available from their local communities and voluntary groups, and we will help those communities and groups develop the capacity to meet these needs. We will use social impact bonds and social prescribing to support this. This will apply across all age groups. |
| …with joined up care… | Where individuals have a health or care need this will be delivered in an integrated way, with a single plan developed with and owned by the individual in true partnership and available wherever people access the system. Local integrated delivery teams will be in place which recognise the central role of the GP and reflect a broad range of skills and expertise from across the organisations. We will make care boundaries invisible to people using our services by removing operational boundaries between organisations and we will ensure that co-production is embedded in everything we do. |
| …underpinned by specialists… | Specialist care will always be needed, but there are times when care could be safely provided under the remote supervision of a specialist across a digital solution. For example, by developing better digital links between practices and hospitals we believe that more care can be provided locally by GPs and other health or social care staff based in the community. This is particularly important given our rurality challenge. Our workforce, organisational development and recruitment plans will focus on making sure that we make Herefordshire and Worcestershire an attractive place to work so we have a stable and committed workforce, with much less reliance on agency employment. |

| | What we mean |
|---|---|
| …delivered in the best place… | We will have completely adopted and embraced the principle of "home first" and will deliver as many services as possible close to home. We will carefully balance the need and benefit of local access against that of service consolidation for quality, safety and cost effectiveness. We will reduce as far as possible the need for people to travel out of their area to access most services. Some services will be brought out into communities and delivered in GP surgeries, community hospitals or other local premises. Equally some services will be consolidated where clinical sustainability or quality of care is significantly improved by doing so. Joined up transport planning will enable us to support people in planning their travel arrangements where this is the case. We will involve the public in any decisions and provide the information needed to understand how and why things need to change. |
| …by the most appropriate person. | We need to create the capacity and resilience to enable GPs to be clinical navigators and senior clinical decision makers in the out of hospital care setting. This will be with a particular emphasis on people who are frail and those at risk of emergency admission. We will develop extended roles such as physician assistants and advanced practitioners in areas such as physiotherapy, dermatology and pharmacy and review the skill mix to free up the GP time needed to focus on patients with the most complex needs. Equally there are times when the demarcations in roles are too prohibitive and result in the need for additional roles that add more cost than value. This will change with alignment of pathways of care. Over time we have introduced a degree of complexity and cost that is not sustainable. The work we do to implement this plan will mean that people will be seen by the right person in the right place at the right time. This will mean change to the way in which services are delivered. |

# The essence of our Sustainability and Transformation Plan

Our health and care economy has become too dependent on reactive bed based care that results in reduced wellbeing, a poor patient experience and higher cost of services. There remains a public perception that being in hospital is the best place to be when people are unwell. This is despite there being considerable evidence to the contrary, particularly for people who are frail. The essence of our STP is to change this by keeping people well and enabling them to remain in their own homes. We will achieve this by focusing our efforts more on what happens in our communities, not just in hospitals. We will build our system around resilient and properly resourced general practice, that has community services wrapped around them. This will relieve pressure on our hospitals, which will be freed up to focus on efficiently dealing with complex elective and emergency care. Waiting times and outcomes for patients will be better. For the system it will enable us to live within the financial means available by the end of the 5 year period. To achieve this change we will require all partners to commit to this approach and to deliver this through their operational planning and delivery work. It will also require change from the population. We will need local residents and citizens to take more control of their own health and well being, to take more responsibility for supporting others in their communities. Building strong and resilient communities, through wider work around employment, housing and education, will be an essential foundation for this. As a result, people will no longer need the historic range and level of public services, and will be sensible consumers of the services we do need to provide.



# A single page summary of the big priorities for this STP

## Sustainable General Practice

- Prioritise investment to ensure delivery of the General Practice Forward View – developing primary care at scale "bottom-up" with practices , community pharmacy, third sector and health and care services.
- Redesign the primary care workforce, sharing resources across primary and secondary care to provide resilience and sustainability as well as capacity.
- Adopt an anticipatory model of provision – with proactive identification, case management and an MDT approach for those at risk of ill-health.
- Share information across practices and other providers to enable seamless care.
- Move to "big system management" – with real time data collection and analysis providing the intelligence to support continuous quality improvement and demand management.

## Primary & Community Services

- During 2018/19, organise and provide services from locality based Multi-Speciality Community Providers (Worcestershire) and similarly formed alliance model (Herefordshire).
- Through the One Herefordshire Alliance and the Worcestershire Alliance Boards, develop population based integrated teams wrapped around general practice covering physical and mental health, wider primary and social care services and engage with the population to deliver services close to home.
- Support patients and carers to self-manage their own conditions, harnessing voluntary sector partners and communities to support independence and reduce loneliness.
- Develop plans which integrate specialist support, reducing the time taken to access specialist input and reducing the steps in the pathway. Initially focussed on supporting people living with frailty and end of life care, but adopting principles and learning quickly to a range of other priority pathways.

## Prevention & self care

- Embed at scale delivery of evidence based prevention interventions across all providers of health and social care, achieving population behaviour change.
- Put long term life outcomes for children, young people and their families' needs at the heart of the STP agenda in order to prevent the need for more intensive and high cost services now and in the future.
- Support people to manage their own health, linking them with social support systems in their communities and identify when a non-clinical intervention will produce the best experience and outcomes for patients.

## MH & LD

- Deliver the requirements of the national taskforce.
- Work with NHS specialised services to increase local child mental health services to reduce demand for complex out of county services and enable repatriation of complex cases back to the local footprint.
- With local authorities, develop joint outcomes and shared care for people with learning disabilities.

## Urgent Care

- Reduce the number of individual physical access points to urgent care services across the STP footprint by 2020/21.
- Retain 3 units with an A&E function across the footprint. Explore the need for the number of MIUs and the Walk in Centre as we move to 7 day primary care services, and the opportunity for standardised opening hours for MIUs in Worcestershire.
- Shift to home based care – explore whether we should reduce the number of community based beds across the system and shift resources to primary and community services.

## Maternity

- Implement the clinical model for maternity inpatient, new born and children's services within Future of Acute Services in Worcestershire programme.
- Develop a jointly commissioned, jointly provided maternity service across the whole footprint delivering the Better Births strategy.
- Establish a single service with specialist teams working under a common management structure, delivered locally within both counties.

## Elective Care

- Develop 4 key prevention programmes to reduce demand for surgery delivered at scale and improve the likelihood of positive clinical outcomes following surgery.
- Undertake a greater proportion routine elective activity on "cold" sites to reduce the risk of cancellations and to improve clinical outcomes.
- Develop strategic partnerships with external partners to secure organised access to elective surge capacity in a planned and managed way.
- Expand pan STP working on cancer services and deliver the requirements of the national taskforce.

## Infrastructure

- Explore the benefits from integration in pathology, radiology and pharmacy services across the footprint.
- Develop robotic pharmacy functions and maximise the use of technology.
- Develop a single strategy and implementation plan for a joined up place based back office across all local government and NHS partners.
- Develop a place based estates strategy and a place based transport strategy.

# Our STP development journey – past, present and future

**Between February and April 2016 we…**

- Developed our leadership team.
- Established a Programme Board, Planning Group and PMO.
- Completed our local triple aim gap.
- Agreed clinical pathway priorities based on care and quality gaps.
- Identified enabler workstreams that will be critical in delivering transformation.

**Between April and October 2016 we…….**

- Established our communications and engagement workstream and started briefing staff and key stakeholders.
- Developed our first draft Plan with 5 priorities for transformation, agreed by system leaders.
- Received feedback and direction from NHS England and NHS Improvement.
- Used an allocative budget analysis to agree a strategic approach to investing and disinvesting in service areas.
- Developed a full set of concept papers presenting transformational solutions to address our triple aim gap.
- Initiated work on clinical, staff and local engagement.
- Confirmed that we would need to allocate at least half of the STF funding to support sustainability during the five year period, with a plan to retain the rest for transformation (noting the associated risk to delivery).
- Submitted a balanced financial plan for 2020/21 agreed by system leaders, subject to some caveats and assumptions that needed further work and a recognition of the challenge presented by the revised control totals in 2017/18 and 2018/19.

**From October 2016 to April 2017 we will…**

- Conduct further and more detailed analysis of strategic demand and patient flow to enable us to more accurately project need for services over the full planning period.
- Translate our strategic intentions from the STP into aligned commissioner and provider operational plans.
- Undertake detailed analytical work to develop clearer proposals for alternative pathways.
- Establish a clear plan for stakeholder engagement and consultation on any changes that need to be considered immediately.
- Extend community engagement to ensure that communities have the opportunity to shape and develop our plans.
- Extend clinical engagement to ensure that front line staff help to shape the development of ideas and implementation plans to deliver the transformation required.
- Use the STP priorities as the basis for contracting to ensure that services developments and plans are affordable within the financial resources available to partners.
- Roll out our communications and engagement plan, including written briefs, drop-in sessions and road shows in all partner organisations as well as interactive #yourconversation webinars, blogs, etc.
- Agree and implement a delivery structure that will enable the development and testing of the required modelling, assessment of the impact our STP plans on quality.
- Progress work to join up commissioning strategies and joint working across commissioner and provider organisations across the footprint.
- Explore opportunities to align primary care, community services and secondary care more closely.
- Agree how we phase our available funding across the period so that we can pump prime our key transformation proposals.

# Our biggest challenges – health and well being

Overall, health outcomes in Herefordshire and Worcestershire are good but we face significant challenges now and into the future. We recognise that radically scaling up prevention activities across all our health and care interactions with the population will be a vital element of securing improvements.

- **The gap between life expectancy (LE) and healthy life expectancy (HLE)** There are large numbers of people living in poor health in our older population and this is one of the most significant gaps to reduce. In Herefordshire the gap at 65 years of age is 7.8 years for men and 9.4 years for women. In Worcestershire 7.1 and 9.1 years respectively. Closing these gaps is essential to improving the quality of life for the population.

- **Premature mortality rates vary significantly between the two Counties** Worcestershire mortality rates are most concerning – the county ranks 55th out of 150 Authorities nationally (where 1st is best) for premature mortality rate per 100,000 population. Herefordshire ranks 21st out of 150. In comparison with its statistical neighbours, Worcs ranks 12th out of 15, with a premature death rate of 320 per 100,000, compared with 256 for the 1st ranked. This is equivalent to around 370 additional premature deaths a year. Herefordshire ranks best for its comparative group, with a premature death rate of only 287 per 100,000.

- **There are some condition specific premature mortality concerns -** In Herefordshire, colorectal cancer, heart disease and stroke are slightly higher than expected (but not significantly), whereas in Worcestershire, premature mortality in some of these areas is amongst the worst or actually is the worst for its comparator group (for example colo-rectal cancers and heart disease) .

**Gap between life expectancy & healthy life expectancy**

| | Men | Women |
|---|---|---|
| Herefordshire | 7.8 yrs | 9.4 yrs |
| Worcestershire | 7.1 yrs | 9.1 yrs |

**Premature mortality rates compared to other areas (1 is best performing)**

| | England | Family |
|---|---|---|
| Herefordshire | 21st of 150 | 1st of 15 |
| Worcestershire | 55th of 150 | 12th of 15 |

# Our biggest challenges – health and well being

**There is a gap in mortality rates between advantaged and disadvantaged communities, particularly in Worcestershire** - The range of years of life expectancy across the social gradient at birth is 7.8 years in Worcs and 4.9 in Herefordshire. In our rural areas, health inequalities can be masked by sparsity of population but we know differences exist which need to be tackled, including issues of access.

**Some outcomes for children and young** people which are lower than expected:

- **School readiness** - In Herefordshire only 40% of Children receiving free school meals reach a good level of development at the end of the reception school year. In Worcestershire the figure is 46%. Both are worse than the England average of 51%.
- **Neonatal mortality and stillbirth rates** – These are amongst the worst in the comparative groups for both counties. In Herefordshire it is 9.7 per 1,000 live births and Worcestershire 7.5 per 1,000.
- **Obesity** – In Herefordshire 22% and in Worcestershire 23% of reception class children are obese or overweight.
- **Alcohol admissions under 18s –** In Herefordshire the figure of 56 per 100,000 population and in Worcestershire 46.5 per 100,000 are both significantly higher than the England average of 40. This equates to an additional 30 admissions in Herefordshire and 37 in Worcestershire per annum.
- **Breast-feeding initiation rates** are both below the national average (68% in Herefordshire and 70% in Worcs with a national figure of 74%).
- **Occurrence of low birth weight** in both counties is amongst the worst of their comparator groups.
- **Teenage conceptions** - 24 per 1,000 in Herefordshire and 25 per 1,000 in Worcestershire are the highest rates amongst their comparator groups.

**Mortality variation between different social groups**

**Difference between less deprived and more deprived areas**

| | |
|---|---|
| **Herefordshire** | 4.9 yrs |
| **Worcestershire** | 7.8 yrs |

**Areas of concern regarding poor outcomes for children and young people across both counties**

Older ---------- Younger

- **Neonatal mortality and still births**
- **Low birth weight**
- **Breastfeeding rates**
- **School readiness**
- **School age obesity**
- **Under 18 alcohol admissions**
- **Teenage conception rate**

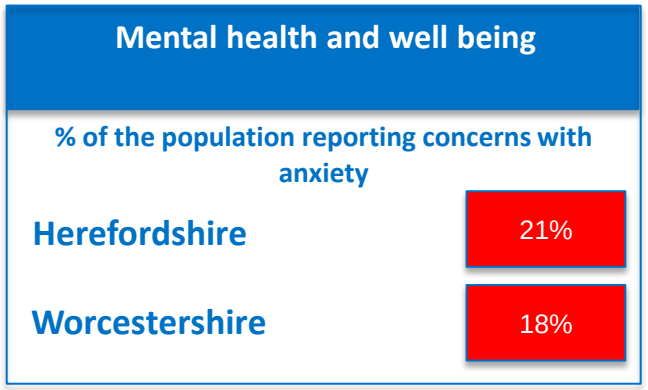
# Our biggest challenges – health and well being

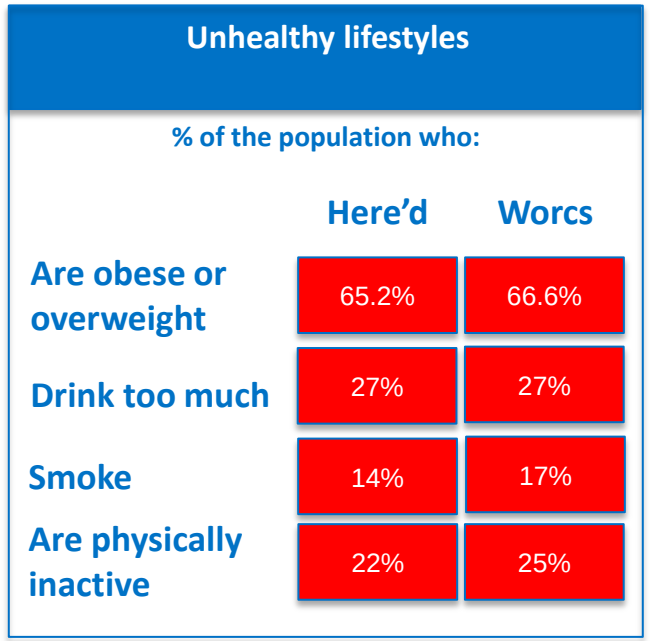
**Mental health and well-being -** This is a theme that cuts across and impacts on all the outcomes**.** On the Integrated Household Survey 21% of residents in Herefordshire and 18% in Worcestershire reported an anxiety score of over 5/10. In addition, we know that people suffering from mental health conditions suffer higher levels health inequality and outcomes across an array of measures. We will focus on improving mental health and well-being which will in turn impact on capacity for individual behaviour change.

To narrow the gaps identified above, we will focus on changing the lifestyle behaviours that increase risks of poor health outcomes**.** We want to reduce:

- **The numbers of people eating too many high fat, salt and sugar foods** - In Herefordshire 65.2% of adults are overweight or obese and in Worcestershire 66.6%.
- **Alcohol consumption** - in both counties about 27% of the drinking population drink at increasing or higher risk levels
- **Smoking** - 14% of adults in Herefordshire and 17% in Worcestershire still smoke
- **Physical inactivity** - 22% of adults in Herefordshire and 25% in Worcestershire are inactive

Although we are generally at national average in terms of these behaviours, the national figures themselves give rise for concern and average performance should not be allowed to provide false comfort. If unchecked, these issues will mean that the rising burden of avoidable disease will continue. Furthermore, there are marked differences between deprived and non-deprived areas which will require careful referral and targeting (for example smoking prevalence among routine and manual workers is 25% in Herefordshire and 32% in Worcestershire). The biggest single staff group across the footprint is employed by the NHS and local government. We will focus on implementing local strategies to support our own workforces to lead the way in changing behaviour for others.



# Our biggest challenges – care and quality

In addition to our health and well being challenges, we also have a number of areas where our performance on care and quality can be significantly improved. We know there are significant workforce challenges in a number of areas leaving services too reliant and locums and agency staff to meet demand.

Our biggest challenges include:

- Lack of capacity and resilience in primary care and general practice.
- Social care provider capacity & quality (domiciliary and residential care capacity is stretched).
- One Trust in the CQC special measures regime and one that has recently emerged from it, having been re-categorised as "requires improvement".
- Poor Urgent Care performance on a number of measures including ambulance measures, 4 hour waits in A&E, long trolley waits and challenges around including stroke performance.
- Poor performance against elective care referral to treatment times (18 week waits) and access to mental health services such as psychological therapies.
- Poor performance of cancer waiting times.
- Low dementia diagnosis rates.
- Poor performance in parts of the STP area on a number of maternity indicators such as uptake of flu vaccinations, smoking at the time of delivery, low birth weight and breastfeeding initiation.

**Sept 2016 Highest risk areas for key NHS Constitutional standards**

| | |
|---|---|
| **Urgent Care** | • 4 hour A&E standards across all sites<br>• Poor patient flow resulting in 12 Hour Trolley breaches (WAHT)<br>• Stroke TIA (WVT)<br>• Ambulance Handovers |
| **Planned Care** | • Referral to treatment 18 week (WVT & WAHT)<br>• Cancer 62 day wait<br>• Cancer all 2 week wait referrals<br>• Cancer 2 week wait – Breast Symptomatic<br>• Cancelled operations (WAHT) |
| **Mental Health** | • Dementia Diagnosis<br>• IAPT Access (Improved access to psychological therapies)<br>• IAPT Recovery |

# Our biggest challenges – finance and efficiency

The STP has developed a financial model that sets out a 'do nothing' scenario for the health and care economy. The model has been calculated showing the impact of increases in demography, inflation and other factors. The model also includes those investments required to deliver the priority areas set out in the Five Year Forward View. The Programme Board has reiterated the importance of the investment in delivering the programmes set out in the General Practice Forward View. The 'Do Nothing' base case for Herefordshire and Worcestershire split by sector is:

| Area | Herefordshire | Worcestershire | Do nothing gap |
|---|---|---|---|
| NHS Commissioners | £33.2m | £53.4m | £252.6m* |
| NHS Providers | £53.3m | £112.7m | |

**includes £23.0m investment requirement to deliver the NHS Five Year Forward View.*

***In addition to this, the financial modelling shows that the two local authorities combined have a "do nothing" gap of circa £84m that are being addressed through local efficiency savings alongside the STP– taking the system gap to £336.6m.***

We recognise the importance of addressing this position as quickly and effectively as possible. Whilst spending allocations will increase from £1.168bn to £1.327bn, if the population continues to access services in the same way as now, and we continue to provided them in the same way, then our spending will be likely to increase by an additional £175m over and above this increase. When added to our opening gap and the social care gap, this results in the total financial challenge for the system by the end of 2020/21 of £336m.

| NHS £226.9m gap by area | 2020/21 'Do Nothing' | Population | Per head |
|---|---|---|---|
| Herefordshire *Including net import from Wales* | *-£86.6m* | *225,000* | *£384* |
| | -£86.6m | 185,000 | £468 |
| Worcestershire | -£166.0m | 595,000 | £279 |

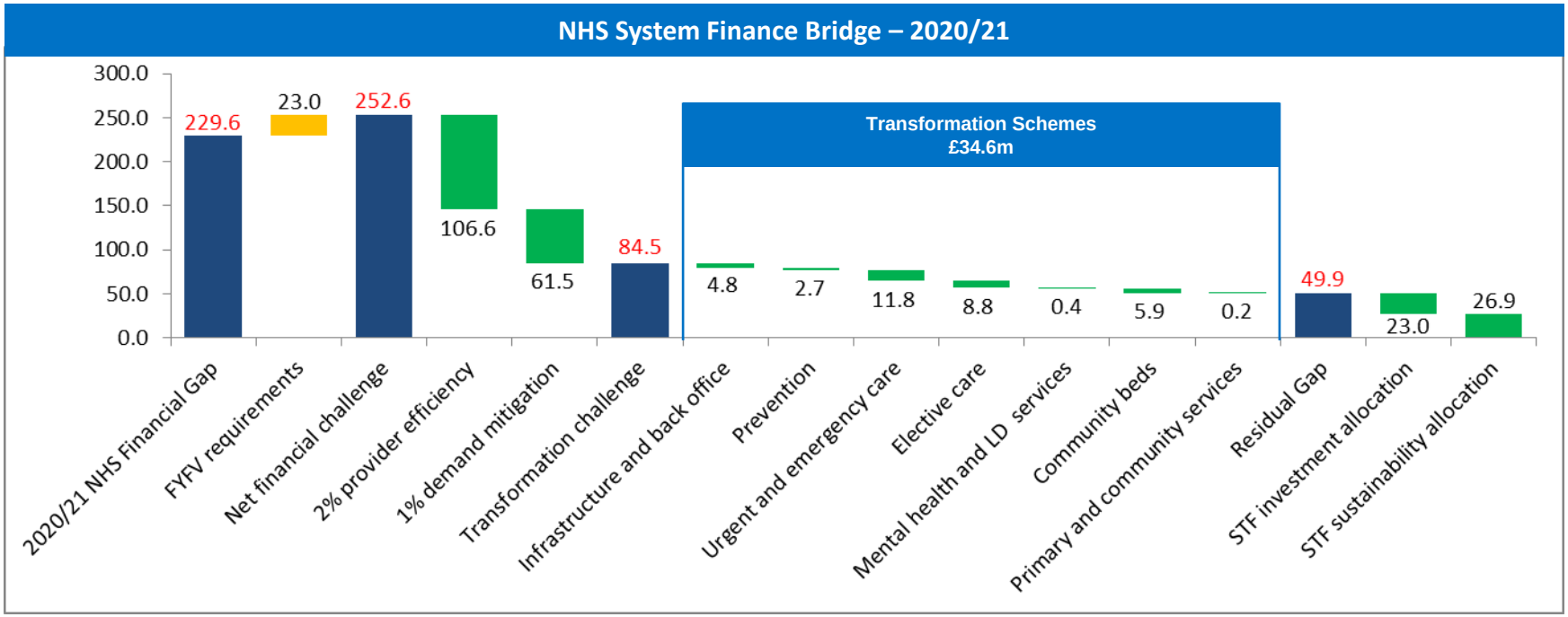
We are very conscious of the challenge between the need to live within individual control totals in the short term and the delivery of a balanced and sustainable system in the long term. In seeking to meet both challenges, we recognise the need to take radical steps, but equally will be careful not to compromise long term sustainability with rash steps towards short-term financial savings.

There is a significant disparity in the scale of the financial challenge across the footprint. The additional challenge in Herefordshire, in part, stems from the inherent additional costs resulting from serving a very dispersed rural population where there is limited access to the internet. These challenges are not fully reflected in the national funding formula.

# Our biggest challenges – finance and efficiency

**Closing the NHS Gap by 2020/21**

If we achieve the national planning assumptions of 1% demand mitigation and deliver 2% provider efficiency gains and additional QIPP savings, then our local modelling suggests that we will reduce the NHS deficit by £168m but will still be left with a financial gap in the NHS at the end of the period of £61.5m (£84.5m-£23.0m investment requirement). We have currently identified transformational schemes totalling £34.6m that could begin to bridge the gap, leaving £26.9m to be covered by the STF money after covering the investment requirement from our STF allocation. Delivering this scale of transformation will be challenging without access to sufficient transformation resource to support change (see page 17 for plans). This is one of the key risks that the system will need to address as part of the next phase of development. In implementing any changes to services, all partners have agreed to the principle that we must not take decisions in one part of the system that have an adverse effect or shunt costs into another part of the system, without this being part of an agreed and organised approach. We are very conscious that there may be a tension between the need to live within the control totals of individual organisations in the short term and the delivery of a balanced and sustainable system in 2021. In seeking to meet both challenges, we are ready to take radical steps, but we will not be foolhardy, in taking rash steps towards short-term financial savings that undermine outcomes in the longer term.'



# Opportunities identified using Right Care to support demand mitigation

In order to deliver our commissioner QIPP and provider CIP challenge we intend to apply the NHS Right Care approach and the wider efficiency work recommended by national reviews such as *Carter* . The CCG Right Care Commissioning for Value packs show that there are significant opportunities for demand mitigation compared to other areas in both elective and non-elective care. Other sources of analysis show opportunities in Continuing Healthcare and variation in GP prescribing.

### Elective Admissions

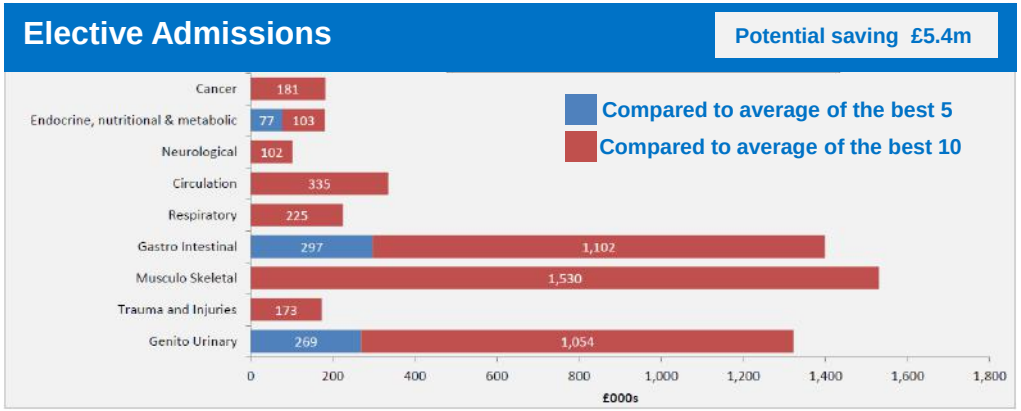
- There are significant opportunities to deliver efficiencies in this area, most notably in Gastro-Intestinal and Musco-skeletal
- Total saving opportunity =
  - £643k against the top 10 comparators
  - £5.4m against the top 5 comparators

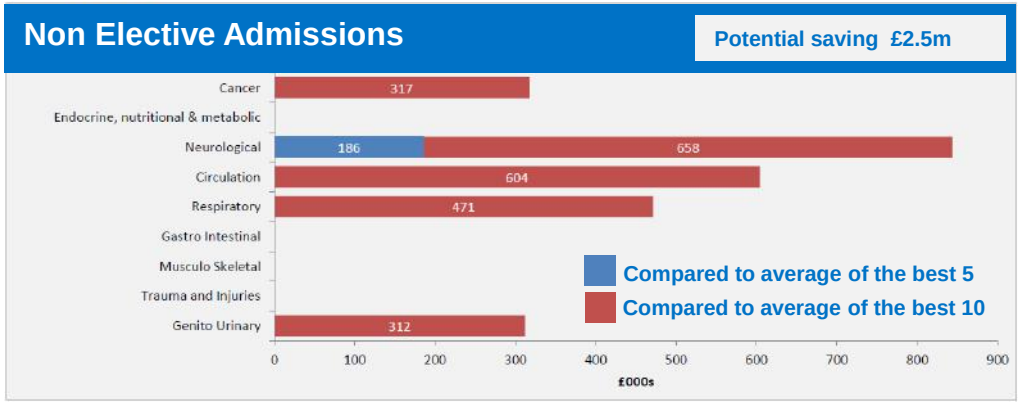
### Non Elective Admissions

- There are also significant opportunities to be pursued in the non-elective admissions, but in a smaller number of areas. The most significant being Neurological.
- Total saving opportunity =
  - £186k against the top 10 comparators
  - £2.5m against the top 5 comparators

### Other areas (not shown in charts)

- In addition to these areas CCGs have also identified CHC and GP Prescribing as areas to target for demand mitigation strategies with savings of £2.1m and £3.7m targeted.




In addition to existing schemes, jointly developed QIPP/CIP schemes will be developed through the operational planning process to support delivery of these savings, alongside the additional requirements to support control total compliant spend in 2017/18 and 2018/19.

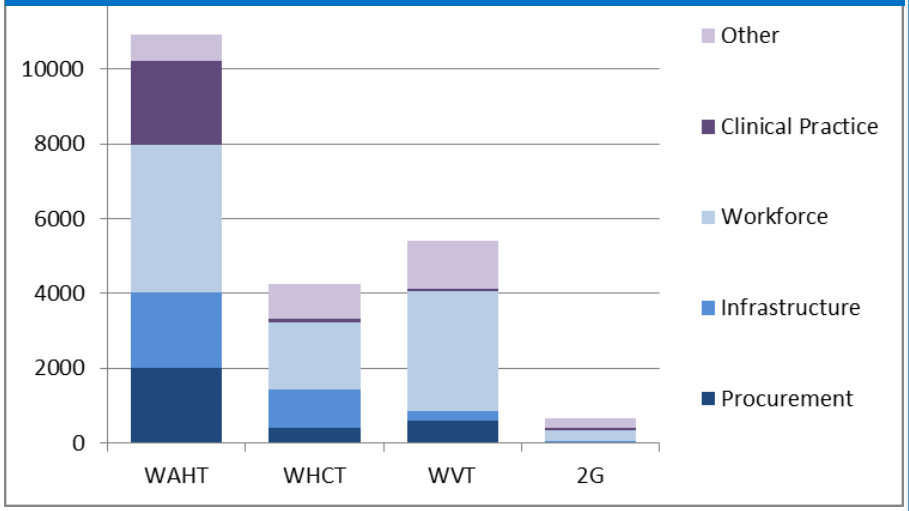
# Identification of provider cost improvement plans – 2017/18 and 2018/19

Providers are developing plans to deliver the 2% cost improvement requirements outlined on slide 12. These plans are consistent with the areas set out in the Carter review and include the following elements:

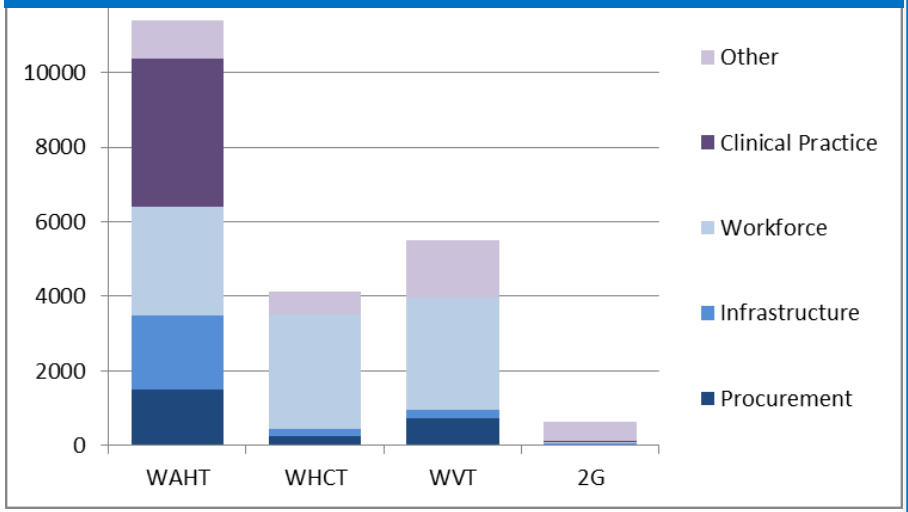
- **Procurement** – a total of £3.0m savings across the 4 providers in 2017/18 and a further £2.5m in 2018/19
- **Infrastructure** - £4.4m in 2017/18 and a further £2.5m in 2018/19. These savings are based on spend to save schemes, likely impairments and increased commercial income as part of an efficiency review linked to the Carter recommendations and other benchmarked opportunities such as estate management and PFI efficiencies.
- **Workforce** – this is the biggest area of focus in provider plans and is centred heavily on reducing spend on temporary staffing. Plans currently aim for £9.2m in 2017/18 and a further £9.0m in 2018/19.
- **Clinical Practice** – a reduction of £2.5m in 2017/18 and £4.0m in 2018/19. These savings include productivity and efficiency improvements in areas such as length of stay, day case rates, outpatient follow up rates, reducing non attenders and readmissions as well as more efficient prescribing practise and improved theatre utilisation.
- **Other** - £3.1m in 2017/18 and a further £3.7m in 2018/19. These savings include improved income recovery through better productivity, improved CQUIN performance and better contract management.

Note that, combined, these savings equate to £21.2m and £21.7m respectively for the next two years. However, in order to achieve control total compliant expenditure, additional savings across the providers or almost £27m will need to be identified in 2017/18.

**2017/18**



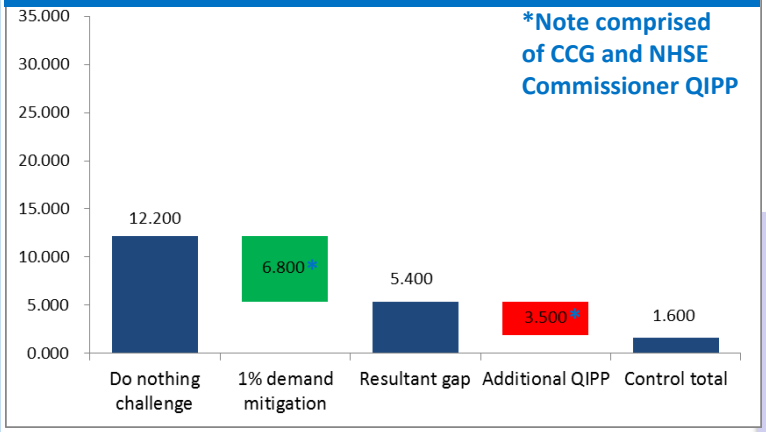

**2018/19**



# Our biggest challenges – finance and efficiency

Our financial modelling shows that we can bring the system into financial balance by 2020/21 by using £26.9m of our STF allocation to support sustainability. However, we have a significant challenge in achieving the system control totals for 2017/18 and 2018/19. In order to achieve the 2017/18 control totals the Herefordshire system would need to achieve combined savings of £28.3m in year. For Worcestershire this figure is £54.4m. In reality because a significant proportion of the commissioner challenge would be in spend areas with the provider, the provider challenge would be further magnified. Significantly for the two acute providers these programmes equate to circa 15.0% and 9.3% of income respectively.

## Herefordshire Commissioner Bridge 2017/18

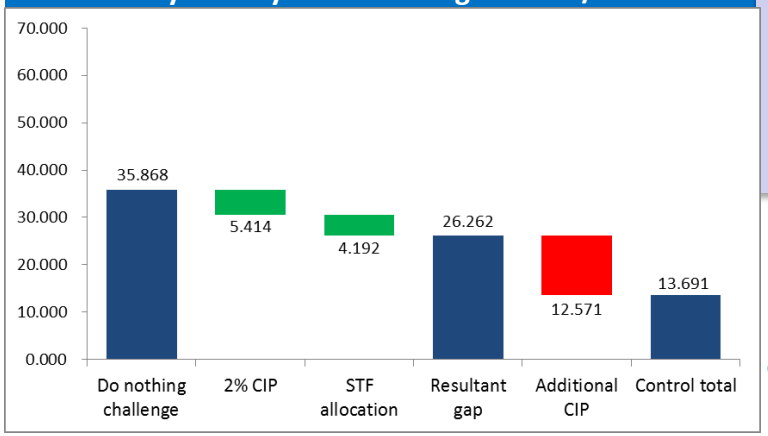



## Herefordshire Challenge

£6.8m
£3.5m
**£10.3m**

**£28.3m**

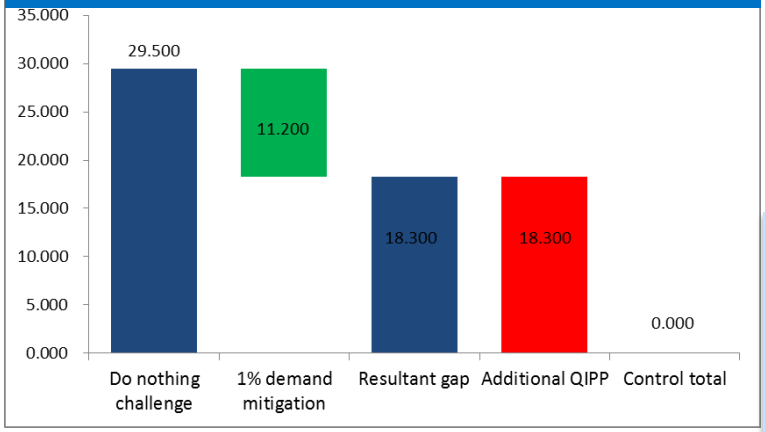
## Wye Valley Finance Bridge – 2017/18




£5.4m
£12.6m
**£18.0m**

circa **15.0%** CIP (inc impact of commissioner QIPP)

## Worcestershire Commissioner Bridge 2017/18

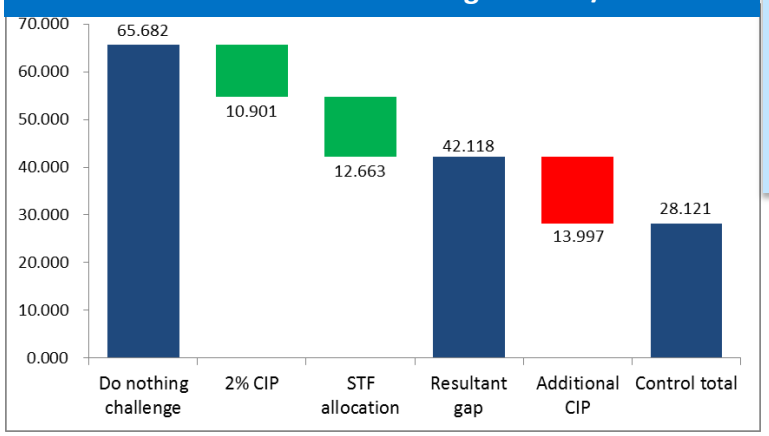



## Worcestershire Challenge

£11.2m
£18.3m
**£29.5m**

**£54.4m**

## Worcs Acute Finance Bridge – 2017/18




£10.9m
£14.0m
**£24.9m**

circa **9.3%** CIP (inc impact of commissioner QIPP)

# Investing in change and transformation

## An Allocative Approach to Budget Prioritisation

Partners on the programme board agreed to take a strategic approach to making investment and disinvestment decisions across the system budgets. A budget allocation exercise was facilitated by The Strategy Unit of the Midlands and Lancashire Commissioning Support Unit.

This process included partners reviewing national "asks", local performance and outcome information from the gap analysis and agreeing a strategic direction of travel for how we believed we could most efficiently optimise the use of resources to achieve the best outcomes for the population.

The core purpose was to enable rational allocation of any growth money that CCGs will receive in their allocations over the STP period and agree where the most significant efficiencies and service changes would need to be targeted in order to achieve this strategic intent. The intention is to use this process to support the strategic shift in resources over the lifetime of the STP.

However, it will be a significant challenge for the system to achieve this quickly using traditional methods of contracting. Any additional investment highlighted in the table is naturally reliant on the system's ability to disinvest equivalent amounts in the other areas. It is therefore a priority of the STP to move towards population based capitated allocations using more flexible contracts to enable commissioners and providers to ensure that resource is targeted to the right areas.

Through the joint operational planning process, CCGs and Providers are working together to develop joint schemes to support each other to deliver their respective financial positions. By the end of December 2016 these arrangements will be clarified and included in published operational plans.

| Funding area | Indicative funding share | Real terms change* | Actual funding increase |
|---|---|---|---|
| Running costs | Reduce | -26% | -15% |
| Back office and infrastructure | | -7% | |
| Urgent care and emergency admissions | Reduce | -6% | +7% |
| Maternity care | Increase | +1% | +15% |
| Mental health and learning disability services | Increase | +8% | +23% |
| Elective treatment – life threatening conditions (cancer, cardiac etc) | Increase | +7% | +22% |
| Elective treatment – non life threatening conditions | Reduce | -20% | -8% |
| Diagnostics and clinical support services | Reduce | -11% | +2% |
| Medicines optimisation | Reduce | -8% | +5% |
| Core primary care (GMS) | Apply national formula and GPFV requirements | | |
| Extended primary and community services to support proactive out of hospital care | Increase | +17% | +33% |
| **Total** | | **0.0%** | **+13.0%** |

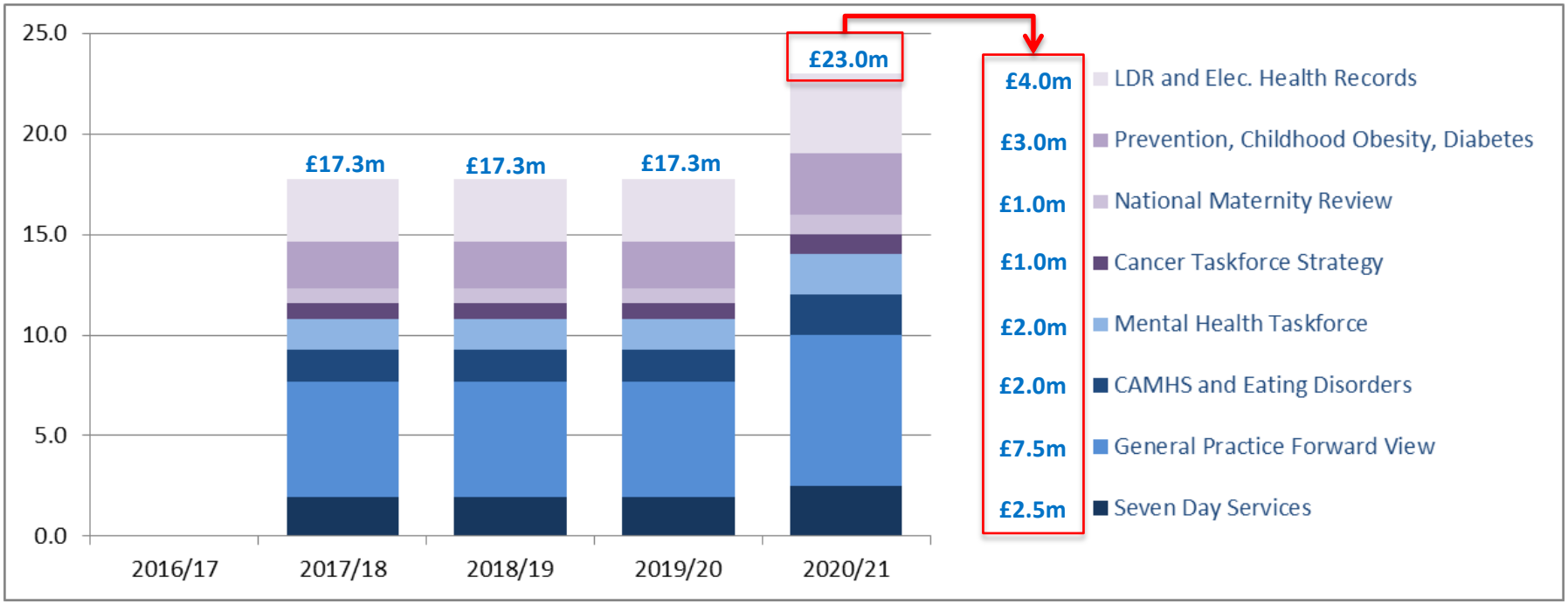
**Ambition for funding growth above inflationary increase*

# Investing in change and transformation

**Allocating the STF Money**

The allocation exercise was also used to inform discussions and prioritisation for use of the transformation element of the STF. These investments will need to be made early in the planning cycle if they are to begin delivering the scale of transformation required to improve services and achieve financial balance. Any risk to our ability to make this investment will severely compromise our ability to deliver a balanced plan by the end of the period.

The chart below shows the initial proposed allocation of the STF transformation element. It shows a build up from £17.3m from 2017 through to the end of 2020, before growing to £23.0m in 2020/21. It is important to note that this is the initial proposed allocation and may be subject to change as further work is conducted to develop the project delivery plans in each area.



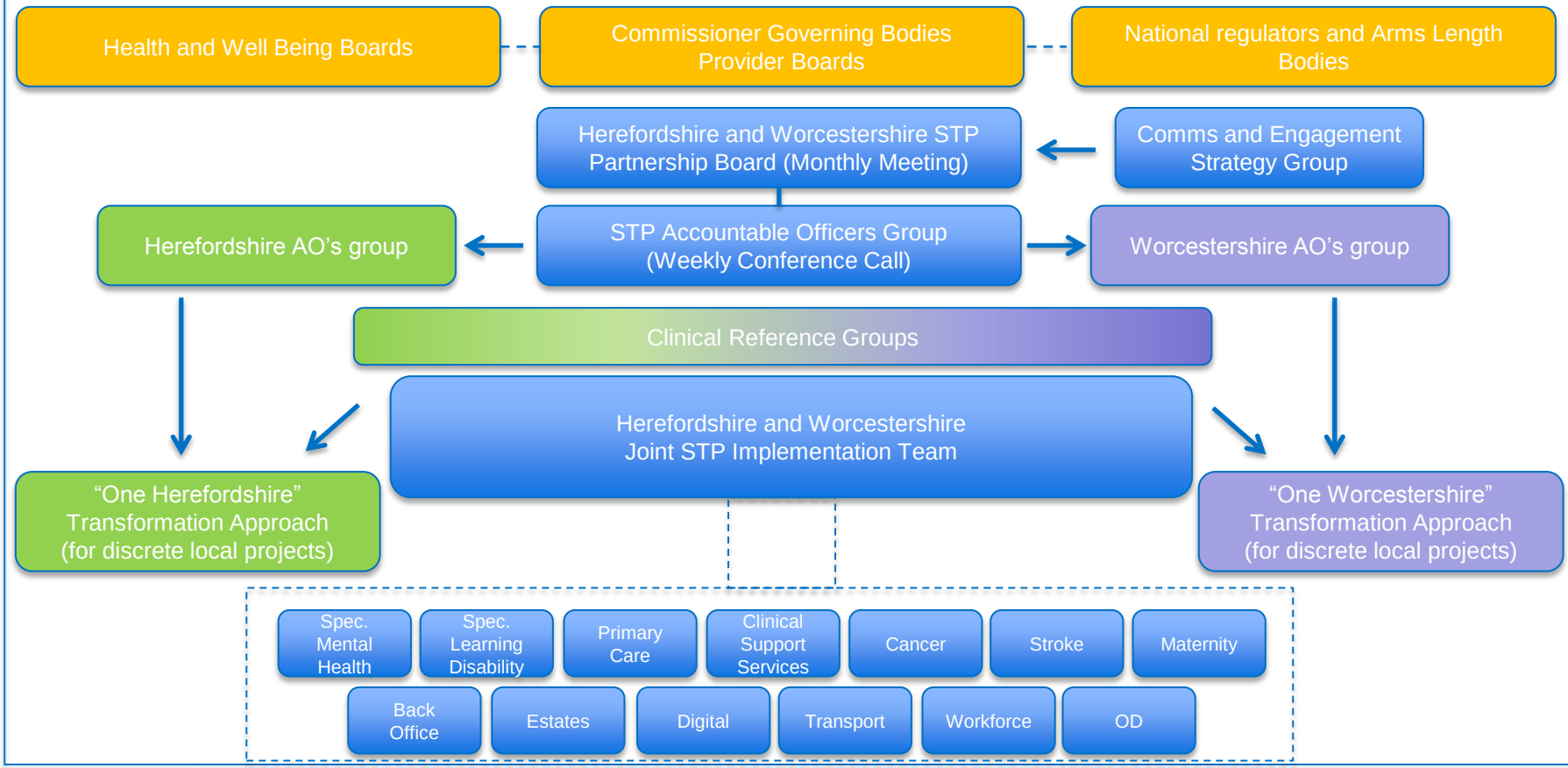

Within the use of this transformation resource there are specific primary care data sharing and governance issues that will need to be resolved.

# Our priorities for transformation

| Transformation Priorities | Delivery Programmes | Enablers |
|---|---|---|
| 1 Maximise **efficiency and effectiveness** across clinical, service and support functions to improve experience and reduce cost, through minimising unnecessary avoidable contacts, reducing variation and improving outcomes. | • Maximising efficiency in infrastructure and back office services (annex 1a)<br>• Transforming diagnostics and clinical support services (annex 1b)<br>• Medicines optimisation and eradicating waste (annex 1c) | Develop **the right workforce and Organisational Development** within a sustainable service model that is deliverable on the ground within the availability of people and resource constraints we face.<br><br>Invest in **digital and new technologies** to support self care and independence and to enable our workforce to provide, and patients to access, care in the most efficient and effective way, delivering the best outcomes.<br><br>Engage with the **voluntary and community sector** to build vibrant and sustainable partnerships that harness innovation, further strengthen community resilience and place based solutions.<br><br>Develop a **clear communications and engagement plan** to set out our strong commitment to involving key stakeholders in the shaping of our plan and describe the process and potential timelines associated with this. |
| 2 Reshape our **approach to prevention**, to create an environment where people stay healthy and which supports resilient communities, where self-care is the norm, digitally enabled where possible, and staff include prevention in all that they do. | • Embedding prevention in everything we do and investing in 4 key at scale prevention programmes (annex 2a)<br>• Supporting resilient communities and promoting self care and patient activation (annex 2b) | |
| 3 Develop an improved **out of hospital care** model, by investing in sustainable primary care which integrates with community based physical and mental health teams, working alongside social care to reduce reliance on hospital and social care beds through emphasising "own bed instead". | • Investing in primary care to develop the infrastructure, IG requirements and a new workforce model that has capacity and capability as well as resilience (annex 3a)<br>• Redesigning and investing in community based physical and mental health services to support care closer to home (annex 3b)<br>• Redefining the role for community hospitals (annex 3 c) | |
| 4 Establish **sustainable services** through development of the right networks and collaborations across and beyond the STP footprint to improve urgent care, cancer care, elective care, maternity services, specialist mental health and learning disability services. | • Investing in mental health and learning disability services (annex 4a)<br>• Improving urgent Care (annex 4b)<br>• Delivering improved maternity care (annex 4c)<br>• Improving elective care and reducing variation (annex 4d) | |

# Arrangements for delivering the plan

**Governance and delivery arrangements -** A robust and inclusive framework has been developed to support the work undertaken to date on developing the STP. There is an independent chair of the programme board, which is comprised of all key organisational leads and stakeholders. Working to the programme board there is a programme management office (PMO) in place that will be enhanced as we move into the delivery phase. There is an STP wide communications and engagement strategy group and there are clinical references groups supporting both counties that will come together to agree on pan STP clinical issues. We will develop an STP wide transformation team to bring together transformation resources across the footprint to work in a more coordinated way. Where it makes sense to do so, programmes will be developed across the STP area, where there are local or geographic imperatives that require local solutions, these are and will continue to be managed within each county's tailored transformation programme structure.



# Nine must dos for 2017-18 and 2018-19 : STP Year 2 and 3

| 9 Must Dos | | Delivery Programme |
|---|---|---|
| 1. STP | • Implement agreed STP milestones, so that you are on track for full achievement by 2020/21.<br>• Achieve agreed trajectories against the STP core metrics set for 2017-19. | STP Priorities 1,2,3 & 4 |
| 2. Finance | • Deliver individual CCG and NHS provider organisational control totals, and achieve local system financial control totals. At national level, the provider sector and CCG Sector needs to be in financial balance in each of 2017/18 and 2018/19.<br>• Implement local STP plans and achieve local targets to moderate demand growth and increase provider efficiencies.<br>• Demand reduction measures include: implementing RightCare; elective care redesign; urgent and emergency care reform; supporting self care and prevention; progressing population-health new care models such as multispecialty community providers (MCPs) and primary and acute care systems (PACS); medicines optimisation; and improving the management of continuing healthcare processes.<br>• Provider efficiency measures include: implementing pathology service and back office rationalisation; implementing procurement, hospital pharmacy and estates transformation plans; improving rostering systems and job planning to reduce use of agency staff and increase clinical productivity; implementing the Getting It Right First Time programme; and implementing new models of acute service collaboration and more integrated primary and community services. | We have a significant challenge in achieving the system and provider control totals for 2017/18 and 2018/19. In order to achieve the 2017/18 control totals, Herefordshire would need to deliver a combined QIPP/CIP programme of £28.6m and Worcestershire £37.2m<br><br>Through delivering our programmes of work we will;<br>• Reduce spend across back office functions through sharing expertise and eradicating duplication, including reduced transaction costs of the NHS "market".<br>• Improve access to diagnostics to promote ambulatory care. Streamline pathways and reduce waste in diagnostic services through reducing unnecessary requests. Improve efficiency through centralisation of supporting infrastructure and pooling of functions<br>• Reduce variation in prescribing patterns and increase adherence to approved use of medicines, allowing allocation of additional resource available for new and proven treatments to support prevention and demand control<br>• To transform the way care is provided, proactively supporting people to live independently at home and providing responsive, compassionate and personalised care, delivered by an integrated health & social care workforce. |
| 3. Primary Care | • Ensure the sustainability of general practice in your area by implementing the General Practice Forward View, including the plans for Practice Transformational Support and the 10 high impact changes.<br>• Ensure local investment meets or exceeds minimum required levels.<br>• Tackle workforce and workload issues, including interim milestones that contribute towards increasing the number of doctors, pharmacists working in general practice by 2020,the expansion of Improving Access to Psychological Therapies (IAPT) in general practice with more therapists in primary care, and investment in training practice staff and stimulating the use of online consultation systems.<br>• By no later than March 2019, extend and improve access in line with requirements for new national funding.<br>• Support general practice at scale, the expansion of MCPs or PACS, and enable and fund primary care to play its part in fully implementing the forthcoming framework for improving health in care homes. | STP Priority 3 | **Programme 3a: Developing sustainable primary care**<br>• Work with patients to develop improved access to routine and urgent primary care appointments across 7 days a week through roll out of Prime Minister's Access Fund initiatives.<br>• Local primary care working "at scale", developed through a "bottom-up" approach with practices working in partnership with patients, community pharmacy, third sector and public sector services as well as community and mental health services.<br>• We will implement the "10 high impact areas for General Practice" within and across practices.<br>• With increased capacity within primary care we will work with patient to adopt new ways of working: Moving to a proactive model of care, identifying and case managing through an MDT approach adopting early clinical assessment within a robust process to direct patients to the most appropriate clinician to achieve "right patient, right place, right time". This would ensure continuity of care for those with complex needs as opposed to those requiring same day episodic access. |

# Nine must dos for 2017-18 and 2018-19 : STP Year 2 and 3

| 9 Must Dos | | Delivery Programme |
|---|---|---|
| 4. Urgent & Emergency Care | • Deliver the four hour A&E standard, and standards for ambulance response times including through implementing the five elements of the A&E Improvement Plan.<br>• By November 2017, meet the four priority standards for seven-day hospital services for all urgent network specialist services.<br>• Implement the Urgent and Emergency Care Review, ensuring a 24/7 integrated care service for physical and mental health is implemented by March 2020 in each STP footprint, including a clinical hub that supports NHS 111, 999 and out-of-hours calls.<br>• Deliver a reduction in the proportion of ambulance 999 calls that result in avoidable transportation to an A&E department.<br>• Initiate cross-system approach to prepare for forthcoming waiting time standard for urgent care for those in a mental health crisis. | STP Priority 4 | **Programme 4b: Improving Urgent Care**<br>• Improve urgent care pathways to improve access, performance and create better outcomes, resulting in a requirement for fewer beds, reduced staffing and estate requirements<br>• Deliver the four priority standards for seven-day hospital services for all urgent network specialist services<br><br>**Programme 4a: Improving mental health and learning disability care**<br>• Access will be clear and timely at a practice, cluster, county, STP and cross STP level, ensuring the delivery of evidence based, sustainable and regulatory compliant provision.<br>• Implement the crisis concordat action plan |
| 5. RRTT and elective care | Deliver the NHS Constitution standard that more than 92% of patients on non-emergency pathways wait no more than 18 weeks from referral to treatment (RTT).<br>• Deliver patient choice of first outpatient appointment, and achieve 100% of use of e-referrals by no later than April 2018 in line with the 2017/18 CQUIN and payment changes from October 2018.<br>• Streamline elective care pathways, including through outpatient redesign and avoiding unnecessary follow-ups.<br>• Implement the national maternity services review, Better Births, through local maternity systems. | STP Priority 3 & 4 | **Programme 3c: The role of community hospitals**<br>• More planned care will be available closer to home, e.g. outpatients and day case, reducing the need to travel for regular appointments<br>**Programme 4c: Improving maternity care**<br>• Citizens will have access to high quality, safe and sustainable, acute, women and neonatal and mental health services, localised where possible and centralised where necessary<br>**Programme 4d: Elective Care**<br>• Two aspects to improving elective care:<br>1. Effective commissioning policies and stricter treatment thresholds<br>2. Efficient organisation of services to meet demand, undertake more routine elective activity on a reduced number of "cold" sites |
| 6. Cancer | • Working through Cancer Alliances and the National Cancer Vanguard, implement the cancer taskforce report.<br>• Deliver the NHS Constitution 62 day cancer standard, including by securing adequate diagnostic capacity, and the other NHS Constitution cancer standards.<br>• Make progress in improving one-year survival rates by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.<br>• Ensure stratified follow up pathways for breast cancer patients are rolled out and prepare to roll out for other cancer types.<br>• Ensure all elements of the Recovery Package are commissioned | STP Priority 4: | **Programme 4d: Elective Care**<br>• We aim to achieve deliver world class cancer outcomes for our population by delivering the national cancer strategy. This will mean fewer people getting preventable cancers, more people surviving for longer after a diagnosis, more people having a positive experience of care and support; and more people having a better long-term quality of life.<br>• We aim to be better at prevention and deliver faster access to diagnosis and treatment. We aim to achieve consistent access of all cancer treatment standards .<br>• There will be fewer diagnoses made through emergency admission or unplanned care provision and better patient experience of cancer care received. |

# Nine must dos for 2017-18 and 2018-19 : STP Year 2 and 3

| 9 Must Dos | | Delivery Programme |
|---|---|---|
| 7. Mental Health | • Deliver in full the implementation plan for the Mental Health Five Year Forward View for all ages; additional psychological therapies, more high quality Children and Young people services, treatment within 2 weeks for first episode of psychosis, increased access to individual placement support, community eating disorder teams and a reduction in suicides.<br>• Ensure delivery of the mental health access and quality standards including 24/7 access to community crisis resolution teams and home treatment teams and mental health liaison services in acute hospitals.<br>• Increase baseline spend on mental health to deliver the Mental Health Investment Standard.<br>• Maintain a dementia diagnosis rate of at least two thirds of estimated local prevalence, and have due regard to the forthcoming NHS implementation guidance on dementia focusing on post-diagnostic care and support.<br>• Eliminate out of area placements for non-specialist acute care by 2020/21. | STP Priority 4 | **Programme 4a:Improving mental health and learning disability care**<br>• The requirements of the National Mental Health Policy "No Health Without Mental Health" and the requirements of the National Mental Health Five Year Forward Vision will be embedded across our footprint – including crisis care, Mental Health liaison, transforming perinatal care and access standards .<br>• Access to mental health and learning disability services will be clear and timely at a practice, cluster, county, STP and cross STP level, ensuring the delivery of evidence based, sustainable and regulatory compliant provision.<br>• Improved access to CAMHs Tier 3.5 to reduce demand for Tier 4<br>• The services in place will be responding to the health and wellbeing gaps and health inequalities identified.<br>• People who require more tertiary care/specialist support will have their care planned for via managed clinical networks. |
| 8. Learning disabilities | • Deliver Transforming Care Partnership plans with local government partners, enhancing community provision for people with learning disabilities and/or autism.<br>• Reduce inpatient bed capacity by March 2019 to 10-15 in CCG-commissioned beds per million population, and 20-25 in NHS England-commissioned beds per million population.<br>• Improve access to healthcare for people with learning disability so that by 2020, 75% of people on a GP register are receiving an annual health check.<br>• Reduce premature mortality by improving access to health services, education and training of staff, and by making necessary reasonable adjustments for people with a learning disability and/or autism. | STP Priority 4 | **Programme 4a:Improving mental health and learning disability care**<br>• Addressing Health Inequalities for people with LD – This is a priority for LD services its aim is to reduce barriers , promote inclusion and therefore increase access to health and social care services.<br>• Transforming care - bringing people with LD and Autism back to their own communities from out of area placements and preventing admission to hospital, achieving safe discharge and robust community support.<br>• Collaborating across Counties to provide Specialist services more efficiently/effectively. |
| 9. Improving quality | • All organisations should implement plans to improve quality of care, particularly for organisations in special measures.<br>• Drawing on the National Quality Board's resources, measure and improve efficient use of staffing resources to ensure safe, sustainable and productive services.<br>• Participate in the annual publication of findings from reviews of deaths, to include the annual publication of avoidable death rates, and actions they have taken to reduce deaths related to problems in healthcare. | Priorities 1,2,3 & 4 | • The STP footprint currently has two acute Trusts in special measures. A key component of our STP is to ensure care is delivered of a standard and quality which is acceptable for our population and to the CQC and is on a trajectory to GOOD and aspires to be OUTSTANDING.<br>• An impact of achieving this will be delivering safe, sustainable and productive services through transformation in general practice, primary care, urgent, non-elective and elective care as described in the annexes of this plan. |

# Key risks and barriers to the delivery of our plan

| | Key risk | Mitigation |
|---|---|---|
| Delivery | Insufficient redesign and transformation skills to transform the system and design care pathways across the health and care system | Learn from best practice elsewhere including successful individual organisational experience of transformation<br>Core group identified and leading the STP<br>Partnerships with external organisations (Provex, CSU to date , future plan being considered)<br>Establish system transformation programme resource and central PMO |
| | | Identify and maximise the transformation skills we have across the economy and ensure key people are focused on STP priorities |
| | Lack of sufficient capacity to focus on the change programme | Structure and commitment post 21st Oct submission being explored to transfer core STP work streams into operational plans, Programme Board are focused on capacity being identified |
| | Failure to maximise the potential for integration | Joint conversations and AO meetings to enable challenge to each other<br>Significant relationship work has been undertaken to build trust |
| | Do not seize the opportunities presented by collaboration and continue to work in an isolated way | Joint conversations and AO meetings, Best Value challenge agreed at each point |
| | Programme does not deliver as insufficient focus and capacity agreed within the economy to deliver | Central PMO structure supported to 21st Oct submission but refresh of requirements moving forward currently underway |
| | Organisations do not commit to the changes and continue to look after self interests | Continued focus on local needs and the need to work differently as a system, national imperative<br>OD plan moving forward to support more joined up working<br>Develop a system risk share arrangement to incentivise system wide, not organisational thinking |
| | Planning process becomes overly health focused and as a consequence the role of social care, communities and the VCS sector is taken for granted and the associated costs not factored in | Engagement of wide range of partners on the STP Programme Board<br>All SROs to consider this within workstream discussions<br>Review of draft plans to strengthen this aspect<br>Social care and the Voluntary and community sector are actively involved in programme board |
| | Inability to meet the requirements of the national strategies such as the mental health, maternity, and cancer strategies/taskforces within the resources that will be allocated | Establish clear agreement at STP board level over funding priorities<br>Application of the strategic intent for resource allocation to operational plan development<br>Develop alternative strategies where funding requirements cannot be fully met |
| Workforce | Insufficient staff are recruited or developed with the requisite skills to deliver the plan | Workstream focus on "World Class Worcestershire " – making system wide roles attractive.<br>Ongoing recruitment processes<br>Ongoing training programmes and collaboration with Universities to shape training for the future |
| | Retention of staff deteriorates during the changes | Monitoring systems in place to identify deterioration<br>Effective communication and engagement with staff about proposed changes |
| | Fragility of the domiciliary and residential care market | Local Authorities to review the sustainability of the private domiciliary & residential care market |
| | Insufficient primary care staff to deliver at the scale required for the future, (42% of West Mids GP workforce expect to retire or reduce hours in the next 5 years) | Primary care workforce strategy<br>Consideration of new roles and extended roles to support a potentially smaller GP workforce in the future |

# Key risks and barriers to the delivery of our plan

| | Key risk | Mitigation |
|---|---|---|
| Engagement | Inability to resolve fundamental barriers for primary care relating to indemnity and property liability that will compromise their ability to engage with partners in new models of care or contracting arrangements | Recognition of the significance of the challenge at STP Board Level<br>Continue work to explore resolutions that could be achieved to reduce the risk to individual GP partners<br>On-going discussions taking place nationally to reduce structural barriers |
| | Insufficient clinical engagement to own and deliver the plan | Clinical engagement to date through reference groups, internal briefings and input into specific workstream discussions<br>Clinical engagement strategy for post Oct being developed |
| | Insufficient public engagement in the early stages of the plan may undermine support moving forward | Public and community engagement strategy in place. Comprehensive engagement milestones and approaches which recognise co production<br>H&WBB briefed regularly |
| | Failure to maintain continued involvement and support of staff | Regular briefings / updates on progress to staff<br>Engagement strategy in place |
| | Wider clinical engagement does not yield support for the plan | Identify and respond as part of the Engagement strategy |
| Political & Regulatory | Limited or no political support for the decisions | Regular updates to key forums, specific briefings to MPs<br>National recognition of case for change |
| | Disagreement between regulatory bodies around the key proposals | Regular communication with Regulators about emerging themes |
| | The limited capacity of leaders could impact on delivery of the transformation required. Compounded by regulatory processes already in place distracting focus | Identify specific leaders for the transformation process who are not absorbed in delivery of regulator actions day to day |
| Financial | Inability to release the resources from the existing urgent care system to create the ability to invest in scaling up primary and community service investment | Workstreams in place to identify top priorities.<br>Financial support to model impact with CEO oversight |
| | Savings opportunities identified may deliver less than planned | Continued rolling refresh programme to revise assumptions<br>Governance processes in place to provide oversight and assurance |
| | In year financial positions deteriorate further | Organisational recovery plans in place |
| | Insufficient resources allocated to fund the cost of change – Including availability of capital to enable reconfiguration of services | Programme Board oversight of resource requirement at STP level<br>AOs to review internal capacity and how individuals roles and priorities can be aligned to the change and identify where and external expertise will be required and enabled |
| | Inability to access sufficient transformation funding to drive the changes required to release the longer term benefits, including the investment required to deliver the national must do's | Implement a clear process for developing and assessing robust business cases for proposed changes |
| | Decisions made in isolation by partners have unintended knock on consequences to other parts of the system and result in cost shunting | Risks to quality will be identified early stage through existing arrangements incorporating quality impact assessments. Key risks around decisions made under the STP will be fully considered at STP board level so they are identified and decisions are taken.<br>Explore new ways of aligning financial incentives and risk share arrangements |

# Next steps

**There are a number of immediate next steps we need to take to move the STP forward:**

- Refine the planning and financial assumptions based on the new control totals and STF funding allocations, with a particular focus on years 1 and 2.
- Identify the steps required to address the financial gaps related to the additional CIP and QIPP requirements identified on page 15.
- Develop our plan for stakeholder and public engagement plan to help us co-produce solutions to address the challenges set out in this document.
- Take immediate action and further development of the four key “at scale” prevention programmes.
- Take immediate action on the primary care sustainability workstream to increase resilience in core general practice and prepare for delivery of Primary Care at Scale.
- Continue to develop the new out of hospital integrated care models in each county.
- Participate in the West Midlands clinical review of the implementation of transforming urgent and emergency care services in the West Midlands.
- Seek NHSE support to review specific services and test proposals to address them which have a potential solution beyond the STP footprint– eg. Stroke, mental health and cancer.
- Establish the benefits and delivery plan for those benefits of being a rural pathfinder for new ways of commissioning specialised services.
- Explore how we can unlock the benefits of the STP through different contracting models to incentivise delivery and develop partner risk share arrangements.
- Agree the revised governance structure to enable us to complete the planning process and transition into operational planning and contracting
- Commission support to help shape the refinements of specific issues to include :
    - An understanding of the clinical dependencies needed to support an acute service in Herefordshire and the resulting costs, reflecting the challenges of rurality.
    - Undertake further analysis of the bed modelling work and assess the potential for change alongside our ambition to deliver more care at or close to home.

# Detailed Plans

| | |
|---|---|
| **Name of footprint** | Herefordshire and Worcestershire |
| **Region** | Midlands and East |
| **Nominated Lead** | Sarah Dugan, Chief Executive Worcestershire Health and Care NHS Trust |
| **Contact Email** | whcnhs.yourconversationhw@nhs.uk |

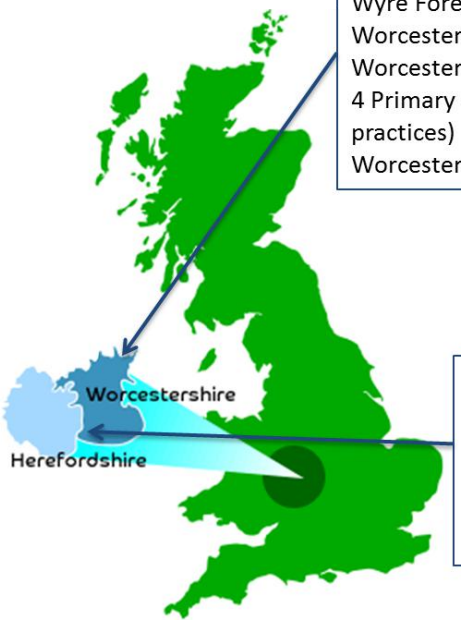
| Partners involved | |
|---|---|
| **GP Practices** | 90 |
| **CCGs** | 4 |
| **Acute Trusts** | 1 |
| **Combined Acute and Community Trusts** | 1 |
| **Combined Community and Mental Health Trusts** | 1 |
| **Mental Health Trusts** | 1 |
| **HealthWatch bodies** | 2 |
| **District and Borough Councils** | 6 |
| **Councils with Health & Well Being Boards** | 2 |

| Key Statistics | |
|---|---|
| **Population** | 780,000 |
| **Area** | 1,500sq miles |
| **Annual NHS Allocation – 2016/17** | £1.168bn |
| **Annual NHS Allocation – 2020/21** | £1.327bn |
| **STF allocation in 2020/21** | £50m |
| **NHS "Do Nothing" financial gap to 2020/21** | £229.6m |
| **NHS Residual Gap after applying national planning assumptions** | £61.5m |

## Herefordshire and Worcestershire

Sustainability and Transformation Plan

*(22nd November 2016 Draft)*




Redditch and Bromsgrove CCG (R&BCCG)
South Worcestershire CCG (SWCCG)
Wyre Forest CCG (WFCCG)
Worcestershire Acute Hospitals NHS Trust (WAHT)
Worcestershire Health and Care NHS Trust (WHCT)
4 Primary Care Collaborations (covering 66 practices)
Worcestershire County Council (WCC)

Herefordshire CCG (HCCG)
Wye Valley NHS Trust (WVT
2gether NHS Foundation Trust (2G)
Taurus GP Federation (representing 24 practices)
Herefordshire Council (HC)

# Contents

# Priority 1 – Maximise efficiency and effectiveness

| Programme 1a | INFASTRUCTURE AND BACK OFFICE | SRO | Clare Marchant, CEO Worcestershire County Council |
|---|---|---|---|
| Overall aim | Reduce spend across back office functions through sharing expertise and eradicating duplication, including reduced transaction costs of the NHS "market". | | |

**What will be different between now and 2020/21**

**We intend to move to a place based model for commissioning support services, infrastructure and back office which results in the best value**
The Back Office and Infrastructure Programme will both deliver improvements in service delivery and savings but will also enable the delivery of other STP work streams.

The key components are:

- **Single Procurement Strategy** - New contracting arrangements over longer time periods and single procurement framework for common services and products across all STP partners where beneficial.
- **Single Place Based Estates Strategy** – enabling co-location and service integration and the release of unwanted property and land. Careful consideration will be needed to see how the primary care estate can be included in this work given the different nature of ownership, financing and liability arrangements in place.
- **Single Transactional Services** – With end to end business processes and administration with joined up support services, commissioned and designed to meet the efficiency and STP programme agenda . – particularly in relation to consolidated approaches with an initial focus on:
    - Finance
    - Payroll
    - Procurement support services through making best use of NHS Shared Services or other competitive provider
- **"Virtual" Single Strategic Estates function** – making best use of collective resources, consistent with the "One Public Estate" ethos (and inclusive of wider partners eg. Police, Fire and DWP). To include considering the extension of Place Partnership Ltd in local NHS Property Management. Specific areas to be explored in wave 1:
    - Hospital Catering
    - EBME (Medical Device Management and servicing)
    - Courier & Taxi Services
    - Hard Maintenance
    - Help Desk
    - Waste Management
- **Joined up Digital Strategy** – with modern integrated technology ensuring 100% Digital Access, and paperless care by 2020 (ensuring all are digitally included and patients are empowered through technology) with a connected infrastructure and joined up access channels, including telephony. Overarching digital strategy which brings together the two Local Digital Roadmaps and future-proofs developments around five key areas: connected infrastructure, improving integration, empowering citizens, working collaboratively, enhancing our understanding.
- **Joined up Transport Strategy** – for patients and service users that ensures transport provision is optimised and a reduction in the number of vehicles on the road.

# Priority 1 – Maximise efficiency and effectiveness

| | | | |
|---|---|---|---|
| **Programme 1a** | **INFASTRUCTURE AND BACK OFFICE** | **SRO** | Clare Marchant, CEO Worcestershire County Council |
| **Overall aim** | Reduce spend across back office functions through sharing expertise and eradicating duplication, including reduced transaction costs of the NHS "market". | | |

**How will this be better for residents and patients in Herefordshire and Worcestershire**

Before reviewing the provision of front line services within the STP we recognise the importance of maximising the value and impact, whilst reducing costs of our business support functions.

Through this programme, we aim to:

- **Reduce spend** across back office functions by more than 20% through more efficient infrastructure, organisation and reduced transaction costs. This will include fundamentally changing the way in which local NHS bodies contract with each other, by moving towards population based capitated budgets rather than having an internal market.
- **Co-locate and integrate services** with shared platforms and administration leading to the optimisation of resources across organisational boundaries and reducing unnecessary contacts and journeys.
- Achieve **intelligent estate planning** across the whole "one public estate" to reduce wasted space, enable the sale of surplus land and property and make better use of existing local facilities to support care delivery.
- **Standardise technology applications** to enable a one stop shop approach across all partners , including things like a single Help Desk.
- **Co-ordinate procurement**, bringing efficiency and standard approaches to maximise purchasing power and operational efficiency.
- **Integrate digital care records** to improve clinical management of patients and result in fewer handovers between services and organisations.
- **Coordinate existing transport** provision more effectively to Improve patient access and customer journeys and **Reduce vehicles** on the road and the associated environmental impact
- **Create a common digital infrastructure** with better digital links across organisations bringing enhanced understanding through new ways of data use, leading to earlier intervention and improved outcomes with enhanced and joined up access channels for customers.
- **Joined up channel and telephony** with integrated and effective channels for improved patient access and customer journey resulting in fewer handovers between services and organisations.

All of these programmes of work will provide the opportunity to explore joint working between a range of public sector partners including fire and police

# Priority 1 – Maximise efficiency and effectiveness

| Programme 1b | DIAGNOSTICS AND CLINICAL SUPPORT | SRO | Chris Tidman, CEO, Worcestershire Acute Hospitals NHS Trust |
|---|---|---|---|

| Overall aim | Improve access to diagnostics to promote ambulatory care. Streamline pathways and reduce waste in diagnostic services through reducing unnecessary requests. Improve efficiency through centralisation of supporting infrastructure and pooling of functions |
|---|---|

## What will be different between now and 2020/21

There are critical changes to be pursued within the STP. (1) **Amalgamation of pathology laboratory** services across the STP footprint and beyond and greater functional sharing and consolidation of infrastructure in other clinical support services such as radiology and pharmacy. (2) **Development of agreed system demand management strategies** and delivery mechanisms, with the aim of eliminating unnecessary requests and reducing overall requested activity.

**Pathology:**

- Early exploration of a consolidated service across both counties.
- Longer term plan to join forces with a larger regional provider or to explore the option of developing a private sector partnership model.

**Radiology:**

- Development of appropriate direct access initiatives to support ambulatory care outside of acute hospital settings.
- Shared arrangements for out of hours cover and diagnostic reporting.
- Centralisation of specialised services to align with emergency and elective centres.

**Pharmacy:**

- Development of a single stores, distribution and procurement function across the STP patch
- Options appraisal into medicines supply outsourcing at Worcestershire Acute.
- Other functional service consolidation such as medicines information.

## How will this be better for residents and patients in Herefordshire and Worcestershire

- There will be fewer unnecessary requests for diagnostic imaging and laboratory testing, resulting in a reduction in unnecessary exposure to radiation and other harm.
- Workforce and processing of pathology samples will be centralised across a much wider footprint releasing costs, creating economies of scale and increasing purchasing power. These savings will offset pressures in other front line service areas.
- Patients will be able to access diagnostic services more local to them in their communities for less complex procedures and greater direct access will result in reduced need for unnecessary hospital stays.
- Some more specialised diagnostic services will be centralised in fewer emergency / major elective centres to ensure quality and sustainability of clinical skills.

# Priority 1 – Maximise efficiency and effectiveness

| Programme 1c | MEDICINES OPTIMISATION | SRO | Simon Trickett, Accountable Officer, RBCCG and WFCCG |
|---|---|---|---|

| Overall aim | To ensure medicines optimisation is integrated across all services to provide safe, cost effective medicines use, reducing variation in prescribing and patient outcomes to secure best value from finite NHS resources. |
|---|---|

## What will be different between now and 2020/21

- Standardised Care pathways to rationalise choice and place in therapy of medicines used.
- Redesign and recommission services to ensure appropriate prescribing/supply of medicines to address issues identified in the pharmaceutical needs assessment and to optimise outcomes and reduce waste.
- Greater use of IM&T to support appropriate use of medicines at every stage of care.
- Reduced variation in prescribing spend between practices.
- Virtual elimination of spend on low priority treatments.
- Enhancing pharmaceutical skill mix to optimise medicines use across all pathways.
- Improving patient reported outcomes that demonstrate effective medicine use.
- Investment into clinical capacity to implement change and deliver new service models, extending into community services.
- Robust and co-ordinated public engagement and communication strategy to support change messages.
- Significantly enhanced role for community pharmacies, including a review of dispensing practices in light of local population access and the most recent guidance and legislation.

## How will this be better for residents and patients in Herefordshire and Worcestershire

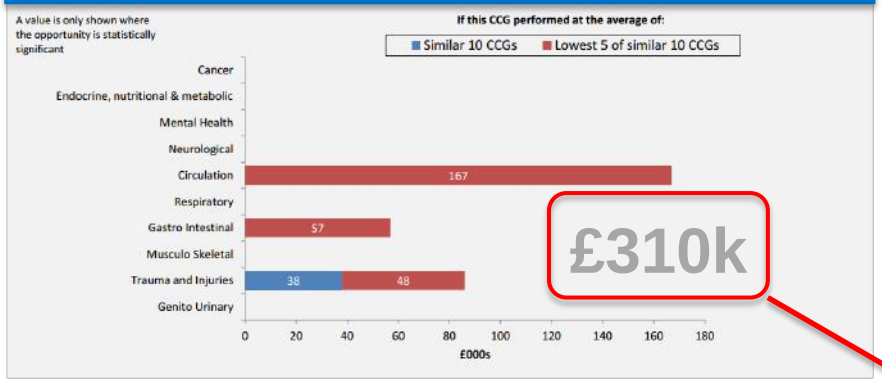
- Transformed access to medicines through service redesign, e.g. off- prescription supply models
- Greater integration and seamless care between all providers.
- Increased reporting of medication reviews across multiple care settings

# Priority 1 – Maximise efficiency and effectiveness

| Programme 1c | MEDICINES OPTIMISATION | SRO | Simon Trickett, Accountable Officer, RBCCG and WFCCG |
|---|---|---|---|

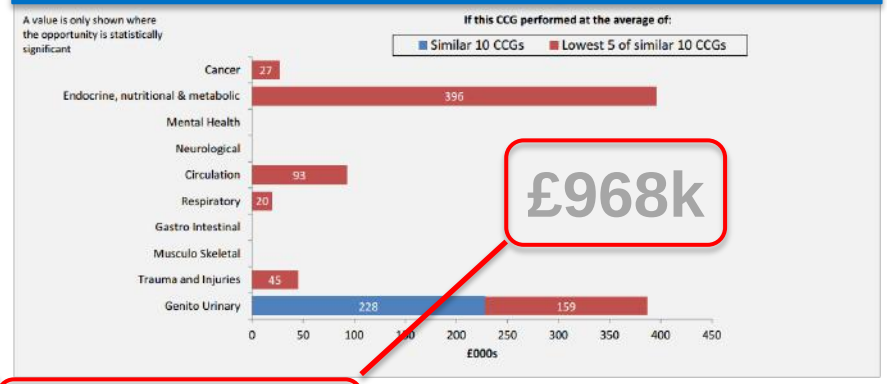
| Overall aim | To ensure medicines optimisation is integrated across all services to provide safe, cost effective medicines use, reducing variation in prescribing and patient outcomes to secure best value from finite NHS resources. |
|---|---|

## Herefordshire




£310k

## Redditch and Bromsgrove

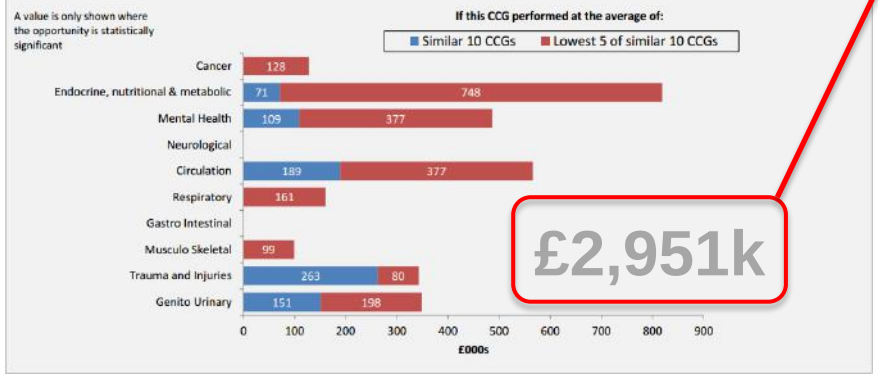



£968k

System total opportunity through achieving RightCare prescribing performance of comparable CCGs is a total **of £4.714m**

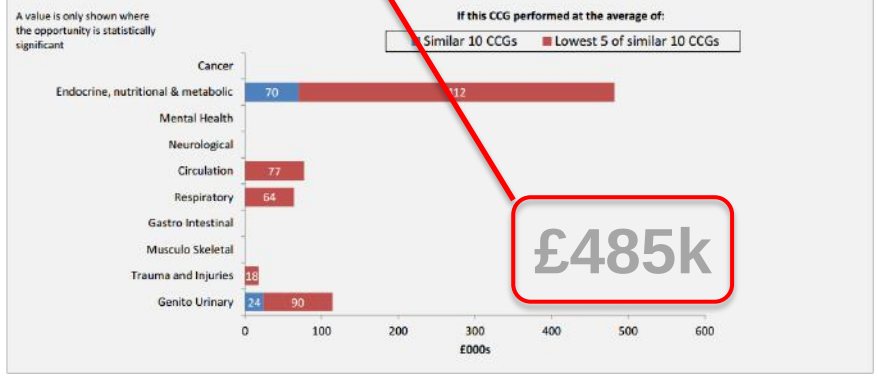
£4,714k

## South Worcestershire




£2,951k

## Wyre Forest




£485k

# Delivery Plan – Priority 1: Maximise Efficiency and effectiveness

| | | | |
|---|---|---|---|
| **Infrastructure and Back Office SRO** | **Clare Marchant –** CEO, Worcestershire County Council | **Programme Lead** | **Pauline Harris -** Programme Manager Worcestershire County Council |
| **Diagnostics and Clinical Support SRO** | **Chris Tidman** CEO Worcs Acute Hospitals NHS Trust | **Programme Lead** | **Richard Cattell** – Director Medicines Optimisation & Pharmacy Worcestershire Acute Hospitals NHS Trust |
| **Medicines and Prescribing SRO** | **Simon Trickett** Accountable Officer – RBCCG and WFCCG | **Programme Lead** | **Jane Freeguard** Head of Medicines Commissioning WCCG's |

| | Work programme | 2016/17 | | 2017/18 | | | | 2018/19 | | | | 2019/20 | | | | 2020/21 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 |
| 1A Infrastructure and back office | **Single Procurement Strategy** – Joined up Procurement Framework, including identification of top three categories for joint procurement and system/process changes and new operating model. | | | | | | | | | | | | | | | | | | |
| | **Single Place Based Estate Strategy** – including virtual single strategy estates function | | | | | | | | | | | | | | | | | | |
| | **Joined Up Transport Strategy** – for patients and service users, | | | | | | | | | | | | | | | | | | |
| | **Single Transactional Services** – Joined up support services, commissioned and designed to meet the efficiency agenda, particularly in relation to consolidated approaches. | | | | | | | | | | | | | | | | | | |
| | **Joined up Digital Strategy** – modern integrated technology, ensuring 1`00% Digital Access and Paperless Care by 2020 with connected infrastructure and joined up access channels | | | | | | | | | | | | | | | | | | |
| 1B Diagnostics and clinical support | Explore the benefits from integration in pathology, radiology and pharmacy across the footprint as per carter | | | | | | | | | | | | | | | | | | |
| 1C Medicines optimisation | Service redesign across STP footprint for community service type medicines that do not need to be prescribed in primary care | | | | | | | | | | | | | | | | | | |
| | Improving medicines optimisation performance in line or better than national and regional outcomes | | | | | | | | | | | | | | | | | | |
| | Review of dispensing practice resources, outcomes and patient equity with respect to access to pharmacy services and recent good practice guidance and legislation dispensing practice review | | | | | | | | | | | | | | | | | | |

# Priority 2 – Our approach to prevention and self care

| Programme 2a | PREVENTION | Owner | Simon Hairsnape, Accountable Officer, HCCG |
|---|---|---|---|
| Overall aim | To embed at scale delivery of evidence based prevention interventions across all providers of health and social care, achieving population behaviour change. | | |

## What will be different between now and 2020/21

- Ensure evidence based prevention is delivered at scale across health and social care prevention is everybody's business
- 4 delivery platforms embedded across all health and social care services:
  - **Social prescribing**: reducing escalation of conditions, supporting recovery and reducing dependence on services.
  - **Making Every Contact Count (MECC) and "a better conversation" health coaching approach**: staff work in partnership with patients having a different type of conversation that guides and prompts individuals to be more active participants in their care and behaviour change to achieve goals and outcomes that are important to them.
  - **Digital inclusion**: preventing social isolation and supporting self-care and recovery
  - **Lifestyle change programmes**: focusing on obesity (diet and physical activity) smoking and alcohol harm reduction. National Diabetes Prevention programme rolled out across the footprint, as part of an integrated obesity strategy.
- System wide approach to tackling key local issues: **Uptake of flu vaccinations in vulnerable groups and carers** as well as both systematic and opportunistic immunisation by staff across all service groups**, Building resilience in parents and children** – redesigned health visiting, school nursing and family support services. **Prevention of Cancer and related Screening**: reducing both the incidence/prevalence of cancer and earlier diagnosis. **prevention of serious injury from falls** contributing to ageing well. **Extended healthy life expectancy**, and **narrowing the health inequalities gap** elimination of variation between practices.
- Developing **'asset rich communities'** where local people thrive in a network of families, neighbours and communities, getting involved in activities and organisations for the benefit of all', and where front line staff across the systems are able to link clients to their local assets easily and constructively. **Dementia friendly communities** – integrating with dementia services to provide dementia friends training and support for Dementia Alliances.

## How will this be better for residents and patients in Herefordshire and Worcestershire

- Staff are confident in undertaking motivational conversations about lifestyle and able to deliver brief intervention and signposting.
- Population behaviour change prevents ill-health - at population level and for individuals
- Reduced levels of preventable disease – reducing demand for both elective and non elective services
- Improved self care by patients and their carers – reducing demand for non-elective services and improving patient experience
- Reduced levels of social isolation – reducing demand for services and improving wellbeing and mental health
- Improved community support of individuals and their carers – reducing demand for services and improving well being

# Priority 2 – Our approach to prevention and self care

| Programme 2a | PREVENTION | Owner | Simon Hairsnape, Accountable Officer, HCCG |
|---|---|---|---|

**Overall aim**

Promoting better long term life outcomes for children, young people and their families' needs to be at the heart of the STP agenda in order to prevent the need for more intensive and high cost services now and in the future. It is important to remember that 'Later interventions are considerably less effective if they have not had good foundations' (Marmot Review 2010).

## What will be different between now and 2020/21

**Best start in life,** Focus on full implementation and adequate resourcing of the healthy child programme and broader early childhood services offer including;

- Effective **early help** - to improve the early identification and response to critical issues affecting children and young people's development as well as supporting parenting and socialisation
- **0 to 5 early years in Herefordshire** – to improve the health, wellbeing, developmental and educational outcomes of children aged 0-5 years
- Through the redesign of the **Integrated Public Health Nursing 0-19 Service in Worcestershire**, all children, young people and their families on their Starting Well journey will have access to the Healthy Child Programme (HCP) delivered by skilled community Public Health teams at key development points
- Implement Connecting Families across Worcestershire taking a **whole system response** in overcoming challenges that prevent and/or delay positive outcomes for children, families and vulnerable individuals
- **Vulnerable Groups -** focus on vulnerable children and young people across the STP footprint who are more likely to experience difficulties in their lives and may need support to help overcome them. More can and should be done to address these health concerns through improving the quality of the workforce and range of interventions
- **Mental Health,** Focus on improving the emotional well being and mental health of children and young people
- Strengthening relationships with the **education and skills sector** as a key stakeholder in improving outcomes

## How will this be better for residents and patients in Herefordshire and Worcestershire

**In the short term:**

- Improve information and support for children and families to enable self- management and independence
- Increase personalised care planning in partnership with children, young people and their families
- Strengthen information sharing across the system to enable a joined up approach and end to end care pathways
- Increase competency and confidence of staff across all sectors to manage children and young families needs in partnership with their parents
- Improve our 19-25 provision improving access to education for all (including recovery college)

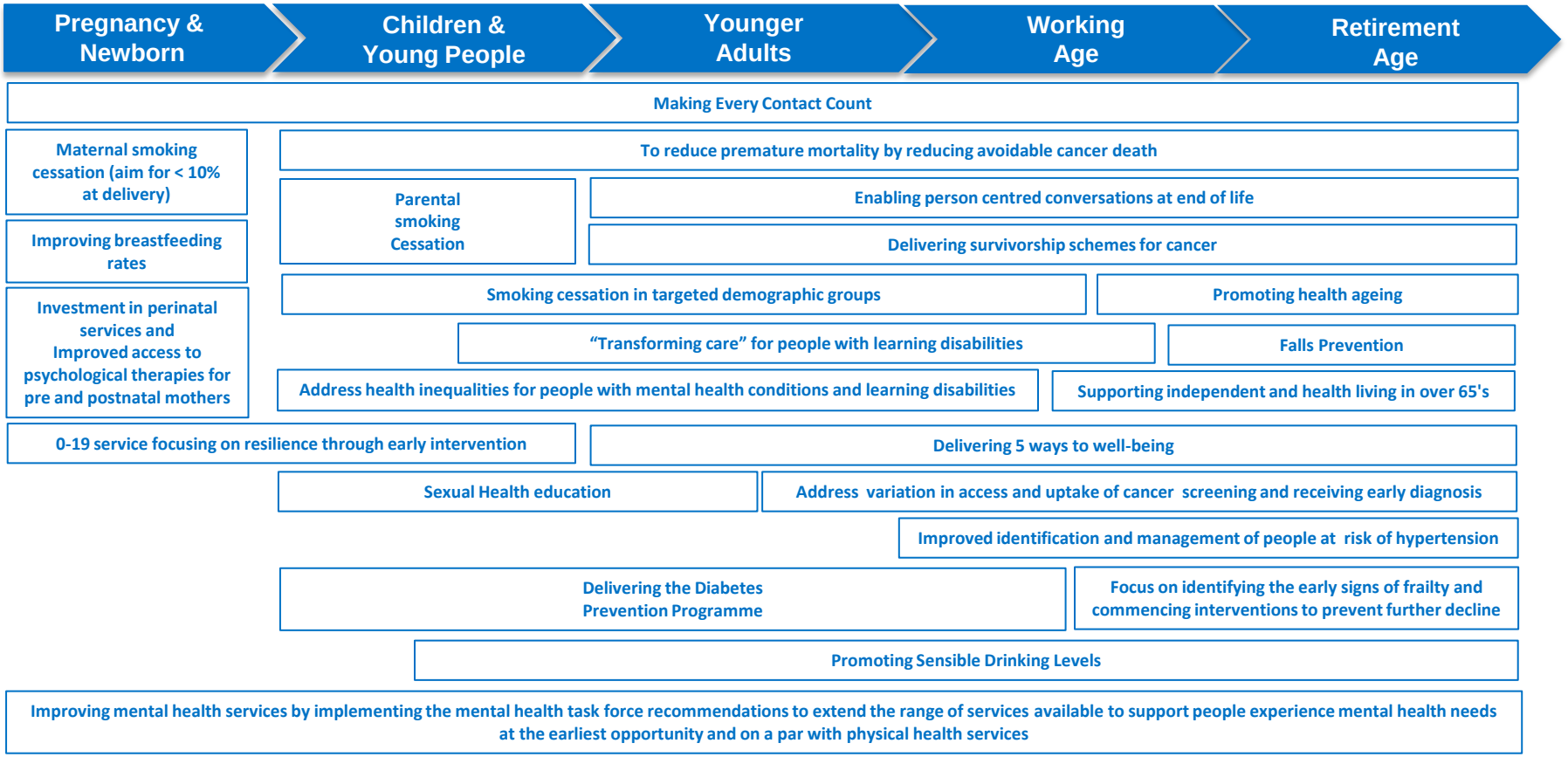
**In the medium term:**

- Increased choice and control through increased uptake of personal budgets
- Reduced referrals to specialist services
- Reduced out of county placements
- Reduced numbers of looked after children
- Improved educational achievement for vulnerable children and young people including those with SEND
- Reduced NEET and increased young people in education/training
- Improved wellbeing for children, young people and families

# Priority 2 – Our approach to prevention and self care

***Reshape our approach to prevention, to create an environment where people stay healthy and which supports resilient communities, where self-care is the norm, digitally enabled where possible, and staff include prevention in all that they do.***

**Driving prevention through everything we do;** The following diagram demonstrates how we are ensuring that a focus on prevention is inherent across our STP for all age groups and all work streams, delivering an improvement in health and well-being.



# Priority 2 – Our approach to prevention and self care

| Programme 2b | SELF CARE | Owner | Simon Hairsnape, Accountable Officer, HCCG |
|---|---|---|---|

**Overall aim**

To support people to manage their own health, linking them with social support systems in their communities and identifying when a non-clinical intervention will produce the best experience and outcomes for patients. This approach should be led by communities with Health, Social Care and the Voluntary Sector working together to support.

## What will be different between now and 2020/21

Building on the success of existing self care initiatives, self-care and care planning will continue to be regarded as a high priority area working in tandem with the prevention agenda. Greater benefits will be realised for local people and staff as the following key interventions are expanded and further innovation applied:

- More individuals will utilise the **range of solutions** available to manage their condition including information, peer support, informal and formal education, digital approaches (eg Map My Diabetes, Patient Management Programme).
- Care planning and self-management will be hardwired into how care is delivered. Care plans will be **digital and shared** between care settings, owned by and useful for patients, their families and carers (eg iCompass).
- People already at high risk of ill health will be identified and offered **behaviour change support** (eg Pre diabetes project, Living Well service).
- **Social prescribing schemes** will be systematic, connecting individuals to non-medical and community support services [eg care navigators based in primary care to signpost and link people to local support, Time to Talk).
- Extension of the roll out of national screening tools used to assess an individuals **motivation** to self-care- thus tailoring the needs of the intervention [eg Patient Activation Measure].
- Early **prevention** will be embedded within each service that the person comes in contact with thus proactively supporting self-care programmes, reducing social isolation and improving social integration [e.g. Health Checks, Falls prevention, Strength and Balance classes, Reconnections] tailoring and focussing services on those who have the greatest need.
- Organisations such as the **Fire Service, Housing Agencies** will be working alongside Health and care to deliver the prevention and self care agenda [eg Home Safety Checks].

## How will this be better for residents and patients in Herefordshire and Worcestershire

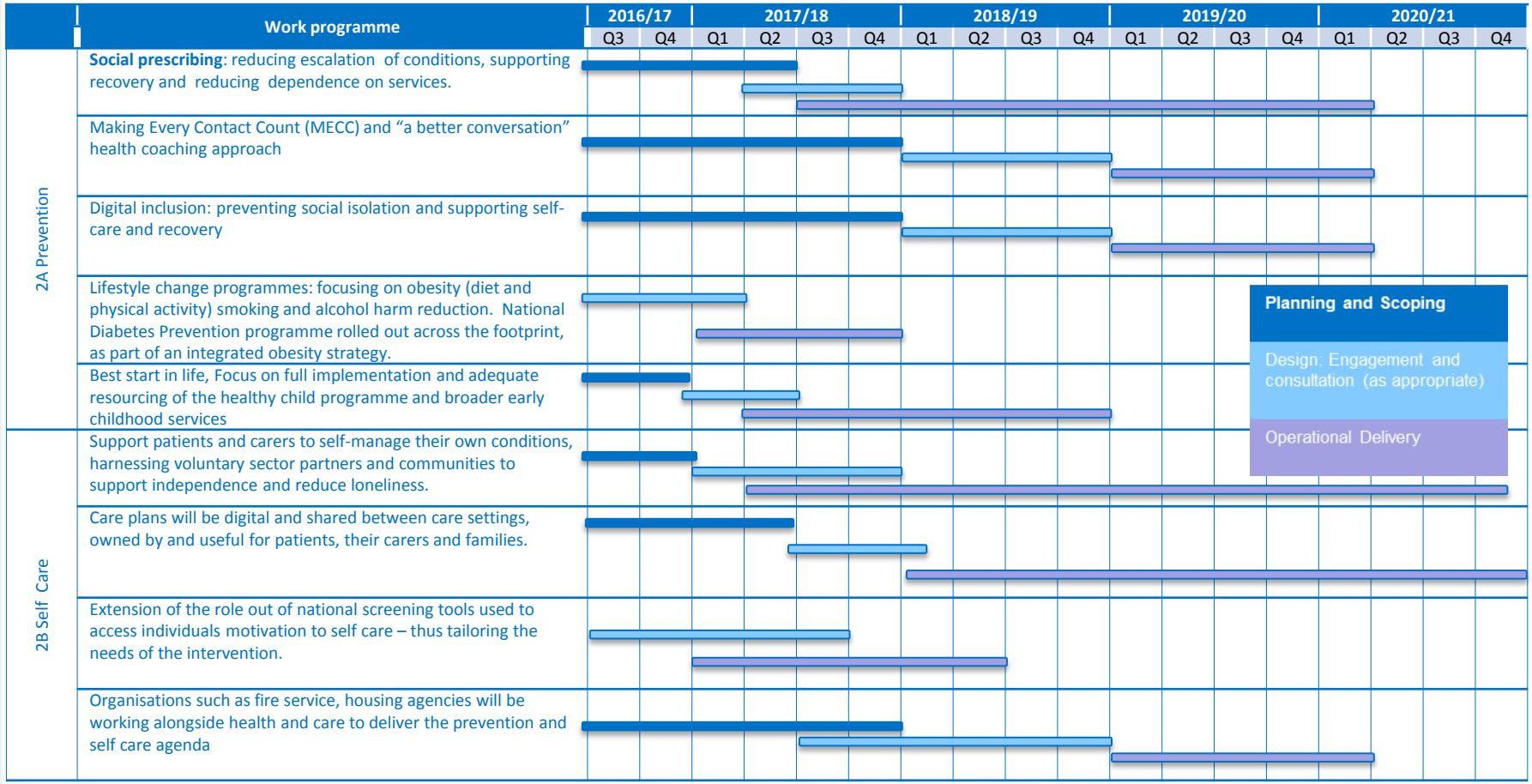
Individuals will be increasingly independent, self-sufficient and resourceful to confidently manage their needs, thus reducing dependency on the health and social care system and improve their wellbeing and lifestyle. Ultimately individuals will:

- Increase their sense of control in their lives
- Feel confident to assess and address their health and well-being needs
- Better symptom management, including a reduction in pain, anxiety, depression and tiredness, reduced stress
- Experience improved health and quality of life
- Are able to accept living with their health condition
- Are able to problem solve, make changes and manage their thinking, moods and behaviours positively
- Live as active participants in their communities
- Reduce their use of key services, with fewer primary care consultations, reduction in visits to out-patents and A&E, and decrease in use of hospital resources.
- Increase their healthy life expectancy

Every contact with a patient in primary, community and secondary care will be used as an opportunity to improve patients knowledge of involvement in their care on an individual basis.

# Delivery Plan – Priority 2: Our approach to prevention and self care

| | | | |
|---|---|---|---|
| **Prevention SRO** | **Simon Hairsnape**<br>Accountable Officer – Herefordshire CCG | **Programme Leads** | **Frances Howie** – Director of Public Health, Worcestershire<br>**Rod Thomson** –Director of Public Health, Herefordshire |
| **Self Care SRO** | **Simon Hairsnape**<br>Accountable Officer – Herefordshire CCG | **Programme Lead** | **Menna Wyn Wright** - Transformation Programme Lead - Worcestershire CCGs |



# Priority 3 – Developing out of hospital care

| | | | |
|---|---|---|---|
| **Programme 3a** | **DEVELOPING SUSTAINABLE PRIMARY CARE** | **Owner** | Graeme Cleland, Managing Director Taurus |
| **Overall aim** | Developing capacity and capability in Primary Care to deliver resilience and sustainability, and seamless working with community and acute services | | |

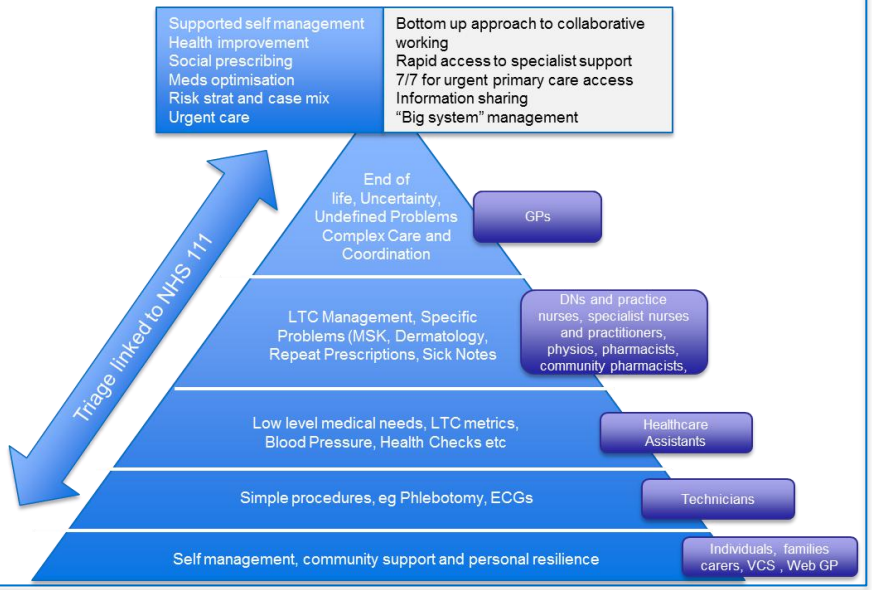
***There are a number of fundamental challenges that need to be resolved to support primary care sustainability. Amongst the most significant of these are clinical indemnity, information governance and property liability. Successful delivery of the STP will be dependent on these issues being resolved in a way that enables full engagement of general practice in the new ways of working.***

**Implementing the GP forward view -** Our system has long benefitted from strong primary care which has enabled us to adapt to change. We have a range of federations, including one of the most well developed federations in the country in Taurus. In Herefordshire there are already 7 day services delivered to the population and this is replicated in parts of Worcestershire. However the ability of primary care to continue to meet the changing needs of our population is at risk. Our approach will include investment from the transformation fund to ensure primary care remains sustainable and at the heart of delivery.

Our out of hospital care models will be based around the GP lists for local populations and this will support a shift of resource to enable out of hospital care to be a reality.

The models will recognise the differing needs across the "continuity of care spectrum" from those patients who absolutely need continuity of care to manage their conditions effectively and efficiently, to those with an episodic need where quick and convenient access is the priority. We will work with localities and practices to identify the "care functions" needed to provide holistic care across the spectrum.

The models will build on what is already working well and will embed social prescribing, health improvement and self-management, utilising digital solutions where possible to provide these at scale and support demand management in primary care. The model will seek to extend 7 day access to high quality primary and community care where needed. It will also deliver proactive anticipatory care, through risk stratification, case finding, case management and an MDT approach. The models are predicated on the sharing of resources and specialist primary care expertise across practices. We will work with localities and groups of practices to develop and implement these using a "bottom up" approach to identify what they will deliver (and be accountable for) at practice level, at locality level or at county level and beyond.



# Priority 3 – Developing out of hospital care

| | | | |
|---|---|---|---|
| **Programme 3a** | **DEVELOPING SUSTAINABLE PRIMARY CARE** | **Owner** | Graeme Cleland, Managing Director Taurus |
| **Overall aim** | Developing capacity and capability in Primary Care to deliver resilience and sustainability, and seamless working with community and acute services | | |

***90% of all NHS contacts happen in primary care and it is widely accepted that if primary care fails then the whole health and social care system would be at risk. Therefore developing capacity and resilience in primary care, and particularly in general practice, is a priority for our STP. Resilient primary care with sufficient capacity and capability is also critical to our ability to improve health outcomes and to manage people closer to their own home/in community settings. It is a core building block to the development of our new model of care strategy***

**What will be different between now and 2020/21**

- We will deliver this through local primary care working "at scale", developed through a "bottom-up" approach with practices working in partnership with community pharmacy, third sector and public sector services as well as community and mental health services.
- We will implement the "10 high impact areas for General Practice" within and across practices. This will include:
  - Embedding prevention and health improvement to "Make Every Contact Count"
  - Embedding social prescribing, to connect patients and their carers with community support
  - Training and educating our staff to be able to support self care by patients and carers
  - Utilising digital solutions to enable social prescribing and self-management, as well as new consultation types such as skype consultations and these at scale
- We will encourage all staff to recognise when the end of life is approaching and to have frank and honest conversations with patients and their loved ones and carers. This will lead to development of shared expectations and clear guidance with a view to helping patients take control.
- Through "big system management" we will use real time data collection and analysis to support continuous quality improvement and demand management
- Through primary care at scale we will redesign the primary care workforce to support comprehensive skills and capacity across primary care. Through alliance contracts such as the One Herefordshire Alliance we will deliver this in partnership with acute providers through a delivery model that:
  - Enables seamless working across health/mental health community teams, social care and acute services to provide seamless out of hospital care
  - Enables sharing of resources (clinicians and managers) across organisational boundaries
  - Supports professional accountability, clinical governance, line management, education and development across organisational boundaries

# Priority 3 – Developing out of hospital care

| | | | |
|---|---|---|---|
| **Programme 3a** | **DEVELOPING SUSTAINABLE PRIMARY CARE** | **Owner** | Graeme Cleland, Managing Director Taurus |
| **Overall aim** | Developing capacity and capability in Primary Care to deliver resilience and sustainability, and seamless working with community and acute services | | |

## What will be different between now and 2020/21

- With increased capacity within primary care we will adopt new ways of working:
  - Moving to a proactive model of care, identifying and case managing through an MDT approach those at risk of ill-health and/or emergency admission
  - Adopting early clinical assessment within a robust process to direct patients to the most appropriate clinician to achieve "right patient, right place, right time". This would ensure continuity of care for those with complex needs as opposed to those requiring same day episodic access).
- We will build upon the success of our "Prime Ministers Access Fund" pilots to provide 7 day primary care services, including 7 day access to Urgent Care.
- There will be a statute and regulatory compliant data-sharing model initially developed and delivered across Primary Care that will manage the risk of data breach. This will learn from existing service leading models and will need to be formally approved by the regulatory bodies and legal advisors. This will go on to form the foundation of the "Big Data" workstream ultimately sharing appropriate live data, throughout the Health and Social Care organisations in real time based on the point of individual need and express consent.

## How will this be better for residents and patients in Herefordshire and Worcestershire

- Improved access to primary care – for example in Herefordshire in 2016/17 an additional 24,106 appointments by the end of 2016/17 through the Prime Minsters Access Fund.
- Confidence that primary care can support their healthcare needs in a timely manner.
- Capacity and capability within primary care to meet their needs.
- Improved experience, and outcomes through support to prevent ill-health and self manage their own conditions.
- Continuity of care provided through consistent access to patient information.
- High quality care at every consultation, with reduced variation within and across practices.
- Resilient primary care, with the capacity to undertake proactive anticipatory care to prevent people becoming unwell.
- Continuity of care for those with complex needs
- Improved access to specialist opinion in primary care settings
- Patients consistently able to access the most appropriate help and support over 7 days, for both elective, urgent care needs and end of life care.

# Priority 3 – Developing out of hospital care

| Programme 3b | INTEGRATED PRIMARY & COMMUNITY SERVICES | Owner | Sarah Dugan, Chief Executive, Worcs Health and Care NHS Trust |
|---|---|---|---|
| Overall aim | To transform the way care is provided, proactively supporting people to live independently at home and providing responsive, compassionate and personalised care, delivered by an integrated health & social care workforce. | | |

**What will be different between now and 2020/21**

Care will be developed and enhanced through the implementation of new models of care . It is recognised that no one model will work for the range of communities that we serve across Herefordshire and Worcestershire. The following approach has been agreed by primary and community care leaders;

*Localities representing General Practice across the STP have come together and agreed to develop a new model of care based on the principles of the emerging MCP vanguards. The local arrangements will be built around natural localities that either already exist or which are rapidly coming together. These localities will range in size from around 35k to potentially more than 150k population. There is widespread agreement about the scope and focus of these localities in bringing together primary, community, mental health and social care services as well as some aspects of acute services that could be more effectively delivered from a community base. There is agreement that there will need to be some form of infrastructure organisation to enable these localities to operate at the required scale to enable integration with county wide partners, to manage risk as well as to provide economies of scale around back office functions. It is agreed that the localities will have a central role in setting local strategy and priorities, but there is widespread recognition that planning and service delivery will need to be layered – with some consistent county or STP wide pathways operating alongside some very local pathways built around smaller groups of practices. Further work is planned to agree how do develop these arrangements into a suitable contracting mechanism and to understand the impact on organisational forms.*

# Priority 3 – Developing out of hospital care

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|---|---|---|---|
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**What will be different between now and 2020/21**

- By April 2019 we anticipate having integrated primary and community services commissioned through an overarching Multi-specialty Community Provider (MCP) or similar alliance framework that supports the efficient functioning of locality based integrated teams.
- During 2017/18 and 2018/19 ideas will be tested and piloted before embarking on a formal commissioning process with a longer term outcomes based contract from April 2018.
- Our workforce will promote the wellbeing at every opportunity to reduce the impact of long term conditions. There will be a core focus on priorities such as immunisation programmes and falls prevention.
- Traditional organisational and professional boundaries will be removed, and a place-based model of care will be in place.
- The focus of the system will shift to an “own bed is best” model of care, using a proactive approach, optimising opportunities for independence to be maintained and reducing reliance on bed based care
- Care will be delivered by an integrated workforce, spanning primary, community, secondary and social care, organised around natural neighbourhoods
- Local hubs will be established as part of a coherent and effective local network of urgent care, managing urgent primary care demand across neighbourhoods – this includes a number of General Practices working collaboratively at scale, releasing GP capacity to care for patients with more complex needs
- Specialist support will be available nearer to patients, reducing the time taken to access specialist input and reducing steps in the pathway.
- Robust information about patients, carers and their circumstances will be available digitally to all professionals involved in delivering care
- Personalisation of care will be prioritised , supporting self management and improvements in population health, working proactively with wider place based partners around the determinants of health (e.g. housing, leisure , education, employment, community engagement)
- An integrated frailty pathway will be in place which ensures people living with frailty are at the centre of services, enabling them to live well with their condition, age well and supporting them to live well until the end of life. There will be a shift in focus on to what a person can do rather than what they can’t do.
- Individual care and support plans will include carer support and encompass emotional as well as physical needs.

# Priority 3 – Developing out of hospital care

| Programme 3b | INTEGRATED PRIMARY & COMMUNITY SERVICES | Owner | Sarah Dugan, Chief Executive, Worcs Health and Care NHS Trust |
|---|---|---|---|
| Overall aim | To transform the way care is provided, proactively supporting people to live independently at home and providing responsive, compassionate and personalised care, delivered by an integrated health & social care workforce. | | |

**How will this be better for residents and patients in Herefordshire and Worcestershire**

- Patients and their carers will be fully involved in the assessment of their needs, and integrated community teams will enable and support them to meet these needs whether they are health or social needs.
- Care plans will be person centred, and reflect specific needs and wishes. The plans should ensure that systems are in place to get help at an early stage to avoid a crisis.
- There will be continuity of care and support, patients will be able to build relationships with staff over time. Care will be delivered in an efficient and timely manner – things happen when they are supposed to and patients will know what to expect, and when.
- With patients permission, information from assessment and care planning is entered on to a digital record, and is shared with everyone involved including the patient. The professionals involved in care talk to each other and work as one team. Everyone has timely digital access to any updated assessments or changes to the care plans.
- Consistent information, is provided to patients and their carers at the right time, and in a format that is easily understood. Patients will have a consistent point of contact if they wish to discuss any concerns.
- Patients will be supported to be independent – our workforce are trained in coaching to enable patients to become more active in managing their own health, wellbeing and care. Staff have time to allow patients to continue to do what they can, make good choices and offer practical support where necessary rather than intervening because its is quicker. Clinicians work in partnership with patients to encourage lifestyle change, support self-management, increase medication compliance and aid complex decision making. This will be measured through Patient Activation Measures (PAMs)
- Patients are empowered to self manage their long term conditions using technology to achieve goals and outcomes that are important to them
- Patients at the end of life will be supported to have conversations about their choices, outcomes of the conversations will be shared and patients will be able to receive their care at home as long as it is safe to do so
- Patients will have one first point of contact in a crises. It will be clear to the patients who to contact day and night and care will be seamless.
- Teams involved in care will have a comprehensive understanding of the range of formal and informal support available, so that they can offer alternative support where appropriate including from voluntary and 3rd sector agencies who will be part of the community teams.
- Carer's needs are considered – the needs and preferences of my family and other informal carers are taken into account, and they are able to access support to continue to care for as long as they wish.
- Where an admission to hospital is necessary, community teams familiar to the patient will in-reach and manage the discharge into the community and provide holistic support tailored to their needs.

# Priority 3 – Developing out of hospital care

| Programme 3c | THE ROLE OF COMMUNITY HOSPITALS | Owner | Simon Hairsnape, Accountable Officer, HCCG |
|---|---|---|---|
| Overall aim | To develop community hospitals as local delivery facilities for an increased range of activity including outpatients, day case and support services and also to develop the potential of some sites becoming specialist centres for frailty, stroke care etc | | |

## What will be different between now and 2020/21

- We will engage with patients, the public, local clinicians and other stakeholders to understand how we can make better use of our community bedded resources to support care closer to home in line with the principle "own bed is best", in line with what the public has told us. A range of activities could be provided from these facilities such as outpatient services and/or elective surgical procedures to support improved local access. Some sites might therefore become specialist centres or be points for new pathways of care (e.g. frailty assessment and specialist stroke rehabilitation).
- Some community hospitals may be able to operate as bedless, e.g. as a "locality hub" for domiciliary based community services integrated with primary care. This may include the co-location and integrated delivery of community teams with primary care based services and/or 24/7 primary care, as part of delivering the functions of an MCP across the STP footprint
- Some community hospitals may be able to operate with a defined role in the system of care, as part of an integrated care pathway and some may need to reduce the number of beds as services are provided in new ways such as domiciliary based care.

## How will this be better for residents and patients in Herefordshire and Worcestershire

Our ambition is that any of the benefits of a new role for community hospitals are consistent with those for community services. In addition, our ambition is that:

- The model of care will move from a reliance on bed based care to care in peoples own homes/their usual place of residence, reducing crisis admissions, onward deterioration and poor outcomes at the point of discharge.
- More planned care will be available closer to home (outpatients and day care for example) reducing the need to travel for regular appointments.
- People will experience more of a "one stop shop" in their Locality Hub as their locality teams (including community, primary and social care staff) will all be co-located.
- People who are frail will experience a wrap around response designed to treat and stabilise so people do not have to go into an acute hospital.

***This work will be undertaken based on the principle of co-production with patients, the public and wider stakeholders to ensure we meet the needs of local populations. We will also work with local clinicians to ensure services are integrated and work seamlessly across 7 days.***

# Priority 3 – Developing out of hospital care

## Improving integration between health and social care

In order to transform our services it is essential that we find more effective ways of organising services to respond to the increasingly complex and chronic health and social care needs of our population. This is to reduce duplication as well as to deliver improved outcomes for people and their carers. The evidence indicates that integration results in improved clinical outcomes and a better patient experience (Ref: Stepping up to the Place, NHS Confed and ADASS, 2016). This is supported by our engagement with local people who live with long term conditions and/or multiple needs, which highlights that people want more joined up care. In particular they tell us that the divide between health and social care often impacts on the effectiveness and the efficacy of the support they receive.

Building on our existing joint work across health and social care we are committed to working towards services that work in a more integrated way; wrapping the necessary skills and competencies around people and their carers to enable them to live as independently at home for as long as possible. We believe that redesigning services around the needs of individuals in a locality / place presents the best opportunity to improve health and well-being and reduce health inequalities whilst also helping to bring about financial sustainability.

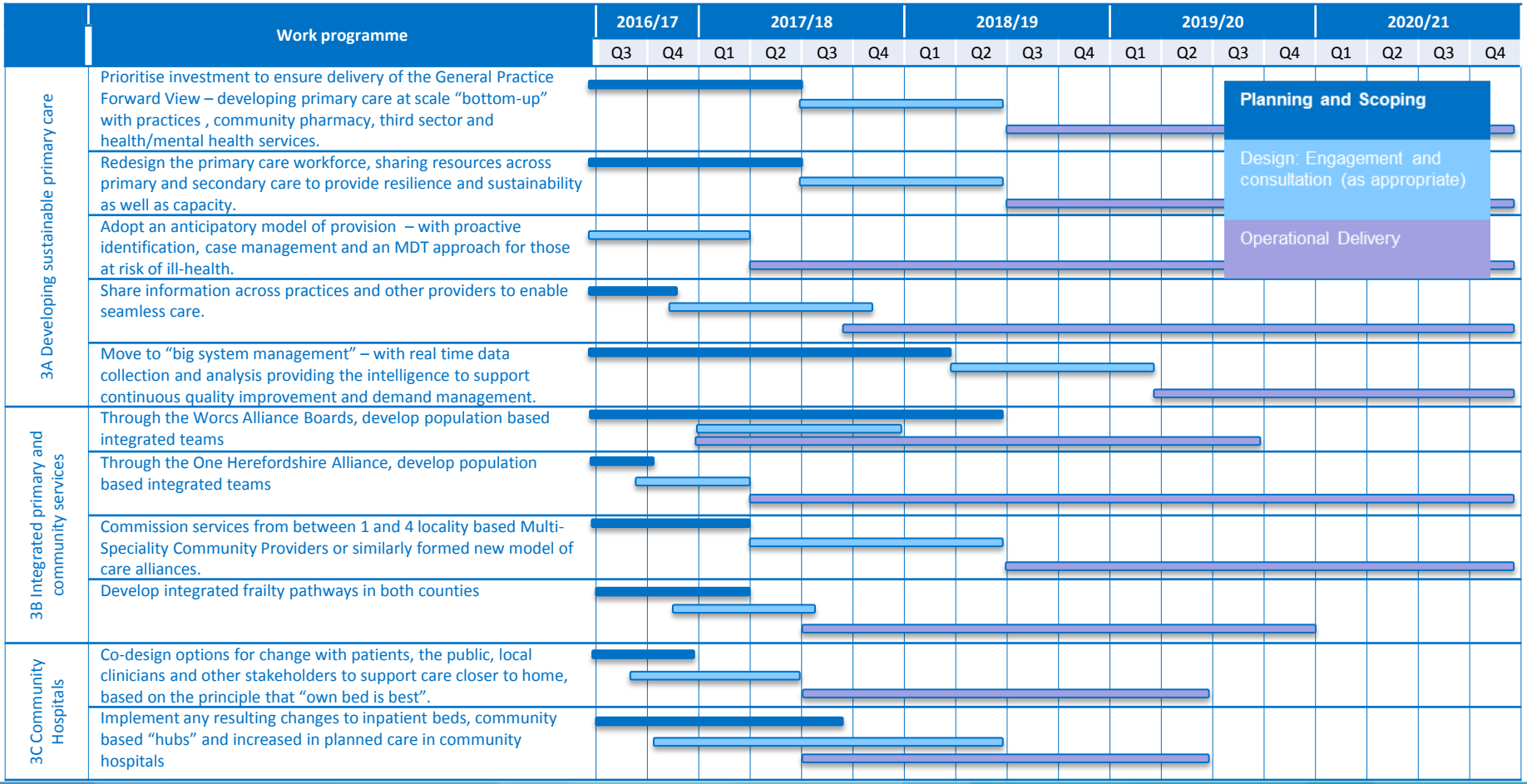
The ambition is to liberate front line delivery; enabling our local workforce to come together effectively as multidisciplinary teams, who share skills, expertise and information. In doing so we will maximise the opportunity for an individual to have the right care first time as well as reducing duplication through a common approach.

To deliver this we will:

- Improve early and consistent provision of advice and information to individuals, their carers and families, to enable proactive decision making that supports and enables independence and self care
- Offer more choice and control for individuals and their carers, including the wider adoption of Direct Payments/Integrated Personalised Budgets as appropriate
- Embed personalised care planning, in partnership with individuals and their carers, as the central tenet to our ways of working. We will ask' "what matters to you", as well as "what's the matter with you."
- Ensure joined up working across disciplines through the MDT approach, supported by shared information
- Develop a multi skilled workforce that can work across organisational and professional boundaries, whilst identifying tasks which can be shared across professional domains to reduce duplication and improve efficiency
- Work with local communities and the voluntary/community sector, to understand where and how partnership working can support individuals and carers to manage their own health and care needs
- Successful delivery will require us to nurture leadership across our workforces, to drive change in both culture and ways of working across personal and professional boundaries.

# Delivery Plan – Priority 3: Developing out of hospital care

| | | | |
|---|---|---|---|
| **Primary Care SRO** | **Graeme Cleland** Managing Director - Taurus Healthcare | **Programme Lead** | **Yvonne Clowsley** - Programme Manager Taurus Healthcare |
| **Integrated Care SRO** | **Sarah Dugan** CEO Worcs Health and Care NHS Trust | **Programme Leads** | **Sue Harris –** Director strategy Worcestershire Health and Care Trust<br>**Matt Stringer –** Strategic lead new models of care WHCT<br>**Alison Talbot-Smith –** Director of Transformation for One H<br>**Nisha Sankey –** Associate Director of Transformation WCCGs |
| **Community Hospitals SRO** | **Simon Hairsnape –** Accountable Officer – Herefordshire HCCG | | |



# Priority 4 – Establish clinically and financially sustainable services

| Programme 4a | IMPROVING MENTAL HEALTH & LEARNING DISABILITY CARE | Owner | Shaun Clee, Chief Executive, 2gether NHS FT |
|---|---|---|---|

| Overall aim | To achieve the ambition of parity of esteem between mental and physical health for children, young people, adults and older people; working together to tackle inequalities as well as to ensure access to good quality mental health care, a decent place to live, a job and good quality relationships between individuals and their local communities. |
|---|---|

## Context

Services in Herefordshire and Worcestershire need to develop to progress the National "Must Do's" set out in the NHS five-year forward view for mental health services (FYFVMH) published by the Mental Health Taskforce. The FYFVMH identifies a five-year programme of developments underpinning the transformation of mental health care and support, aligned to continuously improving the quality of care and support available to people with mental health needs.

We know that nationally :

- Many people with mental health problems are also affected adversely by Social Determinants e.g. Poverty, Social Isolation, Discrimination, Abuse, Neglect, Drug and Alcohol Dependencies, etc, which contribute to poor health outcomes
- A number of medications used to treat physical health care needs can have side-effects that produce psychiatric symptoms
- The side-effects of a number of medications used to treat mental health care needs can have detrimental effects on physical health such as Obesity, Diabetes, Cardiovascular, Nervous and Immune systems
- There are higher rates of unhealthy behaviours amongst people with mental health needs i.e. smoking and use of alcohol or other substances
- People with mental health needs are often less able to motivate themselves and less effective at seeking help
- There are barriers to accessing physical health care support relating to Stigma, Prejudice and Discrimination

PHE data suggests that well being outcomes generally are at average levels but IAPT spend and mental health prescribing in primary care is of concern across our footprint.

# Priority 4 – Establish clinically and financially sustainable services

| Programme 4a | IMPROVING MENTAL HEALTH & LEARNING DISABILITY CARE | Owner | Shaun Clee, Chief Executive, 2gether NHS FT |
|---|---|---|---|

| Overall aim | To achieve the ambition of parity of esteem between mental and physical health for children, young people, adults and older people; working together to tackle inequalities as well as to ensure access to good quality mental health care, a decent place to live, a job and good quality relationships between individuals and their local communities. |
|---|---|

**What will be different between now and 2020/21**

The requirements of the National Mental Health Policy "No Health Without Mental Health" and the requirements of the National Mental Health Five Year Forward Vision will be implemented across our footprint . Within this we will work on the following priorities:

- A specific focus on Perinatal care as it delivers immediate benefits and evidence-based Mental ill-Health prevention
- Increased access to psychological therapies for a range of common mental health disorders and the management of 'Medically unexplained symptoms' to reduce demand within acute and primary care.
- Strengthened management of people with dementia in acute urgent care systems and primary care at scale
- Increased visibility, awareness and acceptability of mental health through a high profile Mental Health Cabinet focused on delivering integration rather than isolation
- Collaboration to deliver a range of care more locally at an STP/STP Plus level i.e. Improved access to CAMHs Tier 3.5 to reduce demand for Tier 4 CAMHS, Locked Rehabilitation, Complex Dementia services, eating disorder and personality disorder services
- Moving mental health care from Good to Outstanding with immediate priorities for delivery focused on talking therapies (IAPT) and Early Intervention Services (EIS)
- We will conduct coordinated work on reducing stigma through campaigns and communications

So that:

- Access to mental health and learning disability services will be clear and timely at a practice, cluster, county, STP and cross STP level, ensuring the delivery of evidence based, sustainable and regulatory compliant provision.
- The services in place will be responding to the health and wellbeing gaps and health inequalities identified within the Herefordshire and Worcestershire JSNA's and resultant Health and Wellbeing Strategies.
- Transforming care - bringing people with LD and Autism back to their own communities from out of area placements and preventing admission to hospital, achieving safe discharge and robust community support.
- People who require more tertiary care/specialist support will have their care planned for and provided across the STP and in partnership with neighbouring STPs via managed clinical networks.
- There is reduced expenditure in other programme areas, such as urgent care and complex care (ie CHC and social care packages) from the increased investment in mental health and learning disability services.

# Priority 4 – Establish clinically and financially sustainable services

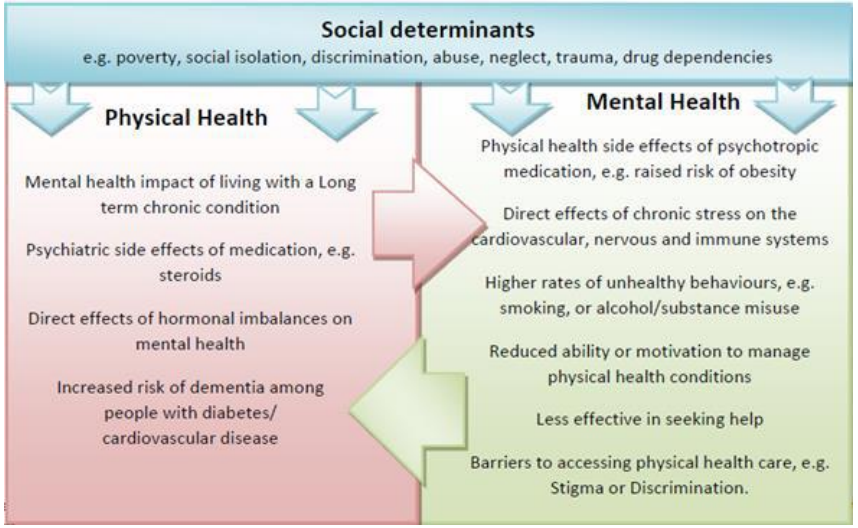
| Programme 4b | IMPROVING MENTAL HEALTH & LEARNING DISABILITY CARE | Owner | Shaun Clee, Chief Executive, 2gether NHS FT |
|---|---|---|---|

| Overall aim | To achieve the ambition of parity of esteem between mental and physical health for children, young people, adults and older people; working together to tackle inequalities as well as to ensure access to good quality mental health care, a decent place to live, a job and good quality relationships between individuals and their local communities. |
|---|---|

**How will this be better for residents and patients in Herefordshire and Worcestershire**

- Citizens will have better access to information that promotes and supports positive mental wellbeing – social prescribing, MECC, digital inclusion and lifestyle change programmes – can all impact in the short to medium term. Longer term , tackling social deprivation through economic regeneration and the creation of healthy jobs has a significant role in improving population mental health and well being.
- The population's attitudes to individuals experiencing both common and more complex mental health difficulties will be better informed, more supportive and less stigmatised. This in turn will support earlier access to wellbeing services, diagnostics, treatment and better support and opportunities for recovery.
- Individuals who experience physical and mental health co-morbidities will experience well coordinated, education based packages of care that promote and enable self care and minimise the complications associated with comorbidities.
- Fewer people will need to access specialist services outside of the STP footprint.
- Improved rates of access to or sustained education, training and or employment consistent with local rates of whole population attainment.
- Improved access to and sustained stable accommodation consistent with local rates of whole population attainment.

**Relationships between Social Determinants, Physical health and Mental health Adapted from "No health without mental health" by Prince et al in 2007**



# Delivery Plan – Priority 4:Establish clinically and financially sustainable services

| | | | |
|---|---|---|---|
| **Mental Health & Learning Disabilities SRO** | **Shaun Clee** - Chief Executive 2gether NHS Foundation Trust | **Programme Lead MH**<br>**Programme Lead LD** | **Colin Merker** – Director of Service delivery 2gether NHS Foundation Trust<br>**Liz Staples** – Deputy director of nursing Worcestershire Health and Care NHS Trust |

4a Improving mental health and learning disability care

| Work programme | 2016/17 | | 2017/18 | | | | 2018/19 | | | | 2019/20 | | | | 2020/21 | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 |
| Increasing visibility, awareness and acceptability of mental health through a high profile Mental Health Cabinet | | | | | | | | | | | | | | | | | | |
| Collaboration to deliver a range of care more locally at an STP/STP Plus Level | | | | | | | | | | | | | | | | | | |
| Increasing access and availability of psychological therapy to 25% | | | | | | | | | | | | | | | | | | |
| Develop early intervention services in line with national proposals | | | | | | | | | | | | | | | | | | |
| Development of CAMHs community eating disorder services | | | | | | | | | | | | | | | | | | |
| Development of perinatal mental health services | | | | | | | | | | | | | | | | | | |
| Development of crisis care and 24/7 mental health urgent care services. | | | | | | | | | | | | | | | | | | |
| Development of dementia services – with a focus on early intervention, strengthened VCS links and interface with frailty pathway | | | | | | | | | | | | | | | | | | |
| Development of CAMHS emergency, urgent and routine pathways | | | | | | | | | | | | | | | | | | |
| Development of acute mental health care – reduce the need for admissions out of area and the number of re-admissions | | | | | | | | | | | | | | | | | | |
| Development of integrated mental health and physical health care pathways in line with MCP developments | | | | | | | | | | | | | | | | | | |
| Development of personality disorder services | | | | | | | | | | | | | | | | | | |
| Development of adult ADHD pathways subject to investment profile | | | | | | | | | | | | | | | | | | |
| Development of adult autistic spectrum disorder and neurodevelopment pathways subject to investment profile | | | | | | | | | | | | | | | | | | |
| With local authorities, develop joint outcomes and shared care for people with learning disabilities | | | | | | | | | | | | | | | | | | |
| "Transforming care" for people with learning disabilities – to reduce the number of people accessing services out of area | | | | | | | | | | | | | | | | | | |
| Improving rates of access to or sustained education, training and or employment - for people with learning disabilities - reducing health inequalities | | | | | | | | | | | | | | | | | | |

**Planning and Scoping**

Design: Engagement and consultation (as appropriate)

Operational Delivery

# Priority 4 – Establish clinically and financially sustainable services

| Programme 4b | IMPROVING URGENT CARE | Owner | Richard Beeken, Chief Executive, Wye Valley NHS Trust |
|---|---|---|---|
| Overall aim | Improve urgent care pathways and out of hospital care models to improve access performance and create better outcomes, resulting in a requirement for fewer beds, reduced staffing and estate requirements. | | |

## Introduction

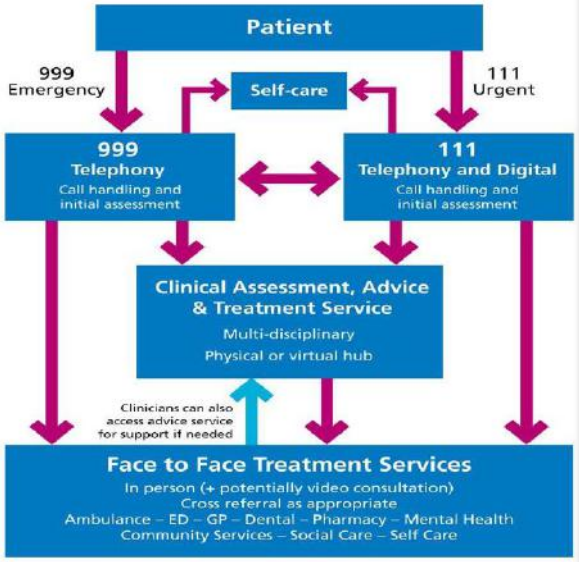
There are a number of key challenges that need to be tackled over the life of the STP, the most pressing challenge across both counties is to address the poor performance in terms of meeting the four hour emergency access standard. We will need to develop more effective streaming of patients to the most appropriate urgent care point and to continue to improve lean patient flow through the system. There are many important aspects to our strategy for achieving this, namely (1) Integrated Urgent Care , (2) Rationalisation of physical access points and (3) Development of seven day services

**Integrated Urgent Care** - Urgent Care systems across both counties already provide 24/7 access for patients that need it. There are three 24/7 Accident and Emergency Departments, two 24/7 Minor Injury Units, 24/7 support and referral mechanisms through NHS111 and of course, accessible ambulance services through 999. In addition to this, although not operational 24/7, there are GPs working with some emergency departments 8 hours a day on weekdays and 12 hours a day on weekends and GPs working with the ambulance service 12 hours a day on weekends and bank holidays. All of these services combine to provide a comprehensive urgent care offering. However, we recognise that we can do more to integrate services more effectively.

CCGs in both counties have recently participated in the regional commissioning of a new Integrated Urgent Care model and will shortly be launching the innovative new service. This new model will provide a single point of access and clear onward referral arrangements to improve patient experience and alleviate pressures across the health and social care systems. The model will include earlier clinical assessment and advice through the introduction of a clinical hub and will support closer working with the wider range of existing urgent care providers.

Within Worcestershire Care UK was selected to deliver both the NHS111 and the Out of Hours service, ensuring that the opportunities for integration are maximised. Within Herefordshire, whilst different providers were selected for the two services, both are required to operate to a service specification that is built around effective integration between the two services.

**The New Integrated Urgent Care Model From November 2016 onwards**



# Priority 4 – Establish clinically and financially sustainable services

| Programme 4b | IMPROVING URGENT CARE | Owner | Richard Beeken, Chief Executive, Wye Valley NHS Trust |
|---|---|---|---|

| Overall aim | Improve urgent care pathways and out of hospital care models to improve access performance and create better outcomes, resulting in a requirement for fewer beds, reduced staffing and estate requirements. |
|---|---|

**Access to Urgent Care** –
Alongside the new integrated urgent care model, we need to review physical access to urgent care services and the provision of specialist facilities – including the number of hospital beds required to support the demand. Changes to physical access is required because the system simply contains too many options, too much duplication; is too confusing for patients and the population and professionals to navigate effectively:

## The complex array of ways to access urgent and emergency care across Herefordshire and Worcestershire

| Current Provision | Herefordshire | Worcestershire |
|---|---|---|
| Telephone access | **NHS 111 and 999** | **NHS 111 and 999** |
| Main A&E departments | **Hereford** | **Worcester and Redditch** |
| Minor Injury Units | **Ledbury**<br>(7 days / 24 hours a day)<br>**Kington**<br>(7 days - *8am to 8pm)*<br>**Leominster and Ross on Wye**<br>(5 days, 8:30 to 5:30) | **Kidderminster**<br>(7 days / 24 hours a day)<br>**Evesham, Malvern and Tenbury**<br>(7 days, *9am to 9pm)*<br>**Bromsgrove**<br>(*Mon-Fri – 8am to 8pm, Weekends – 12pm to 8pm)* |
| Walk In Centres | **Hereford**<br>(*7 days a week – 8am to 8pm)* | **None**<br>(*Worcester's was closed in 2014)* |
| GP Out of hours hubs (dial NHS 111) | **Hereford, Leominster and Ross on Wye**<br>*Weekdays - 6:30pm to 8:00am,*<br>*Weekends – 24 hours a day* | **Evesham, Malvern, Kidderminster, Redditch, Worcester**<br>*Weekdays - 6:30pm to 8:00am,*<br>*Weekends – 24 hours a day* |
| Prime Minister's Access Fund | **Primary Care Access Hubs in**<br>**Across Hereford, Leominster and Ross on Wye**<br>*Mon-Fri 6.30pm to 8pm, Weekends 8am to 8pm* | **Clinical Contact Centre (Telephone and face to face)**<br>*Mon-Fri 8am to 8pm, Weekends 8am to 12 noon*<br>**Patient Flow Centre** |
| GP Practices | **24 Practices**<br>*Mon-Fri 8:00am to 18:30pm* | **67 Practices**<br>*Mon-Fri 8:00am to 18:30pm* |

# Priority 4 – Establish clinically and financially sustainable services

| Programme 4b | IMPROVING URGENT CARE | Owner | Richard Beeken, Chief Executive, Wye Valley NHS Trust |
|---|---|---|---|

| Overall aim | Improve urgent care pathways and out of hospital care models to improve access performance and create better outcomes, resulting in a requirement for fewer beds, reduced staffing and estate requirements. |
|---|---|

**Access to Urgent Care** – A&E and MIU Attendances during the last five years

## A&E and MIU Attendance Trends - Worcestershire


**Trend over 5 yrs**

A&E = +7.8%

MIU = +14.1%

*Amb conveyed patients to A&E +26.5%*

## A&E and MIU Attendance Trends - Herefordshire

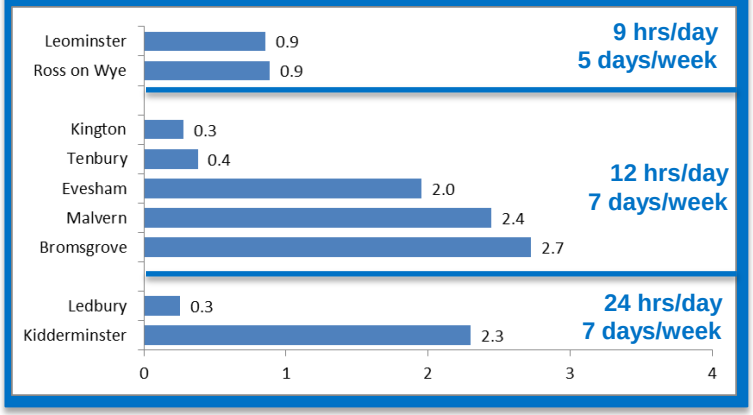

**Trend over 5 yrs**

A&E = +14.9%

MIU = +24.6%*

*From 2013/14 otherwise opening hours not comparable*

## Average number of MIU attendances per hour open




- Activity in urgent care facilities has increased over the past five years across both counties. In Herefordshire the growth has been higher in main A&E department and MIUs than it has been in Worcestershire.
- Usage of MIUs varies significantly across the two counties, with not surprisingly, the busier units being based in larger population centres.
- There is a clear need to review the demand and capacity match across all sites to ensure that best use of resources is obtained from the facilities that are provided.
- Through implementation of the integrated urgent care model we expect to see this recent annual increase in demand mitigated initially before seeing actual reductions in later years of the STP as the service becomes embedded.

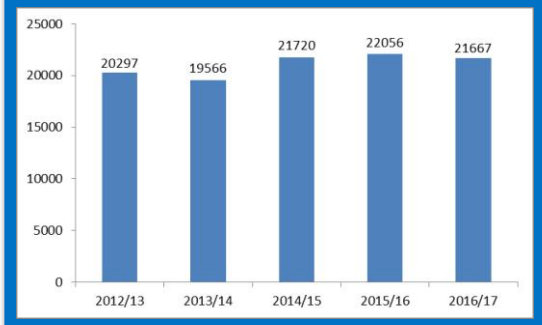
# Priority 4 – Establish clinically and financially sustainable services

| Programme 4b | IMPROVING URGENT CARE | Owner | Richard Beeken, Chief Executive, Wye Valley NHS Trust |
|---|---|---|---|

| Overall aim | Improve urgent care pathways and out of hospital care models to improve access performance and create better outcomes, resulting in a requirement for fewer beds, reduced staffing and estate requirements. |
|---|---|

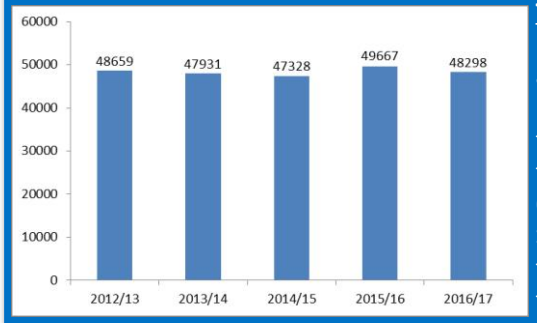
**Access to Urgent Care** – Emergency Admissions during the last five years

## Emergency Admission Trend - Herefordshire




**Trend over 5 yrs**
Emergency admissions have increased by 6.7% over the last 5 yrs, but have steadied this year

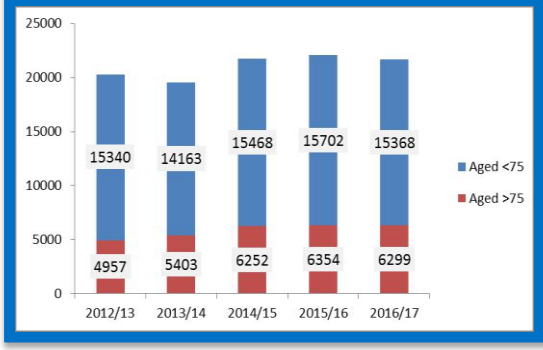
## Emergency Admission Trend - Worcestershire




**Trend over 5 yrs**
Emergency admission have been flat over the period, but there has been a 6.8% increase in >75 admissions this yr compared to last yr.

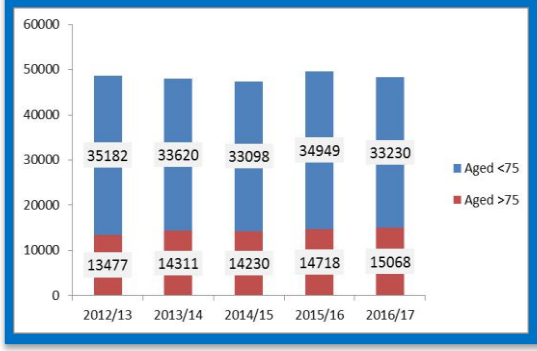
Successful delivery of our strategy to improve out of hospital care will relieve pressure on main A&E departments and the need for emergency admissions.

## Emergency Admission Trend – Herefordshire Age Group




**Trend over 5 yrs**
>75 admissions have increased by 27% over the period and now represent 29% of all emergency admissions

## Emergency Admission Trend – Worcestershire Age Group




**Trend over 5 yrs**
>75 admissions have increased by 12% over the period and now represent 31% of all emergency admissions

***2016/17 extrapolated from first 6 months and previous annual profiles***

# Priority 4 – Establish clinically and financially sustainable services

| Programme 4b | IMPROVING URGENT CARE | Owner | Richard Beeken, Chief Executive, Wye Valley NHS Trust |
|---|---|---|---|

| Overall aim | Improve urgent care pathways and out of hospital care models to improve access performance and create better outcomes, resulting in a requirement for fewer beds, reduced staffing and estate requirements. |
|---|---|

**Implementing the seven day service standards**

We expect to achieve roll out of the 4 priority clinical standards by November 2017:

| Standard | Our Baseline | Our Plan |
|---|---|---|
| **2 - Time to consultant review**<br>Demonstrate evidence there is a clinical patient assessment by a suitable consultant and a first consultant review within 14hrs,7 days a week. | Target Compliance – 100%<br>Current Compliance – 43.9% | All patients admitted through emergency portals will be reviewed by a consultant within 6 hours, supported by AEC and OPAL services. |
| **5 - Access to diagnostics**<br>Access to diagnostic services 7 days a week for x-ray, ultrasound, CT and MRI, ECG, endoscopy, bronchoscopy and pathology. | Currently mainly 'day time' access to a number of these services x-ray available to Emergency Departments 24/7.<br>Target Compliance – 100%<br>Critical Care Current Compliance Within one hour – 100%<br>Urgent Care Compliance Within 12 hours – <50% | 95% of all patients requiring access to diagnostics will receive this within 12 hours . Direct access to a range of diagnostics will be available for GPs to support admission avoidance |
| **6 - Access to consultant-directed interventions**<br>Hospital inpatients have timely 24 hour access, 7 days a week, to consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements. | Currently quite a traditional model of consultant availability prevails with ad-hoc GP to consultant telephone consultancy.<br>Target Compliance – 100%<br>Current Compliance – 33% | To utilise independent sector consultant telephone support (consultant connect) for urgent care with agreed pathways to AEC, OPAL, and direct diagnostics before March 2017. |
| **8 - On-going review**<br>Patients on the AMU, SAU, ICU and other high dependency areas are seen and reviewed by a consultant twice daily. General ward patients should be reviewed during a consultant-delivered ward round at least once every 24 hours. | Target Compliance – 100% T<br>Twice daily ward rounds Current Compliance – 29% | By July 2017 twice daily ward rounds will be undertaken on MAU, SCDU and ICU with 90% compliance 7 days a week. |

*Note: this table reflects the Worcestershire position, the equivalent audits have not yet been completed in Herefordshire.*

# Priority 4 – Establish clinically and financially sustainable services

| Programme 4b | IMPROVING URGENT CARE | Owner | Richard Beeken, Chief Executive, Wye Valley NHS Trust |
|---|---|---|---|

| Overall aim | Improve urgent care pathways and out of hospital care models to improve access performance and create better outcomes, resulting in a requirement for fewer beds, reduced staffing and estate requirements. |
|---|---|

**What will be different between now and 2020/21**

As part of the West Midland Urgent and Emergency Care Network we expect to participate in a fundamental re-organisation of our existing urgent care system. In line with national guidance we aim to secure, for all patients with urgent care needs, a highly responsive service that provides care as close to home as possible and for those patients with more serious or life threatening conditions we will ensure they are treated in centres with the right expertise, processes and facilities to maximise their chances of survival and a good recovery. Key aspects will be:

- Working collaboratively with all system partners to further develop our urgent care commissioning strategy, clearly defining 'what good looks like', with clear mapping & matching of demand and system capacity and clearly understood outcome measures. Refresh to be undertaken beginning of November
- As part of this strategy we will include the further development of seven day services, including a comprehensive workforce plan to support urgent and patient flow.
- Building on the digital infrastructure across Worcestershire, we ensure all urgent, emergency, physical and mental health partners are connected and that effective and prompt communication underpins and facilitates excellence in urgent care and end of life care.
- Reducing hospital admissions through the local adoption of well proven methodologies; e.g. reducing care home admissions,
- Influencing the regional ambulance commissioning strategy to ensure the provision of an 'urgent care' model of ambulance provision with ambulance clinicians increasing their use of see & treat, making better use of alternatives to ED and therefore reducing ED activity and emergency admissions
- Continuing to progress current improvement initiatives
  - Urgent Care Connect
  - Review of ED GP support
  - 111 - Increased referral to clinical advisors
  - Improving patient flow; e.g. - Streaming at the front door - AEC, OPAL, strengthening D2A and Trusted assessor models and extending to care homes.
  - Reviewing and updating escalation and de-escalation plans, focusing on cross system escalation and rapid de-escalations actions.
  - Exploring benefits of further integration of access points into one single point of access for professionals within Worcestershire

# Priority 4 – Establish clinically and financially sustainable services

| Programme 4b | IMPROVING URGENT CARE | Owner | Richard Beeken, Chief Executive, Wye Valley NHS Trust |
|---|---|---|---|

| Overall aim | Improve urgent care pathways and out of hospital care models to improve access performance and create better outcomes, resulting in a requirement for fewer beds, reduced staffing and estate requirements. |
|---|---|

**What will be different between now and 2020/21**

Given our STP geography and system challenges, there are different but related review areas that we will need to explore locally to address our immediate pressures. These will need to be explored as part of the next phase of redesign and it is important, at this early stage, to identify their potential impact:

- **Review area 1** – Better use of telephone review (NHS 111 or local streaming through clinical contact centres), web based services and clinical navigation in providers to ensure people can either self- direct or are directed to the most appropriate facility. This action is core to our strategy and will be supported through the implementation of the new Integrated Urgent Care Pathway
- **Review area 2** – Review of existing access points and with the potential consolidation onto fewer individual sites. This would enable the scarce staffing to be co-located, resulting in a significantly reduced demand for expensive agency resources and simpler access routes . The sites that would need to be considered as part of this option in Herefordshire are the existing minor injury units, the out of hours GP hubs, and the Herefordshire Walk in Centre, in the context of the development of 7 day access to primary care . This option would have an impact on improving performance, better clinical outcomes through more specialisation and reducing cost through more effective use of existing resources. Within Worcestershire FOASHW will alter the provision of A&E services for certain conditions. The next stage will be to review the Worcestershire Urgent Care Strategy, taking into account national guidance, which may provide the opportunity to review the number of access points further, by creating 3, at least 16 hour, Urgent Care Centres ensuring the best possible match between availability and urgent care demand. We are planning for the provision of an 'urgent care' model of ambulance provision, in line with 'Clinical Models for Ambulance Services' with ambulance clinicians making better use of alternatives to ED, the new UCC's would strengthen this approach, further reducing conveyances to ED.
- **Review area 3** – This would explore the establishment of a single **Emergency Centre with Specialist Services** (ECSS) for Herefordshire and Worcestershire, alongside two **Emergency Centres (providing A&E functions)** (EC-A&E). Based on current configurations, capability and geography, the ECSS) would need to be in Worcester, with EC-A&Es in Hereford and Redditch. Alignment of clinical management and governance systems across the three sites would support more integrated working and mutual support. For seriously ill patients needing transfer we would need to examine the option of air ambulance or dedicated transfer service.

***It is important to emphasise that any work to explore alternative options to the current model of provision would be subject to a full public consultation process.***

# Priority 4 – Establish clinically and financially sustainable services

| Programme 4b | IMPROVING URGENT CARE | Owner | Richard Beeken, Chief Executive, Wye Valley NHS Trust |
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| Overall aim | Improve urgent care pathways and out of hospital care models to improve access performance and create better outcomes, resulting in a requirement for fewer beds, reduced staffing and estate requirements. |
|---|---|

## What will be different between now and 2020/21

**The number of hospital beds required to support the system**

Whichever model is pursued, there will need to be access to the right number of hospital beds to support patient care needs. Detailed modelling has been undertaken by an independent organisation (Strategic Healthcare Planning) to help identify the bed requirements for Herefordshire and Worcestershire over the life of the STP. This has identified that if partners can achieve the transformational changes that are sought in out of hospital and social care provision, there will be a significantly lower number of hospital beds required than there are now.

The modelling, which is based on the agreed system assumptions shows the following:

- **Herefordshire** - The need for a **+15%** increase the number of acute beds in Herefordshire, but the potential for a reduction of **-62%** reduction in the number of community hospital beds.
- **Worcestershire** – There is potential for a small reduction in the number of acute beds and a **-44%** reduction in the number of community hospital and resource centre beds. In terms of acute beds, the main issue to address is location, with more beds required in Worcester but less required in Redditch. In addition to the community bed numbers, there is scope to reduce the number of NHS commissioned beds from the private care home sector from 86 in the base year to 9 in 2020/21.

| | Herefordshire | | Worcestershire | |
|---|---|---|---|---|
| | Base yr | 2020/21 | Base yr | 2020/21 |
| Acute Beds | 226 | 260 | 743 | 740* |
| Community Beds | 97 | 37 | 324 | 182 |
| Total Beds | 323 | 297 | 1,067 | 922 |
| | | -26 | | -145 |

**FoASHW pre-consultation business case projection for 2018/19, all other numbers from the STP strategic model for 2020/21.*

The strategic bed modelling and reconfigurations show that there will be capacity in Redditch to develop a wider range of community services on the Alexandra site. Linking primary, community and mental health services may create the opportunity for a new health campus.

In order to facilitate this scale of reduction in beds overall, the out of hospital care offering needs to be optimised. A proportion of the savings realised from these reductions will be reinvested in community services (modelling not finalised, initially modelled at c50%). This will lead to more care being provided in home based settings, leading to better clinical outcomes and improved independence.

# Priority 4 – Establish clinically and financially sustainable services

| Programme 4b | IMPROVING URGENT CARE | Owner | Richard Beeken, Chief Executive, Wye Valley NHS Trust |
|---|---|---|---|

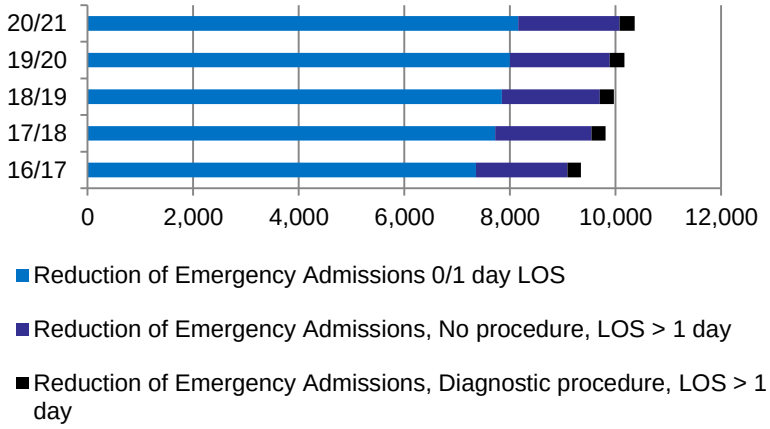
| Overall aim | Improve urgent care pathways and out of hospital care models to improve access performance and create better outcomes, resulting in a requirement for fewer beds, reduced staffing and estate requirements. |
|---|---|

**How will this be better for residents and patients in Herefordshire and Worcestershire**

- Communities will be able to access more convenient alternatives to hospital based urgent care services, such as community pharmacies which are close to home.
- People will have better access to primary care support and advice for their urgent care needs, 7 days a week
- We will have invested in public education to help communities navigate the new services ,making it easier to get the right care, first time by the right person
- Patients who are at heightened risk of emergency admission will have their care more coordinated to reduce the likelihood of a crisis occurring.
- Less patients will be admitted to acute hospitals, meaning they can receive care closer to home and remain in more familiar surroundings
- Patients who require emergency care from acute and/or mental health specialists will be quickly assessed and streamed into the most appropriate management, with fewer delays
- Patients receive supported discharge from hospital into an appropriate community environment, once the acute phase of their care is over
- Waiting time performance for access to key services – such as response to 999 calls and 4 hour waits in A&E will be significantly improved
- People will receive improved outcomes and experience of using urgent and emergency care services in Herefordshire and Worcestershire

The chart below shows the activity that would be removed from the acute sector as a result of a full implementation of an integrated frailty pathway, described within priority 3b.By 2020/21 there would be **10,359 fewer** hospital admissions as a result of these interventions within Worcestershire.

**Admissions that will be avoided as a result of the new integrated frailty pathway.**




The chart above shows that the most significant reduction in emergency admissions will be for those where the length of stay is one day or less.

# Priority 4 – Establish clinically and financially sustainable services

| Programme 4b | IMPROVING URGENT CARE | Owner | Richard Beeken, Chief Executive, Wye Valley NHS Trust |
|---|---|---|---|

| Overall aim | Improve urgent care pathways and out of hospital care models to improve access performance and create better outcomes, resulting in a requirement for fewer beds, reduced staffing and estate requirements. |
|---|---|

**Stroke Services -** The aim is to deliver a more consistent and resilient stroke service across the STP footprint. A sustainable solution cannot be found across the Herefordshire and Worcestershire STP footprint alone due to the consistent workforce issues affecting all providers of stroke care. Consideration has been given to solutions that will begin to address the provision of a seven-day TIA service, support thrombolysis treatment, provide specialist assessment for the inpatient beds and ensures the provision of specialist stroke rehabilitation . Providers are currently rated as Band D under the Sentinel Stroke National Audit Programme (SSNAP) and the plans we are taking forward should achieve B in Worcestershire by 17/18 and B/C-B in Herefordshire once fully implemented.

## What will be different between now and 2020/21

- Joining the existing telemedicine service operated by the University Hospitals North Midlands - brokered through the West Midlands Stroke Network
- Collaboration across three counties (Herefordshire, Worcestershire and Gloucestershire), to deliver a consultant rota and a seven-day TIA service
- Looking at alternative stroke workforce models including assessing the impact of the County Stroke Therapy Consultant in North Worcestershire.

**Specific short term goals for Worcestershire:**

- Improvement of the identification and treatment of atrial fibrillation across Worcestershire
- The acute trust will have in place the capacity and skill mix to achieve TIA service requirements
- A stroke pathway, workforce plan will be developed and agreed that crosses organisational boundaries and uses an appropriate skill mix to deliver an efficient stroke care pathway.
- Agreement to the consolidation of community hospital beds providing inpatient stroke rehabilitation with seven day services.
- Agreement to the consolidation of community hospital beds providing inpatient stroke rehabilitation on one site ensuring maximum capacity available 7 days a week.

**Specific short term goals for Herefordshire:**

- Access to TIA clinics for those at risk of Stroke across seven days
- 24/7 thrombolysis treatment
- 24/7 access to specialist inpatient care advice
- Consistent access to therapists whilst an inpatient
- Consistent access to step-down community services

## How will this be better for residents and patients in Herefordshire and Worcestershire

- Patients will receive improved access to best practice stoke rehabilitation in their own home and where not possible in a dedicated stroke rehabilitation unit
- Long term care and outcomes for disability associated with stroke will be maximised
- There will be a reduction in the incidence of stroke
- There will be increased levels of long term care at home
- Care will be delivered as close to home as possible
- Improved stroke outcomes by timely access to hyper-acute stroke services
- The ability to recruit and retain specialist stroke professionals

# Priority 4 – Establish clinically and financially sustainable services

| Programme 4c | IMPROVING MATERNITY CARE | Owner | Richard Beeken, Chief Executive, Wye Valley NHS Trust |
|---|---|---|---|

| Overall aim | Our vision is that our citizens have access to high quality, safe and sustainable, acute, women and newborn/neonatal and mental health services, localised where possible and centralised where necessary. |
|---|---|

**What will be different between now and 2020/21**

Within Worcestershire maternity services are temporarily suspended on the Redditch site and re-provided on the Worcester site due to the Trust not being able to recruit sufficient staff to provide clinically sustainable services across two sites. The Future of Acute Services at Hospitals in Worcestershire (FOASHW) is about to commence consultation on the permanent centralisation of these services on the Worcestershire Royal Site. This is a critical component of the clinical and financial sustainability of the Worcestershire service.

Beyond this **we plan to develop a single maternity service to delivering Better Births**, locally across both counties. This will result in:

- The removal of traditional county boundaries with sharing of community and hospital based resources across a wider area. This is not expected to result in a change to the provision of obstetric services in Herefordshire.
- A joint maternity care offer with common clinical pathways that guide women to the most clinically appropriate place of birth.
- A maternity specification that is jointly commissioned from Herefordshire and Worcestershire CCGs, and delivered locally by the most appropriate provider.
- Shared maternity service management structure and leadership.
- Integrated specialist/clinical teams (such as Antenatal Screening team, Governance team etc) to increase skills and ensure adequate access for women.
- Development of community hubs for maternity care.
- Integrated neonatal pathways between Hereford and Worcester.
- We will focus on improving the initiation and sustainability of breastfeeding in a coordinated way and will train midwives on skills to be used at 12 week appointments to begin early discussions with parents on breast feeding and identify peer support to increase pre-decision on breast feeding.
- We will also focus on ensuring that all staff who come into contact with pregnant women have a role to play to trigger quit attempts by delivering brief advice on smoking. This will include training all maternity staff in MECC (Making Every Contact Count).
- The use of MECC and motivational interviewing skills of midwives will also support better information sharing and highlight the importance of vaccination to protect the health of the newborn.
- Shared approach for perinatal mental health offer for families.
- Shared end to end electronic maternity information system.
- IT links between the hospitals services .

# Priority 4 – Establish clinically and financially sustainable services

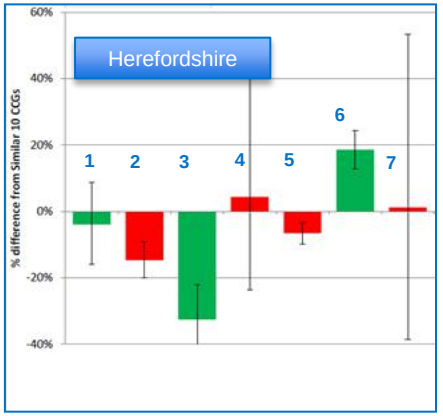
| Programme 4c | IMPROVING MATERNITY CARE | Owner | Richard Beeken, Chief Executive, Wye Valley NHS Trust |
|---|---|---|---|

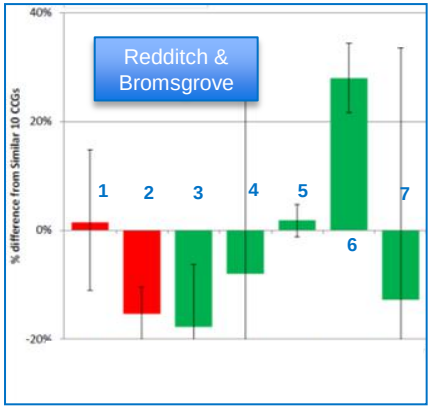
| Overall aim | Our vision is that our citizens have access to high quality, safe and sustainable, acute, Women and newborn/neonatal and mental health services, localised where possible and centralised where necessary. |
|---|---|

## How will this be better for residents and patients in Herefordshire and Worcestershire

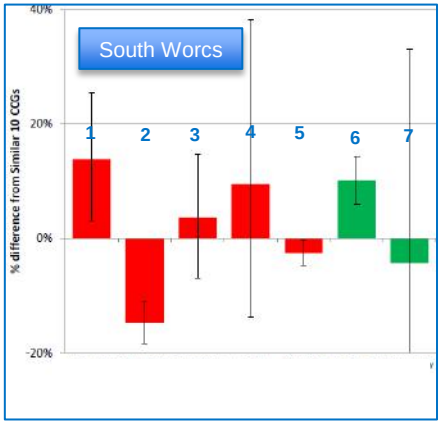
The overriding benefit to the local population will be a higher quality, more sustainable service that achieves improved health and well being outcomes for babies and young children. This will be achieved through:

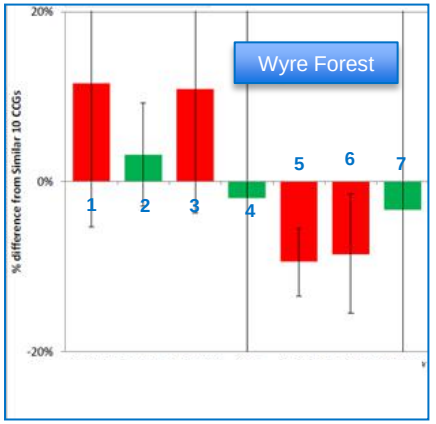
- Increased midwife led care and home birth numbers
- Improve women's access to birth in the most appropriate birth setting
- Reduce out of area neonatal transfers for sick and premature infants
- Increased specialist community based Perinatal Mental Health care
- Improved availability of access to specialist teams across both counties for women and babies
- Retaining local services for women and families within the counties
- Raised profile for maternity and newborn services across the West Midlands
- Reduction in Perinatal mortality rates
- Reduced number of emergency caesarean sections
- Improved learning from strengthened governance will lead to a greater safety culture.
- Shared learning and development opportunities to increase and maintain knowledge and skills.




| 1 < 18 Conception rates | 2 Flu vaccine take-up by pregnant women | 3 Smoking at time of delivery | 4 % of low birthweight babies (<2500g) | 5 Breast-feeding initiation (first 48 hrs) | 6 Breastfeeding at age 6-8 weeks | 7 Infant mortality rate |
|---|---|---|---|---|---|---|



# Priority 4 – Establish clinically and financially sustainable services

| Programme 4d | ELECTIVE CARE | Owner | Carl Ellson, Accountable Officer, SWCCG |
|---|---|---|---|

**Overall aim**

**Non – life threatening conditions** - Reduce clinical variation in referral and treatment, reduce the number of procedures performed where there is a limited clinical benefit or enhanced risk of harm and work with patients to improve their overall well being by seeking lifestyle improvement as part of the elective pathway.

## What will be different between now and 2020/21

There are two key aspects to improving elective care – in terms of clinical effectiveness, achievement of performance standards and financial sustainability.

- **Effective commissioning policies** and stricter treatment thresholds
- **Efficient organisation of services** to meet demand.

During the allocative programme budgeting work, the STP programme board recognised that significantly tightening commissioning policies and treatment thresholds for elective care would be required to support financial balance with the STP. In order to progress this, there were two distinct categories of elective care identified – treatment for life threatening conditions such as cancer, cardiac and renal services and treatment for non-life threatening conditions. The programme board agreed to prioritise investment in the former, in order to do this the following has been agreed:

- Develop a system wide (commissioner and provider across both counties) policy and treatment threshold on procedures that:
  - Have a relatively limited impact
  - Are probably linked to an aesthetic benefit
  - Are perceived to have a close ratio of benefit to harm.
- Develop a policy to support lifestyle improvement by providing prevention interventions and alternatives such as social prescribing with regard to healthy weight (where possible), smoking and alcohol consumption to improve the likelihood of positive clinical outcomes following surgery.

## Potential savings from achieving top decile rates

**Elective procedures for non-life threatening conditions**

| CCG | Probably Aesthetic | Probably lower cost alternative | Limited Effect | Close Benefit to Harm Ratio |
|---|---|---|---|---|
| HCCG | £64k | £521k | £26k | £439k |
| RBCCG | £14k | £362k | £0k | £546k |
| SWCCG | £133k | £784k | £0k | £1,025k |
| WFCCG | £149k | £397k | £48k | £271k |
| Total | **£4,779k** | | | |

**Elective procedures that are likely to be wholly attributable to**

| CCG | Alcohol | Obesity | Smoking |
|---|---|---|---|
| HCCG | £0k | £28k | £72k |
| RBCCG | £124k | £57k | £153k |
| SWCCG | £599k | £59k | £478k |
| WFCCG | £279k | £50k | £199k |
| Total | **£2,098k** | | |

- Achieving top decile performance in these areas against comparator CCGs will release **£6.8m** worth of expenditure.

# Priority 4 – Establish clinically and financially sustainable services

| Programme 4d | ELECTIVE CARE | Owner | Chris Tidman, CEO, Worcestershire Acute Hospitals NHS Trust |
|---|---|---|---|

**Overall aim**

**Life threatening conditions (cancer and others)** -Increase funding to meet demographic pressures and increasing illness burden. Improve efficiency and reduce waste and waits across pathways and for all critical complex elective care, for clinical sustainability and quality outcomes, we will concentrate provision in centres of excellence

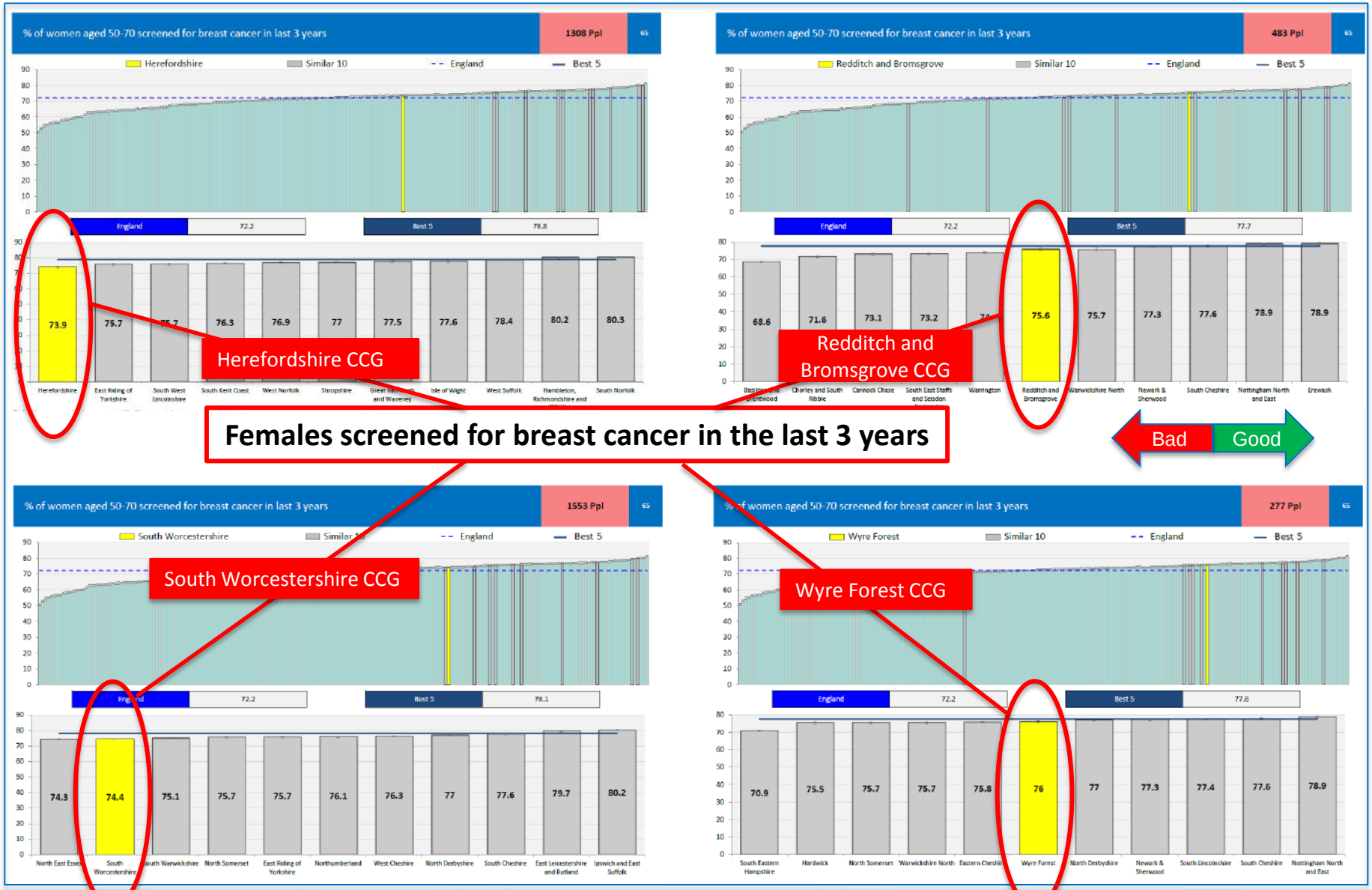
## What will be different between now and 2020/21

- We will have implemented the key changes required from the national cancer strategy
- There will be much greater alignment between prevention strategies and treatment, but adopting a more integrated approach, where driving the prevention and healthy lifestyles message is the responsibility of all partners in the system.
- Far greater uptake of screening programmes across the population, where local performance is currently poor (see overleaf)
- We will ensure that we maximise the use of the diabetes prevention programme pilot currently being implemented across the STP and use the learning from this for other possibilities for using risk identification to target intensive lifestyle interventions.
- Revised pathways with increased pan-STP working, particularly with UHCW and Gloucestershire to enhance clinical sustainability and specialism to improve outcomes.
- Joint staffing appointments to specialist roles across the STP or Pan STP footprint (for example interventional radiology).
- Concentration of specialist complex surgery on fewer sites to secure clinical sustainability and improve outcomes.
- As part of the Specialised Services Rural Pathfinder we expect to redefine existing pathways to be locally commissioned, repatriate some current pathways including renal, some cancers and cardiac care, working closely with regional specialised providers.
- Implement alternative models for cancer survivorship through remote monitoring and supporting patients in out of hospital environments.

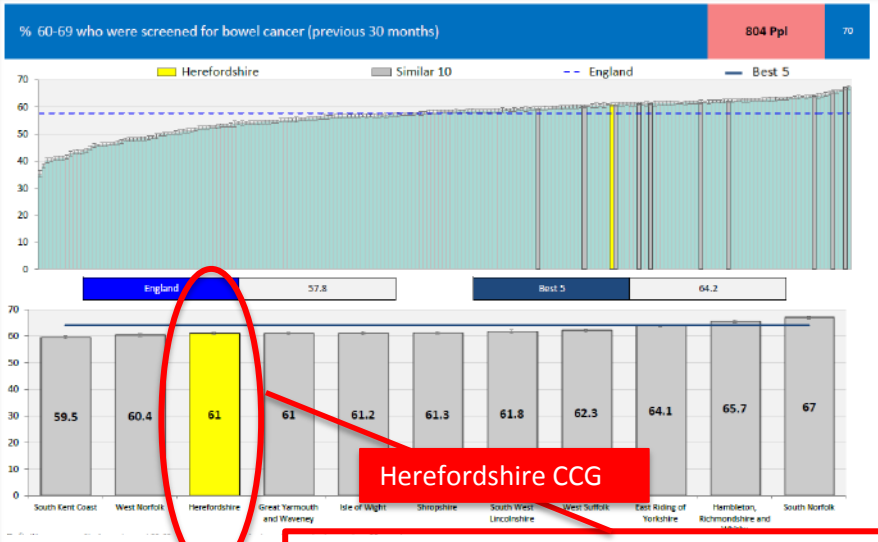
## How will this be better for residents and patients in Herefordshire and Worcestershire

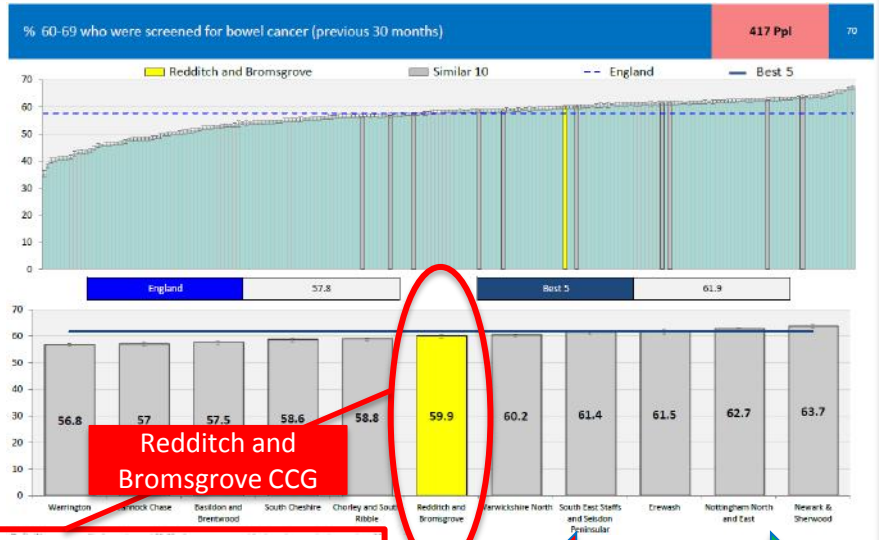
- Local services will be better placed to deliver world class outcomes for cancer care.
- The system will achieve consistent access of all cancer treatment standards.
- Earlier recognition and faster diagnosis of cancers and other life threatening conditions.
- Faster treatments times and improved survival rates.
- Reduced diagnosis through emergency admission or unplanned care provision.
- Better patient experience of cancer care received (which is currently poor – see 3 pages overleaf)

# Breast cancer screening



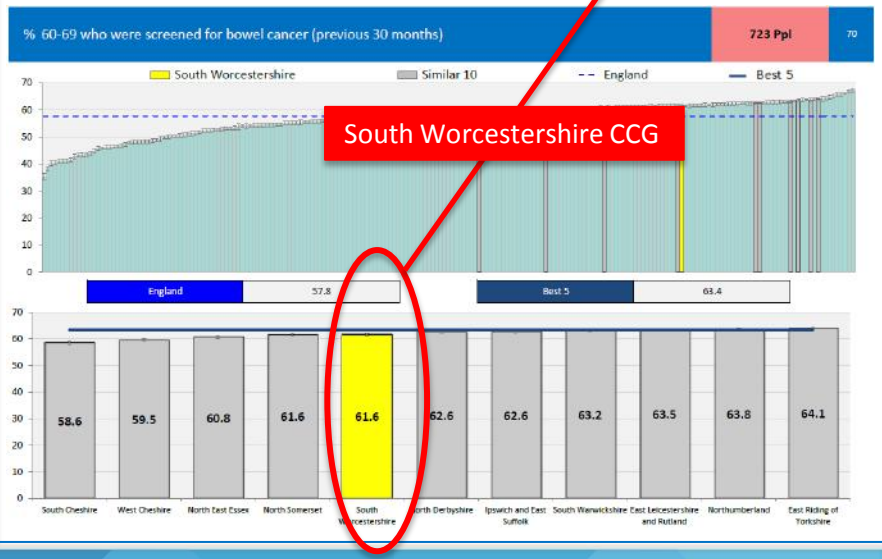
# Bowel cancer screening

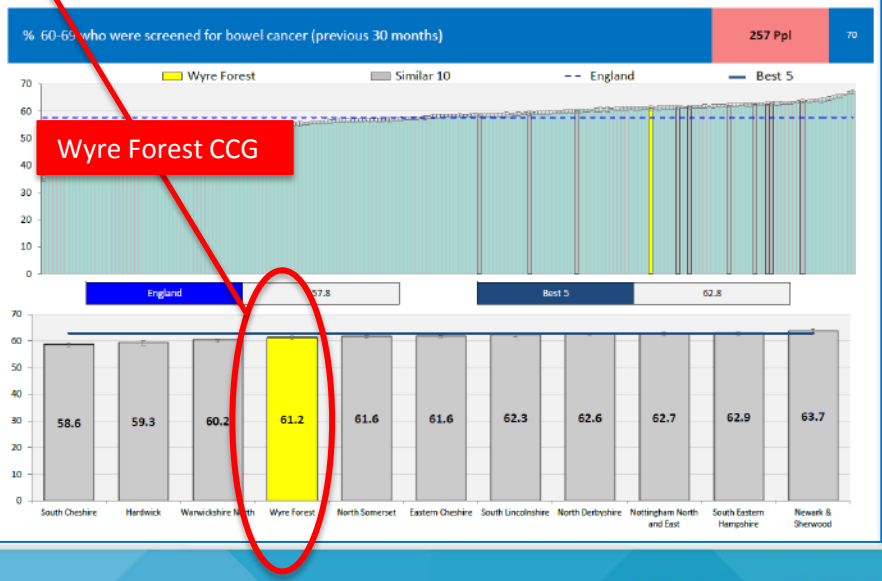


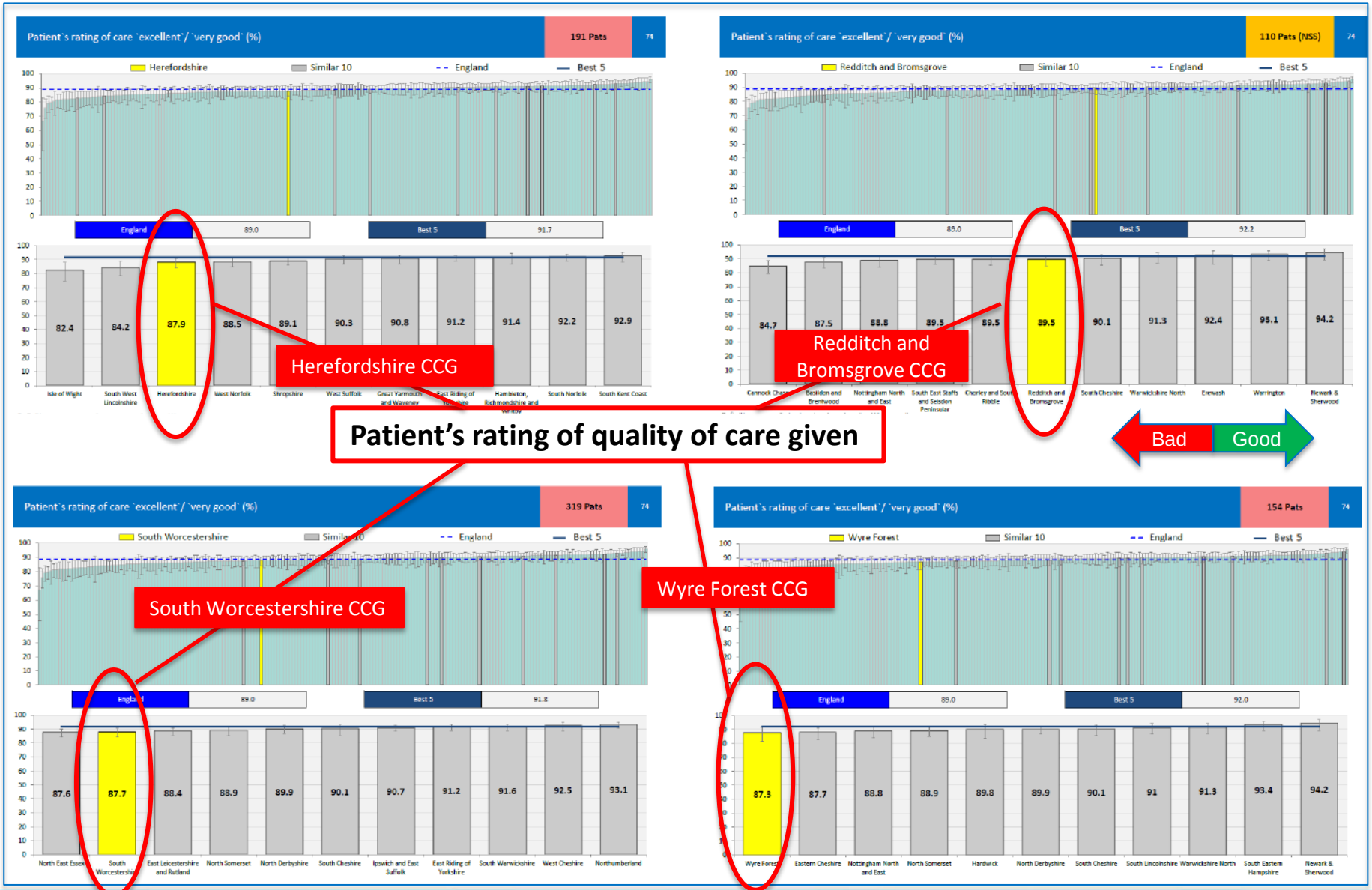

**Population screened for bowel cancer in the last 3 years**

Bad Good



# Patient experience of cancer care



# Delivery Plan – Priority 4: Establish clinically and financially sustainable

| | | | |
|---|---|---|---|
| **Urgent Care SRO** | **Richard Beeken –** Chief Executive – Wye Valley NHS Trust | **Programme Leads** | **Stuart Ide –** Urgent Care Lead – Worcestershire CCGs<br>**Hazel Braund –** Operations Director – Herefordshire CCG |
| **Maternity Care SRO** | **Richard Beeken –** Chief Executive – Wye Valley NHS Trust | **Programme Lead** | **Fay Baillie –** Deputy Director Nursing and Midwifery Worcs Acute Hospitals NHS Trust |
| **Elective Care SRO** | **Carl Ellson** Accountable Officer - SWCCG | **Programme Leads** | **Sarah Smith –** Worcestershire Acute Hospitals NHS Trust<br>**Simon Gartland -** Deputy Director of commissioning WCCGs |

| | Deliverable | 2016/17 Q3 | 2016/17 Q4 | 2017/18 Q1 | 2017/18 Q2 | 2017/18 Q3 | 2017/18 Q4 | 2018/19 Q1 | 2018/19 Q2 | 2018/19 Q3 | 2018/19 Q4 | 2019/20 Q1 | 2019/20 Q2 | 2019/20 Q3 | 2019/20 Q4 | 2020/21 Q1 | 2020/21 Q2 | 2020/21 Q3 | 2020/21 Q4 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 4A Improving urgent care | Reduce the number of individual physical access points to urgent care services across the STP footprint by 2020/21. | | | | | | | | | | | | | | | | | | |
| | Complete review of emergency care provision, exploring reductions to the number of MIUs and the Walk in Centre in Herefordshire and standardised opening hours for MIUs in Worcestershire. | | | | | | | | | | | | | | | | | | |
| | Shift to home based care – reduce the number of community based beds across the system and shift resources to primary and community services. | | | | | | | | | | | | | | | | | | |
| | Agree and implement a workforce plan for urgent care and patient flow across the health and social care footprint | | | | | | | | | | | | | | | | | | |
| 4C Improving maternity care | Implement the clinical model for maternity inpatient, new born and children's services within Future of Acute Services in Worcestershire programme. | | | | | | | | | | | | | | | | | | |
| | Develop a jointly commissioned, jointly provided maternity service across the whole footprint. | | | | | | | | | | | | | | | | | | |
| | Establish a single service with specialist teams working under a common management structure, delivered locally. | | | | | | | | | | | | | | | | | | |
| | Deliver the FOASW objectives for gynaecology | | | | | | | | | | | | | | | | | | |
| 4D Elective Care | Develop a system wide policy and treatment threshold on procedures of limited clinical value | | | | | | | | | | | | | | | | | | |
| | Develop a policy to support lifestyle prevention interventions and alternatives to improve health prior to surgery, thus improving outcomes | | | | | | | | | | | | | | | | | | |
| | Undertake a greater proportion routine elective activity on "cold" sites to reduce the risk of cancellations and to improve clinical outcomes. | | | | | | | | | | | | | | | | | | |
| | Revised pathways with increased pan STP working, reviewing opportunities for repatriating activity and referring out of footprint to achieve the best use of resources and outcomes for patients | | | | | | | | | | | | | | | | | | |
| | Expand pan STP working on cancer services and deliver the requirements of the national taskforce. | | | | | | | | | | | | | | | | | | |

Planning and Scoping

Design: Engagement and consultation (as appropriate)

Operational Delivery

# Enabling change and transformation

# Workforce and OD

| Enabler 1 | WORKFORCE AND ORGANISATION DEVELOPMENT | Owner | Shaun Clee, Chief Executive, 2gether NHS Foundation Trust |
|---|---|---|---|
| Overall aim | Develop the right workforce and Organisational Development within a sustainable service model that is deliverable on the ground within the availability of people and resource constraints we face. | | |

There are approximately 350 different professional demarcations of role in the NHS. As the recruitment pool becomes more shallow and as workforce challenges threaten clinical viability, Herefordshire and Worcestershire need to be in the vanguard of the introduction of new clinical roles. In Herefordshire a "vacancy harvesting" process will be used to trigger plans to review the lines of demarcation and introduce new clinical roles. In Worcestershire, there is, for example, a well advanced programme for the introduction of Physician's Associates into key aspects of hospital delivery.

## What will be different between now and 2020/21

- Erosion of traditional boundaries between organisations and services to **'teams without walls',** supported by a multi-disciplinary learning environment for the existing and future workforce across the system
- Increased **investment** in the **mental health and learning disability** workforce
- **Less** reliance on **agency and temporary staffing**
- **Integrated multi-disciplinary teams** based around the person, supported by access to specialist advice and support e.g. frailty teams
- Increased use of apprenticeship levy to ensure **appropriate training** for existing staff and 'new' roles, alongside work experience and **career pathways** to build the **future workforce**
- A **more diverse skill mix**, with 'new' roles embedded within teams across the system, for example Physician Associates and Advanced Clinical Practitioners
- A shift to a workforce **culture focused on prevention and self-care**, utilising, health coaching conversations across the workforce, improved signposting and better links to public health
- Flexible employment contracts, annualised hours, portfolio careers, and **incentives to recruit and retain staff** across the system
- **GPs** will have more time to focus on patient care by reducing the administrative burden and developing the primary care skill mix
- A more significant role for the voluntary and community sector, the public sector and the unpaid workforce (family, neighbours, carers, volunteers) **working together to deliver better outcomes for local people.**

## How will this be better for residents and patients

- "**Tell my story once**" with fewer 'hand-offs' between clinicians and other practitioners
- **More care will be provided out of hospital**, with greater continuity of care and care wrapped around the person
- Health coaching conversations will support people (patients, residents, workforce) to develop their knowledge, skills and confidence to **enable healthy behaviours, self- management of care** and to access health and social care services appropriately and when required
- People will co-produce and **'own' individual care and support plans**
- People with on-going conditions will have more control over their lives and receive **more care provided closer to home**
- Improved access to **specialist care and expertise will be available when people need it**

# Digital and Technology

| Enabler 2 | DIGITAL | Owner | Clare Marchant, CEO Worcestershire County Council |
|---|---|---|---|
| Overall aim | Invest in digital and new technologies to enable our workforce to provide, and patients to access care in the most efficient and effective way, delivering the best outcomes | | |

## What will be different between now and 2020/21

- **We have two aligned Digital Road Maps within the footprint,** successful delivery of our digital roadmaps for Herefordshire & Worcestershire will be critical to improving access, increasing productivity and changing clinician /practitioner behaviour.
- **Creating a connected Infrastructure** e.g. modern and connected infrastructure enabling practitioners and linking services; e.g. better use of telemedicine and increasing use of e-consultations to improve access to specialist services
- **Improving integration** e.g. Integrated Digital Care Records for patient's and citizens across health and care - providing integrated records that have the ability to be interlinked care settings across the footprint; establishing a consent and information sharing model and robust data standards, security and quality.
- **Empowering residents and citizens through technology** e.g. creating a consistent user and patient experience – including common, digital front doors to our services, complementing traditional interactions. Enabling increased public and patient control and empowerment (i.e better use of apps, wearables and assistive technologies), moving away from a paternalistic culture of care; and supporting self-care and increasing levels of patient activation. A key enabler is consistent local access to broadband / digital options.
- **Enhancing our understanding**: New insights using health & care intelligence - Using data in new ways to lead to earlier intervention and enabling improved outcomes and wellbeing for people and the population
- **Working collaboratively** – ensuring we are reading as a system to work together and to deliver technological changes for the benefits of residents and patients, including using resources smartly and sharing good practice

## How will this be better for residents and patients in Herefordshire and Worcestershire

- **Patient data access and information sharing**, care planning and transitions plans available across providers meaning patients will only have to tell their story once
- Patients access to own care records, giving a **better understanding of care received**
- Improved access to specialist services via telehealth and tele/video conferencing across acute and community, providing **faster access to specialist care**
- Use of tele/video conferencing in GP practices & nursing homes enabling **joined up care**
- Interoperability of systems across footprint allowing **patient choice**
- Use of apps and wearables to support empowerment of patient and residents and **increase levels of patient activation**
- Better sharing of information
- Seamless care for patients
- Patients more engaged and self-sufficient
- Better use of pharmacies and review of medications

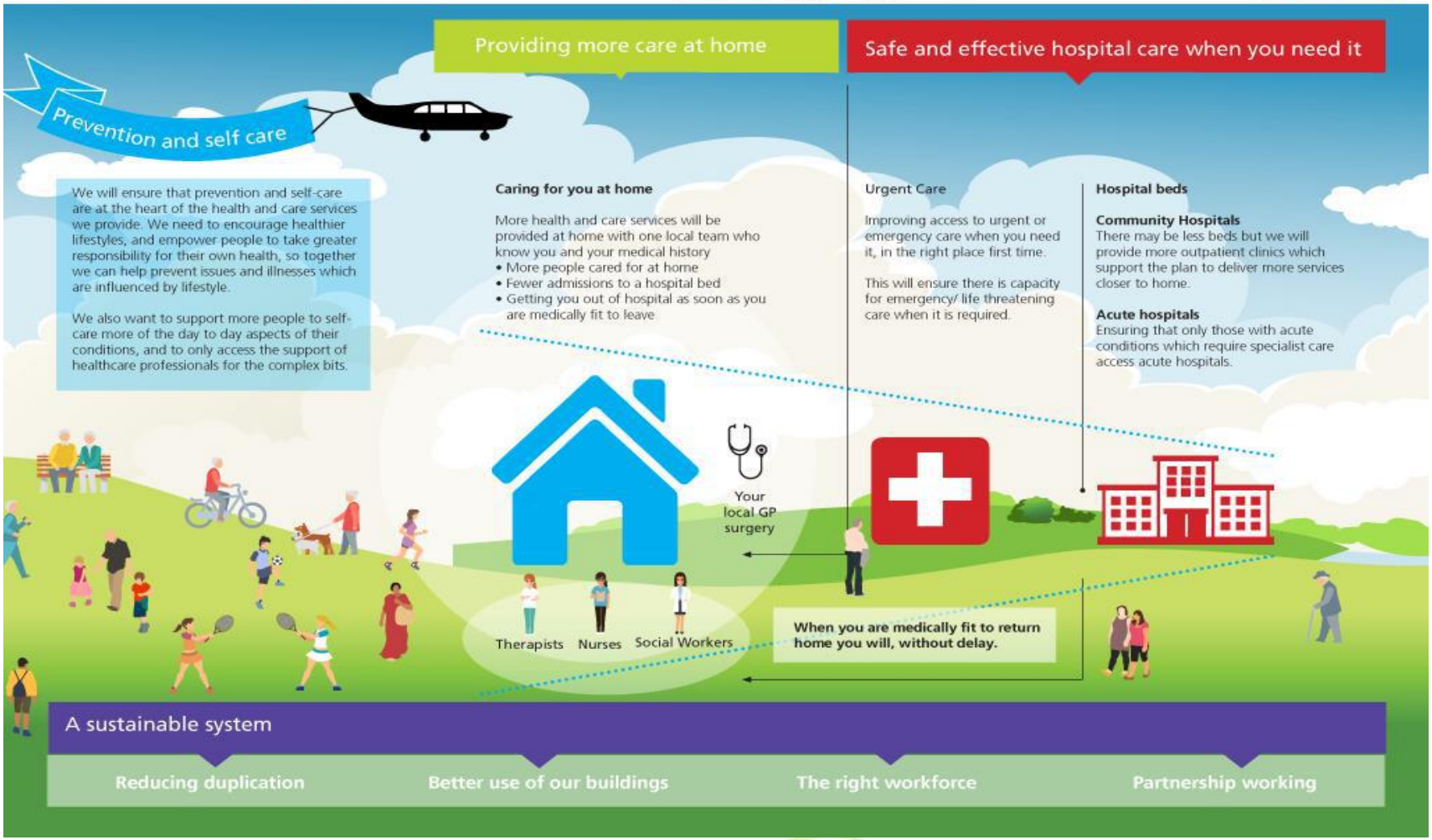
# Engaging communities and the voluntary sector

| Enabler 3 | HEALTHY COMMUNITIES AND THE VCS | Owner | Martin Samuels, Herefordshire Council |
|---|---|---|---|

- We recognise the importance of reengineering our system so that health and care services work alongside thriving communities to realise the value of individuals, their informal networks and wider communities. Being able to respond to the new landscape ahead requires the vision and commitment of all and embracing different partners into a new way of working. In particular this includes listening and responding to different solutions that are presented by the VCS, who often have effective methods, if not the means, to support those facing multiple disadvantage.
- The adoption of “a better conversation” approach across the wider system; including volunteers, community champions to develop a lay coaching model to focus on what is important to the individual in managing their day to day lives with a health condition.
- We recognise the depth of understanding that the sector can bring and the significant benefits of prevention. There are numerous asset based activities already implemented across our STP, creating social capital across our communities and we want to scale up this approach to promote and strengthen the factors that support good health and wellbeing, protect against poor health and foster positive communities and networks.
- The VCS has a vital role in reducing demand on formal services such as unplanned hospital admissions for example through care navigation/bridging roles, peer support and group activities . The sector also helps to address health inequalities by contributing to wider social outcomes such as employment and school attendance.
- Therefore, we need to find ways to tap into the energy, enthusiasm and innovation of the VCS in a coordinated manner, including a simplification of the commissioning process to enhance the contribution that the VCS can make, particularly those grassroots community organisations who struggle with complex commissioning arrangements. We will also strengthen how we support volunteering, recognising the assets and capacity of the workforce in our wider system planning.

# Communications and Engagement Plan

# Communications and Engagement Plan




#YOURCONVERSATION

Your Health & Wellbeing #YourConversation

# Communications and Engagement Plan

*Our STP priorities are not new; they have been central to our engagement for a number of years and include extensive engagement around our strategies for Urgent Care, the reconfiguration of acute hospitals services, increasing out of hospital delivery and the promotion of self care and prevention. The collaborative focus of the STP process has enabled us to bring the learning from these activities together to develop a consistent approach to our future work, namely to effectively scale up the engagement and interaction with our local communities, clinicians and staff from 22nd November.*

- Our collective experience from previous engagement around "the left shift" in the delivery of care is that the majority of stakeholders understand and support both the need for change, as well as the necessity for improvement, especially for older/ more vulnerable people. From April 2016, as STP partners we have been using all our existing engagement events to talk to members of the public and stakeholders about this system wide strategic case for change; providing us with over 100 engagement opportunities across the 2 counties to outline the Triple Aim challenge, our local gaps and gain feedback on some of emerging issues . These early discussions reflected the position above, namely that the rationale for change is supported but there are specific themes that require more exploration and assurance, for example transport and capacity of our workforce to deliver much more care at home.
- The Communications and Engagement workstream is well established and has leads from all partner organisations that meet every fortnight to coordinate activities and feedback, both internally and externally. Each workstream also has an identified communications and engagement lead to ensure consistency of messages.
- From September our STP communication has been branded as #yourconversation and a dedicated website was launched in September www.yourconversationhw.nhs.uk. The website includes some of the previous engagement activities and content, FAQs, details of our engagement events and a questionnaire. There is a weekly #yourconversation bulletin which is issued to all staff and stakeholders.
- Staff engagement in all partner organisations is being increased in preparation for the next phase of STP development. The 'Back Office' and 'Workforce and Organisational Development' workstreams have the potential to affect the working lives of many of our staff and we are engaging with them to help them devise solutions which will make the back office of all our organisations more efficient. Each partner organisation has taken responsibility for engaging with their staff and staffside organisations using agreed messages.

# Communications and Engagement Plan

*We have now reached a point on our STP journey where it is critical that we engage more fully on our emerging thinking, including the ways in which we might work differently to address our priorities if we are to realise onward success. Although we will be formally consulting on Worcestershire's acute services over the next few months, the other areas being explored in our STP are still in formation and we want to facilitate early discussions around the likely direction of travel, the development of local solutions and co-design around more formal engagement going forward (as per the NHS publication on "Engaging Local People - a guide for local areas developing Sustainability and Transformation Plans" September 2016).*

This approach will be cascaded into all formal meetings, stakeholder forums, and staff events, supplemented by roadshows, briefing, social media campaigns and proactive media coverage.

The Sustainability and Transformation Plan for Herefordshire and Worcestershire will be formally launched by the counties' four CCGs at their Governing Body meetings in November and December 2016. The Plan will be published on all four CCG websites on Tuesday, November 22nd as part of the Governing Body Board papers. This will be supplemented by our most recent Public Summary document going out to all staff as well as face to face briefings for key stakeholders in each county.

| Date | Audience | How | Supporting materials |
|---|---|---|---|
| 22-11-16 | Public | CCG Governing Body papers published on websites | #yourconversation |
| 22-11-16 | Media | Press Release<br>Face to face briefing (Herefordshire) | Public Summary<br>Full STP<br>FAQs<br>#yourconversation |
| 22-11-16 | MPs, HWB and HOSC Chairs | Face to face briefing | Public Summary<br>Full STP<br>FAQs<br>#yourconversation |
| 24-11-16 | Public | Redditch and Bromsgrove CCG Governing Body meeting<br>South Worcestershire CCG Governing Body Meeting | Slide Deck<br>Public Summary<br>Full STP<br>FAQs<br>#yourconversation |
| 29-11-16 | Public | Herefordshire CCG Governing Body Meeting | Slide Deck<br>Public Summary<br>Full STP<br>FAQs<br>#yourconversation |
| 06-12-16 | Public | Wyre Forest CCG Governing Body meeting | Slide Deck<br>Public Summary<br>Full STP<br>FAQs<br>#yourconversation |
| December | Public | Provider Board meetings | Slide Deck<br>Public Summary<br>Full STP<br>FAQs<br>#yourconversation |
| Ongoing | Staff | Written briefs<br>Drop in sessions on mobile bus<br>Webinars<br>Blogs<br>Team briefs and meetings | Slide Deck<br>Public Summary<br>Full STP<br>FAQs<br>#yourconversation |
| Ongoing | Voluntary and Community Groups | Attendance at existing meetings by agreed spokespeople | Slide desk<br>Public summary<br>FAQs |
| Ongoing | Public | Roadshows using mobile bus, Interactive webinars and Phone slots to provide feedback | Public summary |

# Communications and Engagement Plan

*We have now reached a point on our STP journey where it is critical that we engage more fully on our emerging thinking, including the ways in which we might work differently to address our priorities if we are to realise onward success. Although we will be formally consulting on Worcestershire's acute services over the next few months, the other areas being explored in our STP are still in formation and we want to facilitate early discussions around the likely direction of travel, the development of local solutions and co-design around more formal engagement going forward (as per the NHS publication on "Engaging Local People - a guide for local areas developing Sustainability and Transformation Plans" September 2016).*

**Clinical Engagement**

There are two countywide clinical reference groups which provide advice to the Partnership Board on all aspects of the STP. In addition there is a joint clinical engagement oversight group which straddles both counties to come together to discuss specific items and concerns. In addition each workstream has clinical input and have plans to involve the wider community in the further development of their ideas and concepts, including an professional Innovation and Engagement section of #YourConversation. Clinical engagement also forms part of the staff engagement programmes in all partner organisations.

**Key stakeholder engagement**

Throughout the year we have updated key stakeholders in the development of the plan, emerging themes and priorities. From 22nd November we will be widening our engagement and we are proposing an open event in the New Year to map current opportunities to work together, join up engagement where possible and identify gaps around engagement and potential solutions. It is also proposed that a more formal group could be established to advise on all STP communications and engagement with the public or alternatively use established meetings (for example sub groups of HWBs) to advise on these issues.

A briefing was held in October in London for the eight MPs who represent Herefordshire and Worcestershire. This was in addition to the individual briefs which they have received from partner organisations. All partner organisations receive updates at their Boards/Governing Bodies and support the STP direction of travel as well as specific briefings as required.

**Engagement with the public**

As partners we will continue to use all our existing engagement events as opportunities to talk to members of the public and stakeholders about the case for change and the emerging thinking in our STP. #yourconversation will be scaled

up as our interactive tool to discuss the issues stakeholders have around STP priorities . This will be supported by awareness raising social media activity, proactive media campaigns, our mobile bus and publicity through open events and forums.

**Future strategy for communications and engagement**

As the conversations around our STP develop it will become clear that some elements of the emerging plan will need formal public consultation. Once the need for public consultation is identified for a specific element of the plan a detailed public consultation plan will be drawn up which will include all the steps which will need to be undertaken before, during and after consultation, the audiences to be engaged and consulted with, the consultation materials that will be needed and the consultation activities and events which will be arranged.

# Healthwatch Perspectives

# Engaging communities and the voluntary sector

The Chairs of Herefordshire Healthwatch and Worcestershire Healthwatch are members of the programme board and asked for the following content to be included in the STP submission:

healthwatch Herefordshire

Healthwatch Herefordshire (HWH) would wish to place on record its thanks to all involved in the production of the Herefordshire and Worcestershire Sustainability and Transformation Plan (2016 - 2021).

Regarding the Plan itself, there has been involvement across the entire Herefordshire's and Worcestershire's Health and Social Care system which has involved key parties such as GP's, The Herefordshire Council, Worcestershire County Council, Acute Hospital and Community Trust and Mental Health Providers, Clinical Commissioning Groups, NHS England, Representation from both the Voluntary and the Community Sector and from both Healthwatch Herefordshire and Healthwatch Worcestershire.

HWH wishes it to be noted that Herefordshire remains the most sparsely populated area of England. NHS England will need to address a number of key issues in relation to the needs of the population of Herefordshire and the future provision of the County's health and social care services.

Firstly, that there is increasing demands from the public/patients for health and social care services. Secondly, the impact and effects of the budget reductions to the Herefordshire Council and its social care will need to be considered. Thirdly, the demographic changes and age profile, will also need to be taken into account, when it comes to the provision of services in the County. Finally, if there is an expectation that the voluntary sector can assist in the future regarding any transformation, then resources need to be made available to the respective organisations, for them to deliver additional work/activity.

In HWH's view the sensitive issue of funding and the particular special case of rurality and rural sparsity is something which NHS England should take into account when it considers overall budget provisions. The final agreed budget will need to fund the particular challenges involved within the rural County of Herefordshire regarding the delivery of its Plan for overall future health and social care provision.

What is also important in this process is that there is honesty, transparency and openness so that the public and patients are fully appraised and briefed on the implications and consequences of any final decision/s which is/are made by NHS England in relation to agreed budgets.

There will also be a series of engagement events/activities for patients and the public to provide feedback on what will eventually be delivered, and HWH will be assisting with these events. HWH believes it would have been a better option to have had discussions, consultations and engagement with the public/patients at a much earlier stage, rather that after the plan had been produced.

# Engaging communities and the voluntary sector

healthwatch Herefordshire

There is no doubt that there will be a number of challenges as well as opportunities regarding the delivery of the Plan within the communities. HWH makes a special a plea to NHS England that in order to reduce the bureaucracy in relation to overall plans being required to be produced, that there be only one plan to be agreed, delivered and actioned for the period 2016 to 2021.

HWH values and appreciates the work undertaken by all the staff involved in the NHS and the wider Health and Social Care System across Herefordshire and HWH thanks them for their dedication, commitment and professionalism. It is interesting to note that in a recent *survey and the question 'What makes us proud to be British?' the top answer was "The NHS."

* Statista - The i newspaper - 18.10.2016.

# Engaging communities and the voluntary sector

healthwatch Worcestershire

Healthwatch Worcestershire [HWW] has been engaged in the process to develop the Sustainability and Transformation Plan for the Herefordshire and Worcestershire footprint since January 2016. HWW's contribution has included membership of the Programme Board since the Board was set up, and on which it is represented by its Chair who has significant experience of working at a strategic leadership level in health and care matters across both Worcestershire and Herefordshire, and in the communications and engagement group in which HWW has provided advice, guidance and support to the NHS and Local Government stakeholders.

HWW recognises the inclusive approach the STP leadership team has taken to engaging with Local Healthwatch as the voice of patients and the public in developing STP proposals, given the constraints we understand have been placed on engagement by NHS England, and welcomes the positive response the team have made to HWW's comments during the process. HWW therefore welcomes the opportunity to make the following comments on the final STP submission:

- HWW recognises the need for change and has a track record of arguing for safe, sustainable and integrated health and care service provision in Worcestershire which, for example has enabled HWW to support the recommendations for the future delivery of acute hospital services in Worcestershire and the developments in primary care such as 'care at home' and MCP new models of care. HWW therefore welcomes the incorporation of these and associated initiatives into the STP, building on Worcestershire's 'Well Connected Programme' as a pioneer and the review of future Acute Hospital Services in Worcestershire.

- HWW is principally concerned with championing the interests of those who use health and care services in Worcestershire. In that context, from the outset HWW has been concerned about the potential implication for Worcestershire's patients and public of 'pooling' the funding allocations to the Worcestershire CCGs with the allocation to the Herefordshire CCG.

In response to HWW concerns the 2020 financial position as between Herefordshire and Worcestershire has been detailed in the STP submissions, which reflects that Herefordshire's potential gap will be £435 per head as opposed to Worcestershire's gap of £246 per head.

HWW welcomes the recognition from STP stakeholders that achieving financial balance across the STP footprint would result in significant subsidy to Herefordshire from Worcestershire, with a consequent impact on service provision for patients and the public in Worcestershire.

- HWW believes the patients and public in Worcestershire expect the NHS to make efficiency savings in the 'back office' and in the delivery of support services as a pre requisite to making savings in patient services. This should include consideration as to the number of commissioners and providers operating in Worcestershire, as well as the STP footprint.

# Engaging communities and the voluntary sector

healthwatch Worcestershire

- HWW is concerned that NHS plans to deliver care at home could place additional burdens on social care services and have raised an issue about domiciliary care based on its knowledge of the review of the existing care market in Worcestershire.
- HWW recognises that the proposals relating to Self-Care and Prevention require significant behavioural change by the population at large and within the NHS, and considers that this is unlikely to be achieved without a national communications/engagement exercise because of the resources that will be required.

NB The restrictions on publication of information relating to the STP have prevented HWW from taking the views of the public into account in formulating the above comments.

Worcestershire NHS
Acute Hospitals NHS Trust

**Date of meeting: 11 January 2017** **Enc D2**

**Report to Trust Board**

| | |
|---|---|
| **Title** | **Trust Management Group (TMG)** |
| **Sponsoring Director** | **Rob Cooper**<br>Chair of the Trust Management Group |
| **Author** | **Kimara Sharpe**<br>Company Secretary |
| **Action Required** | The Board is requested to:<br>• Note the report |
| | |
| **Previously considered by** | *N/A* |

**Priorities (√)**

| | |
|---|---|
| *Investing in staff* | √ |
| *Delivering better performance and flow* | √ |
| *Improving safety* | √ |
| *Stabilising our finances* | √ |
| | |

| | |
|---|---|
| **Related Board Assurance Framework Entries** | 2790 As a result of high occupancy levels, patient care may be compromised and access targets missed<br>2790 As a result of high occupancy levels, patient care may be compromised and access targets missed<br>3193 If the Trust does not achieve patient access performance targets there will be significant impact on finances |
| **Glossary** | RTT – referral to treatment<br>SAFER – **S**enior review, **A**ll patients to have a discharge date, **F**low of patients to commence at the earliest opportunity, **E**arly discharge, **R**eview<br>NEWS – national early warning system<br>NOF – neck of femur<br>HDU – high dependency unit<br>STF – Sustainability and Transformation funding<br>STP - Sustainability and Transformation Plan |

**Date of meeting: 11 January 2017** **Enc D2**

# WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

# REPORT TO TRUST BOARD – JANUARY 2017

## 1. Situation

To inform the Trust Board on the actions and progress of the Trust Management Group (TMG) at its November and December meetings.

## 2. Background

The Trust Management Group provides assurance to the Trust Board on operational issues. TMG meets monthly.

## 3. Assessment

### 3.1 Priorities *(December meeting)*

An outline was presented of the priorities for the next 3-6 months on the Trust Board agenda). Challenge was given over the current tolerance of poor patient experience and a series of actions were agreed to determine the detail including actions in relation to the RTT position. This is being taken forward through the performance regime.

### 3.2 Operational Plan 2017-2019 *(November meeting)*

Each division presented their Development Plans for 2017/19. The next steps are to undertake a prioritisation process and ensure that the aspirations are deliverable given the resource constraints and are linked to the strategic objectives.

### 3.3 Performance

#### 3.3.1 PCIP *(November/December meeting)*

The November meeting discussed the then current Patient Care Improvement Plan (PCIP). There was agreement to review the whole PCIP after the CQC visit to determine the priorities for the Trust. At the December meeting, there was further discussion about ensuring the staff engagement and support to deliver. The Patient Flow and Urgent care work stream is being relaunched by the Medicine Division and the SAFER work is being reenergised through a new lead from the Health and Care Trust, starting in January. There has been progress with improving the ambulance handover time due to the specialist nurses being located within the A&E corridor.

The work to reduce mortality has improved through the good compliance in relation to the NEWS roll out however more work is needed in terms of escalating actions. Also more patients are being effectively screened for sepsis. The fractured NOF plan is also being reviewed. In respect of the outpatient and waiting time improvement plan, there has been significant environmental improvements however the work has been over reliant on the project manager. One key aspect which is being progressed is text reminders to patients. One element of the programme has determined that the management of the referrals into the Trust are not managed as effectively as they should be. The outpatient project has been stalled through the organisational churn and lack of robust accountability and assurance processes. A new streamlined

improvement programme is under development.

The TMG agreed to close the HDU PCIP and move the work into 'work as normal'.

3.3.2 **Q3 performance review** *(December meeting)*
The Q3 performance review meeting was cancelled due to operational pressures. TMG discussed the key challenges. The Medicine Division confirmed that SAFER was being actively utilised on some wards. It was also agreed that the Trust needed to focus on a small subset of metrics to prioritise. This small set will be developed through the new performance reporting regime, being led by the Director of Finance and Performance and in conjunction with the Divisions. This will be reported to the next TMG.

3.4 **Risk register** *(November meeting)*
Each division outlined their red risks and when they last reviewed them. There was acknowledgement that further work needed to be undertaken with directorate teams in respect of assessment and development of controls.

All risks had been reviewed within the last 7 days.

The process for risk management is still being embedded and the Interim CNO is working with the executive team as well as the divisional teams to embed the revised process. The Risk Executive Group, chaired by the Interim CEO had its first meeting in December.

3.5 **Resetting the Ambulatory Medical Unit and Ambulatory Emergency Care** *(November meeting)*
TMG discussed the reconfiguration of the current A&E department at the Worcestershire Royal. The proposal of reconfiguring was to ensure that acute medical patients are seen in a more appropriate setting with a shorted length of stay. Current beds would be transferred into trolleys with a clear maximum length of stay. This proposal would also attract staff to work within such a unit.

3.6 **Financial Plan – 2017-2019** *(December meeting)*
The Plan for 2 years was presented. Trajectories have been set to ensure steady progress on the financial position. The Trust has a deficit trajectory (£40m) without STF. The CCGs are committed to ensure Worcestershire patients are treated within the local hospitals in the long term. The key challenges were discussed i.e. agency, activity and income.

3.7 **Strategic Development Programme** *(December meeting)*
The Director of Planning and Development outlined some early work on the development of the Programme. She has worked with the DMDs to consider detail of some objectives for each clinical division. The detail is attached:

3.8 **Subcommittee reports** *(December meeting)*
TMG received an update on health and safety and security. The H&S Manager is now utilising the regular clinical governance publication on ensuring that learning is disseminated across the Trust.

3.9 **Other items**
**Complaints and Concerns Policy**: This was approved. The performance by the Divisions will be monitored through the performance management framework.
**Herefordshire and Worcestershire STP:** A summary was presented (this is on the Board agenda)

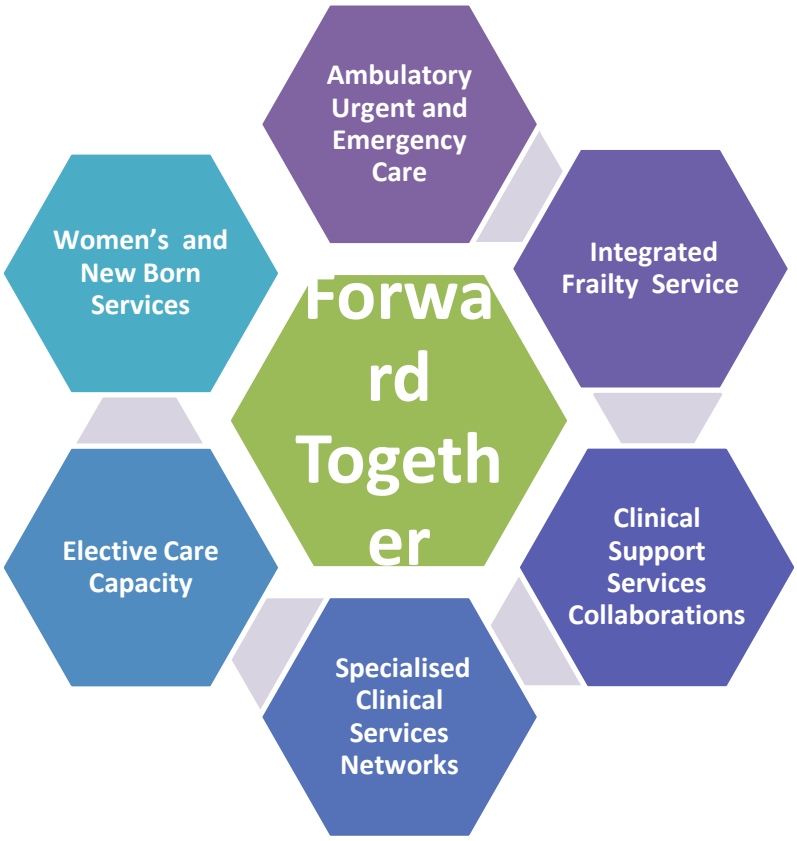
4 **Recommendations**
The Board is requested to:

- Note the report

**Rob Cooper**
**Chair of the Trust Management Group**

**Date of meeting: 11 January 2017** **Enc D2**

**Strategic Development Programme**

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|---|---|
| **Title of Report** | **Trust Management Group** |
| **Name of director** | **Rob Cooper** |

Worcestershire NHS
Acute Hospitals NHS Trust

**Date of meeting: 11 January 2017** **Enc D2**

| FORWARD TOGETHER | Integrated Ambulatory Urgent and Emergency Care | Integrated Frailty Service | Clinical Support Services Collaborations | Specialised Clinical Networks | Elective Care Capacity | Women and New Born Services |
|---|---|---|---|---|---|---|
| **Objective** | To ensure that people accessing urgent or emergency care are seen promptly in the right service with attendance at A&E and admission to a hospital bed reserved only for those that truly need it. | To ensure that people who are frail and elderly can have any intervening acute episodes of care managed without extended stays in hospital , which risks decompensation and increased dependence | To ensure that services that support frontline delivery of care such as Pharmacy, Pathology and Radiology are as efficient and resilient as they can be by realising any economies of scale across hospital providers | To ensure that clinical care that is highly specialised and the skills required to deliver this care are concentrated in a smaller number of larger 'centres' but delivered across a network of hospital sites | To ensure that planned care is delivered consistently and reliably by creating the maximum capacity to separate elective care from emergency care and ensuring that assets are utilised efficiently | To deliver across H&W the best possible model of care for Women and the New born that sustainably meets the standards described in Better Births and increase the resilience and quality of local services |
| **Starter projects** | Implement<br><br>WAHT Acute Medicine Strategy | Develop Older Person's Advice and Liaison service (OPAL) and Frailty Unit(s) at WAHT | Pathology Partnership Project<br><br>Hospital Pharmacy Transformation Plan | Cancer and renal services strategic partnership programme (UHCW) | WAHT Site Strategy and elective repatriation plan | STP work stream - One single managed, locally delivered service for H&W |

| | |
|---|---|
| **Title of Report** | **Trust Management Group** |
| **Name of director** | **Rob Cooper** |

Worcestershire NHS
Acute Hospitals NHS Trust

**Date of Trust Board: 11 January 2017** **Enc E1**

**Report to Trust Board**

| | |
|---|---|
| **Title** | **Quality Governance Committee – report to Trust Board** |
| **Sponsoring Director** | **Dr Bill Tunnicliffe, Associate Non-Executive Director, Chair** |
| **Author** | **Kimara Sharpe, Company Secretary** |
| **Action Required** | The Board is requested to:<br>• Receive the summary of the final report into the never event<br>• Receive assurance in respect of the management of safeguarding<br>• Note the lack of assurance in respect of the time to theatre for patients who had suffered a fracture neck of femur and primary mortality reviews<br>• Note the lack of assurance in respect of the medicine and surgery divisional reports<br>• Note the avoidable mortality report<br>• Note the report |
| | |
| **Previously considered by** | Not applicable |

**Priorities (√)**

| | |
|---|---|
| *Investing in staff* | |
| *Delivering better performance and flow* | √ |
| *Improving safety* | √ |
| *Stabilising our finances* | |

| | |
|---|---|
| **Related Board Assurance Framework Entries** | 2790 As a result of high occupancy levels, patient care may be compromised<br>2895 If we do not adequately understand & learn from patient feedback we will be unable to deliver excellent patient experience<br>3038 If the Trust does not address concerns raised by the CQC inspection the Trust will fail to improve patient care |
| **Legal Implications or Regulatory requirements** | This report covers some statutory issues such as CQC or accreditation visits. |

**Key Messages**

This paper provides the Board with the key achievements, issues, and risks discussed at the Quality Governance Committee on 24 November and 22 December 2016.

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|---|---|
| Title of report | Quality Governance Committee |
| Name of director | Bill Tunnicliffe |

**Date of Trust Board: 11 January 2017** **Enc E1**

**REPORT TO TRUST BOARD – 11 JANUARY 2017**

## 1. Situation

This report provides the Board with key quality issues and risks discussed at the QGC meetings held on 24 November and 22 December 2016.

## 2. Background

This report provides the Board with assurance on matters related to patient safety and quality. The QGC reviews reports from its sub-committees, quality performance data, and risks to meeting strategic quality objectives. In this way it provides assurance in the areas outlined below and identifies risks and areas of concern for the Board's attention. Where appropriate, the Committee also considers county-wide issues.

## 3. Assessment

### 3.1 Clinical Governance Group

It is now evident that the new governance structure is proving a valuable assurance mechanism for the Committee. The work undertaken by the CGG enables the Committee to gain assurance from the Chief Nurse and Chief Medical Officer in relation to clinical governance matters.

The November meeting received the report from CGG which gave assurance in relation to the management of Venous Thrombolytic Embolism (VTE) prevention and on the new process to manage risk.

Unfortunately the December CGG was cancelled due to patient safety issues caused by operational pressures. I would like to express my concern that the meeting had not taken place. As a result, the QGC was not as effective as it could have been.

### 3.2 Quality Governance Assurance Framework Deliverables (November meeting)

The QGC received a presentation showing ward to board electronic information. The system, Safety and Quality Information Dashboard (SQuID) is still under development but members were impressed with the range of information available at ward level which at a click of the mouse could be aggregated to board level.

### 3.3 Divisional reports

The Medicine and Surgical Divisonal Reports still need a substantial amount of work for the QGC to be able to assure the Board that risks have been identified and actions in place to mitigate the risks. QGC can assure the board on the management of risks within Women and Children and Specialised Services Division. In particular, QGC received the harm review for the radiology backlog and can assure the board on the robustness of the work undertaken. No patients suffered harm relating to the backlog. Four patients were adversely affected in the months of June, July and August.

The Board should be aware that the QGC is particularly concerned about the lack of progress with treating patients who have suffered a fractured neck of

femur in a timely way. Assurance cannot be given that management of this pathway is being undertaken effectively and members are unclear as to whether the appropriate improvement skills are present within the team leading this work.

Concern was also expressed about the lack of any wider organisational development for the senior divisional management teams. It was felt that the teams could benefit from such training.

**3.4 Avoidable Mortality (November and December meetings)**

This are of work continues to be of concern. HSMR and SHMI continue to be an outlier and analyses have shown that the coding of comorbidities and palliative care are unlikely to be major contributing factors. The main factor appeared to be the deteriorating patient. The number of primary mortality reviews undertaken continues to be low.

The Committee was encouraged with the work that is being undertaken across the health economy and would urge the board to support the concept of reviews of the patient pathway when patients have been discharged and die unexpectedly.

**3.5 Research and Development Strategy (December meeting)**

The Committee received a draft strategy which will be presented at the next Board meeting.

**3.6 Never event – final report (December meeting)**

The final report with respect to the never event (wrong site surgery) was received. The root cause was human factors (lack of challenge and lack of following the correct policy). Training has been undertaken and a new process introduced to ensure compliance with the policies.

**3.7 System wide quality issues**

Members discussed areas to raise with commissioners. These included:

- Community associated urinary tract infection
- Appropriateness of patients transferred to the Acute Trust who are end of life
- Discharge of complex patients with mental health/behavioural problems
- Patients being admitted with pressure ulcers.

**3.8 CQC feedback (December meeting)**

The Committee received a report which outlined the initial CQC feedback.

**3.9 Board Assurance Framework**

The Committee agreed to close risk 2902 and accepted a new risk 2665.

**3.10 Safeguarding Expert Forum**

The Head of Safeguarding gave a comprehensive report which focussed on the effort being undertaken to ensure staff were being trained appropriately. She has also revised all the policies and pathways and has strengthened the

safeguarding team. There was universal praise for the work that she has undertaken since her appointment.

## 4 Recommendation

The Board is requested to:

- Receive the summary of the final report into the never event
- Receive assurance in respect of the management of safeguarding
- Note the lack of assurance in respect of the time to theatre for patients who had suffered a fracture neck of femur and primary mortality reviews
- Note the lack of assurance in respect of the medicine and surgery divisional reports
- Note the avoidable mortality report
- Note the report

Dr Bill Tunnicliffe
**Chair – Quality Governance Committee**

| | |
|---|---|
| Title of report | Quality Governance Committee |
| Name of director | Bill Tunnicliffe |

Worcestershire NHS
Acute Hospitals NHS Trust

**Date of Trust Board: 11 January 2017** **Enc E2**

**Report to Trust Board**

| | |
|---|---|
| **Title** | **Trust Priority Improvement Plan (Summary)** |
| **Sponsoring Director** | **Rob Cooper, Interim Chief Executive** |
| **Author** | **Sarah Smith, Director of Planning and Development** |
| **Action Required** | The Board is requested to:<br>• Receive the summary plan of the Trust and Divisional priorities for improvement<br>• Note the next steps in the delivery and monitoring of the improvements<br>• Seek assurance that the plans can be delivered |

| | |
|---|---|
| **Previously considered by** | Executive Management Team |
| **Priorities (√)** | |
| *Investing in staff* | √ |
| *Delivering better performance and flow* | √ |
| *Improving safety* | √ |
| *Stabilising our finances* | |
| **Related Board Assurance Framework Entries** | 3038 If the Trust does not address concerns raised by the CQC inspection, the Trust will fail to improve patient care |
| **Legal Implications or Regulatory requirements** | Subject to satisfactory improvement, the CQC has included conditions on the Trust's registration relating to the time to initial assessment in the Emergency Department and reporting in Radiology |
| **Glossary** | NHSI – NHS Improvement<br>CQC – Care Quality Commission |

**Key Messages**

Worcestershire Acute Hospitals NHS Trust (WAHT) was placed in special measures by NHSI in December 2015 due to quality concerns identified by the CQC following their inspection of the Trust in July 2015 and publication of the final report. The Trust was re-inspected by the CQC in November 2016 and whilst the final report will not be available until early Spring 2017, it is clear that the patient care improvements required since the Trust was placed in special measures, have not been delivered at sufficient scale and pace.

Due to ongoing concerns around urgent care and patient flow at the Trust, the CQC called a risk summit on December 22nd 2016 to agree some immediate actions. Following the CQC re-inspection and the risk summit, the Trust Executive have reprioritised the Trust Improvement Plan and a summary of the agreed priorities and the next steps is presented in this paper.

| | |
|---|---|
| Title of report | Trust Priority Improvement Plan |
| Name of director | Sarah Smith |

**Date of Trust Board: 11 January 2017** **Enc E2**

**REPORT TO TRUST BOARD – 11 JANUARY 2017**

## 1. Situation

The Trust Improvement Programme has been reprioritised in response to the risk summit called by the CQC on December 22nd 2016 and ongoing concerns about the delivery of key improvements required at the Trust.

## 2. Background

Worcestershire Acute Hospitals NHS Trust (WAHT) was placed in special measures by NHSI in December 2015 due to quality concerns identified by the CQC following their inspection of the Trust in July 2015 and publication of the final report.

All Trusts in special measures are required to publish a Patient Care Improvement Plan (PCIP). WAHT was re-inspected by the CQC in November 2016 and it was clear that whilst PCIP improvements in specific areas of the Trust such as maternity and outpatients had been delivered, the Trust - wide issues around urgent care and patient flow remained critical and extremely challenging.

The Trust was able to demonstrate some specific quality and safety improvements and improvements in clinical and corporate governance systems and processes but not at sufficient scale and pace and the improvements are not yet embedded.

The CQC will publish their report from the November 2016 re-inspection in early Spring 2017. Meanwhile, due to concerns around urgent care and patient flow, the CQC called a risk summit on December 22nd 2016 to agree with the Trust and partners some immediate actions to create capacity to meet the anticipated peak demand for urgent and emergency care over the Christmas holiday period.

## 3. Assessment

**3.1** **Patient Care Improvement Plan**. The Trust PCIP, developed during 2015/16, has failed to date to deliver the full range of improvements required. Delivery is inconsistent and has been disrupted by frequent changes in key personnel at the Trust over the past 12 months and lack of accountability and, more fundamentally, by the lack of a culture of improvement at the Trust as staff constantly deal with increasing day to day pressures and performance challenges. There are numerous lessons to be learned from the experience of developing and delivering the PCIP and the organisational development required to enable this will start to be rolled out from January 2017.

Following the CQC re-inspection and the risk summit, the Trust Executive have reprioritised the Trust Improvement Plan and a summary of the priorities is presented below.

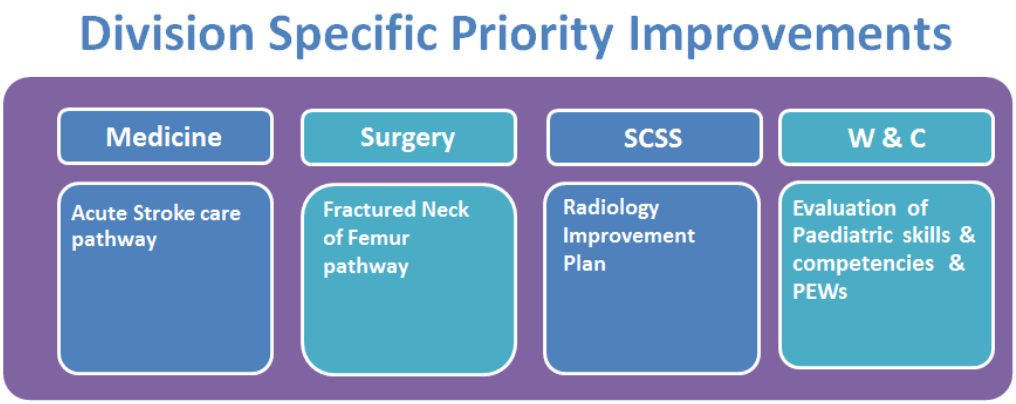
| | |
|---|---|
| Title of report | Trust Priority Improvement Plan |
| Name of director | Sarah Smith |

**Date of Trust Board: 11 January 2017** **Enc E2**

# Trust Priority Improvement Programme


| | |
|---|---|
| Title of report | Trust Priority Improvement Plan |
| Name of director | Sarah Smith |

**3.2** **Divisional priorities:** There are some priority areas for improvement that reside with the trust divisions as follows:




**3.2** **Next steps.** Each priority improvement area has an agreed executive lead.

The leads have been tasked with completing project initiation, project planning and progress reporting documentation using standard templates.

In addition to this approach, the Trust is seeking an experienced Improvement Lead to drive delivery and to provide assurance around the programme areas and the improvements being made.

The Chief Executive will hold executive leads to account for delivery through fortnightly progress meetings and relevant improvement measures in the programme will be reviewed at divisional level alongside the divisional priorities as part of the strengthened monthly divisional performance meetings.

## 4 Recommendation

The Board is requested to:

- Receive the summary plan of the Trust priorities for improvement
- Note the next steps in the delivery and monitoring of the improvements
- Seek assurance that the plans can be delivered

**Sarah Smith**
**Director of Planning and Development**

| | |
|---|---|
| Title of report | Trust Priority Improvement Plan |
| Name of director | Sarah Smith |

Worcestershire NHS
Acute Hospitals NHS Trust

**11 January 2017** **Enclosure F2**

## Report to Trust Board

| | |
|---|---|
| **Title** | Integrated Performance Report (Month 8) |
| **Sponsoring Director** | Jill Robinson, Interim Director of Finance and Performance |
| **Author** | Rebecca Brown, Assistant Director of Information and Performance |
| **Action Required** | Trust Board is asked to note the Integrated Performance Report |
| | |
| **Previously considered by** | Finance and Performance Committee |

**Priorities (√)**

| | |
|---|---|
| *Investing in staff* | ✓ |
| *Delivering better performance and flow* | ✓ |
| *Improving safety* | ✓ |
| *Stabilising our finances* | ✓ |

| | |
|---|---|
| **Related Board Assurance Framework Entries** | 2790 As a result of high occupancy levels, patient care may be compromised and access targets missed<br>3291 Deficit is worse than planned and threatens the Trust's long term financial sustainability<br>2895 If we do not adequately understand & learn from patient feedback we will be unable to deliver excellent patient experience |
| **Legal Implications or Regulatory requirements** | Section 92 of the Care Act 2014 ("the Act") creates an offence of supplying, publishing or otherwise making available information, which is false or misleading in a material respect. The offence will apply: to such care providers and such information as is specified in regulations; and, where the information is supplied, published or made available under an enactment or other legal obligation |
| | |
| **Glossary** | EAS – Emergency Access Standard<br>STF – Sustainability Transformation Fund<br>YTD – Year to Date<br>NHSi – National Health Service Improvement |

**Key Messages**

- The Trust is facing ongoing performance challenges against the majority of the operational targets and standards that relate to both good patient access and the STF.
- Performance against the 4 hour emergency access standard (EAS) remains challenging. Increased operational controls are in place to create flow and to release designated assessment area spaces to ensure that patients that are admitted in a timely way to the right bed, first time.
- Performance in respect of the 18 week referral to treatment target continues to show a decline in November, and remains a concern.
- Planned under performance in 62 day cancer pathways will continue until the remaining backlog is cleared. Cancer 2 week waits (breast) is now performing above the target of 93%.
- The Finance and Performance Committee will receive revised trajectories for all key underperforming indicators at its February meeting. The trajectories will be robustly tested against planned actions, for deliverability.

| | |
|---|---|
| Title of report | Integrated Performance Report – Month 8 2016/17 |
| Name of director | Jill Robinson |

Worcestershire NHS
Acute Hospitals NHS Trust

**11 January 2017** **Enclosure F2**

## 1. Situation and Background

This paper presents an overview of performance for November 2016. This is an exception report based on performance against national and local targets and standards. This paper updates the Trust Board on current performance and summarises key areas of risk. For comprehensive data on November performance, please refer to the Trust dashboard.

## 2. Assessment

### 2.1 Urgent care and flow

2.1.1 NHS Constitution sets out that a minimum of 95% of patients attending an A&E department must be seen, treated and then admitted or discharged in under four hours. The Trust performance from April to November 2016/17 is 79%, which is a decrease of 7% when compared to the same months in 2015/16. A&E has had 8.19% more attendances than the same period in 15/16.

2.1.2 *Table showing 4 hour wait performance November 2015 – November 2016*

| | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 4 Hour Waits (%) - Trust inc. MIU | 90.66% | 89.07% | 84.30% | 82.40% | 82.30% | 84.40% | 82.20% | 84.70% | 85.70% | 83.70% | 82.80% | 80.90% | 78.90% |

2.1.3 The STF trajectories for the EAS have not been met for any month of the year, including November. The Trust forecasts that we will not meet the EAS STF trajectory for the remainder of the financial year.

2.1.4 There were 37 12 hour (trolley) breaches in November, and this trend has continued into December. Initial Case Reviews and Harm Reviews are taking place on all trolley breaches in accordance with internal procedures.

2.1.5 December 2016 was a challenged month, and performance continued to deteriorate. All non-urgent elective activity was cancelled; two wards were flipped from surgery to medical; and augmented staffing levels were implemented in line with the Winter Operational Plan. A CQC Risk Summit took place in December, and part of the outcome was an updated Urgent Care Plan, which has contributed to managing the urgent care related performance issues.

2.1.6 Oversight of urgent care and flow issues is gained at multiagency level in the A&E Delivery Board, and supported by the A&E Delivery Board Operational Group. Partners include the Acute Trust, Health and Care Trust, West Midlands Ambulance Service and the County Council. A multiagency plan is in place to improve urgent care performance and flow, in line with national requirements.

| | |
|---|---|
| Title of report | Integrated Performance Report – Month 8 2016/17 |
| Name of director | Jill Robinson |

The Trust elements of this plan include: implementing new front door streaming processes to reduce ED attendances; deploying the Safer bundle and red/ green days (which will result in improved discharge processes); and, changing the way Ambulatory Emergency Care is delivered at both sites.

2.1.7 A Director of Urgent Care has been appointed, and will focus on all performance issues noted above.

### 2.2 Referral to Treatment

2.2.1 Since February 2016 the Trust has seen a month on month decline in performance to a low of 85.03% for November 2016. There were two 52 week waiters in November.

2.2.2 *Table showing incomplete RTT performance November 2015 – November 2016*

| | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| RTT - Incomplete 92% in 18 Weeks | 92.05% | 92.05% | 92.04% | 91.50% | 89.20% | 88.90% | 88.80% | 88.26% | 87.80% | 87.36% | 86.79% | 86.60% | 85.03% |

2.2.3 The current STF recovery trajectory expects achievement of the RTT standard by the end of Quarter 4; however, it is now likely that we will not recover this trajectory in 2016/17.

2.2.4 RTT performance is managed through weekly operational meetings (at directorate level) and through Monthly Performance Meetings at Divisional level. Performance meetings are currently being reviewed for efficacy and rigour, under the Performance Improvement Implementation Plan (see separate agenda item).

2.2.5 The Clinical Service Planning process will be completed by 28th February 2017 for all specialties with a material impact on RTT. This will produce robust plans for 2017/18 delivery.

### 2.3 Diagnostics

2.3.1 Diagnostics performance (6 week standard) has been above the national tolerance for 2016/17 to date and continues to underperform. This is having an adverse impact on the RTT and cancer standards. The core area of underperformance is endoscopy.

2.3.2 *Table showing Diagnostics 6 week wait per-centage November 2015 – November 2016*

| | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 6 Week Wait Diagnostics (Proportion of waiting list) | 0.97% | 1.55% | 1.05% | 0.71% | 3.52% | 5.20% | 5.90% | 2.70% | 2.03% | 3.16% | 2.36% | 3.36% | 2.75% |

2.3.3 A Business Case relating to endoscopy will be received by Finance and Performance Committee in February 2017.

## 2.4 Cancer

2.4.1 Performance in the 62 day cancer metric (85% target) has recovered slightly to a current position in November of 75.4%.

2.4.2 *Table showing Cancer 62 day wait performance November 2015 – November 2016*

| | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 62 Days: Wait For First Treatment From Urgent GP Referral: All Cancers | 79.40% | 89.10% | 86.30% | 84.40% | 75.30% | 75.60% | 79.30% | 68.10% | 67.20% | 65.90% | 73.10% | 74.10% | 75.40% |

2.4.3 The recovery target for the 62 day cancer metric is to achieve 85.1% in December 2016. However due to high backlog and underperformance in the earlier months of the financial year, the Trust is predicting this will not be achieved.

2.4.4 The 93% target for patients being seen with suspected cancer within 2 weeks from referral has not been achieved since March 2015. November 2016 performance is 82.2%. Revised trajectories for the 62 day target, and 2 week wait will come to the February Committee.

2.4.5 The 93% target for breast symptomatic patients being seen within 2 weeks from referral has been achieved in October and November 2016, with November's performance of 94.1% being the highest since May 2015.

## 2.5 Stroke

2.5.1 The three core stroke metrics have been consistently under target for 2016/17 to date.

2.5.2 90% of patients should be admitted directly to a Stroke Ward within 4 hours of arriving at hospital. WAHT is performing below the expected standard with the last reported data in October at 22.7%. This is the third month this indicator has shown an improvement, with significantly more improvement needed to reach the 90% target.

2.5.3 80% of Stroke patients should spend 90% of their stay on a Stroke Ward; the Trust reported 54.5% of patients met this standard in October 2016.

2.5.4 Performance for TIA based on the new guidance (October 2016) has not yet been reported. (The new guidance requires all patients, regardless of whether they are routine or urgent, to be seen within 24 hours of referral). Performance based on routine appointments being seen in 7 days, and urgent patients only being seen in 24 hours, was 4.6% in September 2016. The target is >60%. There has been a dedicated focus on this area and performance is expected to have improved significantly in December and into January 2017.

2.5.5 A health economy wide Stroke Board is managing the wider stroke performance issues, and a weekly update on internal Trust issues will go to Executive Management Team from the start on January.

**2.6 Quality and Safety**

2.6.1 The Trust has an HSMR for the 12 months to July 2016 of 109.14 which makes the Trust statistically higher (worse) than expected for this indicator. The SHIMI value for the rolling 12 months to June 2016 is 109.79 which makes the Trust statistically higher (worse) than expected. The Trust has embarked on a series of improvement programmes to address these issues and ensure continued surveillance. The Trust continues to be a significant outlier for mortality performance, and actions to improve this are being defined and managed by the Mortality Review Group and reported through to Quality Governance Committee.

2.6.2 Performance in time to theatres for fractured NOF remains an issue, with performance not reaching target for the past year. This issue is being addressed by a specific sub-group of the Caring Safely Programme, and forecasts based on the planned actions for quarter 4, and 2017/18 are awaited.

2.6.3 The response rates for both A&E and the Acute Wards have been below target for more than 12 months. A&E are below target for Friends and Family scores. The Acute Wards and Maternity Wards met their targets.

2.6.4 The number of patient falls resulting in serious harm per 1000 bed days is lower for 2016/17 than in 2015/16. There were signs of improvement in sepsis related indicators in October and November (sepsis screening, and antibiotics within 1 hour in the Emergency Department), although more data is needed before a definite trend can be identified.

2.6.5 The Trust Board should note that all Quality and Safety issues are reported through for assurance to Quality Governance Committee.

**Jill Robinson**
**Interim Director of Finance and Performance**

| | |
|---|---|
| Title of report | Integrated Performance Report – Month 8 2016/17 |
| Name of director | Jill Robinson |

# Worcestershire Acute Hospitals NHS Trust

## Quality Metrics Overview

Worcestershire NHS
Acute Hospitals NHS Trust

**Reporting Period: November 2016**

### Patient Safety

| Area | Indicator Type | Indicator | | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Current YTD | Prev Year | 2016/17 Tolerances | | | SRO | Data Quality Kitemark |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | | | | | | On Target | Of Concern | Action Required | | |
| Incidents and Never Events | Local | QPS3.3 | Incidents - SI's open > 60 days (Awaiting closure - WAHT) | 3 | 3 | 8 | 9 | 4 | 7 | 6 | 4 | 1 | 4 | 4 | 1 | 2 | - | - | 0 | - | >0 | CMO | |
| | National | QPS4.1 | Never Events | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 1 | 2 | 0 | - | >0 | CMO | |
| | Local | QPS6.6 | Falls: Total Falls Resulting in Serious Harm (In Month) | 2 | 2 | 6 | 2 | 0 | 3 | 1 | 1 | 1 | 1 | 2 | 2 | 1 | 12 | 26 | <=1 | - | >=2 | CNO | |
| | Contractual | QPS7.5 | Pressure Ulcers: New Pts. with Hosp. Acq. Grade 3 Avoidable (Monthly) | 0 | 1 | 0 | 0 | 2 | 1 | 0 | 2 | 1 | 2 | 3 | 2 | 0 | 11 | 12 | 0 | 1 - 3 | >=4 | CNO | |
| | Contractual | QPS7.7 | Pressure Ulcers: New Pts. with Hosp. Acq. Grade 4 Avoidable (Monthly) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | - | >=1 | CNO | |
| Mortality* | National | QPS9.1 | Mortality - SHMI (HED tool) Inc. deaths 30 days post discharge - rolling 12 months | 115 | 111 | 112 | 110 | 109 | 110 | 110 | 110 | | | | | | - | - | <100 | >=100 to UCL | > UCL | DPS | |
| | National | QPS9.81 | Mortality - HSMR - All Diagnostic Groups - rolling 12 months* | 109 | 107 | 104 | 107 | 106 | 107 | 107 | 109 | 110 | 109 | | | | - | - | <100 | >=100 to UCL | > UCL | DPS | |
| | National | QPS9.21 | % Primary Mortality Reviews completed | | | 73% | 65% | 66% | 61% | 46% | 54% | 56% | 58% | 45% | 53% | | | | >=60 | | <60 | DPS | |
| | National | QPS.9.22 | % Secondary Mortality Reviews completed | | | 0% | 0% | 0% | 0% | 0% | 0% | 17% | 0% | 25% | 6% | | | | >=20 | | <20 | DPS | |
| Safety Thermometer | National | QPS10.1 | Safety Thermometer - Harm Free Care Score | 94.20% | 92.86% | 94.28% | 94.82% | 93.77% | 90.97% | 93.33% | 92.86% | 94.47% | 93.10% | 91.78% | 91.51% | 89.91% | - | - | >=95% | 90% - 94% | <90% | CMO | |
| VTE | National | QPS11.1 | VTE Risk Assessment | 94.91% | 94.19% | 93.20% | 93.86% | 93.58% | 95.64% | 96.19% | 95.43% | 95.64% | 93.80% | 93.89% | 92.84% | 93.46% | 94.60% | 95.00% | >=95% | 94% - 94.9% | <94% | CMO | |
| Infection Control | National | QPS12.1 | Clostridium Difficile (Monthly) | 0 | 2 | 2 | 3 | 2 | 2 | 4 | 2 | 3 | 0 | 6 | 4 | 5 | 26 | 29 | 15/16 Threshold <= 33<br>16/17 Threshold < = 32 | | | CNO | |
| | National | QPS12.4 | MRSA Bacteremia - Hospital Attributable (Monthly) | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 0 | - | >0 | CNO | |
| | National | QPS12.131 | MRSA Patients Screened (High Risk Wards Only) - Elective | 95.70% | 97.97% | 95.31% | 98.61% | 95.40% | 94.50% | 95.00% | 95.40% | 95.80% | 95.90% | 92.70% | 97.10% | 96.60% | 95.40% | - | >=95 | - | <95% | CNO | |

### Patient Experience

| Area | Indicator Type | Indicator | | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Current YTD | Prev Year | 2016/17 Tolerances | | | SRO | Data Quality Kitemark |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | | | | | | On Target | Of Concern | Action Required | | |
| Complaints & Compliments ** | Local | QEX1.1 | Complaints - Numbers (In Month) | 68 | 36 | 63 | 57 | 64 | 59 | 58 | 65 | 57 | 70 | 57 | 60 | 68 | 494 | 629 | - | - | - | CNO | |
| | Local | QEX1.3 | Complaints - Number per 10,000 Bed Days (YTD) | 20.57 | 19.80 | 20.02 | 20.32 | 20.74 | 25.23 | 24.70 | 27.41 | 26.82 | 31.31 | 25.86 | 25.62 | 25.99 | 25.99 | 20.74 | - | - | - | CNO | |
| | Local | QEX1.14 | Complaints - % of Category 2 complaints responded within complainant deadline (WAHT) - NEW | 62.0% | 77.0% | 81.0% | 61.0% | 55.0% | 63.0% | 73.0% | 68.0% | 67.0% | 65.0% | 51.0% | 46.0% | 61.0% | 62.0% | 67.0% | >=90 | 80-90% | <79% | CNO | |
| Friends & Family*** | National | QEX2.1 | Friends & Family - A&E (Score) | 76.6 | 70.7 | 72.4 | 61.6 | 63.2 | 70.2 | 57.4 | 63.8 | 74.7 | 82.1 | 64.1 | 66.8 | 69.1 | 69.0 | 70.8 | >=71 | 67-<71 | <67 | CNO | |
| | National | QEX2.61 | Friends & Family - Acute Wards (Score) | | | 77.0 | 74.6 | 77.1 | 78.8 | 80.1 | 79.7 | 79.2 | 82.1 | 78.0 | 80.0 | 78.0 | 80.0 | - | >=71 | 67-<71 | <67 | CNO | |
| | National | QEX2.7 | Friends & Family - Maternity (Score) | 82.5 | 84.9 | 86.7 | 78.2 | 76.1 | 84.2 | 87.6 | 87.6 | 83.2 | 86.0 | 85.8 | 79.0 | | 86.0 | 84.2 | >=71 | 67-<71 | <67 | CNO | |
| EMSA | National | QEX3.1 | EMSA - Eliminating Mixed Sex Accommodation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | - | >0 | CNO | |

### Effectiveness of Care

| Area | Indicator Type | Indicator | | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Current YTD | Prev Year | 2016/17 Tolerances | | | SRO | Data Quality Kitemark |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | | | | | | On Target | Of Concern | Action Required | | |
| Hip Fracture***** | National | QEF3.1 | Hip Fracture - Time to Theatre <= 36 hrs (%) | 76.0% | 61.8% | 59.0% | 76.0% | 63.1% | 55.1% | 65.9% | 69.6% | 47.7% | 47.9% | 53.4% | 66.1% | 61.4% | 57.7% | 66.0% | >=85% | - | <85% | CMO | |
| | Local | QEF3.1i | Hip Fracture - Time to Theatre <=36 hours (%) - WRH | 80.0% | 65.0% | 55.0% | 66.0% | 48.0% | 52.0% | 68.0% | 64.0% | 40.0% | 46.0% | 40.0% | 67.0% | 50.0% | 53.1% | 65.8% | >=85% | - | >=85% | CMO | |
| | Local | QEF 3.1ii | Hip Fracture - Time to Theatre <=36 hours (%) - ALX | 71.0% | 58.0% | 67.0% | 84.0% | 88.0% | 60.0% | 61.0% | 86.0% | 60.0% | 52.0% | 69.0% | 66.0% | 78.0% | 65.5% | 61.2% | >=85% | - | >=85% | CMO | |
| | National | QEF3.2 | Hip Fracture - Time to Theatre <= 36 hrs (%) - Excl. Unfit/Non-Operative Treatment Pts | 87.0% | 76.0% | 68.0% | 80.0% | 75.9% | 63.0% | 79.0% | 81.0% | 65.0% | 77.0% | 63.0% | 80.0% | 67.0% | 72.2% | 75.9% | >=85% | - | <85% | CMO | |

* Mortality Reviews - reported one month in arrears.
** QEX metrics. From April 2016 these are reported as Complaints closed in month. 15/16 was reported as Complaints open in month. From April 2016 the definition for responding to complaints changed from 25 days to agreed with complianant.
***Friends and Family - following a technical issue this data has not been completed for November 2016 and will be reported in the next dashboard.
***** The target for Fractured NoFs has changed to 85% from 90% - effective April 1st, 2016. The 2015/16 performance is RAG rated against 90%.
Worcestershire Acute Hospitals NHS Trust (WAHT)is committed to continuous improvement of data quality. The Trust supports a culture of valuing high quality data and strives to ensure all data is accurate, valid, reliable, timely, relevant and complete. This data quality agenda presents an on-going challenge from ward to Board. Identified risks and relevant mitigation measures are included in the WAHT risk register. This report is the most complete and accurate position available. Work continues to ensure the completeness and validity of data entry, analysis and reporting.

Data Quality Kite mark descriptions:
Green - Reviewed in last 6 months and confidence level high.
Amber - Potential issue to be investigated
Red - DQ issue identified - significant and urgent review required.
Blue - Unknown will be scheduled for review.
White - No data available to assign DQ kite mark

# Worcestershire Acute Hospitals NHS Trust

## Performance Metrics Overview

Worcestershire NHS
Acute Hospitals NHS Trust

**Reporting Period: November 2016**

| Area | Indicator Type | | Indicator | Nov-15 | Dec-15 | Jan-16 | Feb-16 | Mar-16 | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | Current YTD | Prev Year |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Waits | National | PW1.1.3 | 6 Week Wait Diagnostics (Proportion of waiting list) | 0.97% | 1.55% | 1.05% | 0.71% | 3.52% | 5.20% | 5.90% | 2.70% | 2.03% | 3.16% | 2.36% | 3.36% | 2.75% | 3.52% | 1.28% |
| | National | CW3.0 | RTT - Incomplete 92% in 18 Weeks | 92.05% | 92.05% | 92.04% | 91.50% | 89.20% | 88.90% | 88.80% | 88.26% | 87.80% | 87.36% | 86.79% | 86.60% | 85.00% | 85.00% | 89.20% |
| | Local | CW4.1 | Over 52 week waiters who have been treated in month - NEW | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 2 | 2 | 6 | 7 |
| Theatres | Local | PT2.1 | Booking Efficiency - ALX | 72.00% | 71.00% | 71.00% | 77.00% | 75.00% | 74.00% | 69.00% | 75.00% | 67.00% | 74.00% | 72.00% | 71.00% | 72.00% | | - |
| | Local | PT2.2 | Booking Efficiency - WRH | 84.00% | 77.00% | 82.00% | 77.00% | 85.00% | 86.00% | 80.00% | 83.00% | 87.00% | 81.00% | 81.00% | 87.00% | 87.00% | | - |
| | Local | PT2.3 | Booking Efficiency - KGH | 70.00% | 70.00% | 68.00% | 71.00% | 71.00% | 74.00% | 74.00% | 78.00% | 70.00% | 73.00% | 66.00% | 68.00% | 69.00% | | - |
| | Local | PT1.1 | Utilisation - ALX | 70.00% | 70.00% | 70.00% | 72.00% | 70.00% | 72.00% | 66.00% | 72.00% | 66.00% | 73.00% | 69.00% | 42.00% | 69.00% | | - |
| | Local | PT1.2 | Utilisation - WRH | 73.00% | 70.00% | 72.00% | 70.00% | 72.00% | 74.00% | 68.00% | 72.00% | 76.00% | 75.00% | 75.00% | 78.00% | 78.00% | | - |
| | Local | PT1.3 | Utilisation - KGH | 68.00% | 66.00% | 65.00% | 68.00% | 68.00% | 67.00% | 70.00% | 71.00% | 66.00% | 70.00% | 64.00% | 65.00% | 66.00% | | - |
| A & E | National | CAE1.1a | 4 Hour Waits (%) - Trust inc. MIU - from September 14 | 90.66% | 89.07% | 84.30% | 82.40% | 82.30% | 84.40% | 82.20% | 84.70% | 85.70% | 83.70% | 82.80% | 80.90% | 78.90% | 82.97% | 87.90% |
| | Local | CAE2.1 | 12 hour trolley breaches | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 5 | 1 | 13 | 4 | 4 | 37 | 64 | |
| | National | CAE3.1 | Time to Initial Assessment for Pts arriving by Ambulance (Mins) - 95th Percentile | 28 | 28 | 35 | 49 | 54 | 40 | 33 | 22 | 24 | 32 | 23 | 37 | 35 | 32 | - |
| | National | CAE3.2 | Time to Initial Assessment for All Patients (Mins) - 95th Percentile | 28 | 28 | 32 | 42 | 46 | 34 | 35 | 28 | 30 | 40 | 35 | 31 | 34 | 31 | - |
| | National | CAE7.0 | Ambulance Handover within 15 mins (%) - WMAS data | 42.04% | 41.58% | 41.74% | 38.40% | 37.74% | 54.00% | 56.10% | 57.30% | 59.10% | 60.70% | 57.40% | 54.70% | 53.90% | 57.00% | 43.43% |
| | National | CAE8.0 | Ambulance Handover within 30 mins (%) - WMAS data | 88.10% | 88.18% | 86.02% | 85.58% | 81.65% | 91.70% | 90.20% | 91.70% | 93.00% | 90.30% | 90.80% | 87.69% | 87.70% | 90.80% | 88.62% |
| | National | CAE9.0 | Ambulance Handover over 60 minutes - WMAS data | 26 | 38 | 29 | 26 | 68 | 31 | 51 | 34 | 26 | 70 | 43 | 97 | 81 | 433 | 381 |
| Cancer * | National | CCAN1.0 | 31 Days: Wait For First Treatment: All Cancers | 97.20% | 98.10% | 98.50% | 97.50% | 96.10% | 95.90% | 96.90% | 96.60% | 99.20% | 97.80% | 97.30% | 98.10% | 94.00% | 97.10% | 97.50% |
| | National | CCAN5.0 | 62 Days: Wait For First Treatment From Urgent GP Referral: All Cancers | 79.40% | 89.10% | 86.30% | 84.40% | 75.30% | 75.60% | 79.30% | 68.10% | 67.20% | 65.90% | 73.10% | 74.10% | 75.40% | 72.20% | 81.20% |
| | National | CCAN8.0 | 2WW: All Cancer Two Week Wait (Suspected cancer) | 88.30% | 90.40% | 84.10% | 89.00% | 77.30% | 39.40% | 63.70% | 69.20% | 75.50% | 65.92% | 71.00% | 85.90% | 82.20% | 69.00% | 85.70% |
| | National | CCAN9.0 | 2WW: Wait for Symptomatic Breast Patients (Cancer Not initially Suspected) | 80.10% | 82.60% | 82.90% | 91.20% | 79.40% | 34.50% | 28.00% | 55.70% | 74.50% | 51.98% | 76.09% | 93.40% | 94.10% | 61.40% | 80.00% |
| | National | CCAN10.1 | Cancer Long Waiters (104 Day +) includes suspected and diagnosed - treated in month - NEW | | | 2 | 4 | 5 | 10 | 12 | 18 | 12 | 12 | 11 | 12 | | | |
| Stroke | Local | CST1.0 | 80% of Patients spend 90% of time on a Stroke Ward (Local Definition - until March 2016) | 74.60% | 73.20% | 72.55% | 81.10% | 89.80% | - | - | | | | | | | | 82.21% |
| | Local | CST1.1 | 80% of Patients spend 90% of time on a Stroke Ward (National Definition - from April 2016) | | | | | | | | | 58.30% | 72.70% | 27.30% | 54.50% | | | |
| | Local | CST2.0 | Direct Admission (via A&E) to a Stroke Ward (Local Definition - until March 2016) | 66.00% | 69.20% | 69.23% | 77.30% | 66.10% | - | - | | | | | | | | 74.40% |
| | Local | CST2.1 | Direct Admission (via A&E) to a Stroke Ward (National Definition - from April 2016) | | | | | | | | | 20.00% | 6.80% | 9.10% | 22.70% | | | |
| | Local | CST3.0 | TIA (Local Definition - until March 2016) | 68.20% | 65.90% | 62.07% | 64.70% | 60.00% | - | - | | | | | | | | 64.23% |
| | Local | CST3.1 | TIA (National Definition - from April 2016) | | | | | | 62.50% | 50.00% | 31.80% | 5.60% | 6.40% | 4.60% | | | | |
| Inpatients (All) | Local | PIN1.5 | Bed Occupancy (Midnight General & Acute) - WRH ** | 102% | 102% | 108% | 102% | 102% | 100% | 101% | 99% | 100% | 100% | 100% | 98% | 97% | 99% | 102% |
| | Local | PIN1.6 | Bed Occupancy (Midnight General & Acute) - ALX ** | 96% | 94% | 104% | 104% | 96% | 86% | 87% | 84% | 87% | 86% | 94% | 96% | 96% | 89% | 94% |
| | Local | PIN2.3 | Beds Occupied by NEL Stranded Patients (>7 days) - last week of month | | | | | | | | | | 45.90% | 45.80% | 47.00% | 52.50% | | |
| | National | PIN3.1 | Delayed Transfers of Care SitRep (Patients) - Acute/Non-Acute*** | 25 | 34 | 26 | 33 | 27 | 36 | 33 | 33 | 22 | 26 | 39 | 34 | 45 | 268 | 457 |
| | National | PIN3.2 | Delayed Transfers of Care SitRep (Days) - Acute/Non-Acute*** | 817 | 918 | 807 | 1090 | 725 | 739 | 788 | 1,063 | 704 | 514 | 1,145 | 1,005 | 1,225 | 7,183 | 14561 |
| | Local | PIN4.2 | Bed Days Lost Due To Acute Bed No Longer Required (Days) | 3,133 | 3,832 | 3,966 | 3,320 | 3,468 | 3,038 | 3,252 | 3,106 | 2,409 | 2,459 | 2,899 | 3,387 | 3,402 | 23,952 | 40,369 |
| Elective | National | PEL3.0 | 28 Day Breaches as a % of Cancellations**** | 12.7% | 42.6% | 19.7% | 14.6% | 36.1% | 38.3% | 15.3% | 20.0% | 17.7% | 22.9% | 10.1% | 7.1% | 40.21% | 21.18% | 20.1% |
| | National | PEL3.1 | Number of patients - 28 Day Breaches (cancelled operations) | 7 | 17 | 14 | 14 | 26 | 23 | 13 | 15 | 11 | 11 | 7 | 7 | 39 | 126 | - |
| | National | PEL4.2 | Urgent Operations Cancelled for 2nd time | 1 | 1 | 1 | 0 | 0 | 0 | 1 | 4 | 1 | 1 | 0 | 0 | 1 | 8 | 4 |
| Emergency | Local | PEM2.0 | Length of Stay (All Patients) | 4.3 | 4.6 | 5.0 | 4.6 | 4.7 | 4.7 | 4.4 | 4.8 | 4.3 | 4.7 | 4.8 | 4.6 | 4.56 | 4.6 | 4.8 |
| | Local | PEM3.0 | Length of Stay (Excluding Zero LOS Spells) | 5.9 | 6.5 | 6.9 | 6.5 | 6.5 | 6.5 | 6.1 | 6.6 | 5.9 | 6.4 | 6.9 | 6.6 | 6.78 | 6.5 | 6.6 |

| Tolerance Type | 2016/17 Tolerances: On Target | Of Concern | Action Required | SRO | Data Quality Kitemark |
|---|---|---|---|---|---|
| National | <1% | - | >1% | COO | |
| National | >=92% | - | <92% | COO | |
| Local | 0 | - | >0 | COO | |
| Local | Based on Target Cases per Sessions Utilisation (>8% below target = 'Of Concern') | | | COO | |
| Local | | | | COO | |
| Local | | | | COO | |
| Local | Based on Target Cases per Sessions Utilisation (>8% below target = 'Of Concern') | | | COO | |
| Local | | | | COO | |
| Local | | | | COO | |
| National | >=95% | - | <95% | COO | |
| Local | 0 | | 0 | COO | |
| National | <=15mins | - | >15mins | COO | |
| National | <=15mins | - | >15mins | COO | |
| National | >=80% | - | <80% | COO | |
| National | >=95% | - | <95% | COO | |
| Local | 0 | | >0 | COO | |
| National | >=96% | - | <96% | COO | |
| National | >=85% | - | <85% | COO | |
| National | >=93% | - | <93% | COO | |
| National | >=93% | - | <93% | COO | |
| - | - | - | - | COO | |
| Local | >=80% | - | <80% | COO | |
| Local | >=80% | - | <80% | COO | |
| Local | >=70% | - | <70% | COO | |
| Local | >=90% | - | <90% | COO | |
| Local | >=60% | - | <60% | COO | |
| Local | >=60% | - | <60% | COO | |
| Local | <90% | 90 - 95% | >95% | COO | |
| Local | <90% | 90 - 95% | >95% | COO | |
| Local | <=45 | - | >45 | | |
| - | - | - | - | COO | |
| - | - | - | - | COO | |
| - | - | - | - | COO | |
| TBC | <=5% | 6 - 15% | >15% | COO | |
| TBC | - | - | - | COO | |
| National | <=0 | - | >0 | COO | |
| Local | TBC | TBC | TBC | COO | |
| - | - | - | - | COO | |

** Cancer _this involves small numbers that can impact the variance of the percentages substantially.*
***Bed occupancy data source is Bed State Report.*
****w/c 22nd Oct was not available, so the previous week has been used to calculate October performance.*

*Data Quality Kite mark descriptions:*
*Green - Reviewed in last 6 months and confidence level high.*
*Amber - Potential issue to be investigated*
*Red - DQ issue identified - significant and urgent review required.*
*Blue - Unknown will be scheduled for review.*
*White - No data available to assign DQ kite mark*

Worcestershire Acute Hospitals NHS Trust (WAHT)is committed to continuous improvement of data quality. The Trust supports a culture of valuing high quality data and strives to ensure all data is accurate, valid, reliable, timely, relevant and complete. This data quality agenda presents an on-going challenge from ward to Board. Identified risks and relevant mitigation measures are included in the WAHT risk register. This report is the most complete and accurate position available. Work continues to ensure the completeness and validity of data entry, analysis and reporting.

Worcestershire NHS
Acute Hospitals NHS Trust

**11 January 2016** **Enclosure F3**

## Report to Public Trust Board

| | |
|---|---|
| **Title** | **Financial Performance – Month 8 2016/17** |
| **Sponsoring Director** | **Jill Robinson – Interim Director of Finance & Performance** |
| **Author** | Haq Khan – Deputy Director of Finance<br>Jo Kirwan - Assistant Director of Finance<br>Katie Osmond – Assistant Director of Finance |
| **Action Required** | The Trust Board is asked to:<br>➢ note the financial position<br>➢ note intention to reflect loss of STF income due to failure to deliver operational metrics |
| **Previously considered by** | *Finance & Performance Committee* |

**Priorities (√)**

| | |
|---|---|
| *Investing in staff* | |
| *Delivering better performance and flow* | |
| *Improving safety* | |
| *Stabilising our finances* | ✓ |

| | |
|---|---|
| **Related Board Assurance Framework Entries** | 3290 If plans to improve cash position do not work the Trust will be unable to pay creditors impacting on supplies to support service.<br>3291 Deficit is worse than planned and threatens the Trust's long term financial sustainability.<br>3193 If the Trust does not achieve patient access performance targets there will be significant impact on finances. |
| **Legal Implications or Regulatory requirements** | The Trust must ensure plans are in place to achieve the Trust's financial forecasts.<br><br>The Trust has a statutory duty to breakeven over a 3 year period. |
| **Glossary** | ***Commissioning for Quality and Innovation (CQUINs)*** – payments ensure that a proportion of providers' income (currently up to 2.5%) is conditional on quality and innovation and is linked to service improvement. The schemes that qualify for CQUIN payments reflect both national and local priorities.<br>***Earnings before interest, taxation, depreciation and amortisation (EBITDA)*** – is a measure of a trust's surplus from normal operations, providing an indication of the organisation's ability to reinvest and meet any interest associated with loans it may have. It is calculated as revenue less operating expenses less depreciation less amortisation. |

| | |
|---|---|
| | ***Liquidity*** – is a measure of how long an organisation could continue if it collected no more cash from debtors. In Monitor's Risk Assessment Framework, it is measured by the number of days' worth of operating costs held in cash or cash-equivalent forms and is a key component of the continuity of services risk.<br>***Quality, innovation, productivity and prevention (QIPP)*** – is a programme designed to identify savings that can be reinvested in the health service and improve quality of care. Responsibility for its achievement lies with CCGs; QIPP plans must therefore be built into planning (and performance management) processes.<br>***Marginal rate emergency tariff (MRET)*** – is an adjustment made to the amount a provider of emergency services is reimbursed. It aims to encourage health economies to redesign emergency services and manage patient demand for those services. A provider is paid 70% of the national price for each patient admitted as an emergency over and above a set threshold.<br>Introduced in 2003, **payment by results (PBR)** was the system for reimbursing healthcare providers in England for the costs of providing treatment. Based on the linking of a preset price to a defined measure of output of activity, it has been superseded by the national tariff. |

**Key Messages:**
**OVERVIEW**

- Against the pre STF control total there is a £1.75m gap between the current underlying monthly run rate and required run rate. The settlement with commissioners (once signed) will reduce the gap to c£1m per month over the last 4 months.

- The remaining challenge of £4.4m requires a stepped improvement to the underlying run rate via enhancing agency controls and challenging current expenditure levels. It is unlikely that this on its own will reduce expenditure to the required level and the Trust will need to mitigate via other measures including cessation of discretionary expenditure and technical adjustments.

- The divisions will be set control totals and will be required to rapidly develop plans to ensure delivery of the required improvement in the run rate. Delivery will be managed through the monthly performance reviews.

**I&E POSITION YTD**

- At the end of November the Trust is recording a YTD deficit of £25.3m. This is £1.6m worse than plan, and consistent with the adverse variance against STF of £1.6m driven by the failure to deliver the STF trajectories for the operational performance metrics.

- Adverse income variance of £3.1m has been offset by favourable expenditure variances due to vacancies across non clinical and scientific, technical and therapeutic staffing and reduced levels of activity.

- The underlying deficit for November is £3.6m. Although this is a £0.4m improvement on October, the underlying deficit remains high compared to the run rate required to deliver a pre STP planned deficit of £47.7m at the end of the financial year.

**I&E POSITION FORECAST**

- The November deficit was £1m worse than forecast with the underlying deficit being £1.4m worse than forecast. Note that the forecast assumed recovery of deficits reported in prior months.

- The Trust continues to report a full year forecast that meets the control target of £34.6m.

- At M8 delivery of the planned pre-STF deficit of £47.7m is challenged by two key components;
    - Recovery of Patient Care Activity/Income
    - Further reduction in agency expenditure

- Without corrective action, a continuation of the current run-rate would result in a FY deficit of £55.4m - £7.7m adverse variance to plan (£5.7m patient care income and £2m expenditure).

- The level of financial risk is showing no material improvement except for the income risks. A settlement for 2016/17 including prior years has been agreed with signatures pending. The proposed settlement, if agreed, will leave the income position £2.4m worse than forecast but £3.3m better than the current run rate.

- Following contract negotiations with Worcestershire CCGs, a verbal agreement was made with the CCG on the 13th December that would mitigate £3.3m of the gap. The remaining challenge of £4.4m requires a stepped improvement to the underlying run rate via enhancing agency controls and challenging current expenditure levels.

- It is evident the Trust is unable to absorb the loss of STF monies as a result of non compliance with the operational performance metrics and submitted a Q2 appeal to that affect. A revision to the FY forecast can be made at Q3 reporting points via the standard NHSI quarterly reporting process. The Trust will undertake a Divisional review of the forecast at Q3 and will consider revising its FY forecast to reflect the loss of STF monies associated with the delivery of the operational metrics.

**INCOME POSITION**

- Although patient care income delivered to the income plan, the November income position fell short of the forecast by £0.5m which is reported across three key areas: Emergencies £0.18m, Electives - £0.14m, Maternity £0.16m.

**CAPITAL POSITION**

- Capital funding applications have been submitted to NHSI. The funding requested within the emergency application is £2.57m and the main application is £5.053m. The Trust is awaiting a decision.

| | |
|---|---|
| Title of report | Financial Performance – Month 8 2016/17 |
| Name of director | Jill Robinson |

- If the loans are not approved or a decision is not forthcoming in a timely basis, the Trust will have to reprioritise other capital schemes to ensure the Trust remains within budget. The December CPG agreed a detailed plan to keep the expenditure within the CRL which will be overseen through monthly reviews led by the Director of Finance.

**KEY RISKS**

- The proposed income settlement with commissioners will leave the Trust £2.4m worse than forecast but £3.3m better than the current run rate. The remaining risks requiring the greatest level of management are:

    - **Reduction in agency expenditure** – Managing expenditure within the agency ceiling is crucial to delivery of the CIP target. A continuation of the current run rate and cost pressures exceeding forecast levels will result in the Trust breaching its agency ceiling. Furthermore, a reduction in agency expenditure is key to the overall delivery of the Trust's financial plan.

      Immediate actions to include:

        - Executive Team to agree agency expenditure reductions across staff groups and confirm Executive lead – 10th January.
        - Executive led confirm and challenge sessions with high agency spend Directorates – January 2017.
        - Freeze on all new non clinical agency/consultancy requests – immediately.

    - **Cost pressures** – These need to be contained within the £1m included in the forecast. The Interim Director of Finance to present an update on the agreed cost pressures and process to manage any value in excess of the £1m to the Executive Team by 10th January 2017.

Worcestershire NHS
Acute Hospitals NHS Trust

# Finance Report
# Month 8

Jill Robinson

Interim Director of Finance

6th January 2017

# Executive Summary

Worcestershire NHS
Acute Hospitals NHS Trust

At the end of November (M8) the Trust reports a YTD deficit of £25.3m – this is £1.6m worse than plan and consistent with the adverse income variance driven by the failure to deliver the operational performance related metrics of the STF noting adverse variances across in-patient activity and CIP have been supported via non recurrent benefits.

Although patient care income delivered to plan in month – it did not recover to the forecasted level falling short by £0.5m. With expenditure continuing to increase, the underlying November run rate of £3.6m remains high and poses a significant risk to delivery of a pre STF deficit of £47.7m this year, and also moving into 2017/18 when the required pre STF planned deficit decreases to £42.7m.

***Table 1:I&E Summary***

| | M8 Actual £m | M8 Plan Variance £m | M8 Forecast Variance £m | YTD Actual £m | YTD Plan Variance £m | Variance Analysis | Pages |
|---|---|---|---|---|---|---|---|
| Income | 32.3 | 0.0 | (0.4) | 251.4 | (3.1) | **Plan Variance (M8 £0m breakeven)** – M8 Patient care income £16k adverse variance – adverse - (Non EL) £0.2m, (OP) £0.2m and (Maternity) £0.1m adverse reduced by a favourable (EL) £0.1m, (DC) £0.2m and (Other income) £0.2m. The YTD adverse variance of £4.4m holds with the key adverse variances across (EL £2m, DC £0.3m, Non EL £2.6m).<br><br>Although M8 delivered against the income plan, Patient Care income fell short of forecast by £0.5m. DC activity was better but all other points of delivery fell short - (EL) £0.1m, (Non EL) £0.2m, (OP) £0.1m. | Pages 6 and 10 |
| Expenditure | (36.3) | (0.1) | (0.2) | (284.0) | 3.1 | **Plan Variance (M8 £0.1m adverse)** – The underlying level of underspend has reduced due to slippage against the ramped up CIP target, increased agency expenditure and some cost pressures materialising.<br><br>Vacancies across non clinical and ST&T staff groups contribute £1.2m towards the YTD favourable variance with the majority of the remainder due to lower than planned levels of activity.<br><br>CIP slippage results in a £1m YTD adverse variance driven by two key schemes – theatres improvement project and further reduction in agency expenditure. | Pages 10-12 |
| **Total – Pre STF** | **(4.0)** | **(0.1)** | **(0.6)** | **(32.4)** | **0.0** | | |
| **STF** | 0.8 | (0.3) | (0.4) | 7.1 | (1.6) | Continued non compliance against the STP operational performance metrics explains a further £0.3m in month and £1.6m YTD. | |
| **Total – Post STF** | **(3.2)** | **(0.4)** | **(1.0)** | **(25.3)** | **(1.6)** | | |
| **Non Rec** | **(0.4)** | **(0.4)** | **(0.4)** | | | M8 non recurrent items | |
| **Underlying position** | **(3.6)** | **(0.8)** | **(1.4)** | | | | |

*Values are net of non PbR pass through movements*

# Financial Performance

Worcestershire NHS
Acute Hospitals NHS Trust

| Ref | | Risk or Opportunity | Pages |
|---|---|---|---|
| R1a | **Pay Expenditure** - Pay costs in November were consistent with October levels of £21.3m and were £0.3m above forecast. Increased agency costs continue to challenge the position at a time when CIP plans had assumed a downward trend in premium expenditure. A reduction in agency expenditure is a key component to the Trust improving its run rate and further assurance is required to demonstrate that agency expenditure is under control. | Risk | Pages 10-12 |
| | **Non Pay Expenditure –** (excluding non PbR drugs and devices) increased from £8.9m in October to £9.6m in November. Although this position is consistent with forecast, backdated costs from Computacenter of £0.4m relating to 'transitional milestone payments' were incurred in month. A deep dive into the Computacenter costs versus budget back dated to commencement of the contracts is in progress and an update will be provided to the February FPC. | | Pages 10-11 |
| | **Income -** YTD income reports an adverse variance of £4.8m against plan, which has worsened by £0.3m in November. Inpatient activity was favourable in month by £0.1m offset by underperformances on Outpatients and Other income. The patient care income position pre STP is £16k adverse in November and £0.3m adverse post STP. The Emergency position has improved in month compared to previous months with a notable improvement in Cardiology and T&O income levels. However, General Surgery emergencies underperformed in November with no material improvement on previous months.<br>The refreshed forecast assumes that elective and day case activity recover broadly to plan. At the end of November Elective activity is under performing significantly against YTD plan (£1.9m) and is also lower than the comparable period last year (partly due to reduced use of additional activity sessions and the independent sector). The year-end settlement with the Worcestershire CCGs will mitigate some of the FY adverse variance once it has been factored into the financial position. | Risk | Pages 6 and 10 |
| R2 | **Cost Pressures –** The value of cost pressures stands at £3.6m with £1m factored into the forecast. M8 included c.£0.1m of costs in excess of forecast predominately due to medical backfill . | Risk | |
| R3 | **CIP** – The CIP gap holds at £3.9m with the forecast assuming closure of the gap in two key areas – the Theatres Improvement Programme and a further reduction in agency expenditure. With elective inpatient activity remaining below plan YTD and agency costs increasing – neither scheme is demonstrating sufficient delivery. At M8 CIP delivery is £1m behind the YTD target. | Risk | |
| R4 | **CQUINs** – Total CQUIN is worth £7.6m. Currently, £5.2m is risk rated Green, £0.6m is rated Amber and £1.8m is Red. The revised forecast assumes that £1.6m will not be secured following the YTD performance and the above RAG rating. Stronger performance in Q2 has seen CQUIN risk decrease from £3.3m to £2.5m. | Risk | |
| R5 | **Sustainability Transformation Fund –** the revised forecast for Q2 assumes that the Trust receives £12.3m of the £13.1m. This revision assumes that an element of the YTD under performance will be recovered in future months.<br>• Finance – Green £10.2m - Q1 actuals reported within finance element consistent with NHSI reporting.<br>• RTT- Red £0.6m<br>• A&E 4 hour target – Red £1.2m<br>• 62 day cancer waits – Red £0.3m | Risk | |
| O2 | **Fines** - The forecast assumes the following level of fines:<br>• Cancer 2 week wait – Red £1.1m<br>• Cancer 31 day – Red £0.1m | Opportunity | |
| R9 | **Capital –** Capital funding applications have been submitted to NHSI. The funding requested within the emergency application is £2.57m and the main application is £5.053m. The Trust is awaiting a decision on the applications. The Trust has already been informed that the £0.5m requested for preparation of the FOASHW OBC will not be approved. If the loans are not approved or a decision is not forthcoming in a timely basis, the Trust will have to reprioritise other capital schemes to ensure the Trust remains within budget. | Risk | Page 8 |

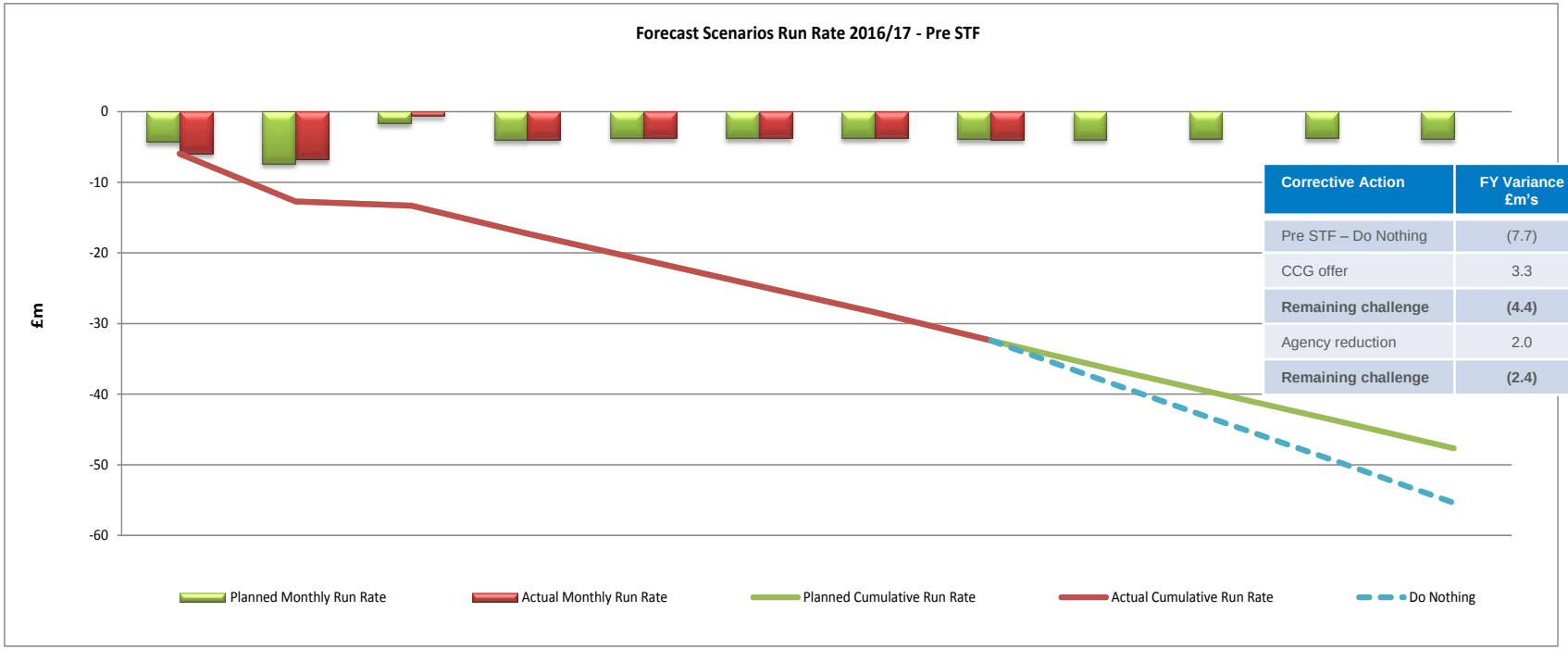
# Run Rate

Worcestershire NHS
Acute Hospitals NHS Trust

At M8 delivery of the planned pre-STF deficit of £47.7m is challenged by two key components;

- Recovery of Patient Care Activity/Income
- Further reduction in agency expenditure

Without corrective action, a continuation of the current run-rate would result in a FY deficit of £55.4m - £7.7m adverse variance to plan (£5.7m patient care income and £2m expenditure).



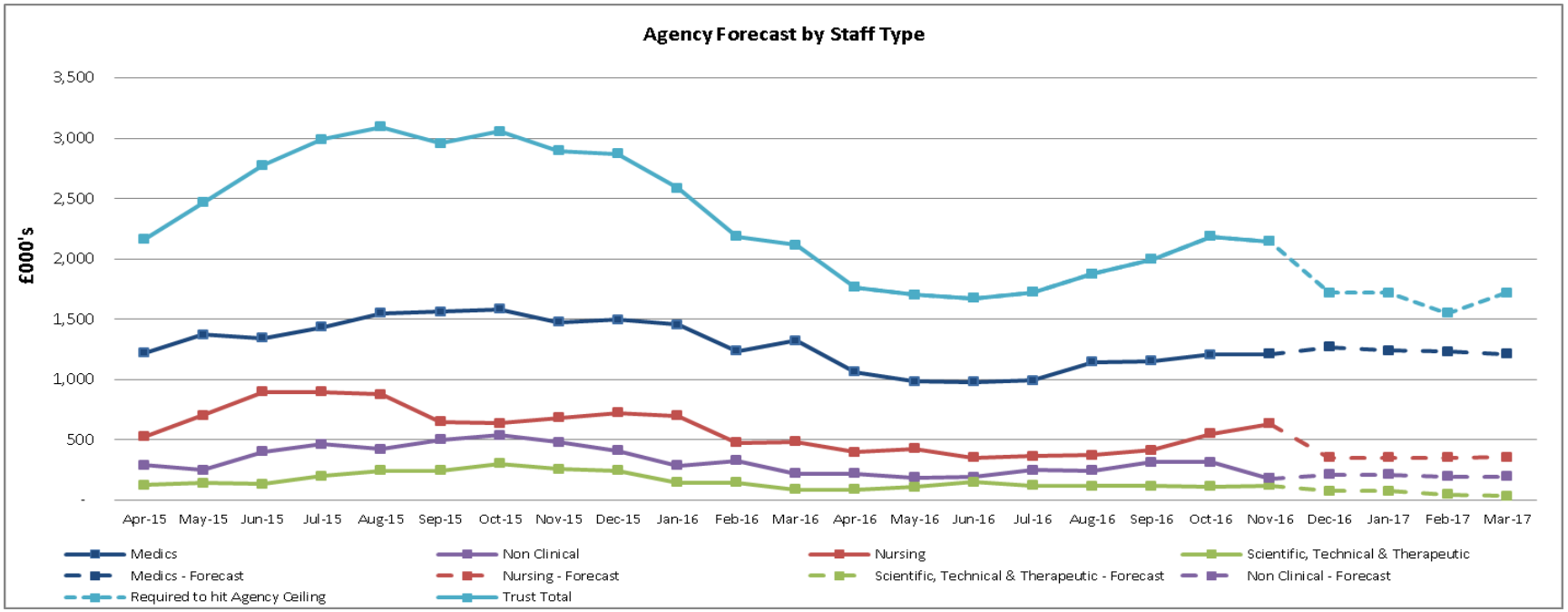

| Corrective Action | FY Variance £m's |
|---|---|
| Pre STF – Do Nothing | (7.7) |
| CCG offer | 3.3 |
| **Remaining challenge** | **(4.4)** |
| Agency reduction | 2.0 |
| **Remaining challenge** | **(2.4)** |

The pre-STF variance of £7.7m requires mitigation. Following contract negotiations with Worcestershire CCGs, on the 13th December a verbal agreement was made that mitigates £3.3m of the gap. The remaining challenge of £4.4m requires a stepped improvement to the underlying run rate via enhancing agency controls and challenging current expenditure levels. It is unlikely that this on its own will reduce expenditure to the required level and the Trust will need to mitigate via other measures including cessation of discretionary expenditure and technical adjustments.

It is evident from the above that the Trust is unable to absorb the loss of STF monies as a result of non compliance with the operational performance metrics and submitted a Q2 appeal to that affect, a response is pending.

# Agency Expenditure

Worcestershire NHS
Acute Hospitals NHS Trust




| Staff Group | Actuals | | | | | | | | | Q2 Forecast | | | | | Full Year Control Total | FOT Var against Control Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 | Oct-16 | Nov-16 | YTD Actual | Dec-16 | Jan-17 | Feb-17 | Mar-17 | FY Forecast | | |
| **Medics - Agency** | 1,062 | 983 | 981 | 991 | 1,144 | 1,151 | 1,207 | 1,211 | 8,729 | 1,269 | 1,240 | 1,232 | 1,211 | 13,680 | | |
| **Non Clinical - Agency** | 219 | 186 | 190 | 247 | *243* | *317* | *317* | *179* | *1,897* | 210 | 210 | 194 | 194 | 2,704 | | |
| **Nursing - Agency** | 398 | 426 | 352 | 366 | *374* | *413* | *550* | *634* | *3,514* | 353 | 353 | 353 | 355 | 4,928 | | |
| **ST&T - Agency** | 87 | 106 | 149 | 119 | *117* | *115* | *112* | *119* | *924* | 75 | 75 | 45 | 33 | 1,152 | | |
| **TOTAL** | **1,766** | **1,701** | **1,672** | **1,722** | ***1,877*** | ***1,996*** | ***2,186*** | ***2,143*** | ***15,064*** | **1,906** | **1,877** | **1,824** | **1,793** | **22,464** | **22,940** | **476** |
| **Plan** | *1,925* | *1,951* | *1,895* | *1,914* | *1,913* | *1,907* | *1,890* | *1,890* | | *1,914* | *1,904* | *1,896* | *1,858* | *22,857* | | |

** Forecast is inclusive of full CIP delivery*

- A detailed review of agency expenditure resulted in £1m moving from medical agency to bank for Ltd Co Bank workers. Note, this does not improve the overall expenditure position of the Trust and is purely a reclassification of expenditure.
- Further reclassification of £0.1m has been performed against the non clinical agency line.
- If the Trust is to maintain agency expenditure within its ceiling of £22.9m –then the average monthly cost cannot exceed £2m. However, as noted on page 4, in order for the Trust to deliver its financial control target - agency expenditure needs to return to Q1 averages i.e. a £0.5m per month reduction against the current run rate.

# Income by Point of Delivery

Worcestershire NHS
Acute Hospitals NHS Trust

| | In Month | | | | YTD | | | | Full Year | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Plan £'000 | Actual £'000 | Var £'000 | % £'000 | Plan £'000 | Actual £'000 | Var £'000 | % £'000 | Initial Plan £'000 | Current Plan £'000 | Forecast £'000 | Var £'000 | % £'000 |
| Elective | 2,382 | 2,501 | 119 | 5% | 18,852 | 16,960 | (1,892) | (10%) | 27,293 | 27,293 | 27,113 | (180) | (1%) |
| Daycase | 3,114 | 3,334 | 220 | 7% | 23,348 | 23,035 | (313) | (1%) | 35,063 | 35,063 | 35,848 | 786 | 2% |
| Non Elective - Emerg | 7,192 | 6,955 | (237) | (3%) | 59,719 | 57,193 | (2,526) | (4%) | 88,795 | 88,795 | 85,963 | (2,831) | (3%) |
| Non Elective - Other | 130 | 139 | 9 | 7% | 1,082 | 1,041 | (41) | (4%) | 1,610 | 1,610 | 2,523 | 913 | 57% |
| **Total Inpatients** | **12,818** | **12,929** | **111** | **1%** | **103,001** | **98,228** | **(4,773)** | **(5%)** | **152,760** | **152,760** | **151,448** | **(1,312)** | **(1%)** |
| Outpatients New | 1,809 | 1,722 | (87) | (5%) | 13,430 | 12,940 | (490) | (4%) | 19,953 | 19,953 | 19,231 | (722) | (4%) |
| Outpatients F Up | 1,758 | 1,621 | (136) | (8%) | 12,970 | 12,503 | (467) | (4%) | 19,312 | 19,312 | 18,866 | (446) | (2%) |
| Outpatients Procedure | 777 | 850 | 72 | 9% | 5,746 | 5,757 | 11 | % | 8,525 | 8,525 | 8,901 | 376 | 4% |
| **Total Outpatients** | **4,344** | **4,193** | **(151)** | **(3%)** | **32,145** | **31,199** | **(946)** | **(3%)** | **47,790** | **47,790** | **46,999** | **(791)** | **(2%)** |
| ED Attendances | 1,387 | 1,330 | (57) | (4%) | 11,171 | 11,205 | 35 | % | 16,645 | 16,645 | 16,971 | 326 | 2% |
| Community MIU | 180 | 180 | 0 | % | 1,446 | 1,566 | 120 | 8% | 2,155 | 2,155 | 2,366 | 211 | 10% |
| **Total ED/MIU** | **1,567** | **1,509** | **(57)** | **(4%)** | **12,617** | **12,772** | **155** | **1%** | **18,800** | **18,800** | **19,337** | **537** | **3%** |
| Maternity - Delivery | 1,020 | 911 | (109) | (11%) | 9,131 | 8,302 | (829) | (9%) | 13,267 | 13,267 | 11,939 | (1,328) | (10%) |
| Maternity Ante Natal | 718 | 695 | (23) | (3%) | 5,849 | 5,727 | (121) | (2%) | 8,625 | 8,625 | 8,567 | (57) | (1%) |
| Maternity Post Natal | 130 | 116 | (14) | (10%) | 1,091 | 970 | (121) | (11%) | 1,598 | 1,598 | 1,421 | (177) | (11%) |
| **Total Maternity** | **1,873** | **1,725** | **(148)** | **(8%)** | **16,115** | **15,018** | **(1,097)** | **(7%)** | **23,555** | **23,555** | **21,954** | **(1,601)** | **(7%)** |
| Paed - Daycase/Elective | 18 | 37 | 19 | 106% | 169 | 177 | 8 | 5% | 250 | 250 | 225 | (25) | (10%) |
| Paed - Non Elective | 560 | 641 | 81 | 15% | 3,486 | 3,551 | 64 | 2% | 5,527 | 5,527 | 5,499 | (28) | (1%) |
| Paed - Outpatient | 242 | 183 | (59) | (24%) | 1,771 | 1,773 | 2 | % | 2,645 | 2,645 | 2,765 | 119 | 5% |
| Paed - BPT, Drugs, CQUIN | 120 | 185 | 65 | 54% | 962 | 976 | 14 | 1% | 1,501 | 1,407 | 1,511 | 104 | 7% |
| Paed - Neonatal Cot Days | 354 | 317 | (37) | (11%) | 2,834 | 2,704 | (129) | (5%) | 4,250 | 4,250 | 3,897 | (353) | (8%) |
| **Total Paediatrics** | **1,294** | **1,362** | **69** | **5%** | **9,222** | **9,181** | **(41)** | **(%)** | **14,174** | **14,080** | **13,896** | **(183)** | **(1%)** |
| **Chemotherapy Delivery** | **310** | **347** | **36** | **12%** | **2,523** | **2,708** | **185** | **7%** | **3,828** | **3,828** | **4,018** | **190** | **5%** |
| Drugs PBR Excluded | 1,959 | 1,959 | 0 | % | 16,099 | 16,099 | 0 | % | 25,700 | 25,040 | 25,040 | 0 | % |
| Critical Care ITU/HDU | 854 | 742 | (112) | (13%) | 6,828 | 6,200 | (628) | (9%) | 10,242 | 10,242 | 9,444 | (798) | (8%) |
| Other Contract Income | 4,983 | 4,950 | (33) | (1%) | 39,657 | 40,194 | 537 | 1% | 60,663 | 59,378 | 60,082 | 704 | 1% |
| **Total Other Contract Income** | **7,796** | **7,651** | **(144)** | **(2%)** | **62,584** | **62,493** | **(91)** | **(%)** | **96,605** | **94,660** | **94,566** | **(94)** | **(%)** |
| Non Elective - Emerg Threshold | 0 | 0 | 0 | | 0 | 0 | 0 | | 0 | 0 | 0 | 0 | |
| Financial Sanctions | 0 | (54) | (54) | | 0 | (720) | (720) | | 0 | 0 | (1,318) | (1,318) | |
| Contractual Risk | (135) | (200) | (65) | | (1,083) | (1,513) | (430) | | (1,624) | (1,624) | (3,132) | (1,508) | 93% |
| **Contractual Deductions/Penalties** | **(135)** | **(254)** | **(119)** | **88%** | **(1,083)** | **(2,233)** | **(1,150)** | **106%** | **(1,624)** | **(1,624)** | **(4,450)** | **(2,826)** | **174%** |
| Commissioner QIPP | (417) | 0 | 417 | | (3,333) | 0 | 3,333 | | (5,000) | (5,000) | 0 | 5,000 | (100%) |
| Non Contract Income | 664 | 636 | (29) | (4%) | 4,175 | 4,163 | (12) | (%) | 7,970 | 5,818 | 5,859 | 41 | 1% |
| Phasing Adj | (96) | (96) | 0 | % | (916) | (916) | 0 | % | 0 | (0) | (0) | 0 | |
| **Pre STP Total** | **30,018** | **30,002** | **(16)** | **(%)** | **237,051** | **232,615** | **(4,436)** | **(2%)** | **358,859** | **354,668** | **353,629** | **(1,039)** | **72%** |
| STP | 1,092 | 764 | (327) | (30%) | 8,733 | 7,096 | (1,637) | (19%) | 0 | 13,100 | 12,254 | (846) | (6%) |
| | **31,109** | **30,766** | **(343)** | **(1%)** | **245,784** | **239,710** | **(6,073)** | **(2%)** | **358,859** | **367,768** | **365,884** | **(1,884)** | **(1%)** |

**Key Activity/Income Messages**

- In November Pre STP position was £16k and £343k Post STP below plan. The YTD position Pre STP is £4,436k and Post STP £6073k below plan.
- Inpatients position has improved in November, Day cases and Electives were above but Emergencies were below plan. Outpatients improved in November but they still continue to underperform , YTD £946k adverse.
- The position assumes the Trust will achieve its financial control total in 2016/17, qualifying for the full £10.1m STF Funding available for the financial element. RTT, A&E and the Cancer 62 day waits standards continue to be non-compliant, creating a £327k under performance in month and £1,637k YTD. There is an opportunity to recover the shortfall via achieving Q3 and Q4 targets for A&E and RTT as the targets are cumulative but the 62 Day cancer target is fixed quarterly. The Trust has submitted an appeal for Q2.

# CIP – Target £28m

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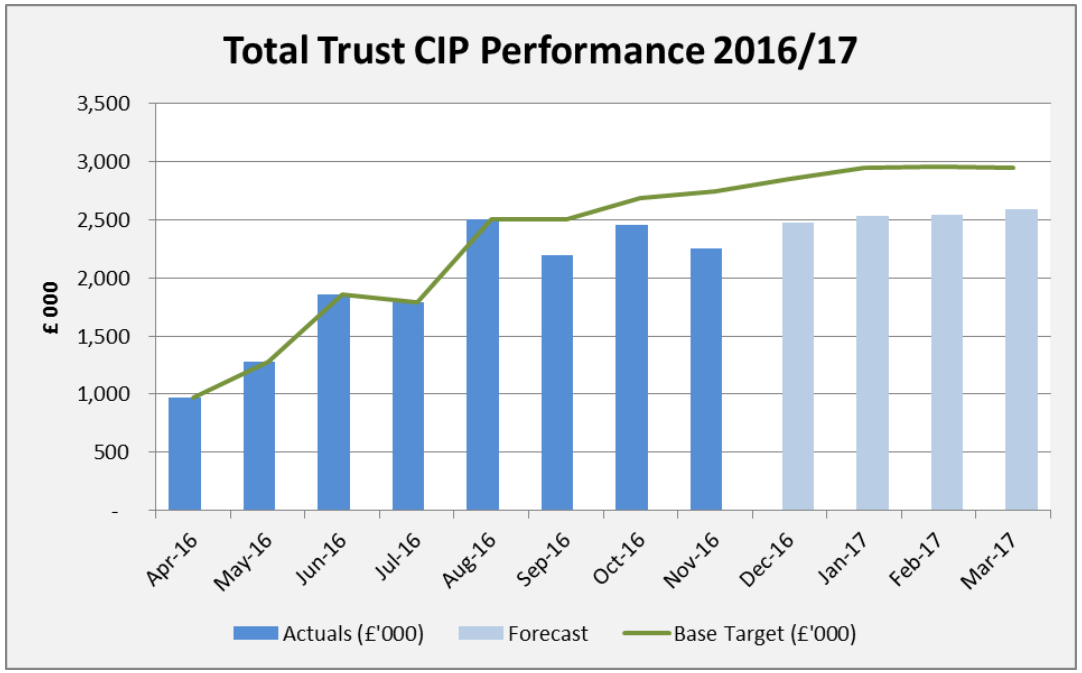
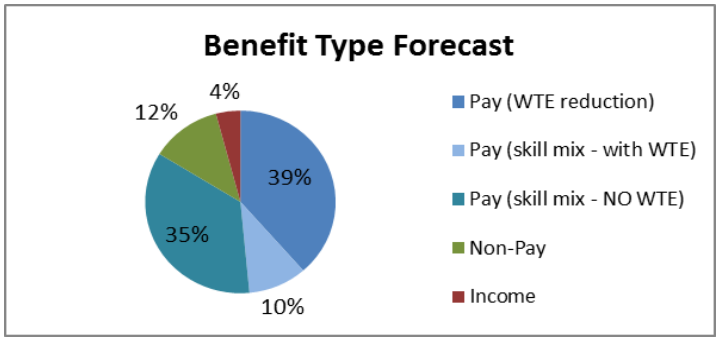
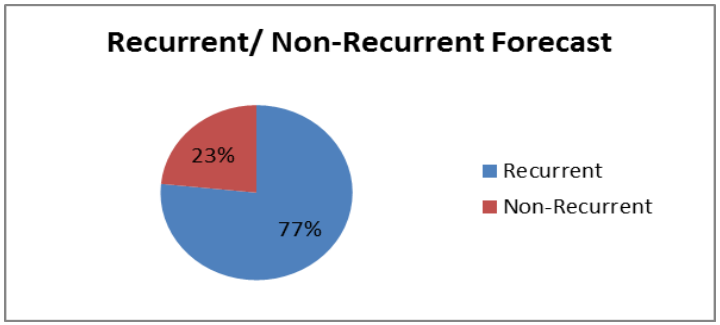
Acute Hospitals NHS Trust




| Month | Base Target (£'000) | Actuals / Forecast (£'000) | Actual v Target (£'000) | Forecast v Target (£'000) |
|---|---|---|---|---|
| Apr-16 | 967 | 967 | 0 | |
| May-16 | 1,284 | 1,284 | 0 | |
| Jun-16 | 1,860 | 1,860 | 0 | |
| Jul-16 | 1,795 | 1,795 | 0 | |
| Aug-16 | 2,502 | 2,502 | 0 | |
| Sep-16 | 2,502 | 2,197 | -305 | |
| Oct-16 | 2,683 | 2,375 | -308 | |
| Nov-16 | 2,740 | 2,334 | -406 | |
| Dec-16 | 2,849 | 2,473 | | -376 |
| Jan-17 | 2,952 | 2,535 | | -417 |
| Feb-17 | 2,959 | 2,547 | | -412 |
| Mar-17 | 2,950 | 2,588 | | -362 |
| | 28,043 | 25,457 | -1,019 | - 1,567 |

At the end of November the Trust is reporting a £1m adverse variance against the CIP target predominately due to slippage in the Theatres improvement Programme and increased agency costs. The Forecast assumes full delivery.

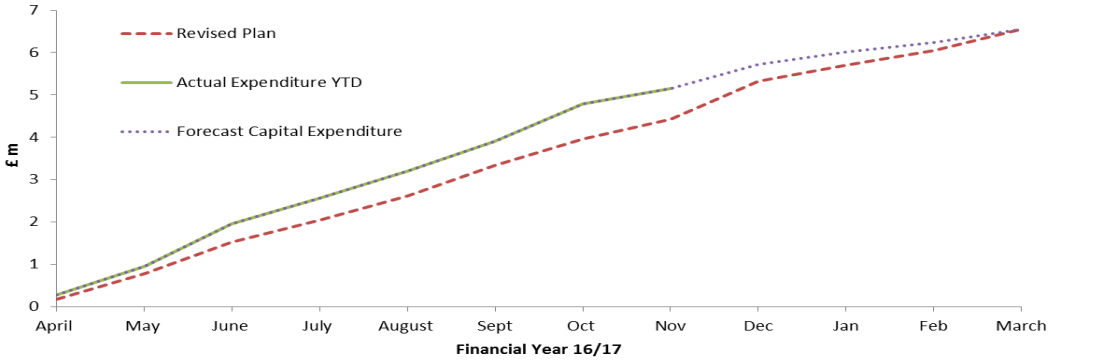
As the table on the left highlights, the monthly targets increased from August with the inclusion of the £3.7m of additional CIP and continues to increase due to phasing of key schemes such as the Theatre Improvement Programme.

Without firm plans the Trust is at risk of undershooting the CIP target. This gap is to be delivered through a combination of savings from the Theatres Improvement Programme and reductions in agency expenditure.

Plans to deliver the Theatres element are encompassed within the Specialty plans to recover elective and day case activity whilst agency expenditure reductions form part of the agency reduction work stream – see risk R1 slide 4.

# Capital Programme 16/17 – M8 Position

Worcestershire NHS
Acute Hospitals NHS Trust




| | £000's | In Month | | | YTD | | | Full year - Prior to any loans | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Workstream | Highlevel Summary | Plan | Actual | Var | Plan | Actual | Var | Plan | Actual | Var |
| Developments | ED Expansion - Overspend offset | 0 | 0 | 0 | (200) | 0 | 200 | (400) | 0 | 400 |
| | ED Expansion | 0 | 0 | 0 | (1,386) | (1,586) | (200) | (1,386) | (1,786) | (400) |
| | ***ASR OBC*** | 0 | (78) | (78) | 0 | (280) | (280) | 0 | (300) | (300) |
| Development Total | | 0 | (78) | (78) | (1,586) | (1,866) | (280) | (1,786) | (2,086) | (300) |
| Property and Works | Routine Works/Backlog Maintenance | (84) | 21 | 105 | (495) | (495) | 0 | (935) | (685) | 250 |
| | Regulatory Standards/Requirements | (13) | 18 | 31 | (220) | (184) | 35 | (465) | (465) | 0 |
| | Clinical Developments / Strategic Schemes | 0 | (11) | (11) | 0 | (146) | (146) | 0 | 0 | 0 |
| | Staffing/Project Costs | (2) | 1 | 3 | (9) | 0 | 9 | (17) | (17) | 0 |
| | Additional Schemes | (11) | (1) | 10 | (16) | (23) | (7) | (220) | (220) | 0 |
| | ***ASR OBC overspend compensation*** | | | | | | | 0 | 300 | 300 |
| Property and Works Total | | (110) | 28 | 138 | (740) | (848) | (108) | (1,637) | (1,087) | 550 |
| Equipment | Equipment | (18) | (11) | 7 | (188) | (188) | (0) | (400) | (400) | 0 |
| Equipment Total | | (18) | (11) | 7 | (188) | (188) | (0) | (400) | (400) | 0 |
| ICT | Systems & Infrastructure | (59) | (57) | 2 | (303) | (385) | (82) | (354) | (604) | (250) |
| | Inflight Project | 0 | 12 | 12 | 0 | (80) | (80) | 0 | 0 | 0 |
| | EPR | (25) | (8) | 17 | (185) | (383) | (198) | (270) | (270) | 0 |
| | Data Centre | (206) | (206) | (0) | (1,287) | (1,287) | (0) | (1,800) | (1,800) | 0 |
| | Hardware and Peripherals | (3) | (15) | (12) | (70) | (57) | 13 | (119) | (119) | 0 |
| | Additional Schemes | (33) | (15) | 18 | (63) | (52) | 11 | (180) | (180) | 0 |
| ICT Total | | (326) | (289) | 37 | (1,908) | (2,244) | (336) | (2,723) | (2,973) | (250) |
| Total Expenditure | | (454) | (350) | 104 | (4,422) | (5,146) | (724) | (6,546) | (6,546) | 0 |
| Alex Land Sale | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Grand Total | | (454) | (350) | 104 | (4,422) | (5,146) | (724) | (6,546) | (6,546) | 0 |

**Loan Application**

Capital funding applications have been submitted to NHSI. The funding requested within the emergency application is £2.57m and the main application is £5.053m. The Trust is waiting for a decision on the application but is hopeful it will be imminent. If the loans are not approved or a decision is not forthcoming in a timely basis, the Trust will have to reprioritise other capital schemes to ensure the Trust remains within budget.

**Year to Date**

The YTD £724k overspend relates to;

- The ED expansion is forecast to overspend by £400k. In the absence of loans this will need to be funded by reducing P&W and ICT allocations further.
- ASR OBC expenditure of £280k YTD with £300k committed to the end of December at which point any further commitments will need to be reviewed.
- ICT has overspent its allocation by £336k. The majority of the costs are project management staff.

**Full year Forecast**

At CPG in December a detailed plan was agreed to ensure the expenditure remains within the CRL.

Monthly meetings with the Director of Finance, Director of Asset Management, Deputy Director of Finance and work stream leads will oversee delivery of the plan.

Worcestershire NHS
Acute Hospitals NHS Trust

# Appendices

# Trustwide Position

Worcestershire NHS
Acute Hospitals NHS Trust

**Table 1**

November 16 (Month 8)

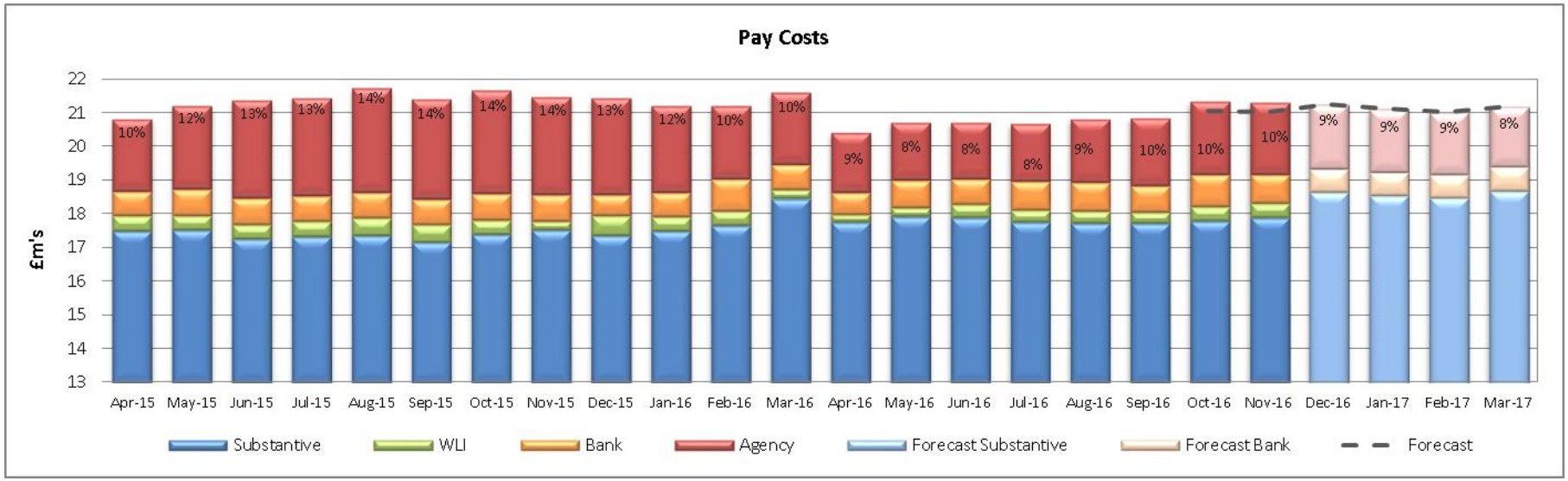
| *Income & Expenditure* | Current Month | | | Year to Date | | | Full Year | | |
|---|---|---|---|---|---|---|---|---|---|
| | Plan | Actual | Var | Plan | Actual | Var | Plan | Forecast | Var |
| | £000s | £000s | £000s | £000s | £000s | £000s | £000s | £000s | £000s |
| **Operating Revenue & Income** | | | | | | | | | |
| Patient Care Revenue | 26,807 | 26,790 | (17) | 212,597 | 208,160 | (4,437) | 317,598 | 316,559 | (1,039) |
| Other Operating Income | 2,217 | 2,300 | 83 | 17,517 | 18,832 | 1,316 | 26,541 | 26,623 | 82 |
| Non PBR Drugs & Devices | 3,212 | 3,212 | (0) | 24,454 | 24,454 | 0 | 37,069 | 37,069 | 0 |
| STF | 1,092 | 764 | (327) | 8,733 | 7,096 | (1,637) | 13,100 | 12,254 | (846) |
| **Total Operating Revenue** | **33,327** | **33,066** | **(261)** | **263,301** | **258,542** | **(4,758)** | **394,308** | **392,505** | **(1,803)** |
| **Operating Expenses** | | | | | | | | | |
| Pay | (21,212) | (21,318) | (106) | (169,319) | (166,861) | 2,458 | (252,015) | (250,812) | 1,203 |
| Non Pay | (9,571) | (9,602) | (31) | (76,216) | (75,548) | 668 | (114,811) | (113,496) | 1,315 |
| Non PBR Drugs & Devices | (3,212) | (3,212) | 0 | (24,454) | (24,454) | 0 | (37,069) | (37,069) | (0) |
| **Total Operating Expenses** | **(33,995)** | **(34,131)** | **(137)** | **(269,989)** | **(266,863)** | **3,126** | **(403,895)** | **(401,377)** | **2,518** |
| **EBITDA *** | **(668)** | **(1,066)** | **(398)** | **(6,688)** | **(8,320)** | **(1,632)** | **(9,587)** | **(8,872)** | **715** |
| EBITDA % | -2.0% | -3.2% | | -2.5% | -3.2% | | -2.4% | -2.3% | |
| Depreciation | (878) | (878) | 0 | (6,974) | (6,974) | 0 | (10,044) | (10,545) | (501) |
| Net Interest, Dividends & Gain/(Loss) on asset disposal | (1,261) | (1,261) | 0 | (10,032) | (10,032) | 0 | (15,024) | (15,238) | (214) |
| **Reported Total Surplus / (Deficit)** | **(2,807)** | **(3,205)** | **(398)** | **(23,694)** | **(25,326)** | **(1,632)** | **(34,655)** | **(34,655)** | **0** |
| Less Impact of Donated Asset Accounting | 6 | 6 | 0 | 48 | 48 | 0 | 72 | 72 | 0 |
| **Surplus / (Deficit) against Control Total** | **(2,801)** | **(3,199)** | **(398)** | **(23,646)** | **(25,278)** | **(1,632)** | **(34,583)** | **(34,583)** | **0** |
| Surplus / (Deficit) % | -8.4% | -9.7% | | -9.0% | -9.8% | | -8.8% | -8.8% | |

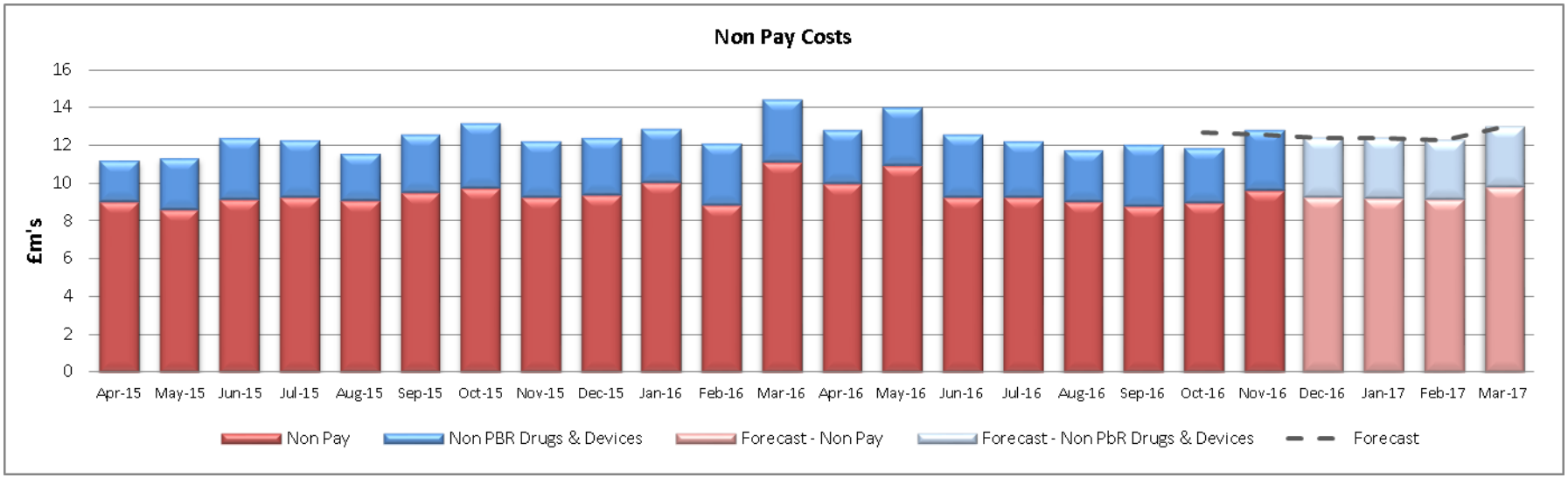
** EBITDA = earnings before interest, tax, depreciation and amortisation*

# Pay & Non Pay Expenditure

Worcestershire NHS
Acute Hospitals NHS Trust

Percentages shows proportion of agency spend against total spend.

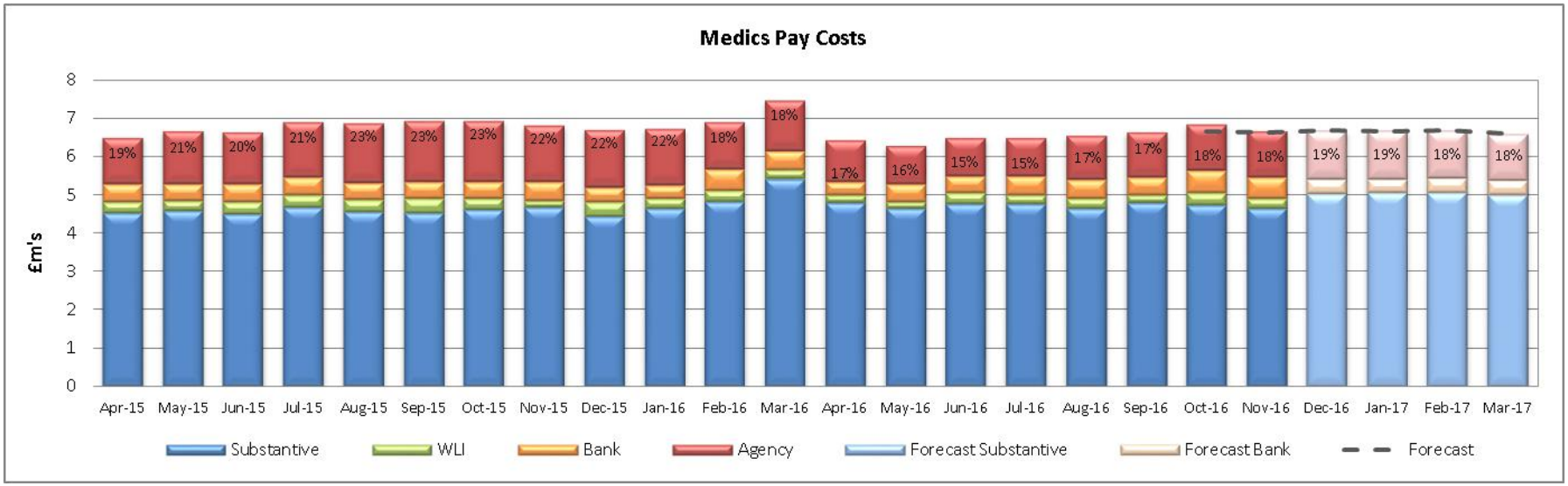


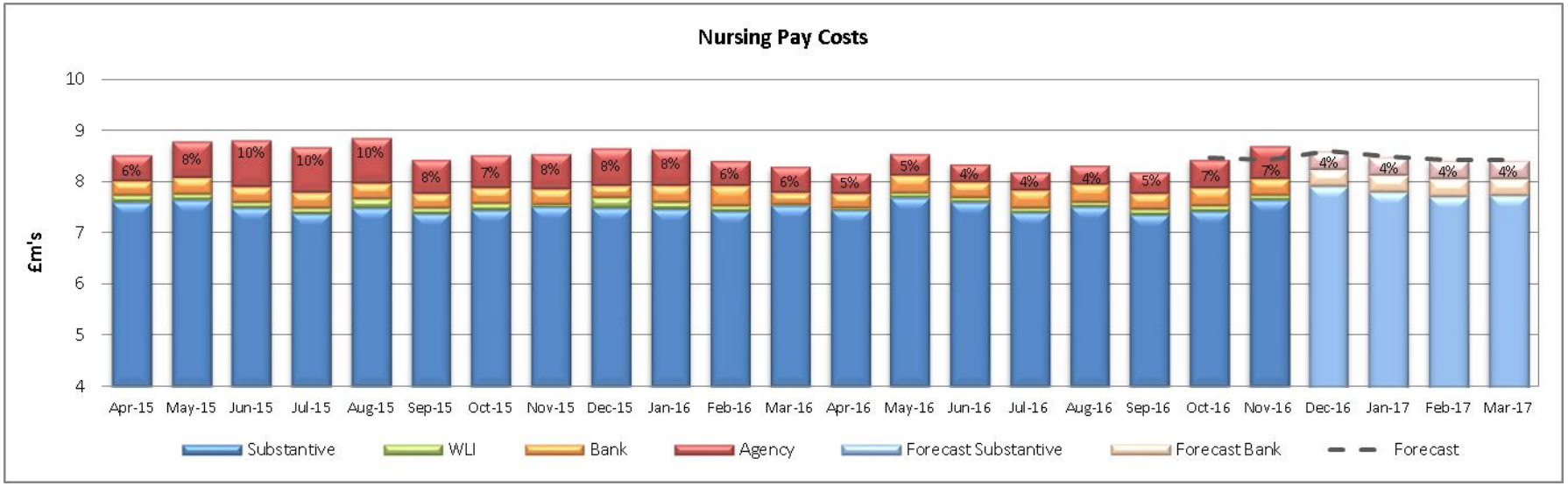



# Medics & Nursing Pay Expenditure

Worcestershire NHS
Acute Hospitals NHS Trust

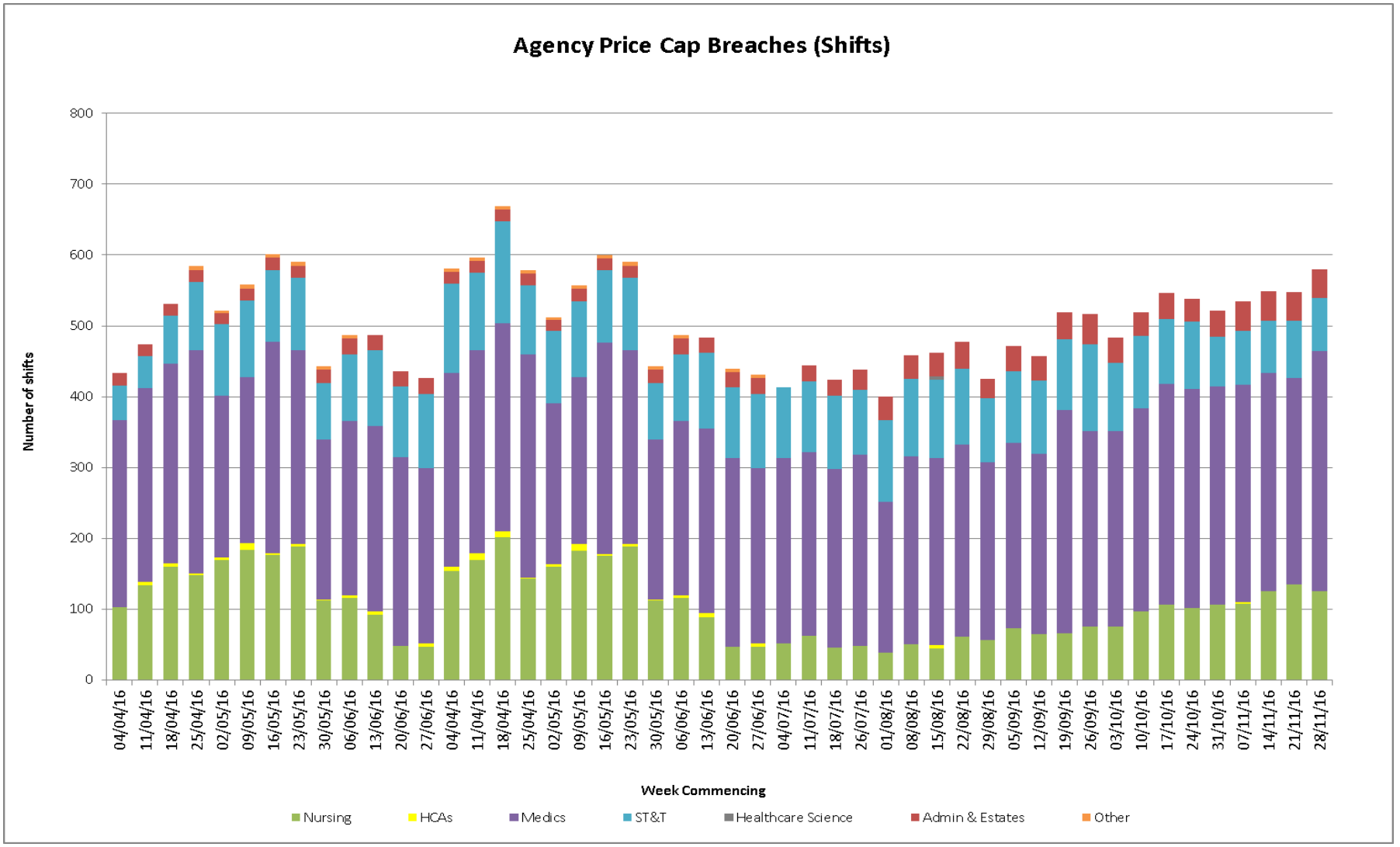
Percentages shows proportion of agency spend against total spend.



# Agency Cap Breaches

Worcestershire NHS
Acute Hospitals NHS Trust




NHS Improvement agency performance is measured against price caps, framework breaches and wage caps. The chart above includes price cap performance only.

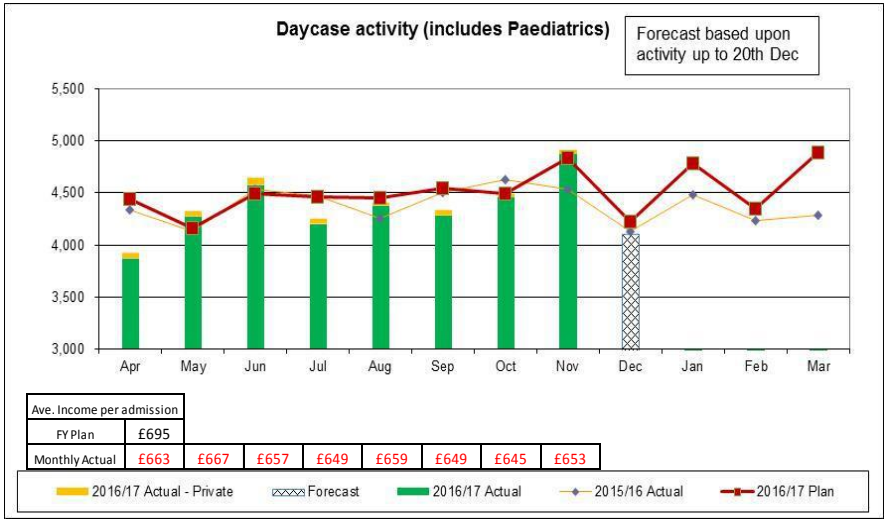
# Activity

Worcestershire NHS
Acute Hospitals NHS Trust

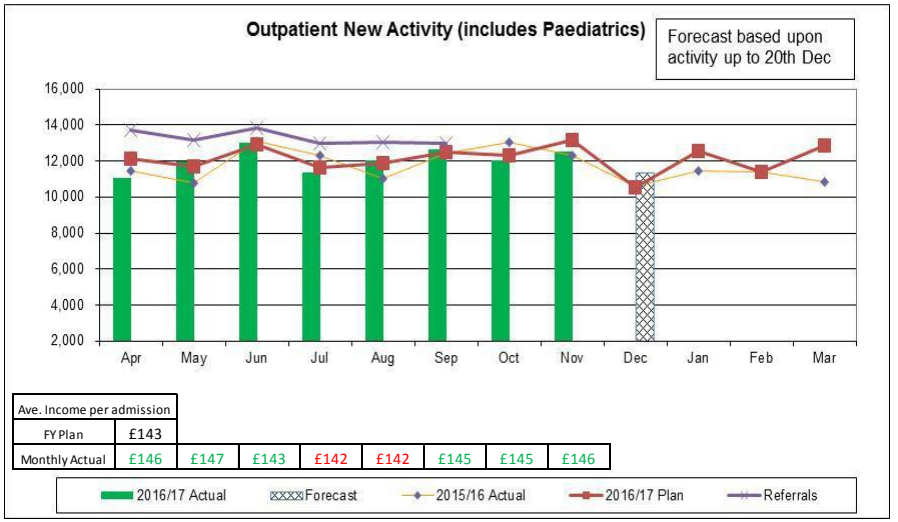
| | In Month | | | | YTD | | | | Full Year | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Plan | Actual | Var | % | Plan | Actual | Var | % | Initial Plan | Current Plan | Forecast | Var | % |
| Elective | 841 | 817 | (24) | (3%) | 6,663 | 5,871 | (792) | (12%) | 9,679 | 9,679 | 9,202 | (476) | (5%) |
| Daycase | 4,808 | 5,154 | 346 | 7% | 35,641 | 35,326 | (315) | (1%) | 64,901 | 53,771 | 55,658 | 1,887 | 4% |
| Non Elective - Emerg | 3,497 | 3,304 | (193) | (6%) | 28,435 | 27,685 | (750) | (3%) | 42,403 | 42,403 | 41,974 | (430) | (1%) |
| Non Elective - Other | 46 | 49 | 3 | 6% | 387 | 420 | 33 | 8% | 575 | 575 | 1,063 | 488 | 85% |
| **Total Inpatients** | **9,191** | **9,324** | **133** | **1%** | **71,127** | **69,302** | **(1,825)** | **(3%)** | **117,559** | **106,429** | **107,897** | **1,469** | **1%** |
| Outpatients New | 12,545 | 12,006 | (539) | (4%) | 93,615 | 91,491 | (2,124) | (2%) | 138,738 | 138,738 | 136,444 | (2,294) | (2%) |
| Outpatients F Up | 22,139 | 20,947 | (1,192) | (5%) | 163,718 | 161,238 | (2,480) | (2%) | 243,400 | 243,400 | 244,035 | 634 | % |
| Outpatients Procedure | 4,458 | 4,513 | 55 | 1% | 32,887 | 32,605 | (282) | (1%) | 48,800 | 48,800 | 50,329 | 1,528 | 3% |
| **Total Outpatients** | **39,142** | **37,466** | **(1,676)** | **(4%)** | **290,220** | **285,334** | **(4,886)** | **(2%)** | **430,939** | **430,939** | **430,807** | **(132)** | **(%)** |
| ED Attendances | 12,732 | 11,950 | (782) | (6%) | 102,521 | 102,219 | (302) | (%) | 152,768 | 152,768 | 155,621 | 2,852 | 2% |
| Community MIU | 3,045 | 3,045 | (0) | (%) | 24,521 | 26,550 | 2,029 | 8% | 36,539 | 36,539 | 40,108 | 3,569 | 10% |
| **Total ED/MIU** | **15,777** | **14,995** | **(782)** | **(5%)** | **127,043** | **128,769** | **1,726** | **1%** | **189,307** | **189,307** | **195,728** | **6,421** | **3%** |
| Maternity - Delivery | 450 | 420 | (30) | (7%) | 4,021 | 3,696 | (325) | (8%) | 5,845 | 5,845 | 5,328 | (517) | (9%) |
| Maternity - Non Delivery | 182 | 213 | 31 | 17% | 1,567 | 1,397 | (170) | (11%) | 2,312 | 2,312 | 1,951 | (361) | (16%) |
| Maternity - Outpatient | 3,785 | 4,142 | 357 | 9% | 29,275 | 30,321 | 1,046 | 4% | 44,112 | 44,112 | 44,500 | 388 | 1% |
| Maternity Ante Natal | 499 | 491 | (8) | (2%) | 4,061 | 3,947 | (114) | (3%) | 5,989 | 5,989 | 5,899 | (90) | (2%) |
| Maternity Post Natal | 472 | 414 | (58) | (12%) | 3,960 | 3,490 | (470) | (12%) | 5,802 | 5,802 | 5,128 | (675) | (12%) |
| **Total Maternity** | **5,388** | **5,680** | **292** | **5%** | **42,885** | **42,851** | **(34)** | **(%)** | **64,061** | **64,061** | **62,806** | **(1,254)** | **(2%)** |
| Paed - Daycase/Elective | 27 | 60 | 33 | 119% | 263 | 280 | 17 | 7% | 415 | 415 | 355 | (60) | (14%) |
| Paed - Non Elective | 731 | 808 | 77 | 10% | 4,554 | 4,488 | (66) | (1%) | 7,220 | 7,220 | 7,013 | (207) | (3%) |
| Paed - Outpatient | 1,463 | 1,486 | 23 | 2% | 10,767 | 11,104 | 337 | 3% | 16,080 | 16,080 | 16,710 | 630 | 4% |
| Paed - BPT, Drugs, CQUIN | 18 | 0 | (18) | (100%) | 148 | 0 | (148) | (100%) | 270 | 221 | 0 | (221) | (100%) |
| Paed - Neonatal Cot Days | 736 | 597 | (140) | (19%) | 5,892 | 5,166 | (726) | (12%) | 8,816 | 8,838 | 7,573 | (1,264) | (14%) |
| **Total Paediatrics** | **2,977** | **2,951** | **(26)** | **(1%)** | **21,622** | **21,038** | **(585)** | **(3%)** | **32,801** | **32,774** | **31,652** | **(1,122)** | **(3%)** |
| **Chemotherapy Delivery** | **1,086** | **1,034** | **(52)** | **(5%)** | **7,238** | **7,896** | **658** | **9%** | **11,130** | **11,130** | **11,988** | **858** | **8%** |
| Drugs PBR Excluded | 0 | 0 | | | | | | | | | | | |
| Critical Care ITU/HDU | 806 | 710 | (96) | (12%) | 6,449 | 6,041 | (408) | (6%) | 9,673 | 9,673 | 9,227 | (446) | (5%) |
| Other Contract Income | 0 | 0 | | | | | | | | | | | |
| **Total Other Contract Income** | **806** | **710** | **(96)** | **(12%)** | **6,449** | **6,041** | **(408)** | **(6%)** | **9,673** | **9,673** | **9,227** | **(446)** | **(5%)** |
| Non Contract Income | | | | | | | | | | | | | |
| Phasing Adj | | | | | | | | | | | | | |
| | | | | | | | | | | | | | |

# Elective, Day Cases & Outpatients New

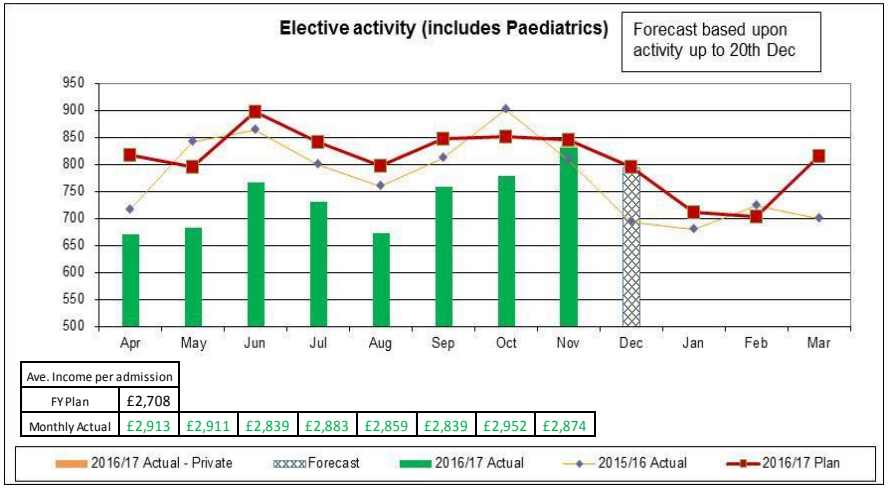
Worcestershire NHS
Acute Hospitals NHS Trust




| Ave. Income per admission | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| FY Plan | £695 | | | | | | | | |
| Monthly Actual | £663 | £667 | £657 | £649 | £659 | £649 | £645 | £653 | |



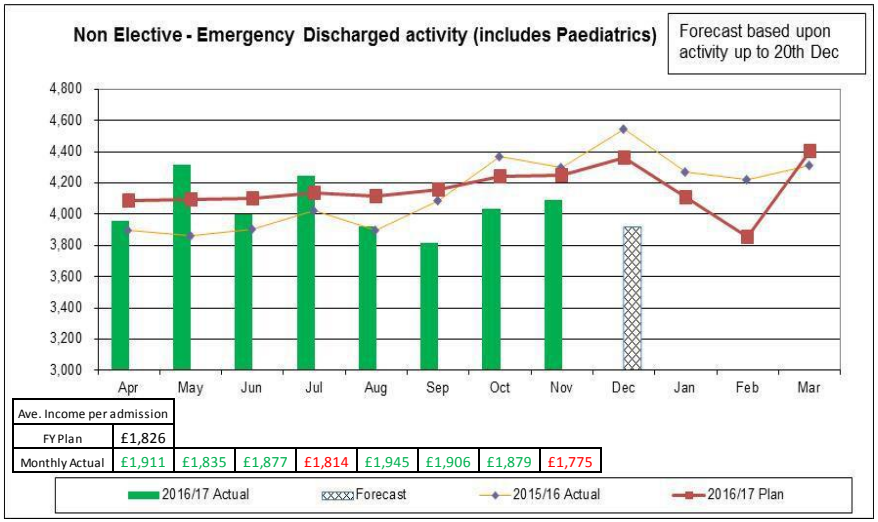

| Ave. Income per admission | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| FY Plan | £143 | | | | | | | | |
| Monthly Actual | £146 | £147 | £143 | £142 | £142 | £145 | £145 | £146 | |



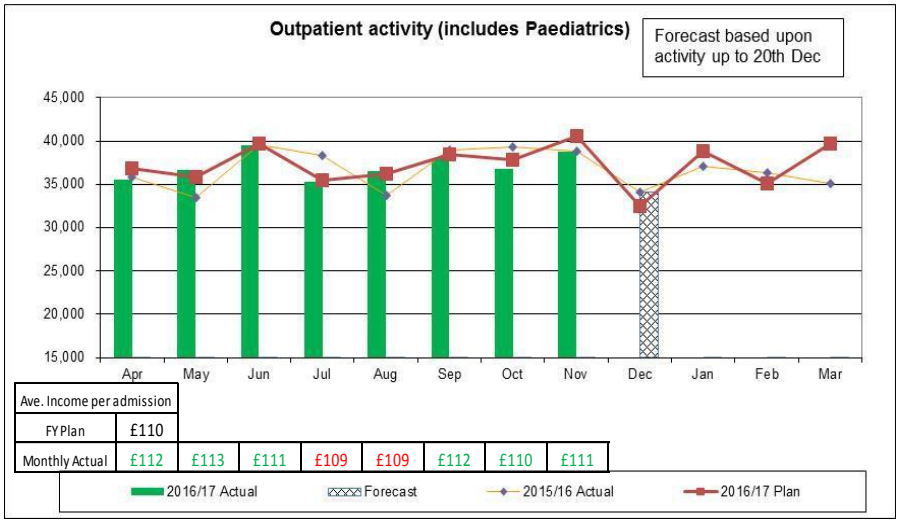

| Ave. Income per admission | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| FY Plan | £2,708 | | | | | | | | |
| Monthly Actual | £2,913 | £2,911 | £2,839 | £2,883 | £2,859 | £2,839 | £2,952 | £2,874 | |

# Outpatients, Non Elective and A&E

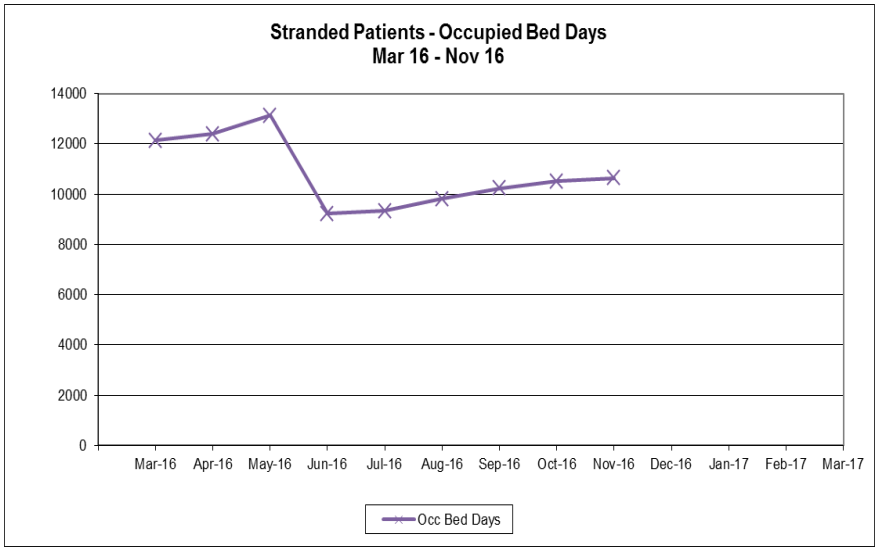
Worcestershire NHS
Acute Hospitals NHS Trust

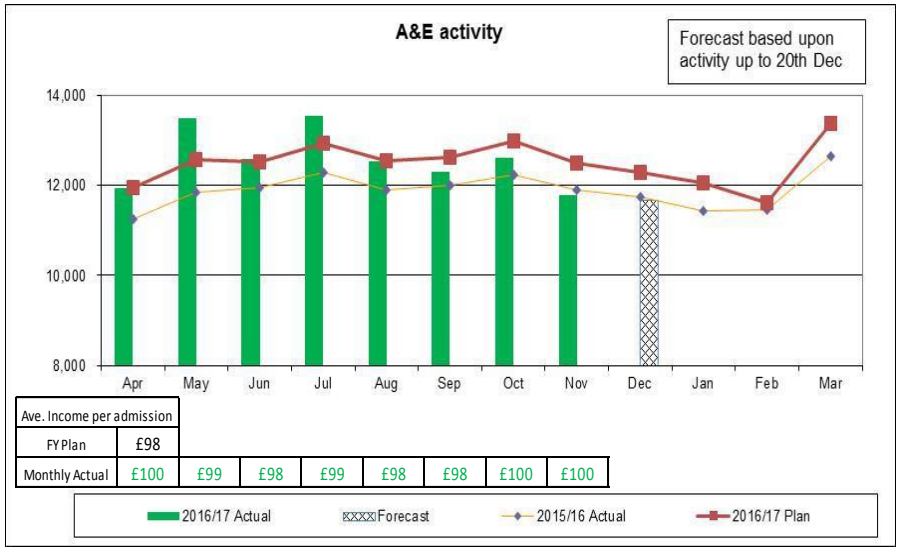



| Ave. Income per admission | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| FY Plan | £1,826 | | | | | | | |
| Monthly Actual | £1,911 | £1,835 | £1,877 | £1,814 | £1,945 | £1,906 | £1,879 | £1,775 |




| Ave. Income per admission | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| FY Plan | £110 | | | | | | | |
| Monthly Actual | £112 | £113 | £111 | £109 | £109 | £112 | £110 | £111 |




| Ave. Income per admission | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| FY Plan | £98 | | | | | | | |
| Monthly Actual | £100 | £99 | £98 | £99 | £98 | £98 | £100 | £100 |

Stranded Patients – there was a reporting issue for Feb to May 2016, which has been corrected from June onwards.

# Balance Sheet

Worcestershire NHS
Acute Hospitals NHS Trust

| | | | | Full Year | | | |
|---|---|---|---|---|---|---|---|
| Balance as at 31 October 2016 | Balance as at 30 November 2016 | Movement in Month | Balance Sheet | Annual Plan | Forecast 31st March 2017 | Variance from Plan | Balance at 31st March 2016 |
| £000s | £000s | £000s | **ASSETS, NON CURRENT** | £000s | £000s | £000s | £000s |
| 249,647 | 249,660 | 13 | Property, Plant and Equipment and intangible assets, Net | 270,605 | 256,777 | (13,828) | 250,590 |
| 3,186 | 3,200 | 13 | Other Assets, Non-Current | 3,238 | 5,918 | 2,680 | 1,669 |
| **252,834** | **252,860** | **26** | **Assets, Non-Current, Total** | **273,843** | **262,695** | **(11,148)** | **252,259** |
| | | | **ASSETS, CURRENT** | | | | |
| 8,112 | 7,980 | (132) | Inventories | 5,800 | 5,601 | (199) | 7,081 |
| 15,467 | 15,387 | (81) | Debtors | 15,121 | 13,031 | (2,090) | 25,823 |
| 11,317 | 7,094 | (4,223) | Cash and Cash Equivalents | 1,900 | 1,900 | 0 | 1,474 |
| **34,896** | **30,461** | **(4,436)** | **Assets, Current, Total** | **22,821** | **20,532** | **(2,289)** | **34,378** |
| **287,730** | **283,320** | **(4,409)** | **ASSETS, TOTAL** | **296,664** | **283,227** | **(13,437)** | **286,637** |
| | | | **LIABILITIES, CURRENT** | | | | |
| **807** | **646** | (161) | PFI leases, Current | 1,936 | **1,941** | 5 | 1,936 |
| **36,795** | **35,633** | (1,161) | Creditors < 1 Year | 38,367 | **35,665** | (2,702) | 48,270 |
| | | | | | | | |
| **37,602** | **36,279** | **(1,322)** | **Liabilities, Current, Total** | **40,303** | **37,606** | **(2,697)** | **50,206** |
| **(2,706)** | **(5,819)** | **(3,113)** | **Net Current Assets/(Liabilities)** | **(17,482)** | **(17,074)** | **408** | **(15,828)** |
| | | | **LIABILITIES, NON CURRENT** | | | | |
| 131,588 | 131,694 | 106 | Creditors > 1 Year | 153,031 | 141,542 | (11,489) | 95,757 |
| 72,055 | 72,054 | (0) | PFI leases, Non-Current | 70,058 | 70,114 | 56 | 72,055 |
| 0 | 0 | 0 | Other Liabilities, Non-Current | 0 | 0 | 0 | 0 |
| **203,643** | **203,748** | **106** | **Liabilities, Non-Current, Total** | **223,089** | **211,656** | **(11,433)** | **167,812** |
| **46,485** | **43,293** | **(3,193)** | **TOTAL ASSETS EMPLOYED** | **33,272** | **33,965** | **693** | **68,619** |
| £000s | £000s | | **FINANCED BY :- PUBLIC EQUITY** | £000s | £000s | £000s | £000s |
| 184,564 | 184,564 | 0 | Public Dividend Capital | 184,564 | 184,564 | (0) | 184,564 |
| 54,320 | 54,320 | 0 | Revaluation reserve | 54,320 | 54,320 | 0 | 54,320 |
| (861) | (861) | 0 | Other reserves | (861) | (861) | 0 | (861) |
| (191,538) | (194,731) | (3,193) | I&E Reserve | (204,751) | (204,059) | 692 | (169,404) |
| **46,485** | **43,293** | **(3,193)** | **TOTAL PUBLIC EQUITY** | **33,272** | **33,965** | **693** | **68,619** |

Worcestershire NHS
Acute Hospitals NHS Trust

**Date of meeting: 11 January 2017** **Enc G1**

**Report to Trust Board (in public)**

| | |
|---|---|
| **Title** | **Audit and Assurance Committee report** |
| **Sponsoring Director** | **Bryan McGinity**<br>**Chair – Audit and Assurance Committee** |
| **Author** | **Kimara Sharpe**<br>**Company Secretary** |
| **Action Required** | The Board is recommended to:<br>• Note the progress with the discharge audit recommendations and the changes being instigated<br>• Note the receipt of the following audits/reviews:<br>  ○ Expenses<br>  ○ Emergency department<br>  ○ Temporary staffing<br>  ○ Fixed assets<br>• Note the review of the F&P committee<br>• Note the receipt of the investigation report<br>• Note the concern the Committee has with respect to policy implementation |
| | |
| **Previously considered by** | N/A |

**Priorities (√)**

| | |
|---|---|
| *Investing in staff* | |
| *Delivering better performance and flow* | |
| *Improving safety* | |
| *Stabilising our finances* | √ |

| | |
|---|---|
| | |
| **Related Board Assurance Framework Entries** | The Committee reviews and provides assurance on the overall management of the BAF risks. |
| **Legal Implications or Regulatory requirements** | |
| | |
| **Glossary** | |

**Key Messages**

This is the routine report from the Audit and Assurance Committee to the Trust Board and covers the meeting held on 10 November 2016.

**Date of meeting: 11 January 2017** **Enc G1**

**WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST**

**REPORT TO TRUST BOARD – 11 JANUARY 2017**

## 1. Situation

The Audit and Assurance Committee met on 10 November 2016. This report details the business undertaken at that meeting.

## 2. Background

The Audit and Assurance Committee provides assurance on systems and processes in place at the Trust. It is a key assurance committee.

## 3. Assessment

### 3.1 Discharge Policy – Update on progress

The Associate Director for Patient Flow attended the meeting to explain the progress being made with the recommendations in respect of the audit undertaken into the discharge process. The Associate Director has reviewed the systems and processes in place and is making some considerable changes to improve their effectiveness. The Patient Flow Centre is now part of the bed meetings which is making a difference to the communication flows. The patient choice policy is not being implemented and he is working with the discharge liaison nurses to ensure implementation is robust.

The Committee were satisfied with the progress that the Associate Director is making with the discharge process. The Policy was due to begin to be revised in December.

### 3.2 External Audit

The external auditors had met with the national audit office in respect of the requirement that local organisational need to assure themselves that ethical standards are being met. Previously this was undertaken by the PSAA (Public Sector Audit Appointments).

External Audit were satisfied with the systems in place for the audit of the accounts in early 2017/18.

### 3.3 Internal Audit

The Committee were pleased that the number of outstanding audit recommendations was down by 50%. A number of the remaining actions had been superseded and once the IT Centre was fully functional a number would be closed. The Committee was satisfied that the new system in place for the monitoring of actions would ensure more timely closure.

The Committee received the following reports:

- Expenses report: The report showed that there was a robust policy in place which was being adhered to for employed staff. The Trust accepted the recommendation that the Trust develop its own agreement for interims which also covered expenses with a request that be done speedily. The figure which was widely quoted in the media from the annual report was, whilst accurate, misrepresented the actual spend as it covered costs other than expenses.
- Emergency department: The report showed that there was a slight discrepancy between the time recorded on the computer and that recorded on the paper notes of the time that patients were transferred out of the department. Mr Capener could not prove or otherwise that there was any deliberate attempt to falsify the figures.
- Temporary staffing: The Committee received the audit which had been given limited assurance. Assurance was received in respect of the controls now in place (the audit referred to a data set relating to November and December 2015).
- Fixed asset review: This advisory piece of work had concluded that the assets were being managed effectively.

**3.4 Finance and Performance committee – assessment of performance**

The Committee reviewed the effectiveness of the performance of this committee with the Committee chair. It was concluded that the effectiveness had improved but that the Committee could spend more time on looking towards the future rather than the past, in particular in relation to performance.

**3.5 Review of tender waivers**

The routine report showed that there continued to be IT and estate waivers. The Director of Asset Management and the Head of Procurement have been asked to attend the next meeting.

**3.6 Investigation report**

The Committee received an investigation report into the declarations of interest by two consultants. The media had alleged that the consultants had misused their position to influence the decisions made in 2012 in relation to the use of the private sector. The report showed that the consultants had declared their interests appropriately. The Trust has subsequently tightened up the declaration of interests' procedure for consultants.

**3.7 Other**

The Committee wishes the Board to note that at several points in the meeting, reference was made to policies not being followed. This is of

concern to the committee and it would wish executive directors to ensure that policies are adhered to and that effective monitoring is in place. Specifically, this related to the Patient Choice Policy, Discharge Policy and Policies around the management of temporary staffing.

## 4 Recommendation

The Board is recommended to:

- Note the progress with the discharge audit recommendations and the changes being instigated
- Note the receipt of the following audits/reviews:
  - Expenses
  - Emergency department
  - Temporary staffing
  - Fixed assets
- Note the review of the F&P committee
- Note the receipt of the investigation report
- Note the concern the Committee has with respect to policy implementation

Bryan McGinity
Chair – Audit and Assurance

Worcestershire NHS
Acute Hospitals NHS Trust

**Date of meeting: January 2017** **Enc**

**Report to**

| | |
|---|---|
| **Title** | **Nursing and Midwifery Workforce Report** |
| **Sponsoring Director** | **Jan Stevens, Chief Nursing Officer** |
| **Author** | **Sarah Needham, Associate Director** |
| **Action Required** | The Trust Board is requested to note the following:<br>• Building a flexible and permanent nursing workforce against a backdrop of national nursing shortages remains a challenge.<br>• The Trust is strengthening its approach to recruitment and retention.<br>• Controls are in place to manage the risks associated with nursing vacancies. |
| | |
| **Previously considered by** | |

**Priorities (√)**

| | |
|---|---|
| *Investing in staff* | √ |
| *Delivering better performance and flow* | √ |
| *Improving safety* | √ |
| *Stabilising our finances* | √ |

| | |
|---|---|
| **Related Board Assurance Framework Entries** | 2678 - If we do not attract and retain key clinical staff we will be unable to ensure safe and adequate staffing levels |
| **Legal Implications or Regulatory requirements** | Required to undertake monthly staffing levels reviews<br>Required to undertake 6 monthly acuity and dependency reviews of ward/ unit areas. |
| | |
| **Glossary** | WTE – whole time equivalent<br>DDN – Divisional Directors of Nursing |

**Date of meeting: January 2017** **Enc**

**WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST**

**REPORT TO TRUST BOARD – January 2017**

## 1. Situation

This paper provides an update on the Nursing and Midwifery Workforce Action group, including the key risks and mitigation plans in the following areas:

- Adult inpatient ward nursing workforce acuity/dependency review
- Trust position on nursing recruitment.
- Compliance information on safer staffing levels at ward and site level.

## 2. Background

In November 2013 The National Quality Board published '*A guide to support providers and commissioners in making the right decisions about nursing, midwifery and care staffing capacity and capability'.* Subsequently in July 2014 NICE published recommendations on safe staffing for adult-inpatient wards.

Reviewing the nursing workforce requires a multifactorial approach to determine the most appropriate skill mix. The review utilised the Safer Nursing Care Tool (SNCT) which is an evidenced based national tool. The tool triangulates data in the following domains:

- Professional judgement
- NICHE guidelines
- Quality Metrics -Nurse sensitive indicators i.e. falls, pressure ulcers, infections, complaints etc.

This nursing workforce review has primarily focused on all adult inpatient wards and excludes maternity, children's wards and Emergency / Outpatient departments and Intensive Care units.

## 3. Assessment

Building a permanent flexible workforce is a programme of work that will commence in March 2017 and will build on existing work streams to further strengthen and coordinate our approach to workforce management. The programme will focus on the following domains; Recruitment, Retention, Return nurses to practice, Utilising our retiring workforce, Redesign - new roles, new ways of working, Reward, Rules-holding to account i.e. NHSP and E-roster.

Current activities to strengthen our workforce include;

-Proactive recruitment continues across the Trust, initiatives include;
-Return to practice awareness in partnership with Worcester University
-Quarterly job fairs at the Trust
-Internal transfer process for all internal staff
-Proactive recruitment of Student nurses and offering their final placements in the areas where they have been appointed at job.
- New mentorship model pilot programme to increase our nursing student capacity.

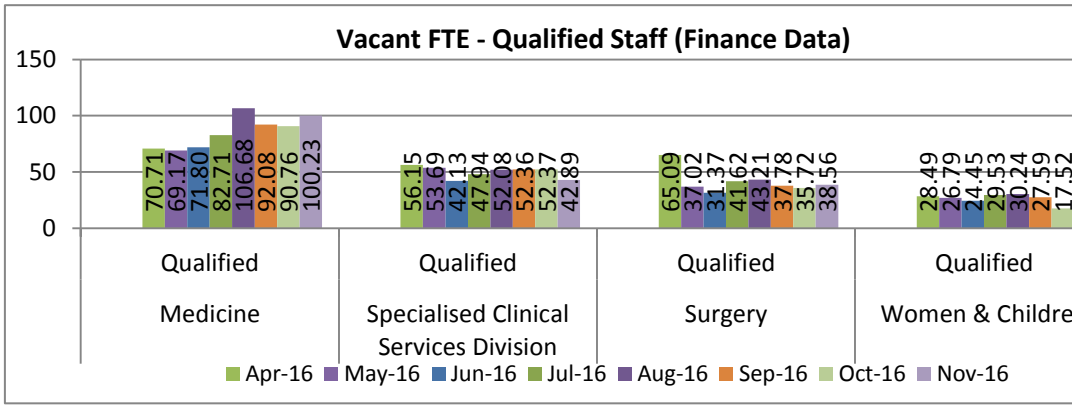
Implementation of new roles
-Ward Administrator

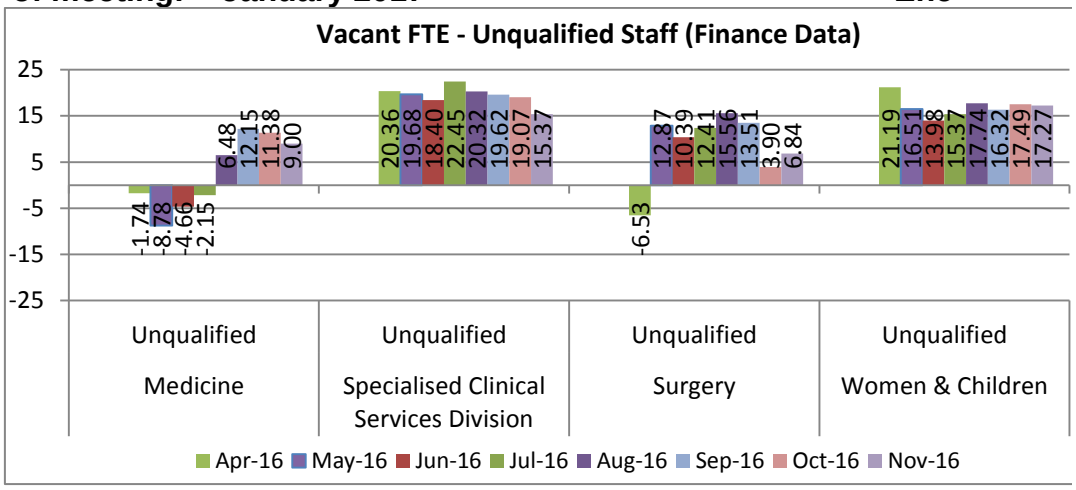
-Ward house keeper
-Midwifery Consultant
-Development and commencement of staff on Band 4 Nursing Associate training
-Advanced Nurse Practitioner training for Endoscopy

The Nursing workforce review has taken place utilising the Shelford group tool, quality metrics and professional judgement between October and December 2016.

- Acuity and dependency assessment has been completed on all adult inpatient wards
- Triangulation on acuity with professional judgement and quality metrics has been completed.
- Meetings between Divisional Directors of Nursing (DDN) and finance completed.
- Analysis and presentation of results to CNO to take place in February 2017 with DDN's and Finance for confirm and challenge session.
- Ward workforce establishment to be signed off by the Board in March 2017.

## 4 Recruitment






5 **Overall Summary**

The current total number of qualified nurse vacancies in the Trust is 200.45 WTE compared to September 2016 board report which reported 199.5 WTE.

The total number of unqualified staff vacancies is 48.48 WTE compared to 63.18 WTE reported in September 2016.

The change in figures reported is not due to an increase in staff leaving the Trust but is as a result of reconciliation of HR/Financial systems to further strengthen our Governance arrangements.

Hot spot areas for vacancies are:
MAU, Alex
Beech B, WRH
Ward 12, Alex

To manage the risk posed by nurse vacancies the following controls are in place:

- Agency/bank use overseen by Divisional Directors of Nursing (DDN)
- Active recruitment
- New roles being introduced.
- Monitoring fill rates.
- Daily review of staffing by Matrons and Divisional Directors of Nursing
- Moving staff to support staffing gaps.

We are further strengthening controls by:

- Regular scrutiny of use of e-roster at ward level.
- Strengthening accountability and responsibility through new performance metrics.

6 **Safer staffing fill rates**

The Board is required to receive information on fill rates per ward and information is also provided per site for the Trust (see appendix 1).

**Date of meeting: January 2017** **Enc**

- Areas below the 80% (national expected fill rate) are highlighted in red.
- Impact on the quality and safety of these areas is scrutinised by the DDNs and Matrons.
- If fill rates are reported as over 100% this is because unqualified staff are utilised to support and backfill trained staff vacancies.
- Reviews of staffing takes place three times per day and staff are mobilised from areas with higher staffing levels into areas which require support.

7 **Recommendation**

The Trust Board is requested to note the following:

- Building a flexible and permanent nursing workforce against a backdrop of national nursing shortages remains a challenge.
- The Trust is strengthening its approach to recruitment and retention.
- Controls are in place to manage the risks associated with nursing vacancies.

Jan Stevens
Interim Chief Nurse

**Date of meeting: January 2017** **Enc**

## Appendix 1

| | Day | | Night | | |
|---|---|---|---|---|---|
| | Average fill rate - registere | Average fill rate - care staff | Average fill rate - registere | Average fill rate - care staff | |
| Acute Stroke Unit | 82.5% | 87.9% | 94.4% | 109.7% | |
| Avon 2- Gastro | 97.6% | 97.2% | 100.8% | 115.2% | |
| Avon 3- Infectious Diseases | 80.7% | 79.6% | 66.9% | 97.0% | |
| Avon 4 | 101.2% | 127.8% | 100.2% | 127.3% | |
| Laurel 1 Cardiology- CCU | 98.6% | 114.5% | 97.3% | 98.9% | |
| Laurel 2 Resp | 93.3% | 103.7% | 104.3% | 105.3% | |
| Medical Assessment Unit WRH | 118.2% | 104.8% | 136.0% | 96.3% | |
| Medical High Care and Short Stay | 100.1% | 116.3% | 93.2% | 104.0% | |
| Silver Assessment Unit | 91.8% | 94.2% | 102.5% | 91.4% | |
| GP Unit WF - ward (TCS) | 59.7% | 75.2% | 97.9% | 51.6% | No longer our service. Data will be removed next month |
| MAU ALX | 67.6% | 88.4% | 95.5% | 89.0% | |
| Ward 12 Medicine | 118.2% | 104.8% | 136.0% | 96.3% | |
| Ward 2 Specialist Med | 121.8% | 104.5% | 88.1% | 87.7% | |
| Ward 5 - Medicine AHD | 120.1% | 212.1% | 107.7% | 99.7% | |
| Ward 6 | 92.9% | 94.8% | 99.9% | 88.8% | |
| CCU- Alex | 76.6% | - | 100.1% | - | |
| Ward 9 | 105.4% | 120.0% | 108.6% | 100.1% | |
| Ward 10 | 88.3% | 90.6% | 111.5% | 98.0% | |
| Ward 11 | 95.8% | 81.6% | 132.5% | 102.8% | |
| Ward 16 | 98.6% | 114.4% | 73.2% | 89.0% | |
| Ward 17 | 100.7% | 111.6% | 117.6% | 82.6% | |
| Ward 18 | 95.4% | 88.6% | 97.7% | 27.2% | HCA's moved to support other areas |
| SCDU & SHDU | 92.6% | 99.4% | 99.9% | 96.7% | |
| Beech A | 102.3% | 118.5% | 66.9% | 109.2% | Additional HCA's utilised to backfill trained Nurse gaps |
| Beech B | 87.0% | 97.4% | 90.8% | 97.1% | |
| Chestnut | 99.4% | 108.4% | 77.8% | 95.4% | |
| Trauma & Orthopaedics | 93.9% | 103.0% | 103.2% | 99.6% | |
| Severn Unit & HDU | 111.2% | 55.1% | 100.4% | 99.6% | Additional trained staff utilised to backfill the staff shortages |
| WRH Delivery Suite & Theatre | 85.1% | 100.0% | 90.6% | 100.0% | |
| WRH Maternity Triage | 100.0% | 100.0% | 100.0% | 100.0% | |
| WRH Meadow Birth Centre | 100.0% | 100.0% | 100.0% | 100.0% | |
| WRH Postnatal Ward | 84.3% | 91.1% | 86.6% | 65.8% | Flexible dependent on capacity demand, staffing for pre/ post and delivery suite is flexed across the three areas, minimum trained staff is 18 per shift which can be increased to a maximum of 21/ 25 dependent on elective work. |
| WRH Riverbank | 103.5% | 75.1% | 102.1% | 134.1% | |
| WRH Neonatal | 110.0% | 93.3% | 102.1% | 96.7% | |
| WRH TCU Nursery Nurses | 83.3% | 100.0% | 83.3% | 93.3% | |
| WRH TCU Midwives | 100.0% | | 96.8% | | |
| WRH Antenatal Ward | 78.0% | 57.1% | 89.5% | 67.2% | |
| ITU ALEX | 100.0% | 100.0% | 100.0% | - | |
| ITU WRH | 100.0% | 50.0% | 100.0% | - | |
| WARD 1 KTC | 100.0% | 100.0% | 100.0% | - | |
| Laurel 3, WRH | 89.5% | 73.3% | 99.2% | 113.3% | |

Key

Above 95%

80-94.9%

below 79.9 %

| | |
|---|---|
| Title of report | Nursing and Midwifery Workforce Report |
| Name of director | Jan Stevens |

Worcestershire NHS
Acute Hospitals NHS Trust

**Date of meeting: 11 January 2017** **Enc H2**

**Report to Trust Board (in public)**

| | |
|---|---|
| **Title** | **Charitable Funds Committee report** |
| **Sponsoring Director** | **Andrew Sleigh**<br>**Chairman, Charitable Funds Committee**<br>**Presented by Bryan McGinity**<br>**Non Executive Director Committee member** |
| **Author** | **Kimara Sharpe**<br>**Company Secretary** |
| **Action Required** | The Board is asked to review the report and note the following:<br>• |
| | |
| **Previously considered by** | *N/A* |

**Priorities (√)** not applicable

| | |
|---|---|
| *Investing in staff* | |
| *Delivering better performance and flow* | |
| *Improving safety* | |
| *Stabilising our finances* | |

| | |
|---|---|
| | |
| **Related Board Assurance Framework Entries** | Not applicable |
| **Legal Implications or Regulatory requirements** | The Charitable Funds are regulated through the Charity Commission |
| | |
| **Glossary** | |

**Key Messages**

When considering this report, members are requested to note that they are doing so as Trustees of the Charitable Fund, not as Trust Board members, thus have duty to ensure that the money is used as requested by the donor for the benefit of the Trust's patients or staff or wide community.

Worcestershire NHS
Acute Hospitals NHS Trust

**Date of meeting: 11 January 2017** **Enc H2**

# WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

## REPORT TO TRUST BOARD – JANUARY 2017

**1. Situation**

This is the routine report to the trust board from the Charitable Funds Committee.

**2. Background**

All Trust board members are trustees of the Charitable Funds monies and so have a duty to ensure the best use of the money. The Trust has approximately £1.67m invested with CCLA and a further cash sum with the Trust's bank.

Funds are utilised where possible for capital projects. There are significant criteria that need to be met prior to the funds being utilised.

**3. Items discussed**

**3.1 Annual Report and Audit Opinion**

The Committee approved the Annual Report and the Audit opinion (appended to this report). The Auditor reported that there had been no matters to bring to the Committee's attention. Both documents will be uploaded to the Charities Commission website by 31 January 2017.

**3.2 Funds over £7k**

The Committee discussed in detail the spending plans for funds with a balance of over £7k. It was reiterated that Charity monies must be used to enhance patient care not for replacement items or items that were a requirement. A number of funds were used to enhance education.

The Committee were assured of the robust procedures in place to ensure that the spend was appropriate and bids for the monies have been turned down.

**4** The Committee expressed their thanks for Andrew as chair and wished him well in the future.

**5 Recommendation**

The Board is asked to

- Note the Annual Report and Audit opinion
- Note the report.

**Andrew Sleigh**
**Non-Executive Director**

| | |
|---|---|
| Title of report | Charitable Funds report |
| Name of director | Andrew Sleigh |