Trust Board
There will be a meeting of the Trust Board on **Thursday 9 December 2021** at 10:00. It will be held virtually and live streamed on You Tube.

Sir David Nicholson
Chair

Agenda			Enclosure	Time
131/21	**Welcome and apologies for absence:**			**10:00**
132/21	**Patient Story**			**10:05**
133/21	**Items of Any Other Business** *To declare any business to be taken under this agenda item*			**10:30**
134/21	**Declarations of Interest** *To declare any interest members may have in connection with the agenda and any further interest(s) acquired since the previous meeting.*			
135/21	**Minutes of the previous meeting** *To approve the Minutes of the meeting held on **11 November 2021** as a true and accurate record*	*For approval*	**Enc A** **Page 3**	**10:30**
136/21	**Action Log**	*For noting*	**Enc B** **Page 11**	**10:35**
137/21	**Chair's Report**	*For noting*	**Verbal**	**10:40**
138/21	**Chief Executive's Report**	*For noting*	**Enc C** **Page 16**	**10:45**
Strategy				
139/21	**Communications and Engagement Update** Director of Communications & Engagement	*For assurance*	**Enc D1** **Page 20**	**10:55**
140/21	**H2 Plan** Director of Strategy and Planning/Chief Finance Officer	*For approval*	**Enc D2** **Page 26**	**11:05**
141/21	**Board Assurance Framework** Company Secretary	*For approval*	**Enc D3** **Page 70**	**11:15**
Performance				
142/21	**Integrated Performance Report** **Executive Summary/SPC Charts/Infographic** Chief Executive/Executive Directors	*For assurance*	**Enc E** **Page 76**	**11:25**
143/21	**Committee Assurance Reports** Committee Chairs		**Page 151**	

Governance				
144/21	**Safest Staffing Report** **a) Adult/Nursing** **b) Midwifery** Chief Nursing Officer/Director of Midwifery	*For assurance*	**Enc F1** **Page 161** **Page 169**	**11:45**
145/21	**CQC Registration – Statement of Purpose** Chief Nursing Officer	*For approval*	**Enc F2** **Page 177**	**11:55**
146/21	**Report of the Audit & Assurance Committee** Committee Chair	*For assurance*	**Enc F3** **Page 194**	**12:00**
147/21	**Report of the Remuneration Committee** Committee Chair	*For assurance*	**Enc F4** **Page 196**	**12:05**
148/21	**Report of the Trust Management Executive** Committee Chair	*For assurance*	**Enc F5** **Page 198**	**12:10**
149/21	**Any Other Business** *as previously notified*			**12:15**
Close				
	Date of Next Meeting *The next public Trust Board meeting will be held on 12 January 2022, virtually.*			

MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON THURSDAY 11 NOVEMBER 2021 AT 10:00 AM HELD VIRTUALLY

Present:		
Chair:	Sir David Nicholson	
Board members:	Waqar Azmi	Non-Executive Director
	Christine Blanshard	Chief Medical Officer
(voting)	Paul Brennan	Chief Operating Officer
	Anita Day	Vice Chair, Non-Executive Director
	Matthew Hopkins	Chief Executive
	Paula Gardner	Chief Nursing Officer
	Dame Julie Moore	Non-Executive Director
	Dr Simon Murphy	Non-Executive Director
	Robert Toole	Chief Finance Officer
Board members:	Richard Haynes	Director of Communications and Engagement
(non-voting)	Vikki Lewis	Chief Digital Officer
	Jo Newton	Director of Strategy and Planning
	Rebecca O'Connor	Company Secretary
	Tina Ricketts	Director of People and Culture
	Sue Sinclair	Associate Non-Executive Director
	Sharon Thompson	Associate Non-Executive Director
In attendance	Simon Adams	Healthwatch
	Justine Jeffrey	Director of Midwifery
	Anna Sterckx	Item 097/21
	Rosie and Sky	Item 097/21
	Andy Wicks	CIO of UHMB (shadowing Mrs Lewis)
Public		Via YouTube
Apologies	Colin Horwath and Richard Oosterom	

114/21 **WELCOME**

Sir David welcomed everyone to the meeting, including the public viewing via YouTube observers and staff members who had joined us. He especially welcomed Sue Sinclair to her first meeting as Associate Non-Executive Director.

115/21 **PATIENT STORY**

Sir David welcomed Rosie and her baby Sky to the meeting and Mrs Gardner introduced the Patient Story. Mrs Gardner advised that Rosie would talk to the Board about of continuity of carer following her experience of home birth, three months ago.

Rosie explained how she had always wanted children but combination of factors she was very scared of the labour process. As a first time mother, she had assumed she would have a hospital delivery and wanted an ELCS due to her fears and which she felt was an informed decision based on known risks. When Rosie first met her midwife Sharon, she asked about an ELCS; the midwife explained that labour did not need to be feared and that due to her postcode, Rosie was in the COC model. Sharon had explained this meant she would be Rosie's midwife throughout and the ream would all know Rosie's story, so even if it was not Sharon at the birth, it would be someone who knew and was familiar with Rosie.

For Rosie, this information was transformational as she very much valued close relationships, explaining how knowing Sharon was there throughout, was very reassuring. Rosie reflected that she was lucky to be in a happy and secure relationship, but that not every woman is as fortunate. When she was asked in her appointments about disclosures, she felt that women would be far more likely to open to someone they know, rather than someone they did not know or had not seen before.

Apart from an early appointment in hospital, the others were at home, reinforcing the message that Rosie was not sick or ill and this could take place at home. Hannah had undertaken the 16 week check at Rosie's home; she knew me and my home and it felt natural to have her there. Through hypnobirthing and learning about labour how be positive experience helped Rosie to realise that she wanted a home birth. Sharon was really positive and explained all the support, two midwives would present and she would be taken to hospital if needed. This was a huge change for Rosie, given she had initially wanted a c section. Rosie felt like she had a coach in Sharon who was supporting her all the way.

Labour developed over a weekend and Rosie maintained contact with the team via text, which helped her to relax. Delivery was safe at home after about 5 hours. Sharon was away, but the rest of the team knew Rosie and what she wanted for her birth experience. Rosie paused for a moment to breastfeed.

The ongoing support was made easier by knowing the team and could ask any questions and check me over. Rosie explained how she felt blessed to be cared for by this team, did not think she would have had the confidence to have the birth at home without them. She described it as being taken under their wing and felt like having 8 sisters who had all had her best interests at heart. She wished this service could be rolled out to all women in the area and not be down to postcode.

Sir David, on behalf of all the Board, thanked Rosie and baby Sky for their story and opened up the item for discussion:

Ms Day reflected upon the articulate points made regarding safeguarding and tackling health inequalities for those who are disadvantaged, which reinforced the value of relationship building. Mr Adams expressed how the story bought an NHS policy to life and had given it meaning. Dr Murphy commented upon a powerful example of continuity of carer in action. We are bringing colleagues with us and Rosie's case should be shared with the midwifery teams to showcase the impact it can have.

Sir David noted that continuity of carer is controversial. There has been criticism of a two tier service for some. Mrs Gardner confirmed this is a new way of working which has caused some angst. The reason for bringing this story is to show the good in both ways of caring and to ensure midwives in the unit are hearing the positivity that comes out of this which is vital to hear. The more we hear of the positivity of the continuity of carer model, the greater chance we have of maximising the benefits of transformation.

Mr Hopkins as the SRO for maternity and neonates across Hereford and Worcester, advised that from a local maternity system perspective we are committed to implementing continuity of carer. We are bringing the voices of mothers and families into the conversation across the system and would be pleased to continue to work with Rosie in the future.

ACTION: Rosie and Sky's story to be shared with midwifery teams and the system

116/21 **ANY OTHER BUSINESS**

There were no items of any other business.

117/21 **DECLARATIONS OF INTERESTS**
There were no additional declarations pertinent to the agenda. The full list of declarations of interest is on the Trust's website.

118/21 **MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON 14 OCTOBER 2021**
There was one amendment to page five to remove reference to the Quality Governance Committee.

RESOLVED THAT subject to the above the Minutes of the public meeting held on 14 October 2021 be confirmed as a correct record and signed by the Chair.

119/21 **ACTION SCHEDULE**
Ms O'Connor presented the action log noting the updates as set out in the paper. All other actions were either closed as per the log, or not due for update at this meeting.

120/21 **CHAIR'S REPORT**
There was nothing to report by exception.

121/21 **CHIEF EXECUTIVE'S REPORT**
Mr Hopkins presented his report which was taken as read. The following key points were highlighted:

- Clinical risk summit had been called as a way to frame what we expect to happen from the system in supporting the significant clinical risks currently being held by WMAS and the ED team
- VMI partners have been on site this week to get a sense of the culture of the Trust and areas of particular focus.
- An update on ICS was within the report; CEO and Chair interview processes were underway and the composition of the ICB Board had been agreed.

A discussion followed regarding urgent care pressures.

- Mr Azmi advised the Board he had attended an event regarding optimising community care, confirming PCN representation was present and there was good representation from general practice.
- Sir David reflected a lack of visibility regarding what partners have signed up to do, asking do we need to formally write to make this crystal clear and publically measure?
- Mr Hopkins referenced attendance at OSC in his report confirming there are system wide metrics monitored via the Home First Committee.
- Dame Julie noted that ambulance delays are of concern, requesting that the system needs more clarity and granularity. It is not good care for patients who in some instances could be better treated elsewhere.

ACTION Mr Hopkins to confirm reporting of Place urgent care metrics across all partners.

The following other items were also referenced:

- Dr Murphy asked with regards to the ICS update, whether partners were happy with the proposed Board composition? Mr Hopkins confirmed there was a comprehensive

discussion with input from all partners which provided opportunity to reach a position on the way forward. There was recognition that there was not a perfect answer and that where we start may not be where we finish and this may be revisited in future

- Sir David asked if there was any guidance in relation to mandatory vaccination? Mr Hopkins advised this was due to be issued; the executive have discussed and met with staff side, however it is difficult to comment without guidance. Mrs Ricketts advised that exemptions, for example on medical grounds, were expected to be included and that Mr Hopkins had already received contacts from staff members who were concerned about their jobs.
- Dame Julie asked if this will be a condition on employment going forwards. Mrs Ricketts confirm his is likely to be the case, as currently with some other vaccinations.

RESOLVED THAT: the report be noted

STRATEGY

122/21 **H2 Update**

Sir David noted this item would be deferred to a future meeting.

123/21 **NHS System Oversight Framework Segmentation**

Mrs Newton presented the report which was taken as read.

The System Oversight Framework introduces a new approach to provide focused assistance to organisations and systems. The Trust has been placed into SOF segment 3; the paper outlining the areas identified many of which the Board has already discussed today. We will be developing a plan to move from level 3 into level 2 and beyond. Sir David reflected this was not a surprise and the issues identified are on our agenda

This rating reflected the issues discussed previously in respect of sharing risk. All of these issues need to be addressed as part of H2 and the Three Year Plan, both of which make inroads into the issues identified.

ACTION: Mrs Newton to confirm the SOF ratings of system partners

RESOLVED THAT: the report be noted

124/21 **Board Assurance Framework**

Ms O'Connor presented the report which was taken as read. The following key points were noted:

- Paper sets out the ongoing development of the BAF and the out of the recent ICS Board development session
- A new risk was proposed at the development session and the full risk detail is appended setting out the scores, controls and mitigations.
- The development of the BAF was described and the full framework in its entirely will come to Board next month.
- Summary position shows one risk having reduced slightly as a result of further mitigations and rescoring but remains at a score of 16.
- Board members will have seen and been part of the Committee reviews and updates which have taken place
- Ms Day confirmed that Audit and Assurance Committee have reviewed the process and BAF format and they were comfortable

- The new BAF risk 21 was discussed and Audit and Assurance Committee had endorsed its incorporation.

RESOLVED THAT: The Board reviewed and endorsed the Board Assurance Framework and approved the incorporation of BAF risk 21

The Board paused to observe the two minute silence.

125/21 **Provider Collaboration**

Mrs Newton presented the report which was taken as read.

She set out how this paper takes us to consideration of the provider collaborative and expands upon the working arrangements which we have in place with SWFT as part of an Improvement Collaboration. Mr Hopkins advised relationships with neighbouring partners and the SWFT group are developing well and also with UHB where we have close clinical collaboration. He described how the approach to SWFT is about learning and sharing learning.

Ms Day queried the Associate Member status, asking as to the Trust's longer term intention with the SWFT group? Mr Hopkins confirmed this is specifically to share learning and that there is nothing that ties them or us beyond that. The teams are working closely and have had a VMI partnership. This is a pluralistic approach to improvement, linked to our working with Leeds on financial improvement.

With regards to other formal arrangements, Mrs Newton described a desire to keep things simple, whereby there is not a proposition to have multiple MOUs for the sake of it. The three year plan will be instrumental in steering this. Mr Azmi noted the national template was silent on benefits realisation, asking what are the outcomes we are expecting from the collaboration? Mrs Newton confirmed this will be driven from the Three Year Plan and ICS plan to inform where can have the most benefit. The linkage to VMI was discussed, with Dr Murphy referencing the 48 hour rapid intervention model in Warwickshire.

Sir David noted that as a Trust we have not always looked outside of ourselves and with the challenges we face, it is easy to look in stressing we should look outwards for solutions. This approach avoids the trap of focus on governance and shared committees and focuses on how we can use the relationship to improve the services in Worcestershire. The arrangement with SWFT was commended for its mutual benefits; we need to confirm the outcomes and what we expect from it.

RESOLVED THAT:

1. **Progress with provider collaborations at ICS level be noted;**
2. **Agreed to further capture tactical collaborations.**
3. **Approved the MoU with SWFT to become an Associate Member of an Improvement Collaborative**

PERFORMANCE

126/21 **Integrated Performance Report**

Mrs Lewis presented the month 6 report. The key points highlighted on the executive summary were noted and discussed. The assurance level overall had not changed and provided an overall level 4 assurance.

The following key areas were highlighted:

Restoration and Recovery

- The extraordinary pressures on the service were acknowledged and the thanks of the Board were expressed to staff for their efforts. Conversations regarding performance were to be had with this in mind.
- Performance on UEC against benchmarked Trusts was improving and however elective performance is challenging and there were issues regarding cancer 31 and 62 day targets
- Dr Blanshard reported lung cancer was experiencing a very high number of referrals. A lung cancer GIRTH review has taken place to ensure we have maximised everything we can do and we are talking to the GIRTH team to see if we can improve this. Recruitment is underway for a further physician, with interviews planned for 2 December
- Breast 2WW pathway is being reviewed to see how we can improve, however there has been a further unexpected increase in referrals
- Sepsis assurance level had decreased from 6 to 5. It was noted this remains primarily a data recording issue, with key outcome measures comparing well to peers, especially via ED. Mortality from sepsis was also noted as good.
- Mr Brennan noted regarding 31 day target, the validated position for the Trust in July was 97% and in August 91.3%; compared to region this puts the Trust in the upper quarter.
- The Trust had been successful in its Community Diagnostic Hub wave 1 bid.
- A bid for mobile CT and MRI at the Alex had also been approved and will increase diagnostic capacity and improve performance on cancer pathways.
- The RTT position in September was 57,252. The target nationally being to ensure the waiting list at March 2022 is not greater than at September 2021. The Trust currently expects to achieve 58,500 and further work is underway to address this.
- Ms Day recognised in some ways we are doing better than expected, however had slight anxiety that as we are measured on metrics, do we treat the highest acuity first, rather than just considering the time spend on waiting list?
- Mr Brennan confirmed that patents are all reviewed and categorised. The Trust's position is clear, that we will focus on P2 (cancer and urgent elective), but this is on a speciality by speciality basis, as waiting lists vary.
- Spot audits are undertaken to ensure we are treating patients in line with our clear policy; those who are urgent first and then in chronological order. There are also harm reviews taking place to minimise the risk of avoidable harm.
- A pilot using an automated system has checked with those on the waiting list, to see if patients feel there is a change in urgency. A second pilot is underway and if successful will roll out on the waiting lists
- ICS is involved in regional work regarding the impact on those waiting for planned surgery and how many of those patients become an emergency attendance or admission.

Finance

- Mr Toole confirmed the Trust did not receive full ERF funding. £3.5m was received in H1 but there is nothing further for the rest of the year; this is reflected in H1 figures and is £0.9m adrift from last year
- The Trust is spending more on Covid than we had expected. This is continuing to increase and we may be understating this expenditure
- We are working to balance recording the correct reason for why we have bank staff e.g. covid
- Cash position remains good

- Capital – more has been allocated to the Trust with additional capital secured, this is drawing time and resources into the Estates teams. A Programme Director will bring additional support, project and programme management to focus on the improvement and to manage impacts.
- H2 would be discussed by the Board in detail later that day

Workforce

- Mr Azmi noted staff turnover of 10%, asking are we competitive and do we do exit surveys? Mrs Ricketts confirmed that yes, all staff are automatically offered an exit interview and they can choose who to have that with. A questionnaire is offered to those who do not want to feedback in person.
- Main reasons for leaving are flexible working and retirement but there is a general change in the national marketplace and the unregistered workforce is changing.
- The Trust are competitive in the registered workforce but the levels of pressure in the NHS are different than to other sectors, thus there are gaps for example in the HCA workforce
- The Trust is working to support apprenticeships and working developing our workforce strategies.

ACTION: Report of exit interview themes and feedback to be received by People and Culture Committee

Sir David concluded by recognised the efforts of staff and the need to get real benefit from Perfect 10 and clarity of expectations of each of our partners in supporting flow.

RESOLVED THAT: the report be noted for assurance.

127/21 **Committee Assurance Reports**

The following points were highlighted by Committee Chairs:

- F&P: focus on H2 which will feature in discussion later that day
- QGC: nothing to escalate outside of the written report. A presentation on domestic violence was received and we will consider what may need to come to the Board in this regard in future.

RESOLVED THAT: the Committee reports be noted for assurance.

GOVERNANCE

128/21 **Safest Staffing Report**

a) Adult/Nursing
b) Midwifery

Adult/Nursing

Mrs Gardner presented the nursing element of the report which covered the period to September 2021 and provided level 5 assurance.

Absence had increased in September due to Covid, non Covid and household contacts. We have implemented enhancements which are having an effect. HCA turnover is at 14% and the Trust is working with local Trusts to hold recruitment days focussed on registered nurses and HCAs. Ms Day was pleased to see support for staff and professional advocate for nurses, asking if there are similar schemes for medics or AHPs? Dr Blanshard confirmed medics and junior doctors have access to a number of support services which offer pastoral,

education and training support. Senior doctors are often less willing to access these, but they can access clinical psychology support and outside of the Trust.

Midwifery
Ms Jeffrey presented the report which had an assurance level of 4. There has been a reduction in fill rates and the team have also re-advertised for posts to increase training. £800k funding will also help support delivery of the Public Health agenda. Sickness is at circa 6% and has been maintained. There were 11 new starters in September/October, vacancies have decreased and turnover is below the Trust's target. If this continues next month, the assurance level will increase to level 5. The x3 daily sit rep and bed meetings are ongoing. The team are reviewing how our escalation plans dovetail with regional plans.

Dr Murphy asked how the morale of the team was developing? Mrs Jeffrey confirmed the numerous launch events had been well attended. Feedback from staff is that the conversation is starting to change, the focus on continuity of carer is not quite where it was before. There are still delays in inductions and the patient experience in these circumstances is reduced. However there is positivity about new starters and the teams are very sighted on plans, with staff reporting they can see things are slowly getting better. Mrs Jeffrey confirmed the senior team are sighted on the list of women delayed on a daily basis and for how long. Other Trusts have similar issues as this is the elective work which we can control when pressured to maintain safety.

Dr Blanshard reflected back to this morning's patient story, especially the impact of relationships and the impact on those who are vulnerable and the decisions made about their care.

RESOLVED THAT: the report be received for assurance.

129/21 **Responsible Officer Appointment**
Ms O'Connor presented the report which was taken as read. The appointment being a formal requirement under the regulations. Dr Blanshard confirmed she had undertaken the necessary training.

RESOLVED THAT: the Chief Medical Officer be appointed as the Trust's Responsible Officer

130/21 **ANY OTHER BUSINESS**
There was no further business noted.

DATE OF NEXT MEETING
The next Public Trust Board meeting will be held virtually on Thursday 9 December 2021 at 10:00am.

The meeting closed.

Signed _____ **Date** _____
Sir David Nicholson, Chair

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

PUBLIC TRUST BOARD ACTION SCHEDULE

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
15.7.21	Patient Story	055/21	Mrs Edwards to ensure property forms and common policies and procedures to be put in place across sites	JE (PG)	Oct 2021	Dec 2021	Policy is due for sign off in December 2021.	
15.7.21	Patient Story	055/21	Mrs Gardner to pursue mobile phone issues (stickering etc) as part of the above action	PG	Oct 2021	Dec 2021	As above	
15.7.21	IPR	066/21	Analysis of waiting lists and how this will be addressed in the context of the winter plan	PB	Oct 2021	Dec 2021	Action complete. Verbal update at meeting	
9.9.21	IPR	087/21	Sir David requested Mr Brennan develop a document for the ICS to bring about mutual accountability with regards to urgent care pressures	PB	Oct 2021	Dec 2021	Action complete. Verbal update at meeting	
14.10.21	Patient Story	097/21	Mrs Gardner to arrange for "essential medical kit do not unplug" stickers	PG	Dec 2021		Verbal update at meeting	
14.10.21	Matters Arising	100/21	An update with regards to HIC would be received at the next Finance and Performance Committee and Trust Board.	JN	Dec 2021		Verbal update at meeting	
11.11.21	CEO Report	121/21	Mr Hopkins to confirm reporting of Place urgent care metrics across all partners.	MH	Dec 2021		This is under review across Place and led by Nikki	

							O'Brien as Chair of the intelligence cell	
11.3.21	Patient Story: Family Liaison Service	131/20	Development of a business case and interim plan to maintain the service and address any lessons learned specifically in addressing BAME needs	DK (PG)	April 2021	Dec 2021	A new Patient Experience Lead Nurse and Sister have been appointed and joined the Trust in April. The Lead Nurse for PE will lead a review of existing resources to embed actions from the feedback and learning from the temporary Family Liaison Service, operationalised during the second wave of the pandemic.	
15.7.21	CEO Report	061/21	Discrimination Charter to be received by Trust Board in October.	TR	Oct 2021	Jan 2022	Charter has been shared with staff and network. Item deferred to January Trust Board to enable TME discussion in December.	
15.7.21	Annual Planning Priorities	062/21	Environmental strategy discussion at Trust Board	PB	Oct/Nov 2021	Jan 2022	To be aligned with the Estates strategy, due to Trust Board in January 22.	
15.7.21	Annual Planning Priorities	062/21	Report on sustainability to come to Trust Board in September	JN	Sept 2021	Jan 2022	ICS net zero green strategy approach to be aligned with the Estates Strategy development.	
10.6.21	Patient story	037/21	Mrs Lewis to raise with WMAS' Chief Digital Officer and the Oasis system supplier	VL	July 2021	Jan 2022	WMAS EPR deployment we are awaiting a further progress report from the CIO at WMAS on their deployment timetable. OASIS upgrade is scheduled for January 2022	

15.7.21	Annual Planning Priorities	062/21	Report on Annual Plan in September to take account of increased efficiency and reduction in ERF	PB/JN	Sept 2021	Oct 2021	H2 plan on agenda. Action complete.	
9.9.21	Covid End of Year Review	084/21	Ms O'Connor to expand the scope of governance task and finish group review to include agility of decision making	ROC	Dec 2021		Report received by Audit Committee in November 2021. Paper to TME to implement. Action complete	
14.10.21	Patient Story	097/21	Ms Sterckx to review and further develop patient groups	AS	Dec 2021		Progress with planned engagement with the D/deaf community has not taken place as planned due to cancelled events (Covid). In light of this engagement has been rescheduled to 2022 and will include: • Inviting members of the D/deaf community to engage with the trust for the tender process for the contract for interpreting and translation • A series of informal coffee mornings to continue the conversation about D/deaf experiences across our hospitals • Continued engagement with the patient who attended Trust Board to progress the action plan to support	

							patients who have a hearing impairment The Patient and Public Forum has increased by two members (Nov/Dec 21) who have been recruited to widen diversity within the group Anna Sterckx has met with HWHCT to formalise links across the ICS – to commence with a new engagement stakeholder group in early 2022 and mapping of fora across the system. Work has progressed with engagement with the Worcestershire Association of Carers: a series of Caring Conversations will be jointly facilitated between the Trust and the association in 2022 – this will include a mixed mode approach for engagement. The ICS Signed Commitment to Carers formalises the process.	
11.11.21	Patient Story	115/21	Rosie and Sky's story to be shared with midwifery teams and the system	JJ/MH	Jan 2022		The Trust are sharing the story at all of the CoC launch events and have arranged for the story to go to LMNS Board in January. Action complete.	

11.11.21	IPR	126/21	Report of exit interview themes and feedback to be received by People and Culture Committee	TR	Dec 2021		An analysis of exit interviews/ reasons for leaving to the P&C Committee on 30th Nov was part of the Integrated People and Culture report	
11.11.21	NHS System Oversight Framework	123/21	Mrs Newton to confirm the SOF ratings of system partners	JN	Dec 2021		Ratings circulated. Action complete.	

Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	9 December 2021
Paper number	Enc C

Chief Executive Officer's Report

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

Accountable Director	Matthew Hopkins Chief Executive Officer		
Presented by	Matthew Hopkins Chief Executive Officer	**Author /s**	Rebecca O'Connor Company Secretary

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

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

Recommendations	The Trust Board is requested to • Note this report.

Executive summary	This report is to brief the Board on various local and national issues. Items within this report are as follows: • Meeting with Health Minister • NHSEI site visit • CQC engagement visit • Presentations to award winners • Single Improvement Methodology • ICS update

Risk			
Which key red risks does this report address?	N/A	**What BAF risk does this report address?**	N/A

Assurance Level (x)	0	1	2	3	4	5	6	7	N/A	X
Financial Risk	None directly arising as a result of this report.									

Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y		N		N/A	X
Are the actions identified starting to or are delivering the desired outcomes?	Y		N			
If no has the action plan been revised/ enhanced	Y		N			
Timescales to achieve next level of assurance						

Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	9 December 2021
Paper number	Enc C

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

Issues and options

Meeting with Health Ministers

In November, I was part of a delegation of Worcestershire health and care leaders and regional NHSEI colleagues who were invited to a virtual meeting with the Secretary of State for Health Sajid Javid and Health Minister Edward Argar, along with our local MPs and the leader of Worcestershire County Council Simon Geraghty. Discussions covered the continuing pressures on our urgent and emergency care services and the importance of a system wide response to the challenges we face in improving patient flow across all our organisations. We also covered the ongoing response to the Covid pandemic and the resulting challenges in tackling our elective waiting lists.

NHSEI Site Visit

Earlier this month we also hosted a site visit by members of the NHSEI national team to Worcestershire Royal Hospital which also focussed on the challenges our local system faces in maintaining safe and effective patient flow in the face of continuing high levels of demand on our urgent and emergency care services. During their visit they toured the site, met with staff from a range of clinical teams and heard about some of the actions we have taken to reduce waits, improve ambulance handovers and deliver a better experience for our patients. The national team recognised the scale of the challenge that we face as a system and will work with us to identify further actions that can be taken in our hospitals and in other parts of the system as we head into what we know will be an extremely challenging winter for all our local health and care services.

CQC engagement visit

We welcomed our CQC Inspection Manager Phil Terry who, with his colleague Sam Harrison, spent two days with us meeting teams from across the Trust to hear directly from them about their lived experiences of the Covid pandemic and the impact it has had, and continues to have.

At our feedback session both Phil and Sam expressed their gratitude for the welcome they received, the openness and honesty of the colleagues they spoke to and their profound admiration for everything you have achieved and are achieving.

Working alongside the CQC, and building a positive working relationship with them, is important because they can provide some invaluable insights into how well we are moving 4ward, as well as helping us to identify areas where there are more opportunities for improvement.

All of that helps to establish our Trust as a well led organisation, where teams are empowered and encouraged to focus on continuous improvement - and that in turn helps to drive the roll out of our single improvement methodology in partnership with the Virginia Mason Institute on our journey to outstanding.

Staff Achievement Awards Presentations

Over the past few weeks I have hosted drop in sessions at the Alexandra, Kidderminster and WRH and invited colleagues who won or were highly commended at our virtual Staff

Achievement Awards to collect their certificates and trophies in person. A number of executive team colleagues joined these sessions which provided a great opportunity for us to meet some of the outstanding individuals and teams who have contributed so much to our Trust. I have also visited some of the teams who weren't able to make it to the drop in sessions to give them their awards and we hope to have the rest handed over before Christmas.

Service Improvement Methodology
Virginia Mason Institute (VMI) team undertook more than 50 face to face and virtual site visits with our staff this month, convened at their invitation. VMI feedback from these sessions indicated a strong desire for support to deliver continuous improvement, with an acknowledgment of the need for a better focus, clearer priorities and alignment of expectations to deliver on said priorities. The co-design phase will focus on development of implementation plan (Q4 21/22), identification of value streams and quick win opportunities (Q4 21/22), driven via the repurposed Transformation Guiding Board. With full executive director, and Divisional Director (SCSD, W&C) membership, attendance to a full day monthly meeting commences this month. Jas Cartwright, the new Director of Continuous Improvement, commenced her role on 1st November.

ICS Update

ICS Transition Update
The Trust Company Secretary has provided advice and support to the proposed draft ICB Constitution which has been submitted to NHSEI. Following an ICSE Development workshop on 3rd November, the proposed Integrated Care Body (ICB) membership model as:

- Chair
- Chief Executive
- 3 Non Executive Directors
- 3 Executive Directors (CFO, CNO, CMO)
- 7 Partner members (3 NHS Trust, 2 Local Authority, 2 Primary Care)

Chief Executive
Simon Trickett has been confirmed as Chief Executive of Herefordshire & Worcestershire ICS, one of 34 systems nationally and the only one in the West Midlands to do so. Interviews for the ***Chair*** role took place this month with the outcome awaited.

Non-Executive Directors
Recruitment for the three Non-Executive director posts has commenced.

ICS Chief People Officer/Strategic Workforce Director
Following a discussion at the People Board and further work to clarify the role with the incoming chair of the new/refreshed People Board, an interim post for a full-time dedicated ICS Chief People Officer is being created. An expression of interest has been requested for system staff with the appropriate experience to come forward to fill this role.

Worcestershire Executive Committee (WEC)
The WEC continues to develop with creation of quality, BI and communication cells led by trust senior staff to build a place based approach. A development session takes place this

month to agree a proposed operating model aligned with the Health & Wellbeing board and the ICB. Accountability of flow across place via an expanded Homefirst continues to develop, which will be further tested through review of the Perfect 10 exercise.

Provider Collaborations

The board has approved a proposal that will see it build a closer working relationship with the South Warwickshire Foundation Group, which has included Wye Valley NHS Trust as a strategic partner since 2016, as well as South Warwickshire NHS Foundation Trust and George Eliot Hospital NHS Trust. As an Associate Member of the Foundation Group, we will have the opportunity to collaborate with other group members on improvement projects, knowledge sharing and best practice and a 'do it once' approach to planning and policy.

Recommendations

The Trust Board is requested to

- Note this report.

Appendices - None

Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	9 December 2021
Paper number	Enc D1

Communications and Engagement Update

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

Accountable Director	Richard Haynes, Director of Communications and Engagement		
Presented by	Richard Haynes	**Author /s**	Richard Haynes

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

Report previously reviewed by		
Committee/Group	Date	Outcome

Recommendations	Board members are asked to note the report

Executive summary	This report provides Board members with examples of significant communications and engagement activities which have taken place recently as well as looking ahead to key communications events/milestones in coming months. In the spirit of our 4ward behaviour of work together, celebrate together, this report includes recent examples of our more successful proactive media and social media work which help to showcase our commitment to putting patients first, and further improve the profile and reputation of our Trust as well as supporting the wellbeing of our staff. This report also looks at some highlights of the partnership working between our communications teams and colleagues in the Worcestershire Acute Hospitals Charity.

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	BAF Risk 11: If we have a poor reputation then we will be unable to recruit or retain staff, resulting in loss of public confidence in the trust, lack of support of key stakeholders and system partners and a negative impact on patient care

Assurance Level (x)	0		1		2		3		4		5	x	6		7		N/A	
Financial Risk	Related activities carried out within the existing communications budget or covered by the budgets of supported projects or programmes.																	

Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
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Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y		N	X	N/A	
Are the actions identified starting to or are delivering the desired outcomes?	Y	X	N			
If no has the action plan been revised/ enhanced	Y		N	X		
Timescales to achieve next level of assurance	**Communications and engagement priorities for 21/22 are aligned with Trust planning priorities and timelines in ways which are consistent with our Communications Strategy, subject to capacity constraints. Progress and issues will be reflected in future Board updates**					

Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	9 December 2021
Paper number	Enc D1

Introduction/Background

This report provides Board members with examples of significant communications and engagement activities which have taken place recently as well as looking ahead to key communications events/milestones in coming months.

In the spirit of our 4ward behaviour of work together, celebrate together, this report includes recent examples of our more successful proactive media and social media work which help to showcase our commitment to putting patients first, and further improve the profile and reputation of our Trust as well as supporting the wellbeing of our staff.

This report also looks at some highlights of the partnership working between our communications teams and colleagues in the Worcestershire Acute Hospitals Charity.

Issues and options

Positive proactive media and social media

Covid Vaccination Clinics for Mums to Be at Kidderminster: Following our press release about our drop-in Covid vaccination clinics for pregnant women, the team at hosted a visit by BBC Midlands today which generated some positive coverage featuring interviews with staff and patients, helping to raise awareness of the clinics and the importance of mums-to-be protecting themselves and their babies by getting vaccinated.

Worcestershire Anaesthetist's 'dream to go green' reduces hospitals' carbon footprint. This story highlighting how our staff are not only focussed on putting patients first, but also thinking of ways to protect our environment, as well as demonstrating our commitment to our 4ward behaviour of do what we say we will do.

Our press release and social media content showcased the progress made by Consultant Anaesthetist Dr Paul Southall and his colleagues who have been using alternative surgical anaesthesia options to reduce the use of the anaesthetic gas desflurane, which is one of the most harmful for our environment. Social media messages were widely shared and liked and the story was covered in several local newspapers and on BBC Radio Hereford and Worcester (including an interview with Dr Southall)

NHS
Worcestershire
Acute Hospitals
NHS Trust

Meeting	Trust Board
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Staff Facing Communications: #CaringForMe

In support of our strategic priority of Best People we launched a #CaringForMe campaign in November to continue to raise awareness of the Trust Wellbeing offer.

The campaign, which will run across various internal channels, including posters, screensavers, intranet banners and across the staff Facebook page, uses colleagues' real feedback/stories to highlight what wellbeing offers have worked for them.

It highlights various Trust offers - including Wellbeing Conversations, Trust psychologist support and Happy Café sessions - as well as signposting to the Health and Wellbeing pinwheel where further support can be accessed.

The campaign supports ongoing, regular internal communications to all staff on wellbeing support which has included crisis cards, a wellbeing brochure and, most recently, an introduction to the Trust's new Mental Health First Aiders.

System/Place Based Working

Communications to support wellbeing is also an area of focus for partnership working at Place and System Level. As members of the Herefordshire and Worcestershire 'Now We're Talking' Communications Group we are supporting that group's work to produce a series of short video messages promoting mental wellbeing over the Christmas and New Year period. The messages will include one from Matthew Hopkins which we have recorded and we are also helping with the editing of contributions from health, care and voluntary sector partners.

The ICS level Communications and Engagement Advisory Group and the Worcestershire Place communications 'cell' referred to in previous updates now have established meeting patterns and are both supporting joined up work with priority areas of focus including vaccination uptake and messages to help members of the public choose wisely when in need of urgent or emergency care.

Charity Communications Update

The communications team continue to work closely with our colleagues in the Worcestershire Acute Hospitals Charity.

Wonders of Worcestershire: With support from the communications team, the Charity recently launched its 2021 Christmas appeal – titled 'Wonders of Worcestershire.'

The aim of the appeal is to highlight the wonderful work of the trust staff and the charity over the last 12 months and to raise as much money as possible to continue to provide continuing support for patients and staff into 2022.

The appeal will be running mostly on social media with links to donate on line and by text and there are branded Teams backgrounds and email signatures for staff to use if they wish. To make a donation, visit the charity website https://wahcharity.org

Alongside running the appeal the charity has secured or funded a gift for all our inpatients on Christmas day and hosting a corporate networking event in the community. The charity is also funding Christmas decorations for the sites and small treats for staff to be handed out during the festive season.

Hospital Engagement Officer: The charity has secured grant funding which will enable recruitment to a new post of Hospital Engagement Officer. Key parts of this role will be to work with stakeholders across the Trust to increase engagement with the charity, improve charitable spending levels and maximise the impact of charity led initiatives.

With a particular focus on charity funded wellbeing projects, the postholder will work alongside the communications team and Trust colleagues leading wellbeing initiatives to improve awareness and uptake by our staff of the charity funded wellbeing support on offer. The post holder will also measure the impact charity funded wellbeing support is having on staff and use this knowledge to help inform discussions on the direction of future wellbeing projects for the charity.

Worcestershire Oncology centre introduces reusable bottle scheme for Radiotherapy patients: Communications support for the Charity included a press release and social media to raise awareness of the initiative developed in partnership between our Radiotherapy team at the Worcestershire Oncology Centre and the Charity to fund reusable, biodegradable Charity branded water bottles.

The bottles help patients undergoing radiotherapy treatment who are required to follow a drinking protocol as part of their treatment. They are also supporting a significant reduction of single use plastic in the Oncology department. Patients given a bottle have the option to make a charitable donation of £2 to Worcestershire Acute Hospitals Charity which will go towards purchasing more bottles for radiotherapy patients.

Social Media Update:

In the three months since the last Communications update to Board, our social media content featuring real stories of how our staff are Putting Patients First has been viewed:

- 416,145 times on Facebook
- 273,491 times on Twitter
- 862,455 times on TikTok
- 123,905 times on YouTube
- 20,409 times on LinkedIn
- 18,765 times on Instagram

Making a combined total of 1,715,170 times that our content has been seen on social media.

Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
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Covid Response

We have continued to focus on ensuring that the most up to date information about all aspects of our Covid response is easily available to colleagues – whether working on site or remotely. At the time of writing this report, production of our electronic Covid Update was continuing to run at three issues a week to reflect the ongoing level of our incident response. On Wednesday 1 December we issued our 261st edition of the Update.

Other Media Coverage

Other issues which have attracted significant media coverage and comment recently (as reflected in our weekly 'In the News' updates) include the continuing pressures on our urgent and emergency care services, and reaction to the service moves to support our surgical service reconfiguration.

Conclusion

Demand for communications and engagement support continues to grow rapidly and with finite capacity we are trying to focus our time and skills on those areas which will provide most value to the Trust's wider strategic and operational priorities.

We are also trying, where possible, to quantify the value added by that support to priority projects by measuring benefits realisation/return on investment, although this is not always easy to calculate precisely.

Recommendations

Board members are asked to note the report

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	9th December 2021
Paper number	Enc D2

H2 (October 2021 to March 2022) Annual Planning 2021/22

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

Accountable Director	Jo Newton, Director of Strategy & Planning Robert D. Toole, Chief Finance Officer		
Presented by	Jo Newton, Director of Strategy & Planning	**Author /s**	Lisa Peaty, Deputy Director of Strategy and Planning Jo Kirwan, Deputy Director of Finance Nikki O'Brien Assistant Director of Business Intelligence, Performance and Digital Felicity Davies, Deputy Director of People and Culture Zoe Scott-Lewis, Head of Transformation and PMO Tim Luckett, Programme Manager

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

Report previously reviewed by		
Committee/Group	Date	Outcome
TME	17th November 2021	Noted the submission made to ICS to meet NHSEI deadline submission
F&P	24th November 2021	Endorsed the final submission made to ICS to meet NHSEI deadline submission

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	9th December 2021
Paper number	Enc D2

Recommendations	It is recommended that Trust Board: • Approve the submission made by the Trust to the ICS, as endorsed by the Finance and Performance Committee • Endorse the agreed position with the ICS as part of onward submission to NHSEI • Note the risks associated with delivery of the plan

Executive summary	This paper provides the final position for the H2 (October 2021 – March 2022) plan submitted on time to the ICS and onwards to NHSEI. It summarises the output and risks which will be covered in detail in the attached slide deck.

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	*BAF 1, 7, 8, 11,18*

Assurance Level (x)	0	1	2	3	4 x	5	x	6	7	N/A	
Financial Risk	*N/A*										

Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y	x	N		N/A	
Are the actions identified starting to or are delivering the desired outcomes?	Y	x	N			
If no has the action plan been revised/ enhanced	Y		N			
Timescales to achieve next level of assurance	**Monthly**					

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	9th December 2021
Paper number	Enc D2

Introduction/Background

NHSE/I published national H2 planning guidance on 30th September 2021. The guidance focuses on priorities for the second half of the financial year, financial arrangements and planning deadlines. This paper identifies the key headlines from the plans submitted including the final system position.

Issues and options

Key headlines

Headline activity and performance data are outlined in the table below. In terms of the 4 key targets our submission outlines:

104+ week waiters
- Plan to meet the standard, except for Orthodontic long waiters and P5/P6s.

52+ week waiters - Plan to achieve the standard

Incomplete RTT waiting list - Plan to meet the standard

Cancer 62 days standard - The trust is projecting 232 62 week wait by end Mar 22 which is down from Sept 21 unvalidated position of 361

Activity Type	Metric ID	PRM to October Submission			Oct to Nov Submission		Reasons for Change
		PRM	Oct-21	Variance	Nov-21	Variance	
Outpatient New	E.M.32	75,385			79,206	+ 3821	WL Validation/Added back intervention
Outpatient FU	E.M.32	124,839			124,839	-	
Daycase	E.M.10a	38,787	38,887	100	38,887	- 100	WL Validation
Inpatient	E.M.10b	3,418	3,418	-	3,912	+ 494	TIF Discharge Lounge & IS General Surgery
Diagnostic - Endoscopy	E.B.26	12,974			12,300	-674	Seasonal change for CDH, reduction for IS 18 Week & WLI
Diagnostic - Radiology	E.B.26	66,249			77,749	+ 11500	Increase in Ultrasound and CT Activity
Diagnostic - Physiological	N/A	8,346			8,346	-	

4 key targets - closely monitored by NHSE/I

Target Type	Metric ID	National Target	Submitted Oct 21	Updated for Final Submission	Variance to National Target	Compliancy against Target	Reasons for Change
104 Weeks	E.B.19	-	387	387	387	Not Compliant	346 Orthodontics and 41 P5 & P6 patients
52 Weeks	E.B.18	6,399	7,366	6,205	- 194	Compliant	Adjusted to 80 percentile of modelling achieved through WL validation
Incomplete RTT WL	E.B.3a	57,251	58,835	57,232	- 19	Compliant	Adjusted to 80 percentile of modelling achieved through WL validation
Cancer 62 Day	E.B.32	210*	280	232	22	Not Compliant	Remodelled with ICS

*ICS (Includes H&W)

Workforce

Each directorate has developed a workforce plan to support the wider H2 planning process where the expected workforce levels based on recruitment, turnover, workforce development, service transformation and delivery of new services are set out. The information has been triangulated back with activity and finance. An underlying principle has been to focus only on workforce linked to priority approved business cases, swop out of bank and agency and projected recruitment to establishment vacancies.

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

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Finance

Trust H2 deficit is £(11.4) m. With System support / reallocations of £10.3m and the addition of the H1 (April to September) cumulative deficit of £(0.9)m we submit a FY (H1+H2) 21/22 deficit plan of £(1.9)m. The ICS has a submitted a break-even position.

	£M
Trust H2 (Oct 21 - Mar 22) Plan	**(11.4)**
B/F H1 (Apr 21 - Sept 21) Actual	**(0.9)**
Total Full Year Deficit	**(12.3)**
Stretched Elective Support	**1.8**
ICS/CCG Support / N-R Reallocation	**8.6**
Full Year 21/22 Plan	**(1.9)**

Key risks

Outlined below are the key risks to delivery of the H2 plan

1. Workforce availability - either impact of sickness absences or staffing levels Staff health and well being - exhaustion.
2. Further COVID and/ or urgent care surge impacting on acute capacity/staffing
3. Covid increase in community impacts on elective care cancellation rates.
4. High incidence of seasonal Influenza and/or RSV
5. Increased 2WW referral activity displacing long waiting routine work
6. An increase in patients with a higher clinical need than those who have been on the waiting lists for some time.
7. The trust has closed the sterile service unit at the Alexandra Hospital due to water ingress and this presents a risk to delivery in the short term.

Next steps

Delivery of activity will be closely monitored by the Restoration Oversight group and PRMs. At a system level this will be achieved via the Reset and Recovery group. A rapid review of learnings from H2 will be built into the upcoming 22/23 planning round.

Conclusion

The planning round for H2 has been completed whilst the Trust continues to deliver services in the live environment. Tight management of risks and mitigations working with system partners will continue to be needed to deliver the plan.

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	9th December 2021
Paper number	Enc D2

Recommendations
It is recommended that Trust Board: • Approve the submission made by the Trust to the ICS, as endorsed by the Finance and Performance Committee • Endorse the agreed position with the ICS as part of onward submission to NHSEI • Note the risks associated with delivery of the plan
Appendices

Appendix One: H2 Activity Figures

Appendix Two – slide deck with detailed plan

Meeting	Trust Board
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Appendix One: H2 Activity Figures

Elective Ordinary Inpatients

The following figures were submitted in draft on the Elective Activity submission:

Type	Oct	Nov	Dec	Jan	Feb	Mar	Total H2
Ordinary Electives	574	568	532	542	583	619	3,418

The following table compares the H2 plan to the H1 actual, and then the H1 actual and the H2 plan to the 19/20 actuals *with March 2020 normalised.

Type	H1 Plan	H1 Actual	H2 Plan	Variance to H1 actual (n)	Variance to H1 (%)	19/20 Actual*	Variance to 19/20 (n)	Variance to 19/20 (%)
Ordinary Electives	3,466	2,960	3,418	458	+15.5% (115.5%)	8,186	1,808	-22.1% (77.9%)

- In summary, we have predicted 15.5% more activity than we did in H1, but we are predicting that we will treat 22.2% less ordinary inpatients than we did in 2019/20. The additional activity will be achieved through improved theatre utilisation and additional capacity released by moving some daycases to the Vanguard theatre.
- The overall reduced activity compared to 2019/20 is a result of a combination of social distancing restrictions, staff that were re-deployed during H1 to support Covid wave 3 and a difference in case-mix as we focus on those patients in most clinical need who are complex and can have longer procedure times.

There is a potential change that may be made before the final Elective activity submission on 16th November:

- Additional activity to be identified from maximising the independent sector.

Elective Daycases

The following figures were submitted in draft on the October Elective Activity submission:

Type	Oct	Nov	Dec	Jan	Feb	Mar	Total H2
Daycases	6,670	6.719	5,963	6,703	6,341	6,491	38,887

The table below compares the H2 plan to the H1 actual, and then the H1 actual and the H2 plan to the 19/20 actuals *with March 2020 normalised.

Type	H1 Plan	H1 Actual	H2 Plan	Variance to H1 (n)	Variance to H1 (%)	19/20 Actual*	Variance to 19/20 (n)	Variance to 19/20 (%)
Daycases	37,237	38,859	38,887	+28	0.0% (100%)	85,774	-8.028	-9.4% (90.6%)

- In summary, we have predicted the same level of activity as in H1, but we are predicting 9.4% less daycases than we did in 2019/20. The additional activity/capacity created by moving daycases to the Vanguard will be utilised for ordinary electives.
- The overall reduced activity compared to 19/20 is a combination of social distancing restrictions, staff that were re-deployed during H1 to support Covid wave 3 and a difference in case-mix as we focus on those patients in most clinical need who are complex and often have longer procedure times.

For ordinary inpatients and daycases, it is worth noting that surgical reconfiguration has been included in the modelling (showing movements between specialties) by the operational leads, but this is related to transferring activity between sites rather than increasing productivity at this stage.

The potential improvements indicated by the GIRFT programme have not been included in this modelling because both the acute operational leads and the ICS reset and recovery team have agreed that these are more likely to impact productivity in 2022/23 than in 2021/22 H2.

RTT (completed) clock stops and starts

The figures below were submitted in draft on the Elective Activity submission:

Type	Oct	Nov	Dec	Jan	Feb	Mar	Total H2
RTT completed - admitted	1,966	1,758	1,607	1,740	1,672	1,709	10,452
RTT completed - non admitted	7,806	7,147	6,708	7,306	6,701	7,378	43,046

RTT clock starts	10,563	10,357	10,539	10,193	10,216	11,067	62,935

The RTT (completed) clock stops and starts were not required for the H1 activity submission.

We have analysed the profiles of stops and starts for all patients that have been treated across a three year period by specialty and then applied some current assumptions. Please note, there will be a level of fluctuation to these predictions due to the complexity of our pathways.

Type	H1 Plan	H2 Plan	Variance to H1 (n)
RTT completed - admitted	11,164	10,452	-712
RTT completed - non admitted	34,690	43,046	+8,356
RTT clock starts	63,072	62,935	-137

The additional clock stops for non-admitted will be driven by more robust monitoring and management of clock stops recorded within the PAS and there will also be a transfer of patients to the PIFU pathway. Another improvement may come from a pilot looking at using automated callers to contact patients from the unseen O/P waiting list. This is still being evaluated. The first pilot indicated that just over 10% (97 from 780 patients) of the cohort contacted had indicated that they have received treatment elsewhere and therefore could be removed from our waiting list. This intervention is still being reviewed.

RTT incomplete waiting list

The following table shows the draft Elective Activity submission.

Type	Oct	Nov	Dec	Jan	Feb	Mar
RTT Incomplete Waiting list	57,867	58,272	60,500	59,945	59,390	58,835

52 week breaches	6,187	6,392	6,631	6,808	6,974	7,366
104 week breaches	217	272	299	329	363	387

- The H2 guidance requires us to sustain the RTT incomplete waiting list at the level of September 2021. The above validated September submission will be finalised and submitted on 19 October. At the time of writing, the unvalidated September figure is 57,265 and the table above shows that we are predicting a slightly higher figure by the end of the financial year.
- The planning guidance requires a reduction in 52 week breaches by March 2022; however other national guidance requires the Trust to focus on reducing the Priority 2/Priority 3 clinical priority patients, so at the moment the trajectory for 52 week patients (many of whom maybe lower clinical priority) is increasing. In order to reverse the trajectory, we would need to rebalance the proportion of patients seen as a clinical priority to those who are long waiters but this could put patients with a higher clinical priority at risk.
- The H2 planning guidance requires the elimination of 104 week waiters by March 2022. We have committed to eliminating all 104 week waiters with the exception of those patients who have deferred treatments due to COVID-19, and those who are waiting Orthodontic appointments/treatments. Orthodontic capacity has been an issue for some time and the wider system is trying to identify a solution to our increasing backlog.

Non Elective spells

The figures below were submitted in draft on the Elective Activity submission.

Type	Oct	Nov	Dec	Jan	Feb	Mar	Total H2
Non elective spells	5,320	5,277	5,214	5,261	4,906	5,194	31,212

The following table compares the H2 plan to the H1 actual, and then the H1 actual and the H2 plan to the 19/20 actuals *with March 2020 normalised.

Type	H1 Plan	H1 Actual	H2 Plan	Variance to H1 (n)	Variance to H1 (%)	19/20 Actual*	Variance to 19/20 (n)	Variance to 19/20 (%)

Non elective spells	28,119	28,474	31,212	+2,738	+9.6%	56,763	2,923	+5.1% (105.1%)

- This increase in H2 reflects the increased non elective emergency pressures that we are currently experiencing and are expected to continue into the winter months.
- This increase supports the increase in bed occupancy (see below).

Bed occupancy

It is worth noting that previous planning guidance has stated that G&A bed occupancy levels should be between 85% and 92%. This is unrealistic with the winter pressures that we are currently experiencing and which are predicted to continue. This year we are also protecting 65 beds for Elective activity. Therefore, we have submitted 100% bed occupancy in the first draft of the H2 plan.

The draft outpatient activity for the November submission currently shows the following:

Type	H1 Plan	H1 Actual	H2 Plan	Variance to H1 (n)	Variance to H1 (%)	19/20 Actual*	Variance to 19/20 (n)	Variance to 19/20 (%)
Outpatient News	74,456	77,649	74,627	-3,022	-3.9% (96.1%)	179,525	-27,249	-15.2% (84.8%)
Outpatient F/Ups	123,159	125,227	123,318	-1,909	-1.5% (98.5%)	304,095	-55,550	-18.3% (81.7%)

Putting Patients First

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Appendix One
H2 Plan Submission Summary

Trust Board

09/12/21

Summary position

Proposed position:

Activity:

- H2 plans are more ambitious than the original H1 plan for **all types of activity.**
- H2 plans will deliver similar to H1 actual or above

Workforce:

- Workforce growth of 98.72 wte from H1. This is made up of 64.46 wte recruitment to approved business cases and 34.26 wte growth in recruitment to posts in the establishment but were vacant in H1.
- Substantive growth of an additional 111.97 but a reduction in bank and agency so 0 wte net difference.

Activity Summary Table

Type	H1 Plan			H2 Plan			FYE compared to 19/20		
	H1 Plan	H1 Actual	Variance H1	H2 Plan	H2 Plan Variance to H1 plan (%)	H2 Plan Variance to H1 actual (%)	H1 Actual + H2 Plan	19/20 Actuals	% of 19/20 Actuals
O/P NEW	74,456	78,126	3,670	79,206	106.4%	101.4%	157,332	179,525	87.6%
O/P Follow Up	123,159	126,056	2,897	124,839	101.4%	99.0%	250,895	304,095	82.5%
I/P	3,464	2,948	- 516	3,912	112.9%	132.7%	6,860	8,186	83.8%
Daycases	37,431	38,952	1,521	38,887	103.9%	99.8%	77,839	85,774	90.7%
Endoscopy	12,655	10,546	- 2,109	12,300	97.2%	116.6%	22,846	22,825	100.1%
Radiology	67,632	75,846	8,214	77,749	115.0%	102.5%	153,595	148,710	103.3%
Physiological	7,760	7,356	- 404	8,346	107.6%	113.5%	15,702	22,227	70.6%

Updated Activity Summary

Activity Type	Metric ID	PRM to October Submission			Oct to Nov Submission		Reasons for Change
		PRM	Oct-21	Variance	Nov-21	Variance	
Outpatient New	E.M.32	75,385			79,206	+ 3821	WL Validation/Added back intervention
Outpatient FU	E.M.32	124,839			124,839	-	
Daycase	E.M.10a	38,787	38,887	100	38,887	- 100	WL Validation
Inpatient	E.M.10b	3,418	3,418	-	3,912	+ 494	TIF Discharge Lounge & IS General Surgery
Diagnostic - Endoscopy	E.B.26	12,974			12,300	-674	Seasonal change for CDH, reduction for IS 18 Week & WLI
Diagnostic - Radiology	E.B.26	66,249			77,749	+ 11500	Increase in Ultrasound and CT Activity
Diagnostic - Physiological	N/A	8,346			8,346	-	

4 key targets - closely monitored by NHSE/I

Target Type	Metric ID	National Target	Submitted Oct 21	Updated for Final Submission	Variance to National Target	Compliancy against Target	Reasons for Change
104 Weeks	E.B.19	-	387	387	387	Not Compliant	346 Orthodontics and 41 P5 & P6 patients
52 Weeks	E.B.18	6,399	7,366	6,205	- 194	Compliant	Adjusted to 80 percentile of modelling achieved through WL validation
Incomplete RTT WL	E.B.3a	57,251	58,835	57,232	- 19	Compliant	Adjusted to 80 percentile of modelling achieved through WL validation
Cancer 62 Day	E.B.32	210*	280	232	22	Not Compliant	Remodelled with ICS

*ICS (Includes H&W)

Workforce Plan H2 Summary

	Business cases	Recruitment B/A swap out	Recruitment to vacancies	Net Impact		Substantive by staff group
Original Workforce Submission	79.58	111.97	162.82	**242.40**		351.54
REVISED	**Business cases**	**Recruitment B/A swap out**	**Recruitment to vacancies**	**Net Impact**		**Support to STT & HCS Staff**
Start point - HR revised	41.72	68.54	60.85	**102.57**		**171.11**
Add back CDH	19.74			**19.74**		**19.74**
Retain original B&A swap level		43.43		**0.00**		**43.43**
Recruitment to vacancies - 50/50 slippage and replacement 61wte				**0.00**		**0.00**
Add back digital	3.0		(26.59)	**(23.59)**		**(23.59)**
Turnover						
Revised workforce position 16.11 Following Exec huddle	**64.46**	**111.97**	**34.26**	**98.72**		**210.69**

What's changed: Workforce

What has changed between PRM & October NHSE/I submission?	What has changed between October and November NHSE/I submissions?
• October submission was the PRM position	• Recruitment to business cases has been reduced by 15.12 because these posts will not be recruited to by 31/3/2022 • Recruitment to posts where there is bank/agency swap out has remained at 111.97 • Recruitment to vacancies that are not bank/agency swap out or not a replacement (growth) has been reduced from 162.82 to 34.26. This is following an assessment of the recruitment pipeline for the remainder of H2.

Finance H2 summary

Revised Position

I&E Type	Actual M1	Actual M2	Actual M3	Actual M4	Actual M5	Actual M6	Forecast M7	Forecast M8	Forecast M9	Forecast M10	Forecast M11	Forecast M12	FY Forecast (H1 Actual plus H2 Forecast)
Employee Expenses Total	(26,898)	(27,324)	(27,294)	(27,353)	(27,471)	(31,469)	(28,870)	(28,952)	(29,012)	(29,066)	(29,237)	(29,299)	(342,245)
Operating Expenses exc Employee Expenses Total	(17,368)	(17,592)	(18,296)	(18,176)	(18,359)	(18,384)	(19,305)	(19,150)	(18,897)	(18,430)	(18,838)	(18,851)	(221,646)
Finance charges	(1,595)	(1,596)	(1,595)	(1,695)	(1,621)	(1,732)	(1,585)	(1,631)	(1,631)	(1,631)	(1,631)	(1,631)	(19,576)
Income Total	46,211	47,212	46,508	47,821	46,484	50,849	47,797	46,692	46,353	46,608	46,575	46,987	566,097
Other - below the line adjustments	14	14	14	14	14	(203)	14	14	14	14	14	14	(49)
Surplus / Deficit for the period	**363**	**714**	**(662)**	**610**	**(954)**	**(940)**	**(1,949)**	**(3,028)**	**(3,172)**	**(2,504)**	**(3,117)**	**(2,780)**	**(17,419)**

Finance Charges	H1	H2	H2 from H1 Movement	Adjustment Offsets
Income	285,085	281,013	(4,072)	(7,979)
Pay	(167,810)	(174,435)	(6,626)	(6,084)
Non Pay	(118,011)	(123,212)	(5,201)	(3,257)
Other / donated assets	(133)	84	217	217
Deficit £k	(869)	(16,551)	(15,682)	(17,103)

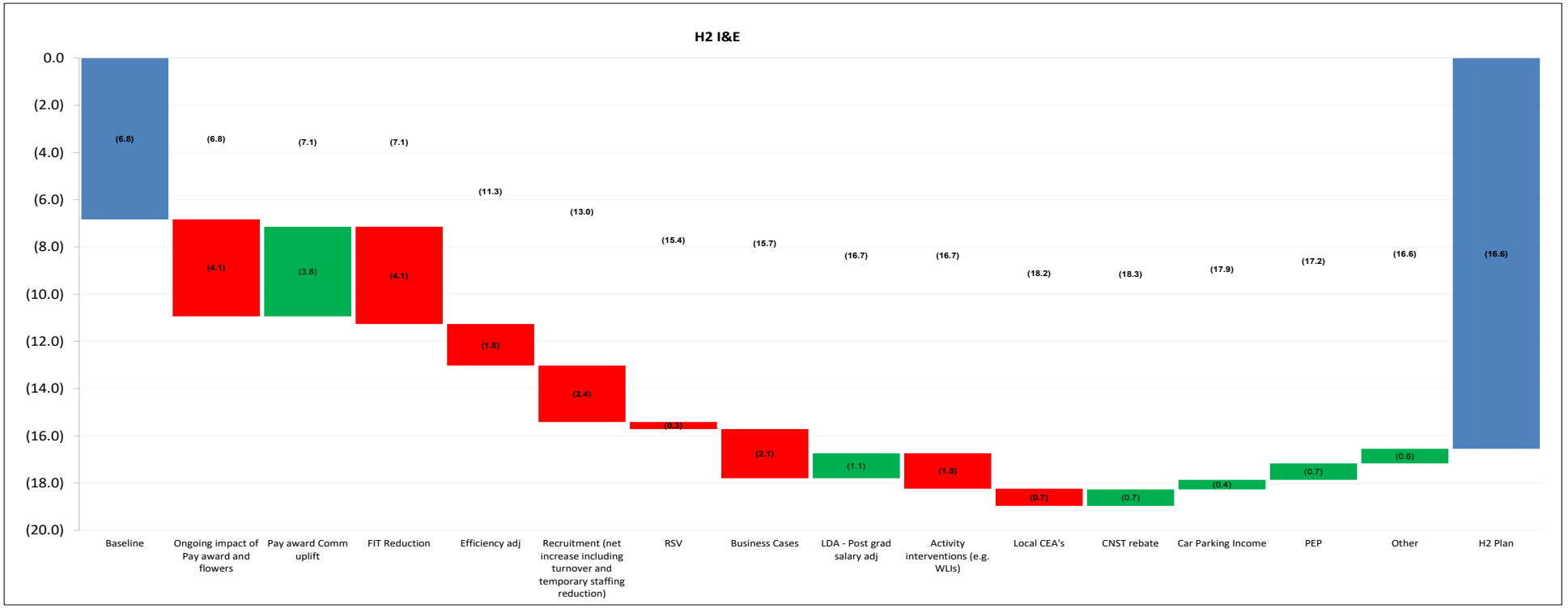
INCOME >> FIT £4.1m, efficiency £1.8m and ERF c.£3m

PAY >> Recruitment £2.4m, CEA's £0.7m, base £1m, business cases £0.6m

NON PAY >> Base £m, DCR £1.3m

BRIDGE INTO H2 pre additional PRM / internal assessment.

The chart below summarises the key drivers influencing the H2 deficit of £(16.6)m pre system discussions.



H2 £ PLAN

Worcestershire Acute Hospitals NHS Trust

The table below provides an initial DRAFT assessment of a worst, best and reasoned position for our Trust.

	PAY	NON PAY	FIN CHARGES	INCOME	TOTAL	WORST	BEST	REASONED
Base Forecast Position H2	**(174.4)**	**(113.5)**	**(9.7)**	**281.0**	**(16.6)**	**(16.6)**	**(16.6)**	**(16.6)**
SIM Business Case - efficiency offset						0.3	0.3	0.3
Transfer activity to IS						1.8	1.8	1.8
Recruitment - modelling - Scenario B							2.5	2.5
Full cost recovery Vanguard							0.7	
NHSE / Associates income change						0.9	0.9	0.9
HSDU - offsite (estimate)						(0.6)	(0.4)	(0.6)
Surgical Reconfiguration (estimate)						(1.0)	(0.2)	(0.5)
ITU capacity - assume funded/or re deployment								
Further workforce variations / principles							***1.6***	***0.8***
H2 Range £m						**(15.2)**	**(9.4)**	**(11.4)**

Final submission **£1.9m deficit** as a result of the following system changes:

- £1.8m stretched elective support
- £8.5m CCG redistribution

	£M
Trust H2 (Oct 21 - Mar 22) Plan	**(11.4)**
B/F H1 (Apr 21 - Sept 21) Actual	**(0.9)**
Total Full Year Deficit	**(12.3)**
Stretched Elective Support	**1.8**
ICS/CCG Support / N-R Reallocation	**8.6**
Full Year 21/22 Plan	**(1.9)**

Note - £1.8m Trf to IS contained in our £11.4m position. Following issue of late guidance this is no longer valid – mitigated by potential ERF achievement and system management of monthly run rate

Summary of H2 (October to March 22) financial plan by month with full 21/22 year (H1+H2) view

Statement of comprehensive income		Balance of Year Plan							
	H1 Actual	M7	M8	M9	M10	M11	M12	H2 Total	Full Year
Operating income from patient care activities	271,670	44,748	45,224	44,310	44,376	44,379	44,450	**267,487**	**539,157**
Other operating income	13,415	3,023	4,186	4,062	4,195	4,185	4,185	**23,836**	**37,251**
Employee expenses	(167,810)	(28,315)	(28,573)	(28,608)	(28,421)	(28,558)	(28,625)	**(171,100)**	**(338,910)**
Operating expenses excluding employee expenses	(108,175)	(18,864)	(18,674)	(18,714)	(17,960)	(18,726)	(18,683)	**(111,621)**	**(219,796)**
OPERATING SURPLUS/(DEFICIT)	**9,100**	**592**	**2,163**	**1,050**	**2,190**	**1,280**	**1,327**	**8,602**	**17,702**
Finance expense	(6,147)	(1,023)	(1,009)	(1,009)	(1,009)	(1,009)	(1,009)	**(6,068)**	**(12,215)**
PDC dividends payable/refundable	(3,688)	(561)	(607)	(607)	(607)	(607)	(607)	**(3,596)**	**(7,284)**
Other gains/(losses) including disposal of assets	19	0	0	0	0	0	0	**0**	**19**
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**(716)**	**(992)**	**547**	**(566)**	**574**	**(336)**	**(289)**	**(1,062)**	**(1,778)**
Remove capital donations/grants I&E impact	(134)	1	1	1	1	1	1	**6**	**(128)**
Adjusted financial performance surplus/(deficit)	**(850)**	**(991)**	**548**	**(565)**	**575**	**(335)**	**(288)**	**(1,056)**	**(1,906)**

Trust Position of £11.4m with ICS support / reallocations of £10.3m = H2 Financial Plan £(1.1)m Deficit
Full Year £(1.9)m cumulative deficit.

RISKS

The following table provides an assessment of key financial risks contained in the H2 plan.

Description	Impact	How will we know if off track?
Activity That COVID levels / winter pressures worsen reducing our ability to ring-fence elective beds	Reduced levels of elective activity Reduced acute bed capacity Increased demand for temporary staffing	Weekly Restoration Oversight Group PRMs Monitoring of Winter plan via Homefirst
Activity Increased demand for ICU capacity due to winter pressures, acuity and COVID	Increased demand for staffing £ increase Redeployment of staff from other departments	Active Divisional /operational management Mutual aid with wider system
Activity Slippage in CDC (formerly CDH) deployment Continued impact of closure of sterile services at the ALex	Reduced levels of activity Impact on income	Oversight through PRM
Workforce Slippage in recruitment against bank and agency conversion trajectory Staff sickness due to fatigue or self isolation Staffing gaps in key roles due to internal and wider vacancies	Impact on staff health & wellbeing Potential retention / retirement Pressure on bank & agency costs leading to £ increase	Oversight of recruitment progress through PRM Daily workforce monitoring Capacity hub feedback
Finance That configuration of services does not deliver benefits realisation	Reduced levels of productivity Impact on Reset & Recovery £ Increase	Visibility of improvement metrics and robust monitoring
Finance That we recruit to posts that are not in todays run rate but are in the agreed establishment	£ Increase	Vacancy factor to be transacted at Specialty level Heightened vacancy control panel
Activity / Finance Slippage in Business Case implementation	Benefits not realised in terms of delivery and / or reduction of costs	Visibility of business case tracker to wider business Tracking via PRMs

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Appendix One

Supporting information (Activity)

H2 Interventions

Intervention	Type	Modelled into H2 plan	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Vanguard theatre	Daycase	Yes	125	125	125	86	86	86
GIRFT productivity assumptions		Yes	0	0	0	0	0	0
Internal productivity assumptions	Outpatient	Yes	40	120	120	120	120	120
Contractual Offer for 18 week (Waterfall only)	Daycase	Yes	84	84	84	84	84	84
Independent sector in-sourcing	Daycase	Yes	80	80	80	80	80	80
Independent sector out-sourcing	Daycase / IP Elective	Yes	240	240	240	240	240	240
Independent sector out-sourcing (GS)	IP Elective	Yes	60	60	60	60	60	60
Mutual aid		No						
Waiting list validation **	All Types	Yes						
Impact of changes to IPC guidance		Yes*	0	0	0	0	0	0
Community Diagnostics Hub impact	Daycase	Yes	1177	1177	1177	1177	1177	1556
Targeted Investment Fund impact	IP Elective	No	0	0	4	44	41	44

* Sustaining the 25% virtual to Face to Face appointments

** Removed between circa 5,000 and 1,500 due to W/L validation and does not impact activity

Elective Ordinary Inpatients

The following figures were submitted in draft on the Elective Activity submission:

Type	Oct	Nov	Dec	Jan	Feb	Mar	Total H2
Ordinary Electives	634	628	596	646	684	723	3912

The following table compares the H2 plan to the H1 actual, and then the H1 actual and the H2 plan to the 19/20 actuals *with March 2020 normalised.

Type	H1 Plan	H1 Actual	H2 Plan	H2 plan Variance to H1 actual (n)	Variance to H1 (%)	19/20 Actual*	Variance to 19/20 (n)	Variance to 19/20 (%)
Ordinary Electives	3,464	2,948	3,912	964	32.69% 132.69%	8,186	-1,326	83.80% -16.20%

- In summary, we have predicted 32.5% more activity than we did in H1, but we are predicting that we will treat 16.2% less ordinary inpatients than we did in 2019/20. The additional activity will be achieved through improved theatre utilisation and additional capacity released by moving some daycases to the Vanguard theatre.
- The overall reduced activity compared to 2019/20 is a result of a combination of social distancing restrictions, staff that were re-deployed during H1 to support Covid wave 3 and a difference in case-mix as we focus on those patients in most clinical need who are complex and can have longer procedure times.

Elective Daycases

The following figures were submitted in draft on the October Elective Activity submission:

Type	Oct	Nov	Dec	Jan	Feb	Mar	Total H2
Daycases	6,670	6,719	5,963	6,703	6,341	6,490	38,887

The table below compares the H2 plan to the H1 actual, and then the H1 actual and the H2 plan to the 19/20 actuals
*with March 2020 normalised.

Type	H1 Plan	H1 Actual	H2 Plan	H2 plan Variance to H1 actual (n)	Variance to H1 (%)	19/20 Actual*	Variance to 19/20 (n)	Variance to 19/20 (%)
Daycases	37,431	38,954	38,887	-67	-0.17% 99.83%	85,774	-7,933	90.75% -9.25%

- In summary, we have predicted the same level of activity as in H1, but we are predicting 9.3% less daycases than we did in 2019/20. The additional activity/capacity created by moving daycases to the Vanguard will be utilised for ordinary electives.
- The additional activity/capacity created by moving daycases to the Vanguard will be utilised for ordinary inpatients. The annual activity levels are negatively impacted by a combination of reduced activity due to social distancing restrictions, staff being re-deployed to ward based activity during H1 to support Covid wave 3 and a difference in case-mix as we focus on those patients in most clinical need who are complex and often have longer procedure times.

For ordinary inpatients and daycases, it is worth noting that surgical reconfiguration has not been included in the modelling (showing movements between specialties) by the operational leads, but this is related to transferring activity between sites rather than increasing productivity at this stage.

The potential improvements indicated by the GIRFT programme have not been included in this modelling because both the acute operational leads and the ICS reset and recovery team have agreed that these are more likely to impact productivity in 2022/23 than in 2021/22 H2.

Outpatients

The following figures were submitted in draft on the October Elective Activity submission:

Type	Oct	Nov	Dec	Jan	Feb	Mar	Total H2
OP – New	13,675	13,729	11,656	13,875	12,372	13,898	79,206
OP - FU	21,825	20,913	17,897	22,741	19,447	22,015	124,839

The table below compares the H2 plan to the H1 actual, and then the H1 actual and the H2 plan to the 19/20 actuals *with March 2020 normalised.

Type	H1 Plan	H1 Actual	H2 Plan	H2 plan Variance to H1 actual (n)	Variance to H1 (%)	19/20 Actual*	Variance to 19/20 (n)	Variance to 19/20 (%)
OP – New	74,456	78,126	79,206	1,080	1.38%	179,525	-26,342	87.64%
								-12.36%
OP - FU	123,159	126,056	124,839	-1,217	-0.97%	304,095	-53,710	82.51%
								-17.49%

Diagnostics

	October	November	December	January	February	March	Total
Endoscopy	1,885	1,841	1,846	2,266	2,176	2,286	12,300
Radiology	13,292	12,972	12,892	13,292	12,131	13,171	77,749
Physiological	1,391	1,391	1,391	1,391	1,391	1,391	8,346

Of which is IS	324	324	294	324	324	324	1,914

* This is included in the figures above - Still waiting for 18 week breakdown although is included in figures above*

The table below compares the H2 plan to the H1 actual, and then the H1 actual and the H2 plan to the 19/20 actuals.

Type	H1 Plan	H1 Actual	Variance to H1 (n)	H2 Plan	Variance to H1 (%)	H2 Plan Variance to H1 actual	H1 Actual + H2 Plan	19/20 Actual	Variance to 19/20 (n)	Variance to 19/20 (%)
Endoscopy	12,655	10,546	1,754	12,300	-14.3%	116.6%	22,846	22,825	21	0.1%
Radiology	67,632	75,846	1,903	77,749	-2.4%	102.5%	153,595	148,710	4,885	3.3%
Physiological	7,760	7,356	990	8,346	-11.9%	113.5%	15,702	22,227	- 6,525	-29.4%

RTT (completed) clock stops and starts

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The figures below were submitted in draft on the Elective Activity submission:

The RTT (completed) clock stops and starts were not required for the H1 activity submission.
We have analysed the profiles of stops and starts for all patients that have been treated across a three year period by specialty and then applied some current assumptions. Please note, the current level of ROTT (referral other than treatment) which stops a clock are lower this year than previous years, this could be as we are seeing less O/P new appointments.
This modelling shows that we will not meet the ERF requirements in four of the six months (require 89%).

2019/20 Clock Stops (Actual)

Metric	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Total
Trust	11318	10847	8993	10706	9819	8523	60206

2021/22 Clock Stops (Forecast)

Metric	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Total
Trust	9772	8906	8315	9046	8373	9087	53498

2021/22 Completion Percentage

Metric	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Total
Trust	**86.3%**	**82.1%**	**92.5%**	**84.5%**	**85.3%**	**106.6%**	**88.9%**

RTT (completed) clock stops and starts

The additional clock stops for non-admitted will be driven by more robust monitoring and management of clock stops recorded within the PAS. Another improvement may come from a pilot looking at using automated callers to contact patients from the unseen O/P waiting list. This is still being evaluated. The first pilot indicated that just over 10% (97 from 780 patients) of the cohort contacted had indicated that they have received treatment elsewhere and therefore could be removed from our waiting list. This intervention is still being reviewed.

RTT incomplete waiting list

The figures below were submitted in draft on the Elective Activity submission:

Type	Oct	Nov	Dec	Jan	Feb	Mar
RTT Incomplete Waiting list	57,867	58,272	60,500	59,411	58,321	57,232
52 week breaches	6,187	6,392	6,631	6,489	6,347	6,205
104 week breaches	217	272	299	329	363	387

- The H2 guidance requires us to sustain the RTT incomplete waiting list at the level of September 2021. At the time of writing, the unvalidated September figure is 57,251 and the table above shows that we are predicting a slightly lower figure by the end of the financial year.
- The planning guidance requires a reduction in 52 week breaches by March 2022; however other national guidance requires the Trust to focus on reducing the Priority 2/Priority 3 clinical priority patients, so at the moment the trajectory for 52 week patients (many of whom maybe lower clinical priority) is increasing. In order to reverse the trajectory, we would need to rebalance the proportion of patients seen as a clinical priority to those who are long waiters but this could put patients with a higher clinical priority at risk.
- The H2 planning guidance requires the elimination of 104 week waiters by March 2022. We have committed to eliminating all 104 week waiters with the exception of those patients who have deferred treatments due to COVID-19, and those who are waiting Orthodontic appointments/treatments. Orthodontic capacity has been an issue for some time and the wider system is trying to identify a solution to our increasing backlog.

Non Elective (emergency) activity

The figures below were submitted in draft on the Elective Activity submission:

Type	Oct	Nov	Dec	Jan	Feb	Mar	Total H2
Non elective spells	5,320	5,277	5,214	5,261	4,906	5,194	31,212

The following table compares the H2 plan to the H1 actual, and then the H1 actual and the H2 plan to the 19/20 actuals *with March 2020 normalised.

Type	H1 Plan	H1 Actual	H2 Plan	Variance to H1 (n)	Variance to H1 (%)	19/20 Actual*	Variance to 19/20 (n)	Variance to 19/20 (%)
Non elective spells	28,119	28,474	31,212	+2,738	+9.6%	56,763	2,923	+5.1% (105.1%)

- This increase in H2 reflects the increased non elective emergency pressures that we are currently experiencing and are expected to continue into the winter months.
- The Covid proportion of the emergency activity is based on the levels in September, and have not been adjusted for the increased levels being seen now. Actvity is c50 Covid admissions per month.
- This increase supports the increase in bed occupancy (see below).

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Appendix

Supporting information (Workforce)

H2 Workforce Narrative

Trust Overall	Re-profiled based on likely recruitment trajectories and using prior year as a comparator. 111.97 increase in substantive workforce with a subsequent reduction in bank and agency: • 58.57 reduction in bank • 53.40 reduction in agency 64.46 growth due to business cases (detail shown on next slide) 34.26 growth in other posts where we know the recruitment has started and individuals will be appointed before 31/3/2022 Recruitment will continue to replace turnover A proposed change to the vacancy control panel will be put in place and staff in post information presented at monthly PRMs to check progress against plans.

H2 Workforce Narrative

WTE	DIVISION	REASON
6.5	Corporate	SIM
3	Digital	Starters will have commenced before 31/3/2022
19.74	SCSD	CDH
24.43	SCSD	CT3 – efficiency development so we get more capacity than we do on the current mobile unit Critical Care- increased staffing for 15 beds to meet national staffing guidelines AOS – efficiency development as it avoids patients attending A&E SABR – clinical development, generates new income from NHSEI Pain Management – service improvement to provide a more holistic approach that will over time negate the need for drug therapy
10.79	W&C	8 Okenden, 2.79 WHU

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Supporting information (Finance)

COMPONENTS OF THE H2 DEFICIT

The following table provides a headline summary of the key drivers of the H2 deficit

	£M
Estimate historic baseline issue – *see next slide*	6
FIT	4.1
Other – includes efficiency target, HSDU offsite provision and Surgical re-config estimate	1.3
Total	**11.4**

FUNDING PRINCIPLES

	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
	Sum of M8 Act 1920	Sum of M9 Act 1920	Sum of M10 Act 1920	Sum of M11 Act 1920	Sum of M12 Act 1920
PAY	(24.82)	(25.36)	(25.64)	(25.77)	(26.31)

Average last 3 months	(25.28)	
Material Non Recurrent Items	x	N/A
Items impacting in 19/20 not represented in base calculation		
- Additional Ward Capacity	(0.28)	Aconbury 2 and 3 opened Mid Feb - monthly costs is £278k.
- ED investment Sec 31, GRAT	(0.13)	Increased staffing as a result of section 31 requirements commenced Jan 20 c. 162k
- Recruitment to vacancies	(0.08)	Non Clinical - not covered by temp posts. Average wte in base period 1,311wte v M12
- Recruitment to vacancies	(0.11)	Medical - growth in worked wte, includes investment in medical take and recruitment
Key Planning Items not in exit run rate		
- Business cases	(0.28)	Commencement of Business cases approved in prior year - Stroke, Neurology,
20/21 Developments		
- Business cases	(0.11)	GEMS - provision of frailty at front door - w.e October
Sub Total Pay Adjustments	**(0.99)**	
Revised Base (PRE INFLATION)	**(26.26)**	

	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
	Sum of M8 Act 1920	Sum of M9 Act 1920	Sum of M10 Act 1920	Sum of M11 Act 1920	Sum of M12 Act 1920
NON PAY	(16.74)	(16.96)	(17.61)	(17.22)	(28.07)

Average last 3 months	(17.10)	
Material Non Recurrent Items	(0.20)	CNST rebate in M9
Items impacting in 19/20 not represented in base calculation		
- Additional Ward Capacity	(0.08)	
Key Planning Items not in exit run rate		
- Business cases	(0.07)	Endoscopy equipment £50k mth - started Jan 20 so £17k in base, FIT Bowel
- Cost pressures	(0.19)	Finance charges £1.4m, Oncology/Newtown backdated and annual cost £0.9m
20/21 Developments		
- Business cases	x	DCR Business case - plan includes £3.6m non pay NEED TO ASSESS WHETHER ANY
CIP	0.08	Energy tarriff
Sub Total Non Pay Adjustments	**(0.46)**	
Revised Base (PRE INFLATION)	**(17.56)**	

2020/21 allocations were predicated on Nov 19 to Jan 20 actuals. These were then topped up to ensure a breakeven position.

Our feedback to NHSI/E at the time identified **c £1.8m** of funding shortfall. This included items such as increased ED nursing in response to Section 31 requirements partially implemented in Jan 20 and our increased bed base in Aconbury 2 and 3 from Feb 20.

Although funding allocations have increased. A level of shortfall remains- hence the profiled deficit moving into 2021/22.

BUDGETS

In April we presented the **ANNUAL** start point budget for our Trust – **inclusive of Productivity and Efficiency Schemes and vacancy factors (pending dissemination to Divisions).**

At that point our FY budget resulted in a **£(15.7)m** deficit > **£(2.9)m** in H1 increasing to **£(12.7)m** in H2 as a result of assumed reduced levels of income. **PEP totalled £5.4m**.

2021/22 FY Phased Budgets

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Grand Total
Income	45,891	45,891	45,891	45,848	45,848	45,848	44,100	44,100	44,100	44,100	44,100	44,101	539,820
Employee Expenses	(27,167)	(27,156)	(26,976)	(26,819)	(26,851)	(26,894)	(26,881)	(26,882)	(26,836)	(26,876)	(26,845)	(26,843)	(323,026)
Operating Expenses exc Employee Expenses	(17,896)	(17,896)	(17,892)	(17,706)	(17,669)	(17,609)	(17,743)	(17,741)	(17,739)	(17,750)	(17,749)	(17,867)	(213,258)
Finance Charges	(1,599)	(1,599)	(1,599)	(1,599)	(1,599)	(1,599)	(1,599)	(1,599)	(1,599)	(1,599)	(1,599)	(1,599)	(19,185)
Grand Total	(770)	(760)	(576)	(276)	(271)	(253)	(2,123)	(2,122)	(2,074)	(2,126)	(2,093)	(2,208)	(15,650)

£(2.9)M DEFICIT

Given the positive variance in YTD across the system, CFOs agreed to offset beneficial YTD M2 variances against the unmitigated system risk in H1 (£6.4m). For us this was £1.8m. A further assessment of ERF achievement was performed following a re submission of activity. This resulted in a further benefit to the position of £1Our H1 revised plan, inclusive of ERF is a £1.1m surplus. Excluding ERF this would be a £(1.1)m deficit.M2, we updated the H1 plan from a deficit of **£(2.9)m** to a surplus of **£1.1m.** The resulting impact of on the full year forecast would be to reduce the FY budget from **£(15.7)m** deficit to **£(11.7m)** deficit.

REVISED 2021/22 FY Phased Budgets

	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Grand Total
Income	45,871	45,871	47,904	46,677	46,928	46,175	44,100	44,100	44,100	44,100	44,100	44,101	544,026
Employee Expenses	(27,079)	(27,069)	(27,111)	(26,880)	(26,911)	(26,957)	(26,881)	(26,882)	(26,836)	(26,876)	(26,845)	(26,843)	(323,171)
Operating Expenses exc Employee Expenses	(17,976)	(17,975)	(17,089)	(17,979)	(17,942)	(17,883)	(17,743)	(17,741)	(17,739)	(17,750)	(17,749)	(17,867)	(213,433)
Finance Charges	(1,590)	(1,590)	(1,585)	(1,585)	(1,585)	(1,585)	(1,599)	(1,599)	(1,599)	(1,599)	(1,599)	(1,599)	(19,112)
Grand Total	(774)	(763)	2,119	233	490	(250)	(2,123)	(2,122)	(2,074)	(2,126)	(2,093)	(2,208)	(11,690)

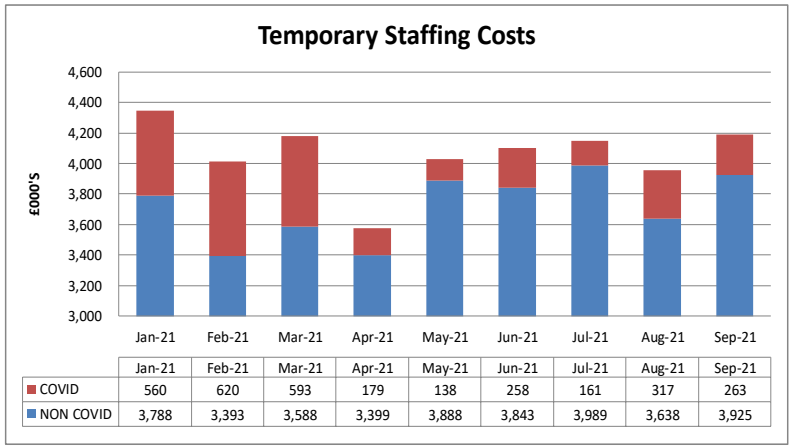
£1.1M SURPLUS

H1 VARIANCES - PAY

		Apr-21 M1	May-21 M2	Jun-21 M3	Jul-21 M4	Aug-21 M5	Sep-21 M6	H1
Plan	EMPLOYEE EXPENSES	(27,079)	(27,069)	(27,111)	(26,880)	(26,911)	(26,957)	(162,007)
BRIDGING ITEMS	Business Case Slippage	151	151	54	136	326	280	
	PEP (slippage/in excess)	86	75	39	(12)	(72)	113	
	Cost pressures - details							
	COVID	194	198	(108)	6	(177)	(108)	
	Pay award						(3,900)	
vacancy factor / COVID / absenteeism	Other	(250)	(680)	(168)	(604)	(637)	(897)	
H1 Actual and H2 Forecast		(26,898)	(27,324)	(27,294)	(27,353)	(27,471)	(31,469)	(167,810)
	Variance	*182*	*(256)*	*(183)*	*(473)*	*(560)*	*(4,512)*	*(5,803)*

Our H1 plan assumed that staffing costs would reduce aligned to a downward trend in COVID admission. Although favourable COVID variances were reported in M1 and M2 our overall temporary staffing cost has remained at c £4m (consistent with Q4 20/21 exit) a month driven by staff absenteeism , patient acuity and continued COVID pressured – ***see next slide***

H1 VARIANCES - PAY



	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
COVID	560	620	593	179	138	258	161	317	263
NON COVID	3,788	3,393	3,588	3,399	3,888	3,843	3,989	3,638	3,925

	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
TOTAL	**4,348**	**4,013**	**4,181**	**3,578**	**4,026**	**4,101**	**4,150**	**3,955**	**4,188**

Pay Expenditure	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Mvmt
gency	(2,075)	(2,123)	(2,339)	266	(2,058)	(2,204)	(2,861)	(1,843)	(2,159)	(2,238)	(2,131)	(1,888)	(2,172)	(284)
ank	(1,433)	(1,469)	(1,748)	(3,964)	(2,289)	(1,810)	(2,203)	(1,735)	(1,867)	(1,863)	(2,019)	(2,067)	(2,327)	(260)
ank & Agency Sub Total	**(3,508)**	**(3,592)**	**(4,087)**	**(3,698)**	**(4,347)**	**(4,014)**	**(5,064)**	**(3,578)**	**(4,026)**	**(4,101)**	**(4,150)**	**(3,955)**	**(4,498)**	**(543)**
/LI	(135)	(366)	(273)	(305)	(284)	(218)	(28)	(135)	(212)	(293)	(400)	(295)	(316)	(21)
ubstantive	(22,537)	(22,251)	(22,543)	(22,861)	(22,744)	(23,145)	(22,880)	(23,185)	(23,086)	(22,900)	(22,804)	(23,221)	(26,655)	(3,433)
ay Total	**(26,180)**	**(26,209)**	**(26,903)**	**(26,864)**	**(27,374)**	**(27,378)**	**(27,972)**	**(26,898)**	**(27,324)**	**(27,294)**	**(27,353)**	**(27,471)**	**(31,469)**	**(3,997)**
gency %	7.9%	8.1%	8.7%	-1.0%	7.5%	8.1%	10.2%	6.9%	7.9%	8.2%	7.8%	6.9%	6.9%	-0.9%
ank %	5.5%	5.6%	6.5%	14.8%	8.4%	6.6%	7.9%	6.5%	6.8%	6.8%	7.4%	7.5%	7.4%	0.1%
ank & Agency %	13.4%	13.7%	15.2%	13.8%	15.9%	14.7%	18.1%	13.3%	14.7%	15.0%	15.2%	14.4%	14.3%	-0.8%

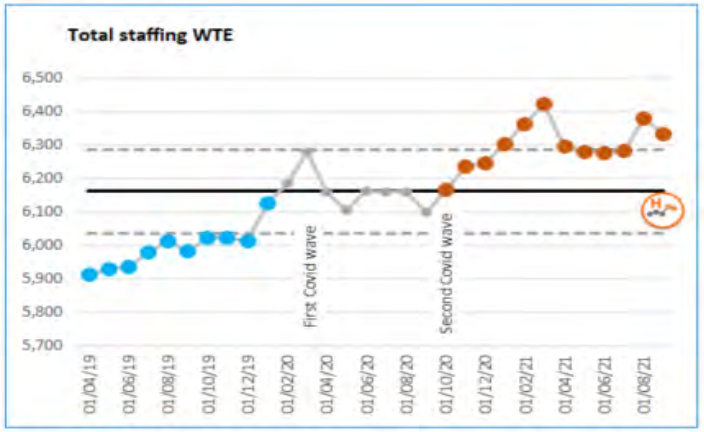
Putting Patients First

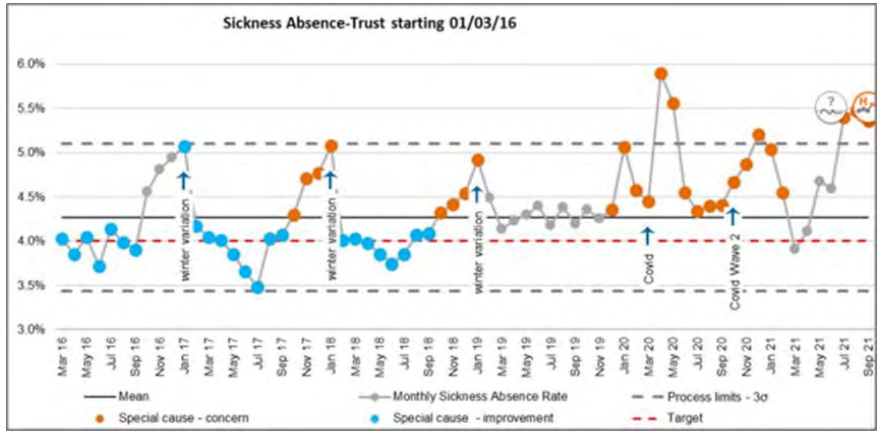
Pay Trends (M6 report)
Worked WTE by Month

NHS Worcestershire Acute Hospitals NHS Trust

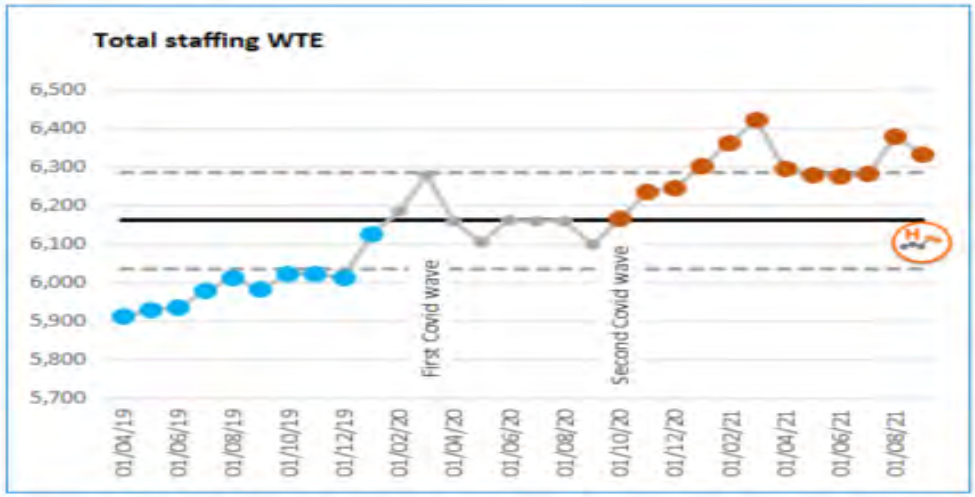
Worked WTE		Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Medical & Dental	Substantive	736	744	750	753	743	743	737	737	733	733	729	752	741
	Agency	75	75	77	65	63	67	67	48	71	72	67	69	62
	Bank	22	22	23	55	57	53	59	49	52	51	60	56	57
Medical & Dental Total		**833**	**841**	**850**	**872**	**863**	**863**	**862**	**834**	**855**	**856**	**856**	**876**	**861**
Nursing and Midwifery	Substantive	2,571	2,596	2,596	2,616	2,620	2,663	2,715	2,741	2,671	2,665	2,653	2,655	2,668
	Agency	102	97	99	98	123	137	133	92	98	98	113	126	128
	Bank	272	296	331	281	338	318	336	258	284	283	312	337	292
Nursing and Midwifery Total		**2,945**	**2,990**	**3,026**	**2,995**	**3,082**	**3,117**	**3,184**	**3,090**	**3,053**	**3,046**	**3,079**	**3,118**	**3,087**
Scientific, Therapeutic and Technical sta	Substantive	930	935	926	933	929	929	927	915	916	914	922	931	929
	Agency	32	31	34	35	26	29	33	35	26	34	20	28	30
	Bank	4	3	3	2	3	4	4	4	7	8	5	7	7
Scientific, Therapeutic and Technical Total		**966**	**969**	**962**	**971**	**958**	**962**	**963**	**954**	**950**	**955**	**947**	**966**	**966**
NHS Infrastructure Support	Substantive	1,343	1,354	1,380	1,391	1,383	1,401	1,393	1,404	1,410	1,407	1,390	1,405	1,400
	Agency	3	3	5	6	6	6	5	2	3	1	0	1	2
	Bank	8	9	12	11	11	11	14	11	9	9	11	11	15
NHS Infrastructure Support Total		**1,355**	**1,366**	**1,396**	**1,408**	**1,400**	**1,418**	**1,412**	**1,417**	**1,422**	**1,418**	**1,401**	**1,417**	**1,417**
WTE Total		**6,099**	**6,165**	**6,235**	**6,245**	**6,302**	**6,361**	**6,422**	**6,296**	**6,281**	**6,275**	**6,283**	**6,378**	**6,331**

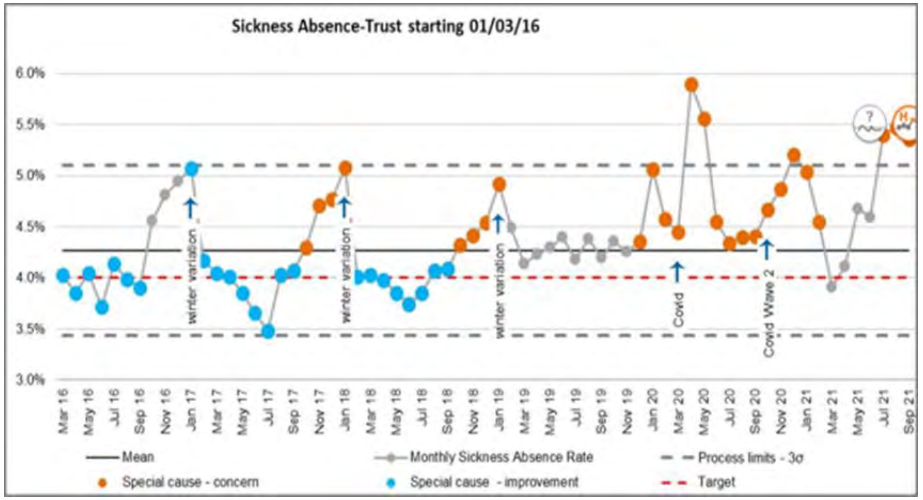
** NHS Infrastructure Support represents non-clinical*





Pay Trends (M6 report)
Worked WTE by Month





Covid spend?

Impact on productivity?

H1 VARIANCES – NON PAY

		Apr-21 M1	May-21 M2	Jun-21 M3	Jul-21 M4	Aug-21 M5	Sep-21 M6	H1
Plan	**NON PAY OPERATING AND FINANCE CHARGES**	**(19,571)**	**(19,570)**	**(18,684)**	**(19,574)**	**(19,536)**	**(19,477)**	**(116,412)**
BRIDGING ITEMS	**Business Case Slippage**	0	0	187	281	198	90	
	Overseas nursing	82	71	74	70	(31)	(11)	
	PEP (slippage/in excess)	(44)	(44)	(40)	(34)	(94)	150	
	Clinical Supplies	388	67	(10)	(162)	0	41	
	Cost pressures - details							
	COVID	(19)	(283)	327	(172)	(110)	(95)	
	Energy restatment						(300)	
CHECK OFFSET WITH INCOME	**Drugs**	(183)	163	(530)	(496)	(372)	(403)	
reduced levels of activity	**Other**	**271**	**520**	**(1,215)**	**215**	**(36)**	**(111)**	
H1 Actual and H2 Forecast		(19,076)	(19,076)	(19,891)	(19,871)	(19,981)	(20,116)	**(118,011)**
	Variance	***495***	***494***	***(1,207)***	***(297)***	***(445)***	***(639)***	***(1,599)***

System Offset of positive variance transacted in M3

H1 VARIANCES – INCOME

	Apr-21 M1	May-21 M2	Jun-21 M3	Jul-21 M4	Aug-21 M5	Sep-21 M6	H1
TOTAL INCOME	**45,871**	**45,871**	**47,904**	**46,677**	**46,928**	**46,175**	**279,426**
ERF	0	1,033	368	1,309	159	173	
O/S COVID and Vaccination	220	156	85	54	104	112	
Pay award	0	0	0	0	0	3,860	
Drugs / Devices	28	28	(3)	374	(69)	191	
Other	**91**	**124**	**(1,846)**	**(595)**	**(637)**	**339**	
	46,210	47,212	46,509	47,820	46,485	50,849	**285,085**
Variance	***339***	***1,341***	***(1,395)***	***1,143***	***(443)***	***4,674***	***5,659***

System Offset of positive variance transacted in M3

NHS
Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	9 December 2021
Paper number	Enc D3

Board Assurance Framework

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

Accountable Director	Chief Nursing Officer, Paula Gardner		
Presented by	Rebecca O'Connor, Company Secretary	**Author /s**	Rebecca O'Connor, Company Secretary

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

Report previously reviewed by		
Committee/Group	Date	Outcome
Audit and Assurance	9 November 2021	
TME	17 November 2021	
Quality Governance	25 November 2021	
Finance and Performance	24 November 2021	

Recommendations	To review and approve the Board Assurance Framework and reported updates on a confirm or challenge basis

Executive summary	This report sets out the full Board Assurance Framework following a process of review by Executives and Committees of the Trust Board. • The full BAF (at the current point of review) is enclosed within the reading room • Audit and Assurance Committee has reviewed the processes in developing and maintaining the BAF • There has been one change to BAF scores since the last high level summary to Trust Board in November. BAF 11 reputation has increased from 12 to 16. • There have been two changes in level of assurance BAF 14 health and wellbeing having increased from level 4 to level 5 assurance; BAF 7 having decreased to level 3 assurance for alignment with income and expenditure reporting in other reports • Supporting detail and control measures for risks have been reviewed and updated.

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	*All BAF risks as outlined in this report.*

Assurance Level (x)	0	1	2	3	4	X	5	6	7	N/A	

Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	9 December 2021
Paper number	Enc D3

Financial Risk	*If the Trust does not have a robust BAF and system of monitoring in place there is the risk that the strategic objectives will not be achieved, which could have regulatory, reputation and financial implications and could impact on the quality of care that is provided. Specific risks relate to financial balance and capital. Individual risks and associated controls and or mitigating actions may have financial implications.*

Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y	X	N		N/A	
Are the actions identified starting to or are delivering the desired outcomes?	Y		N		As per report	
If no has the action plan been revised/ enhanced	Y		N		As per report	
Timescales to achieve next level of assurance	As outlined for each risk					

Introduction/Background

The Trust Board is responsible for identifying and monitoring the risks to the achievement of the Trust's strategic objectives. This is achieved through the development of a BAF, which is monitored by the Trust Board and its Committees for areas of their authority.

The Audit and Assurance Committee also has oversight of the BAF to inform the annual programme of internal audit activity and to allow the Committee to discharge its duties in terms of providing assurance around the robustness of the overall system of internal control, of which the BAF is an integral component. Strategic risks on the BAF are those which are of such importance, that failure to control the same, may cause the Trust to fail to deliver its strategic objectives. This report provides assurance as to the management of strategic risks which are presented on a confirm or challenge basis.

Issues and options

BAF Summary

A summary of the risk position is as follows:

	Number	Comment
New Risks opened	0	
Risks Closed	0	
Risks Escalating	1	BAF 11; increase in score from 12 to 16
Risks De-escalating	0	
Total risks identified	17	
Level of assurance changes	2	BAF 7; level 4 to level 3 (for alignment) BAF 14; level 4 to level 5

A summary of the Trust's risk exposure is below. This shows that whilst the mitigations put in place are slightly reducing the overall risk exposure, this remains very high.

	Extreme	High	Moderate	Low
Current risk score	11	6	-	-
Initial risk score	14	3		

Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	9 December 2021
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BAF Updates

BAF risks have been reviewed and updated, the following changes have been endorsed by Committees as follows:

- **Risks Closed/Closed:**

None

- **Risk Escalating/ De-escalating:**

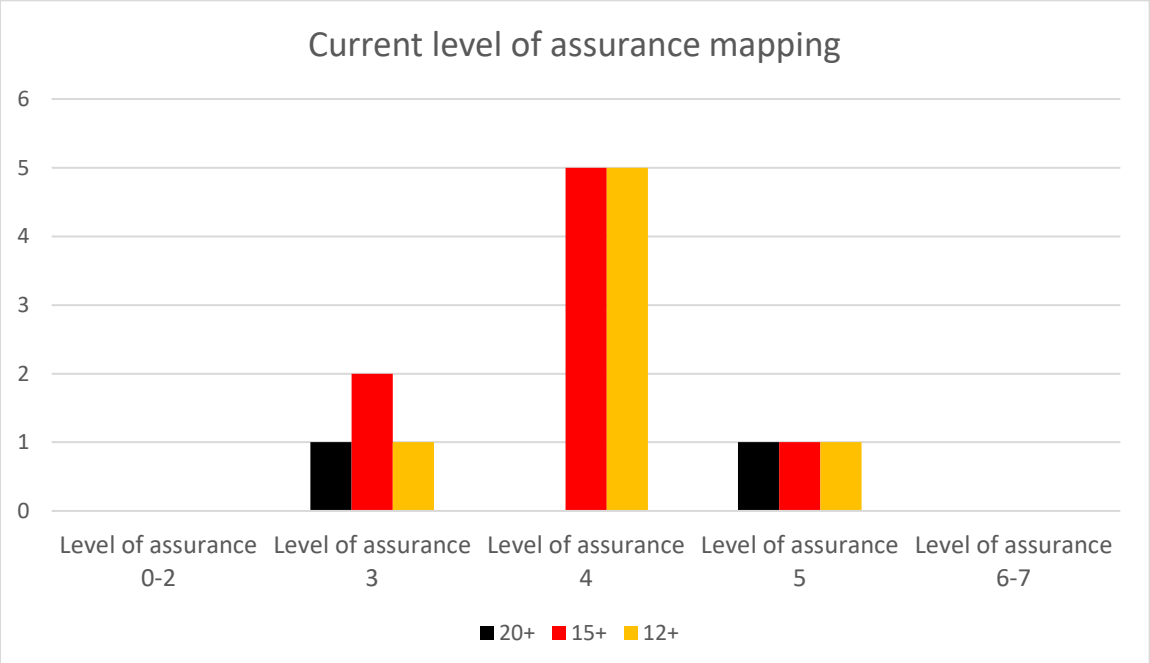
BAF 11 – risk score has increased from 12 to 16 to reflect continuing widespread comment and concerns around urgent and emergency care pressures and service changes.

- **Risk Narrative Updates**

Reviews of all risks have taken place and updates made to all current BAF risks in respect of the actions, controls and mitigations. The latest full BAF is enclosed in the reading room and the high level summary is appended.

Level of Assurance

The level of assurance is mapped as follows. This shows the number of risks and their risk score mapped against the level of assurance; the majority of risks (10) having a level 4 assurance.



There have been two changes in assurance level since the last report;

- BAF 7 having decreased from level 4 to level 3 to ensure alignment of the BAF and consistency of reporting

- BAF 14 having increased from level 4 to level 5 following executive review of the progress and update of mitigating actions

The change in levels of assurance can be tracked in the following table which will be added to throughout the year:

	No. of Risks Nov 21	No. of Risks Dec 21	Change from last Board report
Level of assurance 0-2	-	-	-
Level of assurance 3	3	4	+ 1 (BAF 7)
Level of assurance 4	12	10	-
Level of assurance 5	2	3	+1 (BAF 14)
Level of assurance 6-7	-	-	-

Mapping of Strategic Risks Against Strategic Objectives

The table below shows a mapping of the Trust's strategic objectives and goals against the risks identified in the assurance framework. All strategic objectives and goals are covered by a range of risks.

		BAF 2	BAF 3	BAF 4	BAF 7	BAF 8	BAF 9	BAF 10	BAF 11	BAF 13	BAF 14	BAF 15	BAF 16	BAF 17	BAF 18	BAF 19	BAF 20	BAF 21
Strategic Objective	Best services for local people	X							X	X			X	X	X			X
	Best experience of care & outcomes for our patients		X	X					X							X	X	
	Best use of resources				X	X			X									
	Best people						x	x	X		X	X		X				
Goal	Goal – strategy	X							X	X		X	X	X	X			X
	Goal – quality		X	X					X							X	X	
	Goal - finance				X	X			X									
	Goal – workforce and culture						X	X	x		X	X						

- **Risk Exposure**

The Trust's risk exposure is static from the last report, but increasing in general over the medium term. This is due to a number of factors including the ongoing impact of Covid, its impact on restoration and recovery and urgent and emergency care pressures etc.

Mitigating activity, controls and assurance are identified for all risks and detailed within the reading room. The intention being the mitigations in place demonstrate a reduction in risk exposure from the initial to residual risk scores. However, there are times where despite there being control measures in place, these are not yet sufficiently effective, nor embedded to enable a reduction in

the current risk score. It is not within the Trust's risk appetite to accept risks with no control measures in place.

- **Risk Appetite**

The Trust's risk appetite is not necessarily static, but all risks are expected to have controls and mitigations in place, which aim to reduce the risk exposure to a tolerable level. The Trust Board may vary the amount of risk that it is prepared to tolerate depending on the circumstances at the time. Committees review the BAF and can makes recommendations to the Trust Board regarding the adequacy of the outlined mitigations and control measures. If the Trust Board is unwilling to accept the level of risk to which it is currently exposed, it is invited to consider further mitigating actions or challenge those already identified.

Conclusion
The Trust has a Board Assurance Framework in place which is operational and effective. The Trust's risk exposure is static from the last report and mitigating actions are as outlined in this report.
Recommendations
To review and approve the Board Assurance Framework and reported updates on a confirm or challenge basis
Appendices
High level BAF risk summary Full BAF within the reading room

BOARD ASSURANCE FRAMEWORK
DECEMBER 2021

Risk Number	Theme	Risk Description	Exec Lead	Responsible Committee	Current			Change	Previous Risk Rating	Initial Risk Score	Risk appetite	Level of Assurance
					Likelihood	Consequence	Risk Rating					
Sort	*Sort*	*Sort*	*Sort*	*Sort*	*Sort*	*Sort*	*Sort*	*Sort*	*Sort*	*Sort*	*Sort*	*Sort*
18	Activity	If we are unable to increase elective activity, remove long waits and reduce waiting list size in a timely and cost effective manner, then patient outcomes will suffer, patient care will be compromised and/or costs will increase	COO	QGC/F&P	5	5	25	→	25	25	Low	5
7	Finance	If we fail to address the drivers of the underlying deficit and fail to respond effectively to the new financial regime (post COVID-19), then we will not achieve financial sustainability (as measured through achievement of the structural level of deficit [to be fully determined]) resulting in the potential inability to transform the way in which services operate, and putting the Trust at risk of being placed into financial special measures.	CFO	F&P	5	4	20	→	20	15	Low	3
13	Cyber	If we do not have assurance on the technology estate lifecycle maintenance and asset management then we could be open to a cybersecurity attack or technology failure resulting in possible loss of service.	Chief Digital Officer	F&P	4	4	16	→	16	20	Low	3
16	Digital	If we do not make best use of technology and information to support the delivery of patient care and supporting services, then the Trust will not be able to deliver the best possible patient care in the most efficient and effective way	Chief Digital Officer	F&P	4	4	16	→	16	20	Low	5
19	System working	If we do not have effective system wide working to enhance patient flow and to ensure patients are managed in the most appropriate environment, then we will not be able to manage the level of urgent care activity and patient experience for patients who are clinically ready for discharge, but have not been, will suffer	CMO/CNO	QGC	4	4	16	↑	12	20	Low	4
20	Urgent care	If we do not ensure that all actions are in place to enable discharge at the point of being ready for clinical discharge then we will adversely impact patient experience and inhibit flow	COO	QGC/F&P	4	4	16	→	16	16	Low	4
3	Clinical Services	If we do not implement the Clinical Services Strategy then we will not be able to realise the benefits of the proposed service changes in full, causing reputational damage and impacting on patient experience and patient outcomes.	COO	QGC/F&P	4	4	16	→	16	16	Low	4
17	Engagement with staff	If we fail to effectively involve our staff and learn lessons from the management of change and redesign / transformation of services, then it will adversely affect the success of the implementation of our Clinical Services Strategy resulting in missed opportunity to fully capitalise on the benefits of change and adversely impact staff engagement, morale and performance	CMO/Dir S&P	QGC	4	4	16	→	16	15	Moderate	4
2	Engagement with patients, public and partners	If we fail to effectively engage and involve our patients, the public and other key stakeholders in the redesign and transformation of services then it will adversely affect implementation of our Clinical Services Strategy in full resulting in a detrimental impact on patient experience and a loss of public and regulatory confidence in the Trust.	COO	QGC/P&C	4	4	16	→	16	12	High	3
9	Workforce	If we do not have a right sized, sustainable and flexible workforce, we will not be able to provide safe and effective services resulting in poor patient and staff experience and premium staffing costs.	DirC&E/CNO	QGC	4	4	16	→	16	12	Low	4
4	Quality	If we do not have in place robust systems and processes to ensure improvement of quality and safety and to meet the national patient safety strategy, then we may fail to deliver high quality safe care resulting in negative impact on patient experience and outcomes.	Director of People and Culture	People and Culture	5	3	15	→	15	15	Moderate	4
11	Reputation	If we have a poor reputation this will result in loss of public confidence in the Trust, lack of support of key stakeholders and system partners and a negative impact on patient care.	Director of Comms & Engmt	People and Culture/Trust Board	3	4	12	→	12	16	Moderate	4
21	ICS	If the Trust fails to capitalise on the benefits of integrated care at Place, System or intra System level then this will result in missed opportunities to improve quality of care, patient experience, efficiency or financial sustainability	Director of Strategy	Trust Board	3	4	12	→	12	16	Low	3
14	Health and Wellbeing	If we do not have the capacity and capacity to implement, or staff do not access, health and wellbeing support then we may be unable to maintain safe staffing levels due to higher rates of absence and staff turnover	Director of People & Culture	People and Culture/Trust Board	3	5	12	→	12	15	Medium	5
10	Culture	If we fail to sustain the positive change in organisational culture, then we may fail to have the best people which will impede the delivery of safe, effective high quality compassionate treatment and care.	Director of People and Culture	People and Culture	4	3	12	→	12	15	Moderate	4
8	Infrastructure	If we are not able to secure financing then we will not be able, to address critical infrastructure risks as well as maintain and modernise our estate, infrastructure, and facilities; equipment and digital technology resulting in a risk of business continuity and delivery of safe, effective and efficient care.	CFO	F&P	3	4	12	→	12	15	Low	4
15	Leadership	If we do not have a comprehensive leadership model and plan in place then we may not have the right leadership capability and capacity to deliver our strategic objectives and priorities	Director of People & Culture	People and Culture/Trust Board	3	4	12	→	12	12	Medium	4

NHS
Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	9th December 2021
Paper number	Enc E

Integrated Performance Report – Month 7 2021/22

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

Accountable Directors	Paul Brennan – Chief Operating Officer, Paula Gardner – Chief Nursing Officer, Christine Blanchard - Chief Medical Officer, Tina Rickets – Director of People & Culture, Robert Toole – Chief Finance Officer		
Presented by	Vikki Lewis – Chief Digital Officer	**Author /s**	Steven Price – Senior Performance Manager

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

Report previously reviewed by		
Committee/Group	Date	Outcome
TME	17th November 2021	Approved
Finance and Performance	24th November 2021	Assured
Quality Governance	25th November 2021	Assured
People and Culture	30th November 2021	Assured

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

Key Issues	**Emergency and Urgent care and Patient Flow & Capacity** • Although stable, attendances to our type 1 hospitals remain high compared to those seen in 19/20 and 20/21, the eighth consecutive month of over 12,000. Four hour performance remains static but this masks the day to day pressures experienced at both sites over the course of the month to see and treat our patients, and when the decision to admit has been taken, to find them a bed. • The conversion rate to admission is at its highest with the WRH site at 30% and ALX at 26%, requiring us to find beds at a time when patient flow across the local healthcare system continues to be ever more challenging. • The main indicators used to monitor front door performance are all showing special cause concern. • Total discharges and transfers and discharges before midday are showing special cause improvement due to 7 months in a row above the mean, however, the average length of stay is showing special cause concern being above the mean since Mar-21. Medically fit patients still on the ward 24 hours after becoming medically fit remains special cause concern. The number of patients still in our hospitals 21+ days after admission has decreased by 14% but there was an average of 22 patients deemed MFFD with a LOS >= 21 days each day in October across the Trust.

NHS Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	9th December 2021
Paper number	Enc E

- There has been a step change in the number of admitted Covid patients since mid-October, ending the month at 53 inpatients which has meant that we've had to ring-fence more beds; this bed pressure has continued in to November. The Trust remains committed to ring-fencing G&A beds for elective patients across the Alexandra and Worcestershire Hospital sites.

Recovery and restoration of the elective programme including Outpatients and Diagnostics

- Referrals from primary care continue to drive up the RTT waiting list which is validated at 57,930 in Oct-21.
- 2,169 of our long wait patients have been waiting 78 weeks or more with 324 of that cohort waiting over 104 weeks, noting that 220 of the 324 are waiting for orthodontic treatment.
- Activity levels for diagnostic tests are up a further 4% from the 7% increase observed last month to above 16,000, their highest level since Jan-20. Our overall diagnostics waiting list has reduced by 4% and although there are still 5,456 patients waiting over 6+ weeks this is a 13% reduction from Sept-21's position.
- The H2 plan has now been submitted - total outpatient attendances are at 89% of Oct-19 with 41,275 patients seen; this is +954 to our plan. Total elective spells (6,975) in the month are at 83% of Oct-19 with day case at 85% and elective ordinary spells at 66%. This is -326 spells to our plan.

People and Culture

Workforce continues to be a key risk to the restoration of services as we continue to see higher levels of sickness absence (both covid and non-covid), higher levels of maternity leave and an increase in unfilled shifts through bank and agency.

In addition, we have seen a further increase in our staff turnover rate which is now at 10.5%. During the next period we will focus on swapping out bank and agency for substantive staff to reduce our premium staffing costs.

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	2, 3, 4, 5, 7, 8 ,9, 10, 11, 13, 14, 15, 16, 17, 18, 19, 20

Assurance Level (x)	0		1		2		3		4	X	5		6		7		N/A	
Financial Risk	*N/A*																	

Action						
Is there an action plan in place to deliver the desired	**Y**		**N**		**N/A**	X

Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
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improvement outcomes?						
Are the actions identified starting to or are delivering the desired outcomes?	**Y**		**N**			
If no has the action plan been revised/ enhanced	**Y**		**N**			
Timescales to achieve next level of assurance						

Recommendations
The Board is asked to • note this report for assurance
Appendices
▪ Trust Board Integrated Performance Report (up to Oct-21 data) ▪ WAHT October 2021 in Numbers Infographic ▪ WAHT Maternity and Neonatal Dashboard (Oct-21) ▪ Committee Assurance Statements

Integrated Performance Report

Worcestershire Acute Hospitals NHS Trust

Trust Board

9th December 2021

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

Operational Performance

Summary Performance Table| Month 7 [October] 2021-22

	Performance Metrics	Latest Month	Measure	Target	Performance	Assurance	Mean	Lower process limit	Upper process Limit
EAS	Percentage of Ambulance handover within 15 minutes	Oct-21	52.78%	-		-	67%	52%	81%
	Time to Initial Assessment - % within 15 minutes	Oct-21	72.40%	-	L	-	86%	81%	92%
	Average time in Dept for Non Admitted Patients	Oct-21	251	-	H	-	195	167	223
	Average time in Dept for Admitted Patients	Oct-21	609	-	H	-	400	302	498
	% Patients spending more than 12 hours in A&E	Oct-21	10.00%	-		-	4.64%	1.25%	8.03%
	Number of Patient spending more than 12 hours in A&E	Oct-21	1,211	-		-	521	196	846
RTT	Incomplete (<18 wks)	Oct-21	51.60%	92%	L	F	71%	67%	76%
	52+ WW	Oct-21	6,912	0	H	F	1625	1,076	2,173
CANCER	2WW All	Oct-21	53.78%	93%	L	?	82%	69%	95%
	2WW Breast Symptomatic	Oct-21	31.58%	93%		F	42%	-5%	88%
	62 Day All	Oct-21	53.20%	85%		F	69%	57%	82%
	104 day waits	Oct-21	114	0	H	F	56	23	90
	31 Day First Treatment	Oct-21	95.19%	96%		?	97%	92%	101%
	31 Day Surgery	Oct-21	86.4 %	94%	L	?	77%	53%	101%
	31 Day Drugs	Oct-21	95.19%	98%		?	98%	87%	108%
	31 Day Radiotherapy	Oct-21	100.0 %	94%		?	87%	76%	98%
	62 Day Screening	Oct-21	81.8 %	90%	L	?	66%	29%	103%
	62 Day Upgrade	Oct-21	100.0 %	90%	L	?	66%	39%	93%
Diagnostics (DM01 only)		Oct-21	56.35%	99%	L	F	76%	66%	86%
STROKE	CT Scan within 60 minutes	Sep-21	44.44%	80%		F	44%	19%	70%
	Seen in TIA clinic within 24hrs	Sep-21	42.11%	70%		?	83%	44%	122%
	Direct Admission	Sep-21	22.58%	90%	L	F	42%	15%	68%
	90% time on a Stroke Ward	Sep-21	53.97%	80%		?	74%	58%	90%

Operational Performance Report - Headlines

Operational Performance	Comments
Urgent and Emergency Care	• In Oct-21, the Trust saw 12,696 patients attend our type 1 sites - this volume of attendances is still in excess of historic seasonal variation (average of 11,125 across Oct-19 and Oct-20). Children and young people attendances contributed 24% of the total (having been 25% in Sep-21); this is 1,719 attendances with 407 being conveyed by ambulance. • The trend of special cause concern for the majority of front door metrics continues as the high volume of attendances and subsequent need for admission to the hospital hasn't changed.
Patient Flow and Capacity	• The pressure remains on both hospital sites to manage bed capacity and patient flow, particularly to discharge patients before midday and support our long length of stay and medically fit for discharge patients to leave the hospital when they no longer need an acute hospital bed. • Discharges before midday remained static but those patients still on the ward 24 hours after being assessed medically fit for discharge (MFFD) has plateaued and is still special cause concern. • The number of long length of stay patient increased from 56 on the last day of September to 56 on the last day of October; 26 of the 56 were flagged as MFFD.
Cancer	• **Long Waits:** The backlog of patients waiting over 62 days has decreased to 317 from 363 and those waiting over 104 days has decrease from 119 to 114, with urology contributing the most patients to this cohort of our longest waiters (57%). • Cancer referrals in Oct-21 have remained high. The profile by specialty has fluctuated, of note Breast hitting a new highest on record and lower GI and skin decreasing by ~100. We maintained seeing 2,500 patients but this was our worse month for not seeing patients within 14 days with 1,168 breaches. • The improvements seen in Breast and Breast Symptomatic in Sep-21 have been disrupted by the latest surge in demand; achieving 93% remains at significant risk with the increases in referrals. • Cancer 62 day waits continues to show special cause concern with only 53% of patients starting treatment within 62 days due to delays in the 2WW and diagnostics elements of the pathway. • The delays are impacting the 31 day standard of treatment from decision to treat which is also showing special cause concern and below the 96% standard.
RTT Waiting List	• **Long Waits:** Our patients waiting over a year for treatment can be broken down as follows; between 52 and 78 weeks (4,743), between 78 and 104 weeks (1,845) and those waiting over 104 weeks (324). Of the 324 patients waiting over 104 weeks, 220 are waiting for orthodontic treatment. • The RTT waiting list size remains a cause for concern having increased again to 57,930. Although Advice and Guidance and RAS triage is offsetting some new referrals, our waiting list is growing month on month with the number of referrals being received remaining high.
Outpatients	• **Long Waits:** There are 31,053 RTT patients waiting for their first appointment and only 7,160 of them have been dated. • Oct-21 saw 41,231 outpatient attendances take place (consultant and non-consultant led) and comparing to Oct-19 shows we undertook approximately 89% of historic activity levels. • Both total consultant-led first and follow-up outpatient attendances remained above 10,000. However, there has been a reduction in non-face-to-face activity, with both first and follow-up at their lowest recorded levels in 21/22.
Theatres	• In Oct-21, our total elective spells activity reduced from Sep-21 levels and was 83% of Oct-19. • 8 eligible patients who had their operation cancelled were not rebooked within 28 days in Oct-21; however 28 patients were. • The Independent Sector undertook 58 day cases, 1 EL ordinary and 219 diagnostic tests. • 95 procedures were undertaken in our Vanguard theatre across the following specialties - General Surgery, Gynaecology, T&O, Urology and Vascular Surgery
Diagnostics	• **Long Waits:** 5,453 patients are waiting over 6 weeks for their diagnostic test and of the total number of breaches, 2,633 have been waiting over 13 weeks. 54% are attributable to DEXA and echocardiography. • Activity in Oct-21 was at it's highest since Jan-20 across our modalities with 16,371 tests undertaken, supported by the CDC's. Consequently the waiting list size has fallen by 4% to 12,513, breaches by 13% to 5,453 and DM01 performance has improved from 48% to 43.5% (a 9% fall).

Operational Performance: Urgent and Emergency care

Percentage of Ambulance handover within 15 minutes	Time to Initial Assessment - % within 15 minutes	Time In Department			
		Average (mean) time in Dept. for Non Admitted Patients	Average (mean) time in Dept. for Admitted Patients	% Patients spending more than 12 hours in A&E	Number of Patient spending more than 12 hours in A&E
47.9%	70.3%	251	605	10.1%	1,257

What does the data tell us?

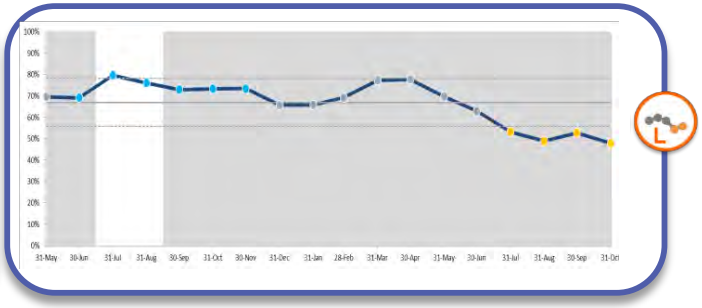
- **Urgent Care Indicators –** slide 6 highlights the continued pressure faced by the Trust during Oct-21 with all of the metrics showing special cause concern (outside the control limits) for the month.
- **EAS** - The overall Trust EAS performance which includes KTC and HACW MIUs was 70.32% in Oct-21 – this is the fifth month of special cause concern in the context of attendances across all settings remaining significantly high at 17,498
- **EAS Type 1 –** EAS performance at both ALX and WRH was below 60% at 58.79% and 59.32% respectively. 2,144 patients breached the 4 hour standard at the ALX, the first time over 2,000 since Dec-19 . There were 12,696 Type 1 attendances across ALX and WRH and although no significant change from previous months it is indicative of the sustained pressure on our emergency departments.
- **CYP Attendances**: The proportion of total attendances to WRH in Oct-21 who were children and young people was 24%, no significant change from Sep-21. This is the fourth month since Jan-21 where total paediatric attendances have been special cause concern, outside of the control limits. 24% of all paediatric attendances arrived by ambulance has moved to special cause concern due to 7 consecutive points above the mean.
- **Ambulance Handovers** - There were 823 x 60 minute ambulance handover delays with breaches at both sites – this increase in breaches from Sep-21 is significant and is linked to the capacity, flow and numbers of patients in our ED's which prevented timely offloading.
- **12 hour trolley breaches –** There were 73 validated 12 hour trolley breaches in Oct-21 compared to 31 in Oct-19 – this remains a special cause concern for our processes.
- **Specialty Review times** – Specialty Review times are now highlighted as a cause for concern with 11 consecutive months below the mean; the target cannot be met.
- **Total Time in A&E:** The 95th percentile for patients total time in the Emergency departments has increased from 962 in Sep-21 to 1,015. This metric shows special cause variation because Oct-21 is outside of the upper control limit.
- **Conversion rates** – 3,537 patients were admitted in Oct-21; a Trust conversion rate of 28.54%. The conversion rate at WRH was 30.09% and the ALX was 26.39%; although comparable to Oct-19, this is with ~1,000 more patients attending ED and ~100 more admissions needing to be made.
- **Aggregated patient delay** (total time in department for admitted patients only per 100 patients – above 6 hours) – this indicator continues to show special cause concern for Oct-21 because the value is above the upper control limit.

Month 7 [October] | 2021-22 | Operational Performance: Urgent and Emergency Care

Responsible Director: Chief Operating Officer | Validated for October-21 as 08th November 2021

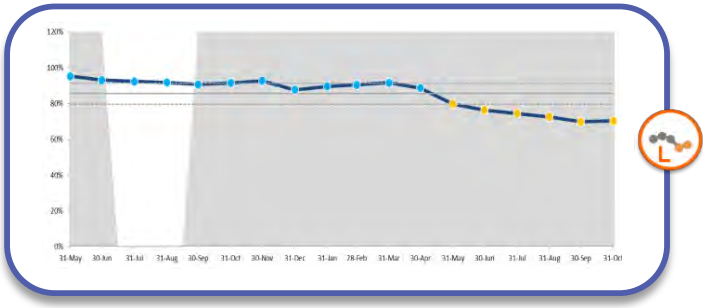
Percentage of Ambulance handover within 15 minutes

47.9%



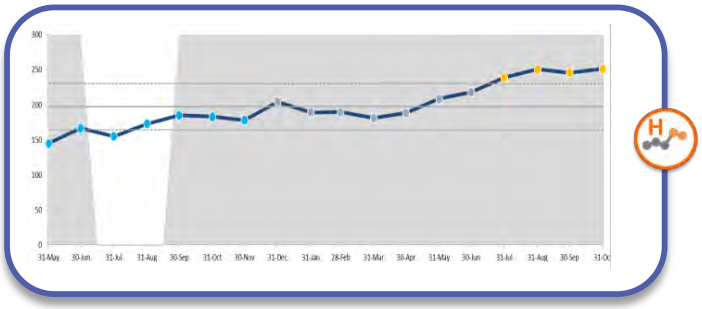
Time to Initial Assessment - % within 15 minutes

70.3%



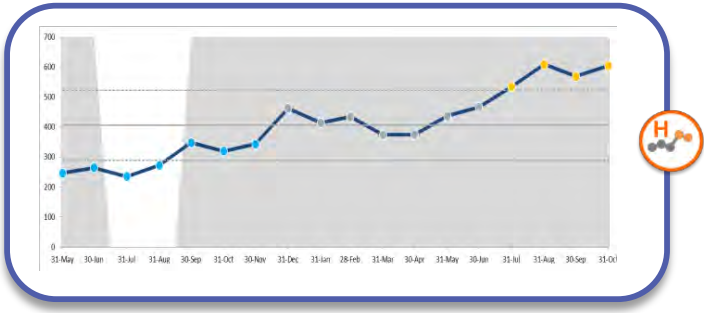
Average time in Dept for Non Admitted Patients

251



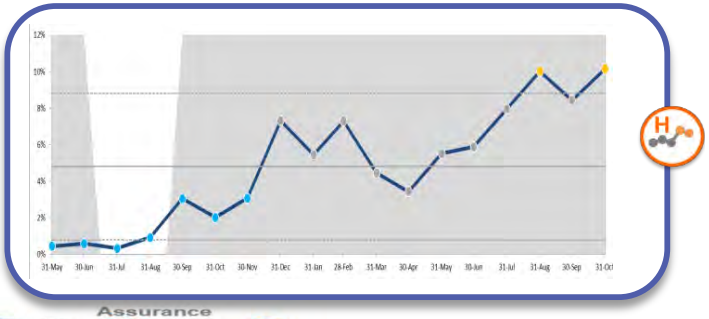
Average time in Dept for Admitted Patients

605



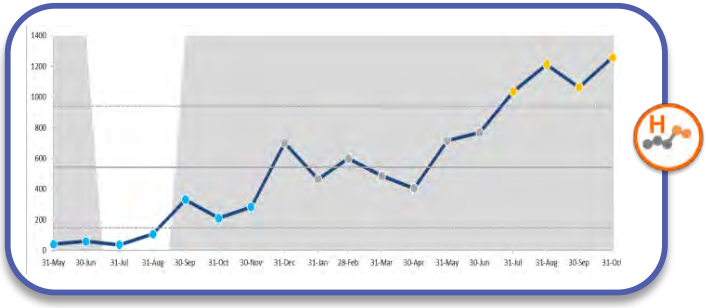
% Patients spending more than 12 hours in A&E

10.1%



Number of Patients spending more than 12 hours in A&E

1,257



Please note: These SPC charts have been re-based to evidence if any changes in performance, post the initial COVID-19 high peak, are now common or special cause variation.

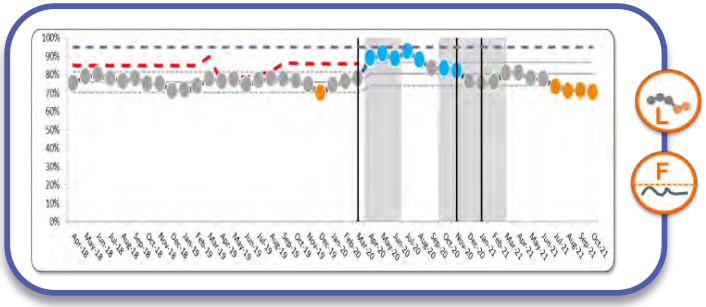
Month 7 [October] | 2021-22 | Operational Performance: Urgent and Emergency Care

Responsible Director: Chief Operating Officer | Validated for October-21 as 08th November 2021

NHS Worcestershire Acute Hospitals NHS Trust

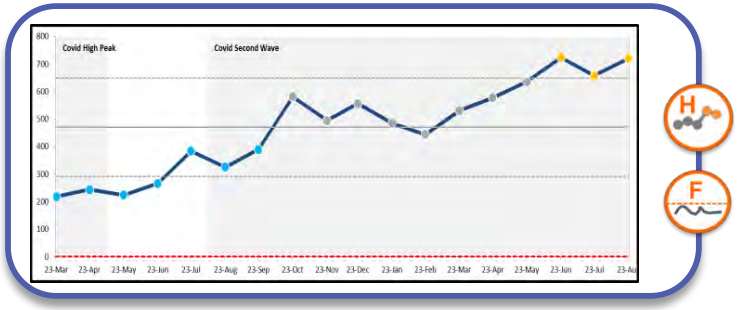
4 Hour EAS (all)

70.32%



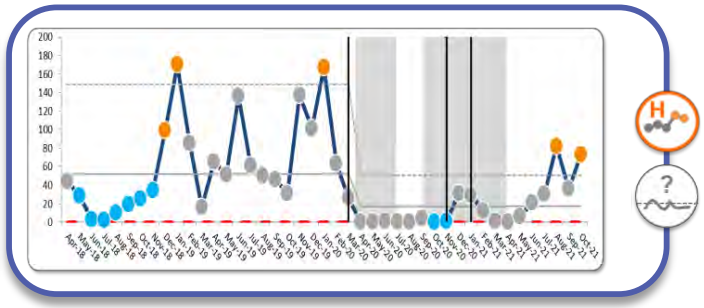
Aggregated Patient Delay (APD)

719



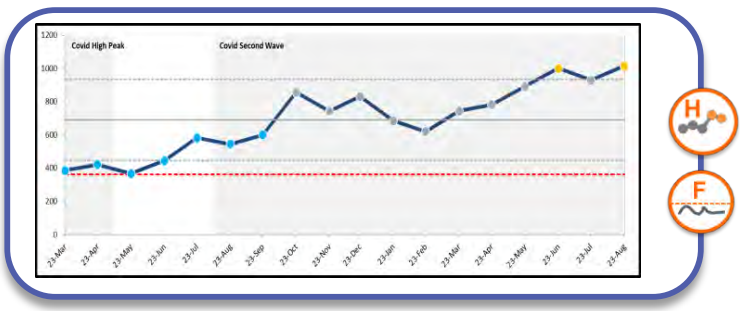
12 Hour Trolley Breaches

73



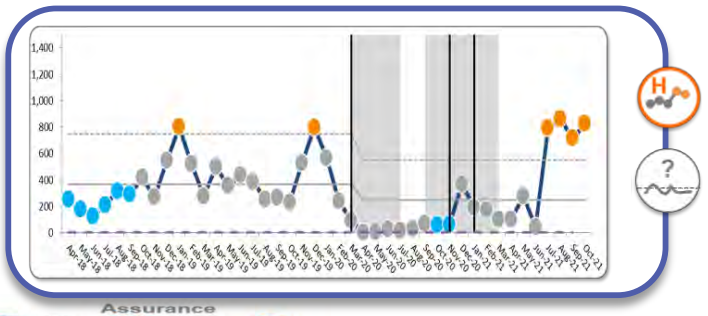
Total time spent in A&E (95th Percentile)

1015



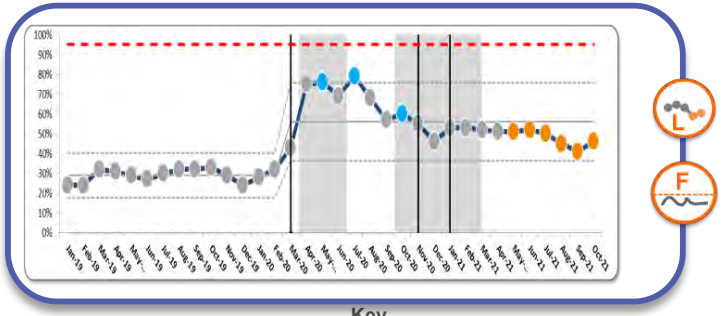
60 minute Ambulance Handover Delays

823



Specialty Review within 1 hour

46%



Please note: These SPC charts have been re-based to evidence if any changes in performance, post the initial COVID-19 high peak, are now common or special cause variation.

Key

- Internal target
- Operational standard

Operational Performance: Urgent Care Benchmarking

2.4 - Complete the implementation of Home First Worcestershire to eradicate corridor care and minimise ambulance handover and admission delays

National Benchmarking (October 2021)

EAS (All) -The Trust was one of 8 of 13 West Midlands Trust which saw a decrease in performance between Sep-21 and Oct-21 This Trust was ranked 6 out of 13; we were 7th the previous month. The peer group performance ranged from 54.18% to 84.67% with a peer group average of 67.88%; Declining from 68.79% the previous month. The England average for Oct-21 was 73.90% a -1.3% decrease from 75.20% in Sep-21.

EAS (Type 1) - The Trust was one of 9 of 13 West Midlands Trust which saw a Decrease in performance between Sep-21 and Oct-21 This Trust was ranked 7 out of 13; we were 8th the previous month. The peer group performance ranged from 48.44% to 80.49% with a peer group average of 56.83%; declining from 58.72% the previous month. The England average for Oct-21 was 61.90% a -2.1% decrease from 64.00% in Sep-21.

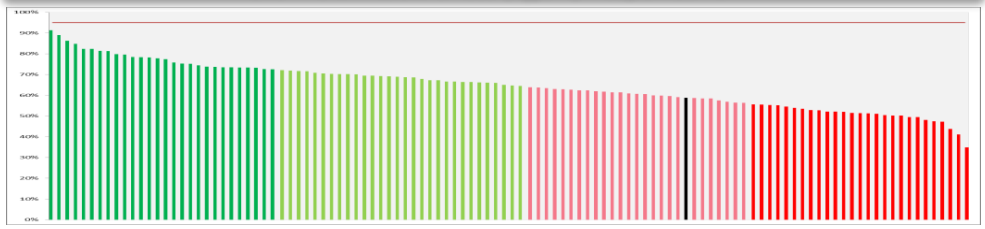
In October-21, there were 7,059 patients recorded as spending >12 hours from decision to admit to admission. 73 of these patients were from WAHT; 1.03% of the total.

EAS – % in 4 hours or less (All) – October -21

EAS – % in 4 hours or less (Type 1) – October-21

EAS – % in 4 hours or less (All) – September- 21

EAS – % in 4 hours or less (Type 1) – September -21



WAHT — Operational Standard 95%

Operational Performance: Patient Flow and Capacity

2.4 - Complete the implementation of Home First Worcestershire to eradicate corridor care and minimise ambulance handover and admission delays

Discharges before Midday				Number of patients with a long length of stay (21+ days)				Overnight Bed Capacity Gap (Target – 0)	Average length of stay in hospital at discharge (non-covid)				30 day re-admission rate (Oct-21)	Discharges as a % of admissions IP only (Target >100%)			
WRH	19.50%	ALX	21.95%	WRH	21	ALX	8	24 beds	WRH	6	ALX	5.16	3.08%	WRH	98.15%	ALX	91.47%

What does the data tell us?

- **Discharges** – Before 12pm discharges (on non-COVID wards) is showing no significant change however the process will not achieve the target of 33% at either site As at the last day of the month, the number of patients with a length of stay in excess of 21 days decreased 65 (30-Sep) to 56 (31-Oct) with 26 patients deemed medically fit for discharge. However, there was an average of 22 patients deemed MFFD with a LOS >= 21 days each day in October across the Trust.
- **Bed Capacity** - Our G&A bed base is 752; beds ring-fenced to Covid patients increased from 49 to 63 in the month due to the sharp rise in admitted Covid patients. We maintained our ring-fencing of beds for elective patients; the average midnight occupancy was 93%.
- **Medically Fit Patients** – for the 9th consecutive month, the number of MFD patients still on our wards 24 hours after becoming medically fit is showing special cause concern, and the last four months are showing as outside of the upper confidence interval.
- **Length of Stay** – the LOS on our non-covid wards is showing no significant change at 5.8 days in Oct-21 but is the 8th consecutive month where it's above the mean and showing special cause concern.
- **The 30 day re-admission rate** shows no significant change since Jun-20; the process limits have widened and this indicates a change during COVID-19 that we have not yet got control of.

Current Assurance Level: 4 (Oct-21) **Agreed at F&P Committee – 24th November 2021**	**When expected to move to next level of assurance:** This is dependent on the on-going management of the increase attendances and achieving operational standards.
Previous assurance level: 5 (Sep-21)	**SRO: Paul Brennan**

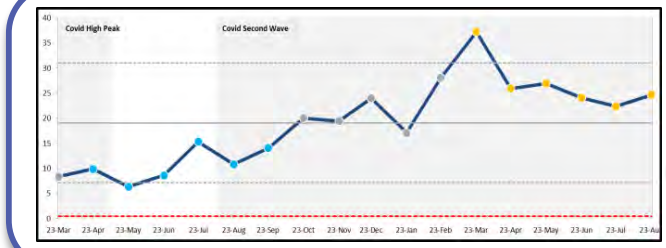
Month 7 [October] | 2021-22 | Operational Performance: Patient Flow and Capacity

Responsible Director: Chief Operating Officer | Validated for October-21 as 08th November 2021

NHS Worcestershire Acute Hospitals NHS Trust

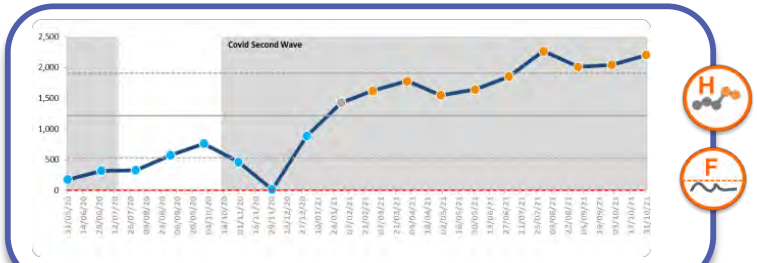
Capacity Gap (Daily avg. excl. EL)

24.2



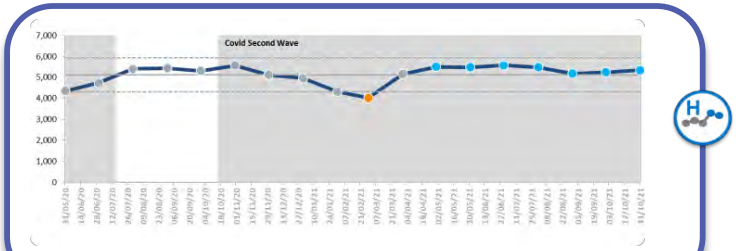
MFFD patients still on the ward 24hrs after becoming MFFD

1,974



Total Discharges and Transfers

5,340

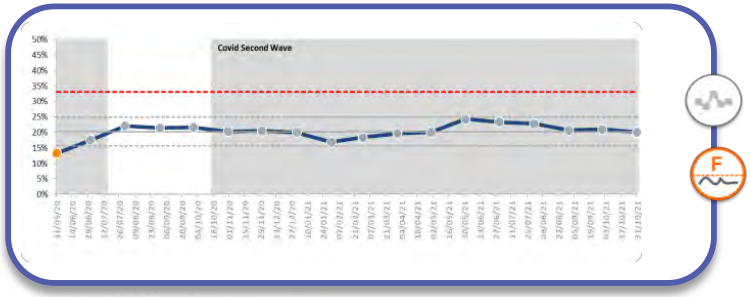


Average Length of Stay in Hospital at Discharge (non-covid wards)

5.8

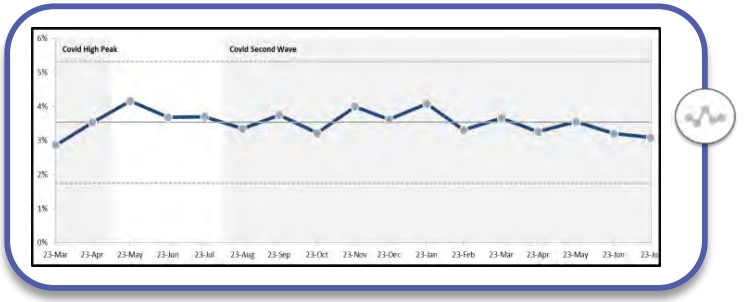
% Discharges before midday (non-covid wards)

20.01%



30 day readmission rate for same clinical condition

3.08%



Please note: These SPC charts have been re-based to evidence if any changes in performance, post the initial COVID-19 high peak, are now common or special cause variation.

Key

- Internal target
- Operational standard

Operational Performance: Cancer

2.4 - Ensure timely access to diagnostics and treatment for all urgent cancer care

NHS Worcestershire Acute Hospitals NHS Trust

Cancer Referrals	Patients seen within 14 days (All Cancers)		Patients seen within 14 days (Breast Symptoms)		Patients told cancer diagnosis outcome within 28 days (FDS)		Patients treated within 31 days		Patients treated within 62 days		Total Cancer PTL	Patients waiting 63 days or more	Of which, patients waiting 104+ days
2,752	53.78%	2,527 seen	31.58%	114 seen	67.54%	2,449 told outcome	95.19%	270 treated	53.20%	172 treated	3,034	317	114

What does the data tells us?

- **Referrals:** Sustained high volumes of cancer referrals have been received, with Oct-21 being the third highest in 2021 with Breast receiving 596, their highest on record. Skin and Lower GI both received ~100 fewer referrals.
- **2WW:** The Trust saw 53.78% of patients within 14 days. Of the 1,168 breaches, 444 were attributable to Skin and 419 to Lower GI. Across all tumour sites, 1,107 2WW breaches were due to the Trust's capacity issues. For the seventh month, this performance is special cause concern as a result of the high number of breaches; this is despite the highest number of patients seen in a month. Only Head and Neck achieved the operational standard of 93% and although an improvement from 5.2% in Sep-21, Skin has only recovered to 35.5% and Breast has decreased from 71.1% to 34.6%, linked to the further, unexpected, surge in referrals.
- **2WW Breast Symptomatic:** The Trust's waiting time performance has reduced to 31.58% with 114 patients seen and 78 breaches.
- **28 Faster Diagnosis:** The Trust has yet to achieve the FDS target of 75%.
- **31 Day:** Of the 270 patients treated in Oct-21, 257 waited less than 31 days for their first definitive treatment from receiving their diagnosis. This validated performance is currently below the CWT target of 96% but has returned to common cause variation.
- **62 Day:** There have been 172 recorded first treatments in Oct-21 to date and 53.20% within 62 days. This remains special cause concern for the second month and the 85% target remains not achievable.
- **Cancer PTL:** As at the 1st November there were 3,034 patients on our PTL with 182 having been diagnosed and 1,745 still suspected. The remaining 1,107 patients were between 0-14 days.
- **Backlog:** The number waiting 62+ days for their diagnosis has been decreased from 361 at the end of Sep-21 to 317 at the end of Oct-21; the number of patients waiting 104 days or more was 114, a decrease from 119 patients at the end of Sep-21 and continues to show as special cause concern. Colorectal, skin and urology have the largest number of patients waiting.

What have we been doing?

- **Do what we say we will do:** A sustained further increase in demand for 2ww Breast since the start of September has seen the service return to a performance of 4.51%. An options appraisal paper has been drafted and is awaiting divisional approval and funding agreement, but if approved could see the service return to performance in February 2022.
- Through a series of additional clinics and rapid triage, Skin are now booking at circa day 14 and if sustained could see them return to performance during December 2021, subject to no further increases in demand.
- **No delays, every day:** Each cancer specialty, with the current exceptions of Head & Neck, now have a remedial action plan (RAP) in place to address performance gaps, and this has been shared with ICS to allow for greater visibility, shared ownership of actions and further scrutiny / holding each other to account.
- **We listen, we learn, we lead:** Work has commenced on the process improvement project pertaining to the 2ww Booking Office with the first workshop held, hassle board in place, immediate actions agreed and second workshop being planned.
- **Work together, celebrate together:** The cancer PTL backlog (63 days plus) reduced for the first time since April 2021 ending the month at 317 patients, of which 114 patients are at 104 days plus., which shows a renewed focus on both the diagnosing and treatment of our long waiting patients.

What are we doing next?

- **Do what we say we will do:** Recruitment under way across a number of specialties to focus on improving 2ww and 28 days FDS performance, most notably within Colorectal, Gynae, Lung, Haematology and Urology.
- **No delays, every day:** Seeking to revert to a more bottom up approach to forecasting the cancer PTL backlog position to year-end, setting realistic but challenging targets for specialties based on their RAP's.
- Seeking to overhaul the current triage process for Upper GI referrals which is leading to delays in some patients being seen. A working group with actions has been formed to address this with CNS triage seeking to be implemented.
- **We listen, we learn, we lead:** Key Team Leader positions within Cancer Services about to be advertised, which will provide further scrutiny of delays at patient level and escalation of issues / themes more timely.
- **Work together, celebrate together:** Commencement of the non-specific symptoms pathway for patients presenting at the GP with concerning history but not tumour site specific symptoms., which seeks to reduce any delays in being assigned to the correct team.

Current Assurance Levels (Oct-21)	Previous Assurance Levels (Sep-21)
2WW – Level 5	2WW - Level 5
31 Day Treatment - Level 5	31 Day Treatment - Level 5
62 Day Referral to Treatment – Level 5	62 Day Referral to Treatment - Level 5

When expected to move to next levels of assurance: when we are consistently meeting the operational standards of cancer waiting times and the backlog of patients waiting for diagnosis / treatment starts to decrease. Improvements in 2WW are expected to be realised in October as a result of Breast services clearing their current backlog and the required 62+ day backlog reduction is to be delivered in Mar-22.

SRO: Paul Brennan

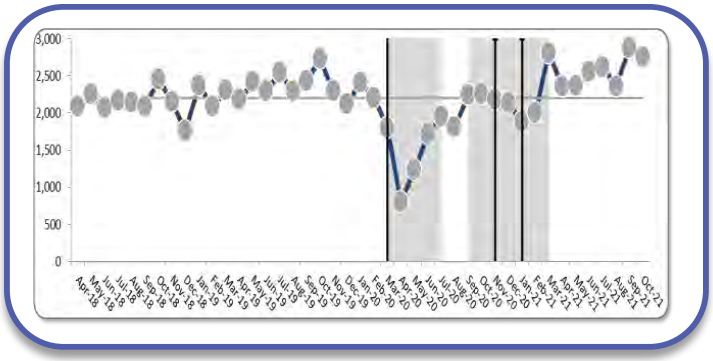
Month 7 [October] | 2021-22 | Operational Performance: Cancer

Responsible Director: Chief Operating Officer | Validated for October-21 as 1st December 2021

NHS Worcestershire Acute Hospitals NHS Trust

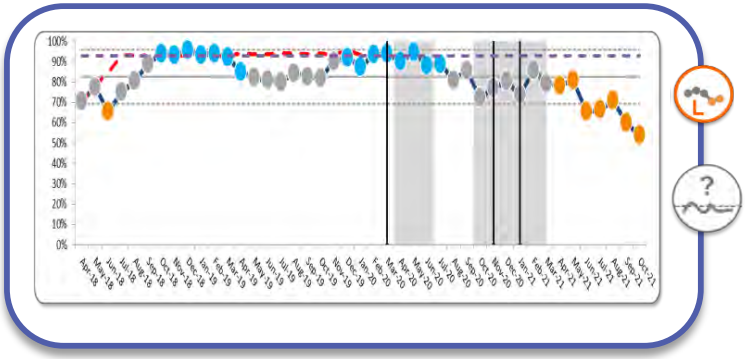
2WW Referrals

2,752



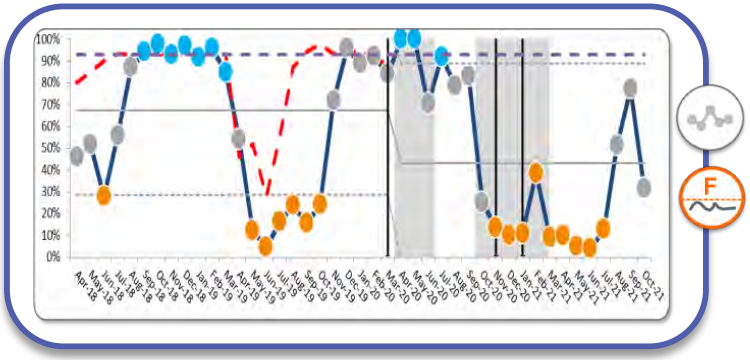
Cancer 2WW All

53.78%



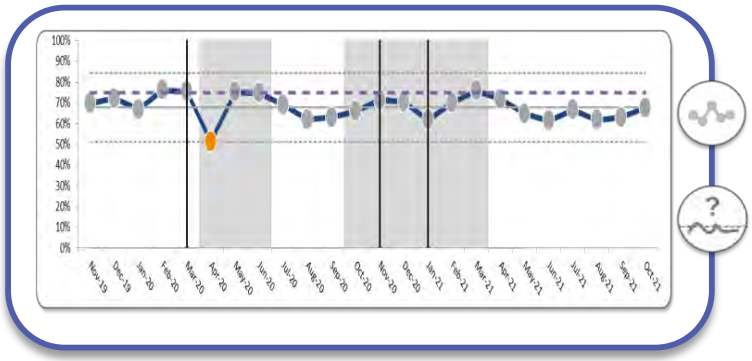
Cancer 2WW Breast Symptomatic

31.58%



Cancer 28 day FDS

67.54%



Key

- Internal target
- Operational standard

Lockdown Period

COVID Wave

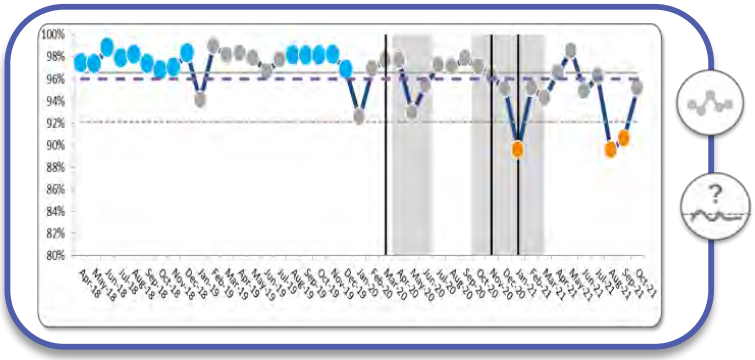
Month 7 [October] | 2021-22 | Operational Performance: Cancer

Responsible Director: Chief Operating Officer | Validated for October-21 as 1st December 2021

NHS Worcestershire Acute Hospitals NHS Trust

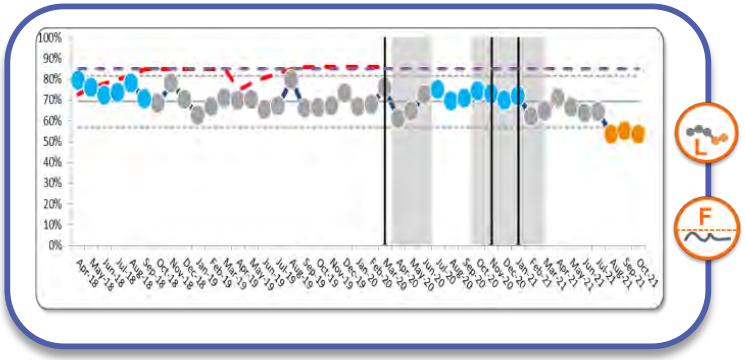
Cancer 31 Day All

95.19%



Cancer 62 Day All

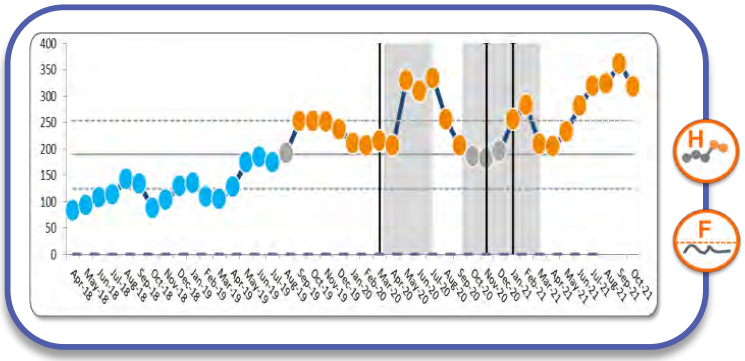
53.20%



Please note that % axis does not start at zero.

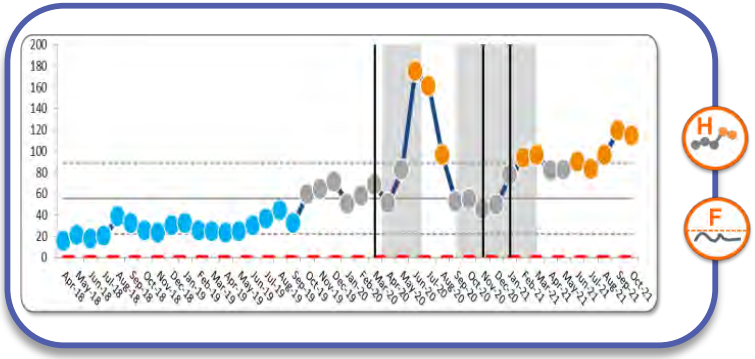
Backlog Patients waiting 62 day or more

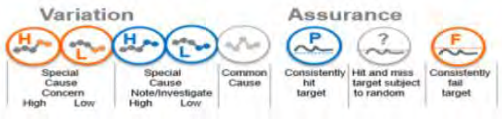
317



Backlog Patients waiting 104 day or more

114





Key

- Internal target
- Operational standard

Lockdown Period

COVID Wave

Please note: the unvalidated data for the current month is highlighted on the SPC chart; when validated it will become a solid colour like the other data points.