Trust Board
There will be a meeting of the Trust Board on Thursday 22 April 2021 at 10:00. It will be held virtually and live streamed on You Tube.

Sir David Nicholson
Chair

Agenda			Enclosure	Time
001/21	**Welcome and apologies for absence:**			10:00
002/21	**Patient Story**			10:05
003/21	**Items of Any Other Business** *To declare any business to be taken under this agenda item*			10:30
004/21	**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.* **Paula Gardne**r, newly appointed Chief Nursing Officer, has declared the following interest:- Entec Si – Has worked with the company in a previous Trust; she does not work for the company but has recommended them to WHAT. **Dr Simon Murphy**, newly appointed Non-Executive Director, has declared the following interests:- Sandwell Estates Partnership – Non-Executive Chair SF Murphy Associates Ltd – Director Worcester Community Trust – Spouse is Chair of Board of Trustees **Matthew Hopkins,** Chief Executive, has updated his declaration as follows:- Partner is Managing Director of Blue Lozenge Ltd, a healthcare strategy and communication consultancy			
005/21	**Minutes of the previous meeting** *To approve the Minutes of the meeting held on **11 March 2021** as a true and accurate record of discussions.*	*For approval*	**Enc A** **Page 3**	**10:30**
006/21	**Action Log**	*For noting*	**Enc B** **Page 15**	**10:35**
007/21	**Chair's Report**	*For approval*	**Enc C** **Page 16**	**10:40**
008/21	**Chief Executive's Report**	*For noting*	**Enc D** **Page 18**	**10:50**
Strategy				

009/21	**Covid-19 Update** Chief Operating Officer	*For assurance*	**Enc E1** **Page 21**	**11:00**
010/21	**Annual Planning 2021/22 Update** Director of Strategy and Planning/ Chief Finance Officer	*For noting*	**Enc E2** **Page 38**	**11:15**
Performance				
011/21	**Integrated Performance Report** **Executive Summary/SPC Charts/Infographic** Chief Executive/Executive Directors	*For assurance*	**Enc F1** **Page 51**	**11:30**
012/21	**Committee Assurance Reports** Committee Chairs		**Page 125**	
Governance				
013/21	**Nursing and Midwifery Staffing Report – February 2021** Chief Nursing Officer	*For assurance*	**Enc G1** **Page 132**	**11:50**
014/21	**Freedom to Speak Up (FTSU) Guardian Report** Director of People and Culture	*For assurance*	**Enc G2** **Page 152**	**12:00**
015/21	**Patient & Staff Safety - Domestic Violence** Director of People and Culture	*For assurance*	**Enc G3** **Page 156**	**12:10**
016/21	**Audit and Assurance Committee Report** Audit and Assurance Committee Chair	*For assurance*	**Enc G4** **Page 162**	**12:20**
017/21	**Annual Review of Terms of Reference** Company Secretary	*For approval*	**Enc G5** **Page 165**	**12:25**
018/21	**Register of Sealing** Company Secretary	*For noting*	**Enc G6** **Page 201**	**12:30**
019/21	**Any Other Business** *as previously notified*			**12:35**
Close				
	Date of Next Meeting *The next public Trust Board meeting will be held on 11 May 2021, virtually.*			

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

Present:

Chair:	Sir David Nicholson	
Board members: (voting)	Waqar Azmi	Non-Executive Director
	Paul Brennan	Deputy Chief Executive/Chief Operating Officer
	Anita Day	Non-Executive Director
	Matthew Hopkins	Chief Executive
	Dame Julie Moore	Non-Executive Director
	Vicky Morris	Chief Nursing Officer
	Robert Toole	Chief Finance Officer
	Bill Tunnicliffe	Non-Executive Director
	Mark Yates	Non-Executive Director
Board members: (non-voting)	Richard Haynes	Director of Communications and Engagement
	Colin Horwath	Associate Non-Executive Director
	Vikki Lewis	Chief Digital Officer
	Richard Oosterom	Associate Non-Executive Director
	Rebecca O'Connor	Company Secretary
	Jo Newton	Director of Strategy and Planning
	Tina Ricketts	Director of People and Culture
	Sharon Thompson	Associate Non-Executive Director
In attendance	Jo Ringshall	HealthWatch
	Kelly Bill	Clinical Service Manager Neurophysiology *for Item 131/20*
	Phil Dolby	Patient *for Item 131/20*
	Jackie Edwards	Deputy Chief Nurse
	Graham James	Deputy Chief Medical Officer
	Donna Krukow	Corporate Lead Nurse for Older People *for Item 131/20*
Public	12	Via YouTube
Apologies	Mike Hallissey	Chief Medical Officer

130/20 **WELCOME**

Sir David welcomed everyone to the meeting, including those viewing via YouTube. In particular to Ms O'Connor on her first Board meeting and Mr James attending for Mr Hallissey.

Sir David paid tribute to Mrs Morris the retiring Chief Nursing Officer, for the fabulous contribution she had made in improving the quality of services for our patients and also in leading the nursing profession in an exemplary way during such challenging times. He also thanked Mr Yates, one of the longest standing members of the Board and an excellent Vice Chair with excellent connections to Worcestershire and wished hi well in his new role at Herefordshire and Worcestershire Health and Care Trust

131/20 **PATIENT STORY**

Sir David explained that each Board meeting starts with a patient story. He was pleased to welcome Mr Phil Dolby, Ms Donna Kruckow Corporate Lead Nurse for Older People and Ms Kelly Bill, Clinical Service Manager Neurophysiology to explain the story of the

Family Liaison Service (FLS).

Mr Dolby was a patient at Worcestershire Royal Hospital (WRH) for a month in April 2020 and in July 2020, spoke to the Board about his experiences of Covid. Ms Krukow explained how as a result of feedback from patients and the reflections of Mr Dolby regarding the role of Family Liaison Officers in the Police force, the Family Liaison Service was established as a temporary service in January 2021. Its aim being to providing vital well-being updates to the families of patients who are unable to communicate or make contact themselves whilst visiting restrictions were in place.

Ms Krukow explained the Family Liaison Hub is staffed by both clinical and non-clinical teams, redeployed staff and military support. Over 1200 patients and families across WRH and the Alex have been connected via bedside video messages, telephone conversations and virtual visiting. This has enabled family catch ups, wellbeing chats and birthday celebrations, even for those with families abroad. It has been hugely emotive, especially in end of life care, but is very rewarding. The emotional impact of this service on both patients and their families cannot to be under estimated.

Ms Bill, a clinical scientist, reflected the rewarding and enjoyable experience of her redeployment and with patients' consent, shared their experiences of FLS.

Mr MC had spent 4 months in ITU, Aconbury 2 and theatre recovery. The FLS facilitated him keeping in touch with loved ones and even contributed to a family quiz. Mr MC's brother said there has been a great benefit for my brother and family knowing the calls are going to happen. His second brother adding the doctors can tell what contact with family has done to aid his recovery – thank you.

Mr M was confused and withdrawn; initially hesitant, the FLS supported calls with his daughter which made Mr M's day. His daughter noting when Mr M moved to Bromsgrove, they did not do this and she felt it had a negative impact on his recovery.

Ms Bill reflected on end of life patients who were able to see their family; couples separated for the first time in 50 years being able to see each other and say I love you, there were even pets on calls. The impact of this service on health and wellbeing has been immense. As a team we have laughed and cried together; the trust families have given us is a privilege. Mrs Morris thanked the FLS team for demonstrating how the service showcases the height of care and compassion.

The Chair asked Mr Dolby, whether the Trust had achieved? Mr Dolby felt the stories were very moving to hear, it almost being the anniversary of him being that patient. He could not wait to tell his family, reflecting you cannot put a price on the positive impact on recovery. He thanked the Board for listening and congratulated the Trust on diving into action. Mrs Morris thanked Mr Dolby for coming back to close those actions.

Sir David thanked all for a remarkable service, asking how this service had supported diversity and the differing needs of our patients? Ms Krukow explained by considering patients' needs and wishes, we able to bring in diversity. She reflected on a visit where there a little resistance from some clinical areas, until we showed them how we could help and be involved. Ms Bill explained how we sat and talked with people and soon wards asking us to help. We were able to support cultural issues, for example chaplaincy needs by helping a man to have prayer at his bedside via phone.

Ms Day expressed her congratulations to the team and Mr Dolby for having instigated

this and her pride in seeing patients and citizens working together. She asked what is next and can we make it even greater? Ms Bill requested digital support initially the number of devices was limited and there are many ways to support communication.

Ms Krukow confirmed a business case was in progress with consideration given to see what other services can be included. Shortly, the staff will be going back to their normal roles. It was noted this is a standard service for dementia patients, so there will be ongoing access and going forward will involve volunteers.

Ms Thompson reflected how special it was to hear the impact of the patient stories. Mr Tunnicliffe agreed and felt the story was inspiring and highlighted the curative element of this service to help patients' improve both physically and emotionally.

Mrs Morris concurred that the business case is key in terms of how we take this service forward. Mr Yates queried whether any pump priming was required for a new service and suggested the possible use of charitable funds to support.

Sir David noted the Trust having heard patient feedback and delivered a service, that the next step regarding the business case is critical to maintain impetus as staff move back to their usual roles. :

ACTION:
1) Development of a business case and interim plan to maintain the service and address any lessons learned specifically in addressing BAME needs

Sir David reiterated the thanks of the Board to the team for their hard work and to Mr Dolby.

132/20 **ANY OTHER BUSINESS**
There were no items of any other business.

133/20 **DECLARATIONS OF INTERESTS**
Sir David has been appointed Chair of Sandwell and West Birmingham NHS Trust. Ms O'Connor had submitted a nil return. The Board noted the full list of declarations of interest were on the website.

134/20 **MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON 11 FEBRUARY 2021**
RESOLVED THAT the Minutes of the public meeting held on 11 February 2021 be confirmed as a correct record and signed by the Chair.

135/20 **MATTERS ARISING/ACTION SCHEDULE**
Ms O'Connor confirmed all actions were complete on the log.

136/20 **CHAIR'S REPORT**
Sir David presented his report advising the Board of his appointment as Chair of Sandwell & West Birmingham NHS Trust from 1 May 2021, whilst very much looking forward to the new role; it would not diminish focus from Worcester. Mr Yates was leaving the Trust and Ms Day will take over as Vice Chair. Dame Julie would take over as Chair of the People and Culture Committee. The appointment of the Senior Independent Director was underway and would be reported to Board at the earliest opportunity.

RESOLVED THAT : The report be noted

137/20 **CHIEF EXECUTIVE'S REPORT**

Mr Hopkins paid tribute to the incredible work of Mrs Morris. She has led the strategic and quality improvement work and is highly respected by her nursing team, doctors and teams within the Trust. Mrs Morris has bought the voice of therapists and non nurses to the Board and is very pleased to see this in Ms Bill's attendance today. He expressed his thanks to Mrs Morris for staying at the Trust during Covid to support her colleagues and professionally lead the nursing workforce throughout the pandemic. Mrs Morris will often step into the breech and her dedication and support has been immense. He wished her a very happy retirement.

Moving on, Mr Hopkins advised of the fantastic progress made in vaccination; 51% of the eligible population in Worcester being vaccinated. A very successful webinar was held by the BAME network to support colleagues regarding vaccine hesitancy. NHS Improvement will be reviewing the Trust's progress at Provider Oversight Committee and this will be reported back to Board in due course.

Mr Hopkins noted how the Board we will look to understand the impact of Covid from an operational perspective, as redeployed staff return to their substantive roles and how we make that step change in a range of indicators on our performance dashboard. Reflecting on the progress needed to eradicate ambulance handover delays, improve mandatory training and support our workforce in progress around sepsis and IPC. Our focus continuing to be "we continue to improve, because better never stops".

Mr Azmi offered his congratulations to Mr Hopkins on the letter from the Regional Director and also to BAME network for the brilliant webinar he attended, asking if we can do more in light of low uptake by BAME staff and in liaison with the wider system regarding stepping up of engagement with BAME communities, faith leaders and large employers?

Mr Hopkins confirmed a discussion in this regard had taken place at the STP. The executive have also discussed how we get the balance right between not being forceful, but understanding what is underneath reluctance which led to the development of the webinar. The Trust are also liaising with staff side representatives and 4wrd advocates to further understand the issues. Ms Ricketts advised 1100 staff who have not been vaccinated have been contacted. Concerns included fertility and religious beliefs and those who feel they do not need a vaccine. Currently 74% of BAME staff have been vaccinated and the Trust is engaging with circa 300 staff to offer further support. Sir David congratulated the great leadership from our BAME staff.

RESOLVED THAT: The report be noted.

138/20 **STRATEGY**

138/20/1 **COVID- 19 Update**

Mr Brennan provided an update on the current position since the report had been prepared as follows:-.

- The headlines are positive. The number of cases is reducing, discharges are holding and the level of beds allocated to Covid pathways is reducing. There has been little change in both length of stay and mortality
- The number of cases reduced across both sites to a low of 70 on 6 March.
- There has been a reduction in the rolling 7 day average of new cases and discharge numbers have now slowed

- Since 6 March there has been a slight day by day increase in positive patients. The numbers are much lower than peak on 21 January of 269, however it demonstrates the need to maintain precautions and testing.
- There is slight volatility in community prevalence which has consistently reduced (currently 82 per 100k population for county) but we are seeing a small but gradual increase in presentations.
- Gold Command met on Tuesday and approved the de-escalation from alert level 5 to 4. Acute based triggers included beds allocated to Covd pathways, prevalence, number of Covid positive patients in hospital etc. We are clear before we consider any further escalation to alert level 3, we expect a broader range of system indicators to apply e.g. access to community beds.
- Alert level 4 still requires a range of actions to be operational to maintain a safe environment both for patients and staff.
- By way of context, the Trust have the fifth highest number of positive cases within the region, with only the larger tertiary centres with more.

Sir David asked whether there are issues with regards to discharge? Mr Brennan confirmed discharges have slowed but the volume has been broadly maintained; as deaths are reducing there is an increase in the number of cases. Of the Covid positive patients, 90% of those are too poorly to be discharged as opposed to be being delayed.

Mr Yates noted the huge effort regarding infection prevention and control and asked how the Trust compares regarding hospital acquired Covid and whether there non symptomatic positive deaths included with in the figures? Mrs Morris outlined how the informatics team are excellent in tracking hospital acquired infection and the robustness and rigour of the command structure. She confirmed the Trust is not an outlier, however nationally they are beginning to encourage safety teams to review rolling data per 100k as a better benchmark. With regards to the second question, Mr Brennan confirmed that yes if a patient is Covid positive and die within 28 days of the swab, Covid will be on death notification form.

Mr Oosterom noted encouraging news in the shift in age groups, perhaps first evidence that vaccination is working, but age groups 65-74 did not see the same effect. Mr Brennan replied that with regards to younger age groups, there is a clear link to the increases in community prevalence, but cannot give a reason for the middle age group referred at this time.

Mr Azmi raised a query regarding the crude mortality rate, the report consistently higher at the Alex than WRH and whether we have any analysis as to why? Mr Brennan advised that overall crude mortality at the Trust is running at 29%, just below national average of 30%. This is broken down to the Alex 33.5% and WRH 25.5%. Death notification forms are reviewed for every patient with a Covid diagnosis and this has not found any indication of concern. It was noted that the level of community prevalence is high in Bromsgrove/Redditch area and this was outstripping the rest of Worcester in vast majority of the second wave and was also higher for over 60 group. Mr Tunnicliffe concurred, this is likely as the populations served are slightly different, reporting he is not concerned we are seeing a systematic issues with care delivery,

Ms Day asked whether we are seeing any impact of long Covid yet? Mr Brennan advised this is not the case at this point and Mr Hallissey confirmed work is progressing with GPs to support the community based response to manage post viral symptoms.

Mr Hopkins expressed his thanks to Mr Brennan and team leading the incident response and highlighted the special "Thank you Thursday" on March 18th; a year since the Trust admitted its first Covid patient.

Sir David was assured the Trust have managed this period effectively, with credit to clinical, managerial leaders and front line staff. It is not over yet and lots of work to do, mortality is important and under Mr Tunnicliffe's leadership the Trust will continue to monitor at Quality Governance Committee (QGC).

RESOLVED THAT The Trust Board received the report for assurance.

139/20 **Update on ICS and Trust Action Plan**

Mrs Newton presented the report summarising the key points of the White Paper:

- It provides for a legislative basis for the work of the ICS and CCGs will cease to exist. There will be a permissive approach to working. We are one of seven ICS's nationally which to enable us to help shape how the system develops.
- 2021/22 will be a shadow year, with establishment of a statutory NHS body and partnership board from April 2021. There are discussions ongoing locally regarding system development and the linkage with HWBBs.
- Clinical leadership is key alongside the duty to collaborate. The emphasis will be on place as key driver of activity with powers delegated from the ICS
- With regards to competition and the provider purchaser split, tariff will not be removed in its entirety; however we are yet to see the financial framework.
- Powers are also moving to the Secretary of State.
- Changes to data sharing are referenced as a key enabler and also the social care element, however this is not transformational and there may be more on this in the future

ICS priority areas have been identified and the Trust is leading on planned care. There have been helpful discussions regarding how we have both recovery and transformational developments. Since the paper was issued, there has been a move to accelerate development of place, by bringing together AEDB and Worcestershire Alliance Board by July. This is consistent with the 8 point action plan previously approved by the Board.

Sir David queried the Trust position with regards to provider collaborative? Mrs Newton confirmed that this is one of the eight points within the Trust action plan. Mr Yates felt items 1-6 will be very fast moving and requested the Board be kept involved in discussions outside of Board cycles, if moving within month.

Mr Horwarth reflected upon the challenge in ensuring enabling strategies are consistent within the ICS, in particular digital will we need to restate those strategies? Mrs Lewis confirmed there is a consolidated view of digital strategy at ICS level. The integrated care record and emerging models of care are all working towards this. She confirmed there is a well-established digital board at ICS level which includes technical design.

Sir David noted the need for clarity regarding what is the ICS is, confirming that it is us working together, not another tier, thus ICS policies should be consistent across partners, as we should be building these together and playing a full part in the system.

Mrs Newton agreed, noting we have good alignment. She thanked Mr Yates for representing the Trust as a NED on ICS Executive and Sir David noted this will be

handed over to Ms Day in her upcoming role as Vice Chair.

ACTION: ICS action plan updates to be scheduled in the Board work programme

RESOLVED THAT The Trust Board noted the details of the ICS White Paper and endorsed the approach outlined by the ICS Executive Forum

140/20 **Annual Planning, Recovery and Medium Term Financial Plan update**

Mrs Newton highlighted the paper outlining the approach in managing the complexity of the annual planning process, restoration of services and medium term financial strategy.

Planning

National changes mean planning guidance for this year has not been issued, resulting in a roll over for quarter one. Locally, due to the level 5 alert status, we have not been able to significantly progress from the paper received by Board in November. However, lots of background work has been completed and some top down approaches have had to be taken.

Currently we are bringing this work together bottom up to support triangulation with workforce and finance information and checking underlying assumptions, pending any guidance. Detail for quarter two is outlined within the paper including the financial framework and system envelope, restoration planning and blended payment approach.

A stocktake of business cases is underway from a PEP perspective and a first cut of activity data. Divisional finance reviews are being held to support budget setting.

Restoration

The STP has developed a draft recovery plan and we are reviewing its alignment with the Clinical Services Strategy and the Trust's elective work.

Mr Brennan outlined the Trust's work programme, noting both internal work is underway and we are also working with primary care colleagues. We are completing work at Kidderminster and relocating the chemotherapy unit; remaining on plan for four theatres fully operational 5 days a week at Kidderminster mid April. Ward 18 at the Alex will be operational as a purple pathway on Monday.

There is an agreed theatre list for next four weeks to restart elective surgery at the Alex. We are planning to extend capacity throughout April and May, with wards 14/16/17/18 becoming fully operational as 103 beds for elective complex surgery and elements of routine surgery. Wards 9 and 10 will be bought online as a multi specialty day unit, with the intention to concentrate elective surgery at the Alex

Phase 2, from quarter two onwards, assesses the potential to open 10 theatres on a 6 day per week basis. The primary issue will be workforce challenges in theatre nursing staff, without increasing recruitment we cannot increase from 5 to 6 day operating. Bed capacity is in the baseline; therefore it is the prioritisation and use of that bed base capacity rather than an increase in the inpatient cost base.

Mr Brennan confirmed the Trust is working with primary care regarding the management of patients referred but not seen between March and October 2020. Clinical colleagues are confident since the advice and guidance service rolled out in full, those patients that with regards to those patients referred in, we ae clear on their condition and management. It is the gap prior we are therefore prioritising. Work is

ongoing though the restoration groups and we expect opening of further outpatient capacity at both WRH and the Alex, over next 14 days.

Finance

Mr Toole reflected the criticality in how we use the resources and capacity constraints we have. As we do not have the throughput we had previously, we need to increase activity in the most cost effective way. This clearly linked to the theatre and outpatient sessions by speciality.

The income position is not yet clear nationally, thus the Trust and system need to manage our cost base and expenditure going forward. The initial financial plan is built on the cost base of the 20/21 financial plan and adjusted for agreed business cases and inflationary increases. This is challenging, but we are working with divisions over this week and next to triangulate the funded capacity and activity projections.

Sir David opened the item up for questions:

- Mr Tunnicliffe asked where restoration ends and recovery begins - is our plan ambitious enough to address the magnitude of the waiting list and if not, what other opportunities do we have to increase both diagnostics and theatre capacity?
- Mr Brennan advised the size of the incomplete list was today circa 44,000. By way of context of scale, pre pandemic a work programme to eliminate 40 week waits had reduced the number to 23 patients; the number of patients now is just under 11,000.
- The Trust is modelling how much activity can be delivered via five/six day working and the impact this will have on the waiting list size and those waiting over 40 weeks. He noted caution, reminding the Board the first priority was to see patients referred but not seen. This is expected to lead to significant conversation rates which will further increase the waiting list. Initial estimates are that it will take between 2.5 to 3 years to get back to where we were pre pandemic.
- Mr Ooseterom appreciated the complexity of the task, however is concerned the Trust will go from managing the Covid crisis into managing a waiting list crisis, which will impede our ability to make the structural changes required, to improve from a performance information perspective. We need dedicated management time to develop plan that looks fundamentally at improving by implementing the Clinical Services Strategy based on the lessons learned from Covid. Secondly, the pandemic has meant we have lost a year in respect of delivering on PEP and developing new ideas meaning the drivers of costs are not fundamentally changing.
- Mr Hopkins noted the need to make connections between the Clinical Services Strategy implementation and approach to addressing the implementation plan via the changes made to elective surgery. It was noted that this would be a discussion at the Board development seminar next week.
- Mr Brennan reflected on the work being done to deliver a colder site, whilst maintaining two EDs. The plans see the majority of elective surgery being undertaken at the Alex and Kidderminster. There are some services that cannot be moved from WRH but these are relatively small. The vast majority of the waiting list is day cases, thus the multi-specialty daycase unit at the Alex and ward 1 at Kidderminster are intended to maximise throughput and capacity. This aligns with maintaining two site ED provision, whilst enabling WRH to have a greater hot/emergency focus. In respect of the volume of activity we need to deliver, it will be a specialty based allocation of theatre resource, aligned to waiting list size and prioritisation of patients on those lists.
- Sir David noted the importance of this discussion and the upcoming development

session. It was agreed to shorten the remainder of this agenda and allow this important debate to continue.

- Mrs Morris reflected on the benefits of clinical nurse specialist roles and advanced clinical practice. We do not want to lose the positive benefits of more efficient ways of working and through the QIA process we will maximise this as restoration develops.
- Mr James noted on the opportunity in working collaboratively with system partners and with Birmingham. This is not a local issue and there is recognition that for some services we need to collaborate on a region wide basis.
- Dame Julie queried whether some patients could be day cases and highlighted work around pre operative optimisation in the community. Mr Brennan agreed reflecting the need to ensure we also have the best post operative recovery to support rapid and safe discharge. A STAR chamber has been operating which has challenged proposals for undertaking surgery on WRH and has seen some shifts to Kidderminster as a result. Dame Julie noted there are some very good virtual post operative models and we have to progress faster and more efficiently.
- Mrs Newton outlined this how this work is underway with the divisions, the Site Strategy being a key enabler along with the high impact changes we need to accelerate over the coming weeks.

Sir David thanked the Board for a comprehensive discussion and noted the need for some simple rules and principles by which we operate, for example we do not approve business cases unless we have a source and application of funding etc. It was noted this item will be discussed in further detail at the Board development seminar.

RESOLVED THAT: The Trust Board

1. **Noted the changes to the timescale and approach for annual planning 2021/22 following Wave 2 COVID and recent national announcements;**
2. **Acknowledged the complexity of annual planning given the need for restoration and recovery of services and alignment with the emergent ICS;**
3. **Endorsed the direction of travel and approach proposed**

141/20 **PERFORMANCE**

141/20/1 **Integrated Performance Report**

141/20/1 **Executive Summary**

Mrs Lewis presented the month 10 report covering January 2021, during the alert level five period. Many of the items already discussed today are referenced and for expediency would not be repeated.

Key areas of challenge, many of which have already been discussed today included:

- Management of the impact of Covid 19, surge and super surge areas and how operational services have responded whilst maintaining operational grip and control via the command structures
- Issues in relation to the waiting list
- Impact on infection prevention and control and managing the same across hospital areas
- The health and wellbeing of our staff and putting in place some immediate focus and support.
- Changes in financial regime for 20/21

Mr Horwarth queried the assurance level of 6 in relation to the section on maternity services, which appeared to contradict the CQC report? Mrs Morris advised the

importance of being explicit upon what we are basing those levels of assurance on. The level is on the basis of the systems and processes in place and is not directly related to the CQC report.

Sir David reflected the CQC report was somewhat surprising, in that our processes had not alerted us to the issue in advance. Is there work to be done, to explore why? Mrs Morris advised there are some reflections for the divisional team, but this report looks back at the time preceding some of the issues around staffing and is in the context of the impact of Covid. The opportunity to give a voice to staff could have been more robust, however there were walkabouts and safety huddles every day from which staff could raise concerns, but we did not do enough for those staff who had concerns and it is important we make opportunity to address.

Mr Hopkins reflected the extent to which changes in the way midwives will be working by being allocated to either an inpatient or community setting and to the continuity of carer is a significant change process and we will reflect on how going forward this implementation is managed. During Covid we had stepped down divisional performance review meetings and would have ordinarily expected this to be raised there as part of their key risks and will strengthen this as they restart.

Mr Tunnicliffe wished to provide assurance as to the debate and scrutiny at QGC regarding the assurance level for maternity service and the level six should stand. He noted the CQC report is now historic, with lots of changes having been made since December. Finally reflecting how the change process played an important part in disquiet. There was disappointment at QGC that whistleblowing was the origin of the inspection and the Trust wants staff to be able to raise concerns, to the executive team or via other channels, so whistleblowing becomes unnecessary.

Sir David flagged sepsis as a point of concern, noting a session was coming up soon and also the performance of urgent and emergency care in January, however understood this has improved. Mr Hopkins confirmed a sepsis deep dive coming up with QGC and the executive team will be focusing on the actions required to drive forward as Covid numbers drop. With regards to 4 hours performance, this has improved significantly at the Alex since January, but pressures continue at WRH, making reference to the earlier discussion regarding flow and system working.

Mr Tunnicliffe confirmed sepsis is a key focus at QGC and the deep dive is essential to ensure we have the correct measureables and understand the barriers to this as a wicked issue.

WORK PROGRAMME: increase agenda time for performance at the next meeting.

RESOLVED THAT: The report be received for assurance.

142/20/1/2 **Committee Assurance Reports**

The following points were highlighted by Committee Chairs:

- F&P: focus on digital programme and estates strategy
- QGC: #callme and PALS
- P&C: maternity staffing had been reviewed in detail

RESOLVED THAT: The Finance and Performance Committee and the Quality Governance Committee reports be noted for assurance.

143/20	**GOVERNANCE**
143/20/1	**Nursing and Midwifery staffing report – December 2020- January 2021** Mrs Morris presented the report providing an overview of the staffing safeguards for Nursing and Midwifery during December 2020 and January 2021. She highlighted that greater detail had been included in respect of maternity staffing. It is transparent in respect of the challenges in staffing in maternity during October – November 2020. Adult nursing has been reviewed at both QGC in respect of both staffing and safety and at P&C regarding system and process to endure rigour of safer staffing. She highlighted the appendix which outlines measures taken regarding blended staffing models and confirmed support to staff is ongoing regarding decompression, as they move into their normal roles. Mrs Morris confirmed there were no incidents related to staffing in this reporting period. Mr Oosterom complimented the flexibility of all staff for making this possible during a very challenging time. Mrs Morris reiterated her thanks to staff, noting NWAG's work and rigour to keep care as safe as it can be during Covid whilst maintaining focus on controls and processes to make sure we are as efficient as we can be, in job planning and the utilisation of clinical nurse specialists. **RESOLVED THAT: The report be received for assurance.**
144/20	**CQC Inspection Report - Maternity December 2020** Mrs Morris presented the report noting the earlier discussion which had already taken place in relation to maternity. It was disappointing the outcome of the CQC inspection for the Women and Childrens division, had gone down from Good to Requires Improvement. The team were very disappointed; however Mrs Morris thanked them for their determination to address the issues raised, as set out in the report. As discussed earlier, there are lessons to learn in how we communicate and manage the continuity of care changes, so staff are supported to understand those changes and specifically in relation to feedback on actions taken in response to issues raised. It is important to note that on the day of inspection, there were no safety concerns. Ms Day, shared the disappointment in the use of whistleblowing as initially concerns were raised in October, despite there being a freedom to speak up matron in maternity, asking what are we doing to address cultural issues that mean staff feel the need to whistleblow? Mrs Morris advised that work has been undertaken with the team to understand the actions taken in relation to concerns and incident reporting. Some of the staff did not understand how continuity of care would work and the flexibility of being able to pull from the continuity of care teams to support staffing. It is difficult when whistleblowers remains anonymous, as we would like to understand what they would have wanted to have in place. We had good attendance in sessions with community midwifes; they were very open and gave each other challenge. There are lots of actions to undertake, but the divisional team and executive are clearly committed to making sure staff can share their concerns. Sir David reflected this was a problem which was recognised too late, but once recognised we look rapid action to make change happen. However, we had a group of midwives who felt management was unresponsive. Mrs Morris noted management had taken action, the issue being one of communication of actions taken to ensure staffing

was safe. There was a clear escalation each time, but we did not communicate it.

12:32 – Mr Oosterom leaves the meeting

Sir David thanked the team for early submission of the action plan.

WORK PROGRAMME: Board to have oversight of maternity transformation at a future meeting.

RESOLVED THAT: The Board received the CQC report published on 19th February 2021 and noted the associated actions that will be taken in responding to the Must and Should Do's.

145/20 **Going Concern**

Mr Toole requested Board endorsement that the Trust is operating on a going concern basis following recommendation by Finance and Performance and Audit and Assurances Committees. The Board noted the Trust is likely to achieve breakeven this year, due to funding received in- year.

RESOLVED THAT: the Trust Board endorsed the recommendation that the Trust is a going concern. This in readiness for further approval by the Trust Board despite the significant cash requirement within the 2021/22 draft financial plan.

146/20 **Trust Management Executive Report**

Mr Hopkins presented the report giving a summary of the items discussed at the Trust Management Executive (TME) meetings held in January and February 2021.

RESOLVED THAT the report be received for assurance.

147/20 **DATE OF NEXT MEETING**

The next Public Trust Board meeting will be held virtually on Thursday 22 April 2021 at 10:00am.

The meeting closed at 12:44pm

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

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

PUBLIC TRUST BOARD ACTION SCHEDULE – APRIL 2021

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
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	April 2021	May 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.	
11.3.21	ICS Action Plan Updates	139/20	ICS action plan updates to be scheduled in the Board work programme	ROC	April 2021		Action complete. Bimonthly updates scheduled on the work programme. Review frequency in Q2.	
11.3.21	Integrated Performance Report	141/20/1	Schedule on Board work programme an increased agenda slot for discussion of this item next month	ROC	April 2021		Action complete as per agenda timings. Action closed.	
11.3.21	CQC Inspection Report	144/20	Board to have oversight of maternity transformation at a future meeting.	ROC	April 2021		Action complete. Bi monthly reporting with escalation as required on a monthly basis.	

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Chair's Report

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

Accountable Director	Sir David Nicholson Chair		
Presented by	Sir David Nicholson Chair	**Author /s**	Rebecca O'Connor Company Secretary Martin Wood Deputy Company Secretary

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

Report previously reviewed by		
Committee/Group	Date	Outcome

Recommendations	The Trust Board are requested to: • Approve the appointment of the Vice Chair as Senior Independent Director • Approve the change in the use of terminology to Trust/Committee Chair • Ratify the Chair's action undertaken since the last Trust Board meeting in March 2021.

Executive summary	**Senior Independent Director** The Senior Independent Director has a key role in supporting the Trust Chair in leading the Board of Directors, acting as a sounding board and source of advice for the Trust Chair and being available to Board members to resolve concerns where the usual mechanisms may not be appropriate. Following the previously announced departure of the Vice Chair and Senior Independent Director Mark Yates, in discussion with Non-executive directors, Anita Day, Trust Vice Chair has been appointed as Senior Independent Director. **Terminology** Upon review of the Trust Board papers and in response to a query from a member of the public, I have agreed, from April 2021, to implement non gender specific titles for Committee Chairs by way of use of the generic term Chair.

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	Chair's Action In September 2020 the Trust Board approved the Equipment Services Deed and Direct Agreement Deed with Siemens and in March 2021 NHSEI requested a Supplementary Deed for this contract. The Chair undertook a Chair's Action in accordance with Section 24.2 of the Trust Standing Orders to approve entering into this Supplementary Deed. The Chief Finance Officer supported this proposal.

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	
Assurance Level (x)	0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | N/A | X		
Financial Risk	*State the full year revenue cost/saving/capital cost, whether a budget already exists, or how it is proposed that the resources will be managed.*		

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						

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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

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: • Welcome back to shielding staff • Commission on Race and Ethnic Disparities • Annual Planning Round • Integrated Care Systems

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						

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

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Issues and options

Shielding staff

As we continue our journey of recovery from the second wave of the Covid pandemic, further easing of the lockdown restrictions has bought about significant changes, especially for those members of staff and our patients who have, like me, been shielding. Our incredible response to the Covid pandemic has been a team effort. It has taken the combined efforts of colleagues working tirelessly, flexibly and courageously across all our hospitals, from their homes, in wards and on Teams calls to get us through and we are delighted to welcome returning staff back. We have all been touched by this pandemic, faced our own traumas or tragedies and we will all need to find our own ways of reflecting, recovering and resetting as we look forward to the future.

Kindness, compassion and empathy for each other is absolutely vital as we support each other and rebuild our services for a post-Covid future and embrace our 4ward behaviour of work together, celebrate together as we work together to deliver better services for local people.

Commission on Race and Ethnic Disparities

The recently published report from the Commission on Race and Ethnic Disparities has sparked much discussion around its recommendations, which have not been well received by the BAME community nationally.

Our BAME network is working hard to recommend ways in which we can become more inclusive and, in light of the report and the associated debate, I wanted to once again re-emphasise my commitment, and that of our Trust Board, to work with the BAME network to build an inclusive and diverse organisation and to ensure we have a systematic approach to eradicating discrimination in our policies, processes and behaviours.

Annual Planning

Work is well underway with clinical and corporate divisions with regards to planning for the coming year and we continue to lead and contribute to the development of system-wide plans for the next year and beyond.

Planning discussions are underway with divisions setting a clear ambition for exploiting the productivity improvement and waste reduction opportunities. We will be challenging ourselves to maximise capacity and ensure we are making best use of the resources we have, as we move away from the Covid pandemic command and control arrangements.

Integrated Care System

As the largest provider in the system and in the context of annual planning, we will be increasingly looking beyond our organisational boundaries to engage with colleagues across the system to develop service models and ways of working that put our patients first, wherever they are being cared for and whoever is providing that care.

Leaders at all levels, in every part of our system, will have to embrace different models of management. Across our clinical and corporate services more joined up working is likely to bring new opportunities for us all. This is a potentially radical shift in how NHS and social care organisations work, but if we approach it in the spirit of putting our patients first, and in ways which enable us to show our 4ward behaviours at their most positive then I am sure we can play a leading role in making our ICS a success.

Conclusion

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Recommendations
The Trust Board is requested to • Note this report
Appendices - None

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COVID-19 Longer View

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

Accountable Director	Paul Brennan, Deputy Chief Executive & Chief Operating Officer		
Presented by	Paul Brennan, , Deputy Chief Executive & Chief Operating Officer	**Author /s**	Gordon Stovin, John Reading and Paul Brennan

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

Report previously reviewed by		
Committee/Group	Date	Outcome
TME	24 March 2021	Report noted

Recommendations	The Committee are invited to note this report for assurance.
Executive summary	The reductions in inpatient numbers for those who have tested positive for Covid-19 continues to fall. ▪ At the time of this report, the total number of Covid inpatients is 50 and takes us back to a level last reported on 31 October 2020. ▪ These reductions, although slowing slightly, are currently outpacing those that we reported during wave 1. ▪ Discharge numbers are reducing. This could be due to system-wide pressures. It could also be due to the reduced number of Covid inpatients. ▪ Hospital acquired infections have remained low. This might be assisted by the current staff vaccination levels (first dose). ▪ There has been a reduction in the prevalence of older age groups within new positive cases. This will likely lead to further improvements in the crude mortality rate, reduced length of stay etc. ▪ Crude mortality rates and actual reported deaths continue to improve (slightly). 30 and 7-day trends in mortality have improved. ▪ The monthly number of 'excess deaths' attributable to the pandemic peaked in January but has subsequently reduced. Despite these improvements there are still challenges ahead: ▪ The demands on ITU, whilst reduced, have not fallen substantially for over a week. ▪ Demand for Non-COVID ITU capacity has not reduced. ▪ The number of daily new positive cases, particularly those that are defined as community-onset cases, appears to be levelling out.

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	This may be as a result in the rates of reduction in community prevalence slowing down. ▪ Readmissions are relatively stable and the majority are more than 14 days after the initial discharge. This does raise a question about the potential for 'long Covid' admissions over the coming weeks/months. ▪ Excess deaths attributable to Covid-19 now stand at 447 for the period up to and including February 2021.

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	
Assurance Level (x)	0	1	2	3	4	**5** X	6	7	N/A
Financial Risk	*State the full year revenue cost/saving/capital cost, whether a budget already exists, or how it is proposed that the resources will be managed.*		
Action			
Is there an action plan in place to deliver the desired improvement outcomes?	**Y**	N	N/A
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	Dependent on community-prevalence		

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Introduction/Background

The aim of this report is to provide a broad and long view of the current wave of COVID-19 and its impact on the Trust. Specifically around inpatient numbers and trends, a comparison of deaths and treated patients.

For the sake of brevity please assume that the term 'inpatients' only refers to those inpatients who have tested positive for Covid-19 virus and not all inpatients across the Trust. Should this not be the case it will be made clear in the accompanying text.

Unless otherwise stated any reference to wave 1 has a start date of 23 March and wave 2 is 23 September 2020.

In each the source of the information in question has been provided along with some observations. The latter of these are not definitive but instead represent those observations made whilst constructing the charts or from participating in the daily bronze briefing. Comments, questions and challenges in respect of these observations are welcomed.

Issues and options

Current situation, Inpatient numbers and Trends

The following tables summarise the total number of COVID inpatients treated (inc. those that are still inpatients), their combined length of stay (ie. total bed days), the numbers discharged (treated) and those who died (in hospital). They also show the crude mortality rate and average length of stay.

Combined (Since 23 March 2020)

Site	Total No. inpatients	Combined LOS	Discharged (treated)	Died (in hospital)	Combined discharges	Crude mortality rate	Avg LOS (treated)	Avg LOS (died)
ALX	1316	15773	909	388	1297	29.9%	11.5	12.2
WRH	1407	16000	1087	301	1388	21.7%	11.0	12.1
Trust	**2723**	**31773**	**1996**	**689**	**2685**	**25.7%**	**11.2**	**12.2**

Last updated: 18 March 21

As the pandemic progresses we are starting to see the crude mortality rate and average length of stay for all Covid inpatients stabilise with just subtle changes taking place week by week.

The following two tables outline the same data for wave 1 and wave 2 (separately).

Wave 1 (23 March - 22 September 2020)

Site	Total No. inpatients	Combined LOS	Discharged (treated)	Died (in hospital)	Combined discharges	Crude mortality rate	Avg LOS (treated)	Avg LOS (died)
ALX	401	4631	258	143	401	35.7%	11.8	11.1
WRH	360	4004	260	100	360	27.8%	11.3	10.7
Trust	**761**	**8635**	**518**	**243**	**761**	**31.9%**	**11.6**	**10.9**

Last updated: 18 March 21

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Wave 2 (23 September 2020 to 15 March 2021)

Site	Total No. inpatients	Combined LOS	Discharged (treated)	Died (in hospital)	Combined discharges	Crude mortality rate	Avg LOS (treated)	Avg LOS (died)
ALX	915	11142	651	245	896	27.3%	11.4	12.8
WRH	1047	11996	827	201	1028	19.6%	10.9	12.8
Trust	**1962**	**23138**	**1478**	**446**	**1924**	**23.2%**	**11.1**	**12.8**

Last updated: 18 March 21

Observations:

- The current wave now exceeds wave 1 by 1201 patients and over 14.5k bed days (ie. combined LOS).
- The crude mortality rate for the pandemic thus far is 25.7% and is continuing to improve, albeit slightly.
- The crude mortality rate for the current wave continues to improve and is almost nine percentage points lower (ie. better) than wave 1. That this situation is continuing to improve suggests that, as the pandemic continues, survivability for hospitalised patients is improving.
- Average length of stay for the current wave is relatively stable.

At the time of writing the number of inpatients across the Trust who have tested positive for Covid-19 continues to fall and is now 50 inpatients.

If we compare current reductions to wave 1 we appear to be seeing our inpatient numbers at a quicker rate.

For example: In the first wave it took 15 days to go from 143 inpatients (peak of wave 1) to 96. In the current wave it took 13 days to fall to from 144 (closest day to peak of wave 1) to 92 inpatients.

Unlike the first wave, where this reduction slowed down somewhat, we seem to be seeing less or shorter plateaus in patient numbers.

For example: In the first wave it took 25 days to go from 105 inpatients to 51. So far, it has taken 18 days to fall to from 105 inpatients to 50.

Over the last week the inpatient cohort has reduced by an average 4.4 patients per day. This is ever so slightly less than the 4.7 we reported last time. The fluctuation in this metric perhaps reflects a reduced opportunity to discharge patients (ie. reduced patient sample) and also improving survivability for existing inpatients.

In the previous version of this report we indicated that the Trust had reached a position comparable to 19-20 November 2020 (based on inpatient numbers). We are currently in a position where we have similar inpatient numbers to 31 October 2020 (inc. those patients who were clinically suspected at the time).

The impact on the number of beds required for COVID patients can be seen on the following chart. This shows the inpatient 'snapshot' as reported on a daily basis. It compares **wave 2** (up to 18 March 2021) with **wave 1**. It also includes a **rolling 7-day average** for wave 2.

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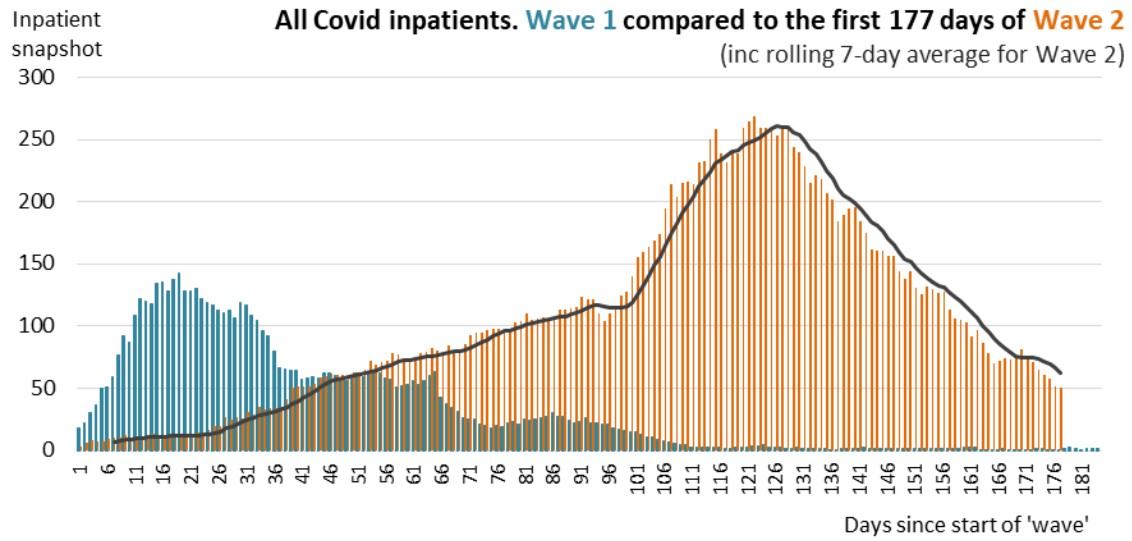
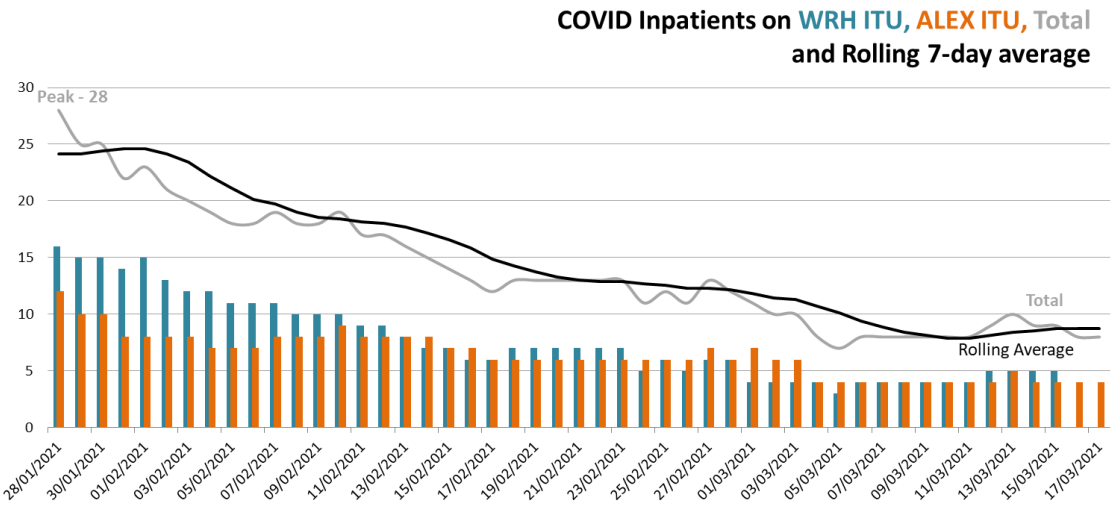


The pace of the reduction in inpatient numbers is not currently reflected in those patients requiring ITU-based care. Whilst there is an obvious reduction in ITU occupancy (Covid) since the beginning of the year this appears to have plateaued over the last two weeks. ITU Covid occupancy (including Surge ITU's) is illustrated by the following chart.



Although not included within this report it is worth noting that demand of non-Covid ITU beds has risen over the last two weeks. At the time of writing we have 15 patients in ITU, nine of which are being treated for/with Covid-19. The Trust currently has four open areas that are being utilised for the treatment of ITU based patients.

The following chart shows the *daily* new positive inpatients. As before, this compares **wave 2** (up to 16 March) with the first 175 days of **wave 1**. It also includes a **rolling 7-day average** for wave 2.

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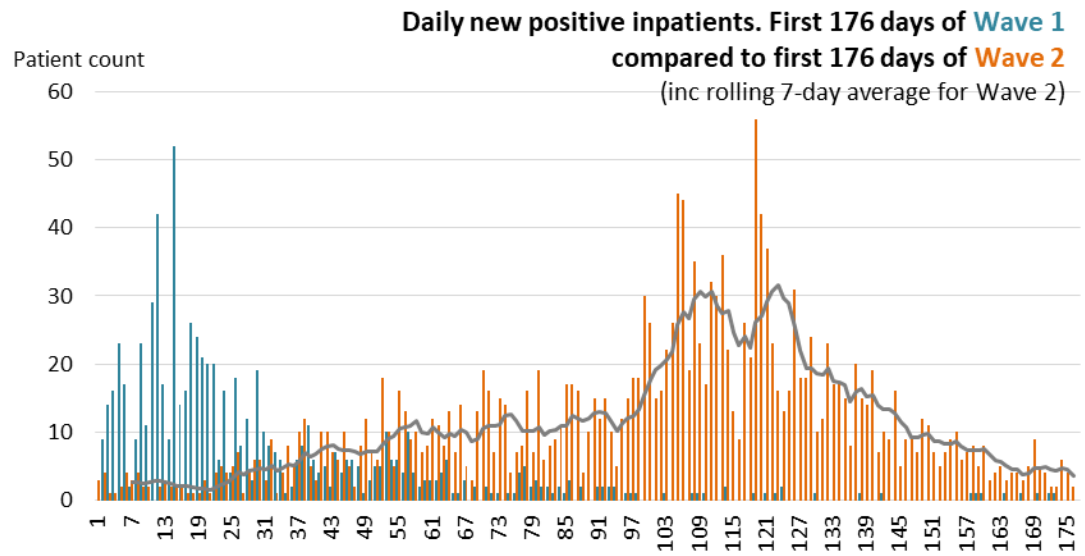
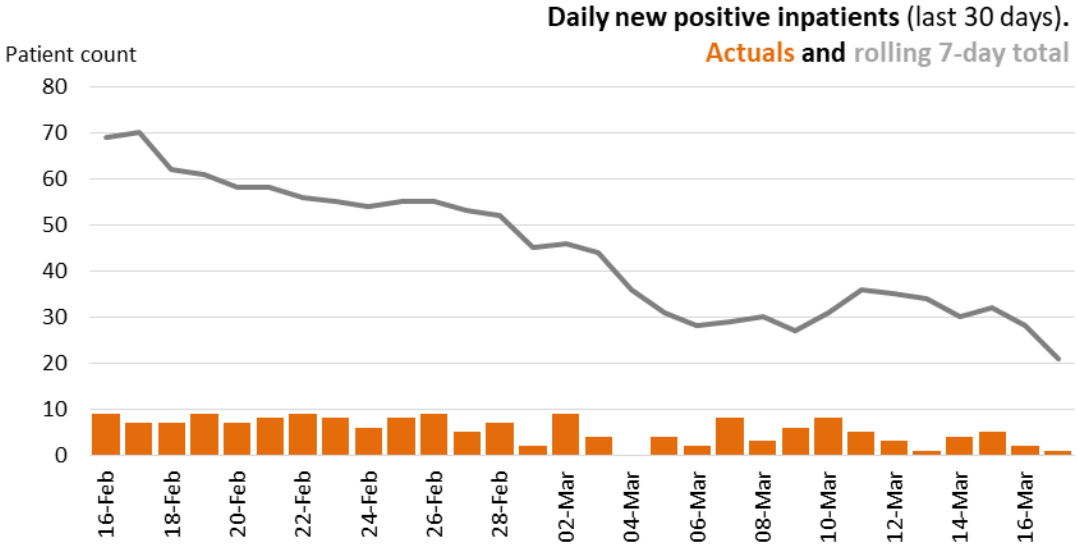


Please note: This excludes readmissions.

It would appear that, after a sizeable reduction in the daily number of newly detected positive inpatients, this is now showing signs of slowing down or even levelling off. The next chart shows this trend over the last 30 days. It is quite possible that this is attributable to the slowdown in community-wide prevalence. This hypothesis is supported by a later chart showing community-onset case numbers.



Observations:

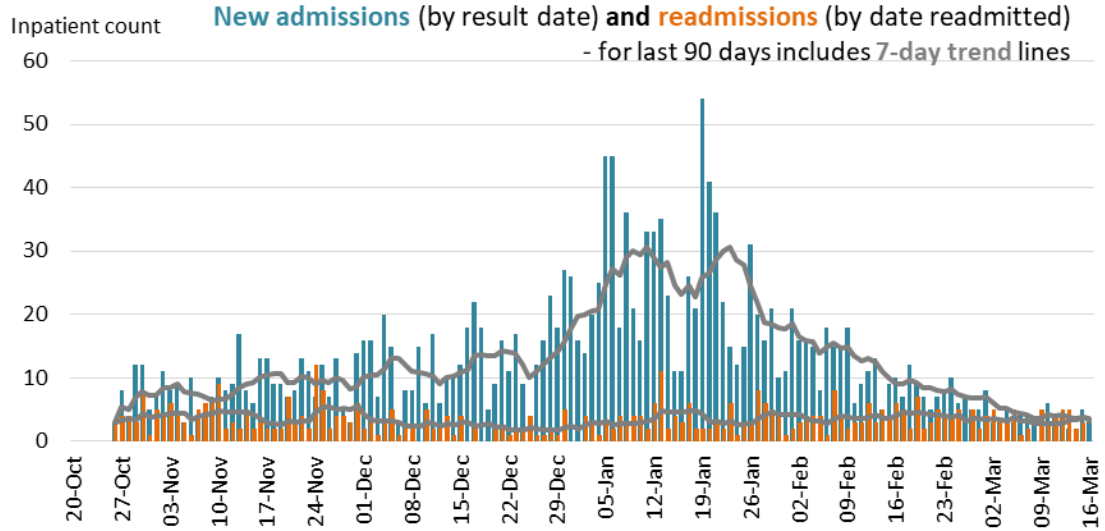
- The reduction in the number of Covid inpatients continues, effectively taking us back to the start of November 2020 when we were seeing consistent but relatively small increases in inpatient numbers. Or to mid/late May 2020 when we were emerging from the first wave.
- Despite a similar scale of reduction in ITU, this is still operating at a heightened level. This is being exacerbated by non-Covid demands for ITU space. Also, as ITU LOS

tends to be markedly longer, further reductions may be lagged behind overall inpatient trends.

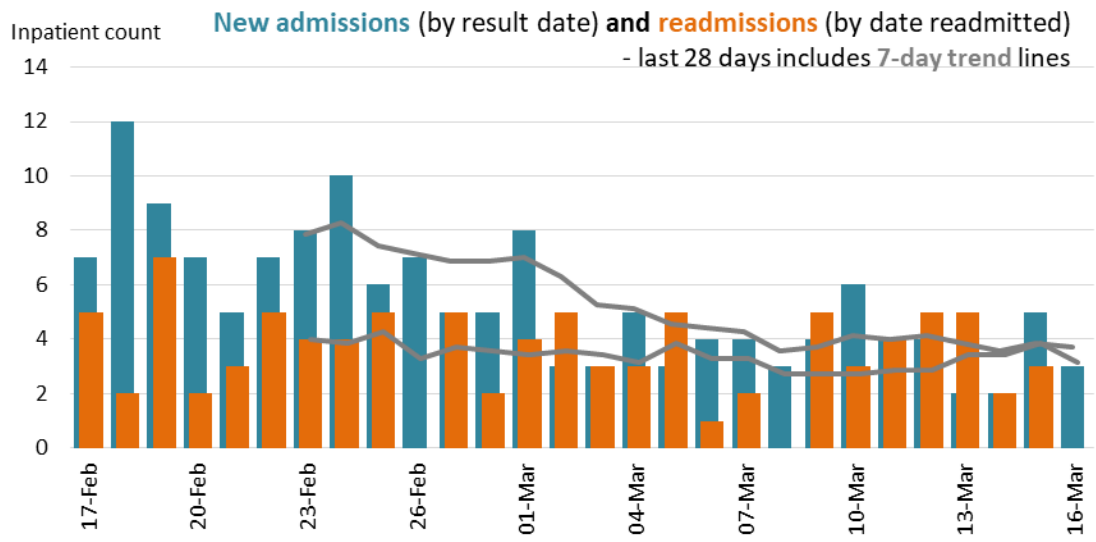
- Reductions in new positive cases (inpatients), whilst reduced from the peak in January, has recently plateaued. This may be linked to current trends in community prevalence.
- The short term trend would continue to suggest reduced inpatient numbers.

Readmissions

The following chart shows the daily number of **newly detected inpatients** (based on sample date) compared to **readmitted patients** for the current wave. It also shows the rolling 7-day trends for both of these. In this case the term 'readmission' excludes those patients who were previously/only discharged from ED (ie. not from an inpatient bed).

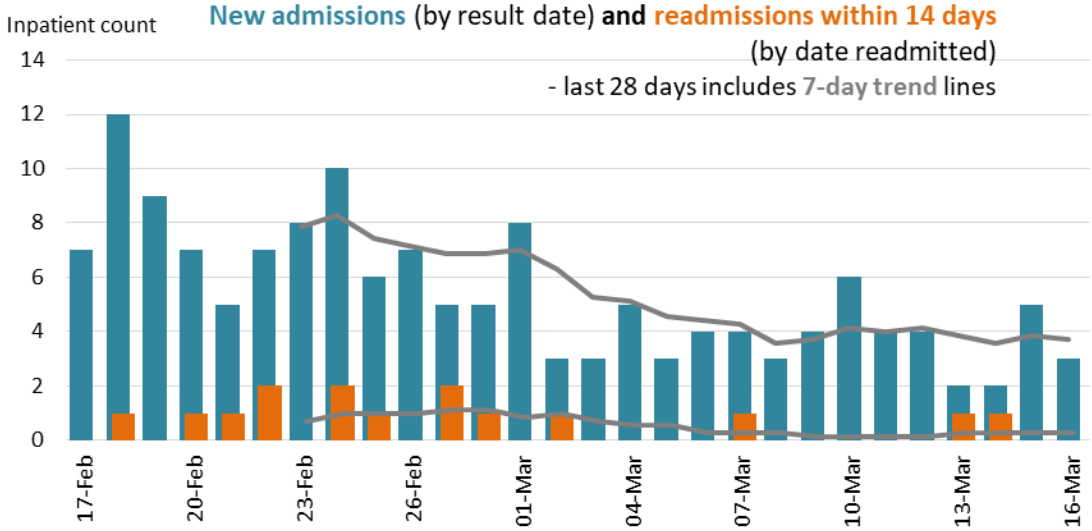


The following chart uses the same information but focusses on the most recent period of time.



Trends in readmissions are pretty stable but now roughly equal those of new admissions.

It is worth noting that these include all readmissions. The next chart uses the same information again, but only includes patients readmitted within 14 days of their original Covid-19 Detected result. Clearly, the majority of our readmitted Covid inpatients are more than two weeks following their original treatment.



Observations:

- New admissions have continued to fall but are now starting to level off.
- Readmissions during wave 2 are relatively stable, but readmissions within 14 days of their original diagnosis are much lower and reducing (ie. we are seeing increased numbers of days with zero readmissions).
- This could be evidence of the longer-term impact of Covid-19. However, if we are seeing 'long Covid' manifest in hospitalisation, this is both small and relatively stable.

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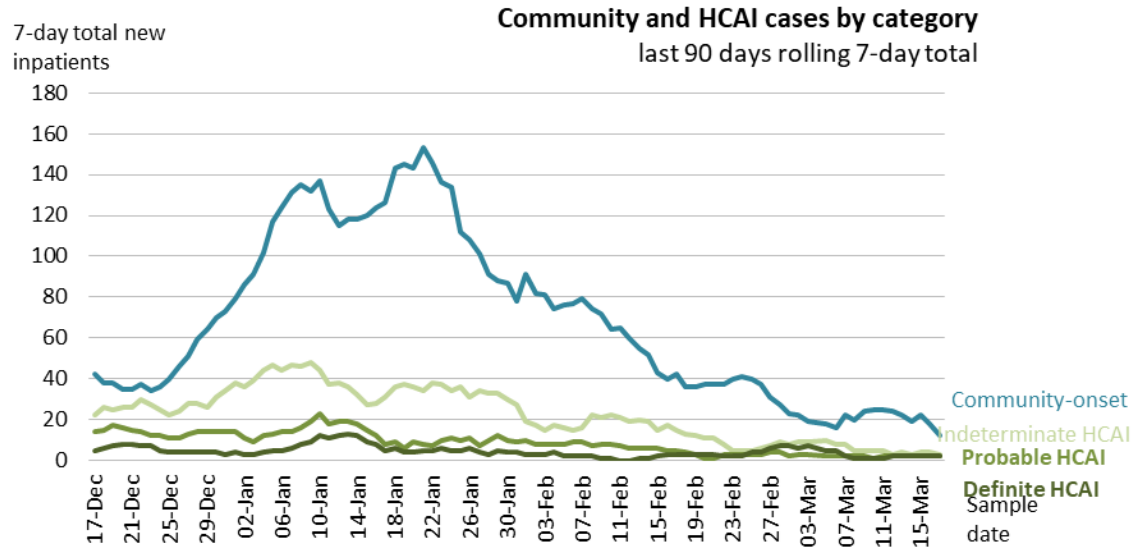
Healthcare Associated Infections (HCAI)

The following chart shows the breakdown of our new positive cases by the HCAI category, which is based on the time between admission and the positive swab being taken.



Observations:

- Community-onset cases continue to remain the main factor behind our inpatient cohort.
- However these have seemingly plateaued, perhaps as a result of current trends in community prevalence across the county.
- HCAI cases are reduced.

Staff vaccination

The continued suppressed levels of hospital acquired cases of Covid-19 may, in some part, be a result of staff vaccination levels.

The following table shows the current staff vaccination progress for the past three weekly returns.

	14-Mar	08-Mar	01-Mar
Substantive staff (headcount)	6409	6317	6317
Substantive staff (vaccinated)	5206	5205	5176
Substantive staff (% vaccinated)	**81.23%**	**82.40%**	**81.94%**
Substantive Staff Declined	127	125	111
Substantive Staff Exempt	20	17	17
BAME staff (headcount)	1107	1087	1087
BAME staff (vaccinated)	775	785	779
BAME staff (% vaccinated)	**70.01%**	**72.22%**	**71.67%**
CEV staff (headcount)	108	137	137
CEV staff (vaccinated)	79	88	88
CEV staff (% vaccinated)	**73.15%**	**64.23%**	**64.23%**

As part of the Lateral Flow app being used to collate staff testing results, we have been asking for the barriers from those staff members who have not yet had the vaccine. We have received 41 responses so far, 40 are from females and 1 male. The themes are as follows: 31% is related to pregnancy or fertility concerns, 24% due to allergies, 24% no time or not offered vaccine, others responses are : personal choice, need more information or not applicable currently as had Covid-19.

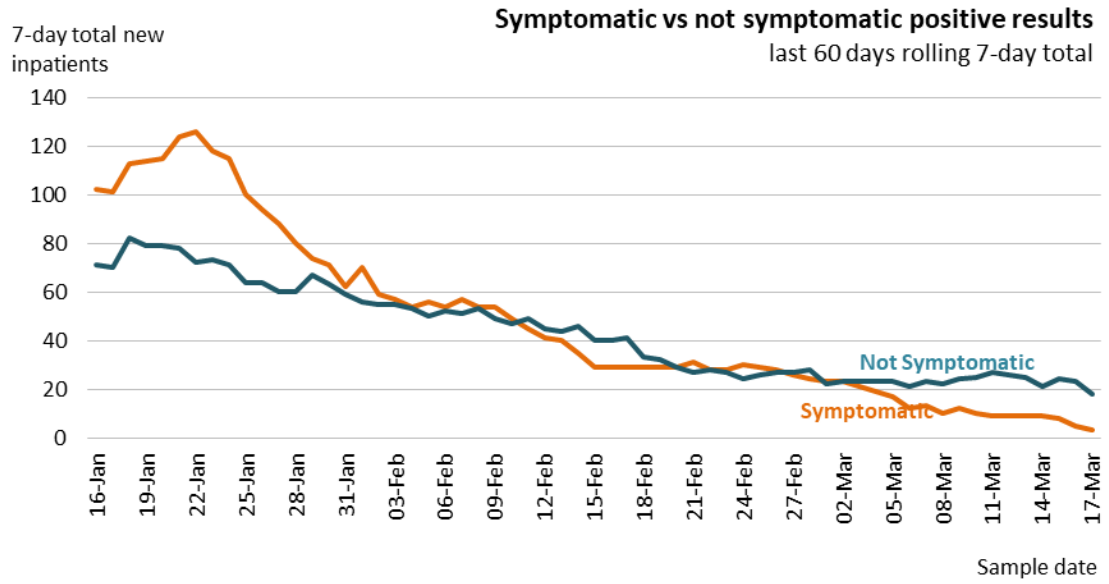
Observations:

- All staff vaccination rates are consistent and at/around the 82% mark.
- BAME staff vaccination rates, whilst consistent are around ten percentage points less than the rate for all staff.
- CEV staff vaccination rates having previously been <70% have improved.

Prevalence of Symptomatic patients

Please note: The symptomatic/not symptomatic distinction is currently not a clinical assessment of the patient. However we are moving towards a clinical assessment with the implementation of a clinical checklist to determine whether symptoms are present.

The following chart represents whether the inpatient is described as symptomatic or not (at the point at which the resulting positive test is taken).

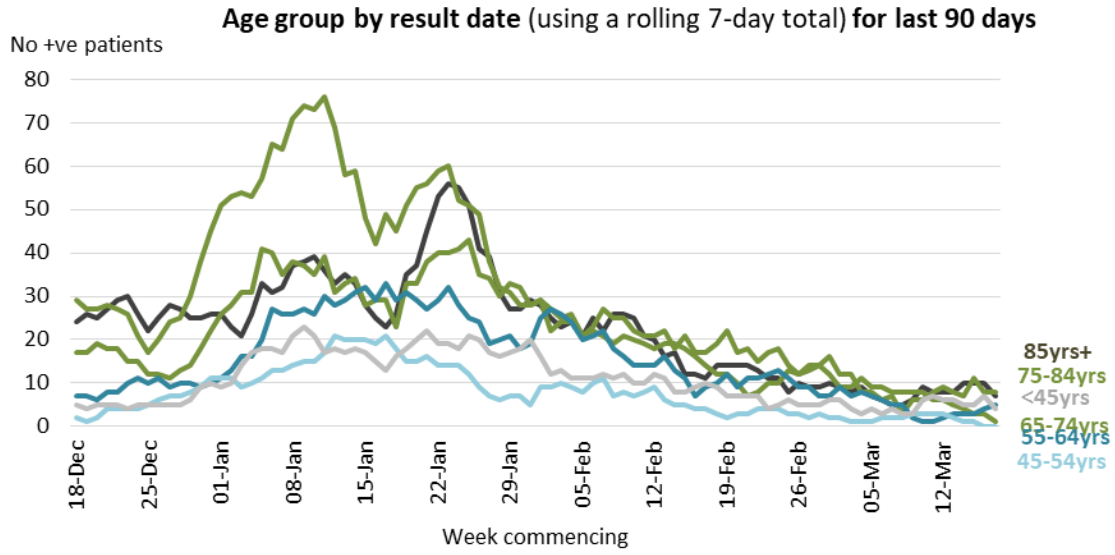


Observations:

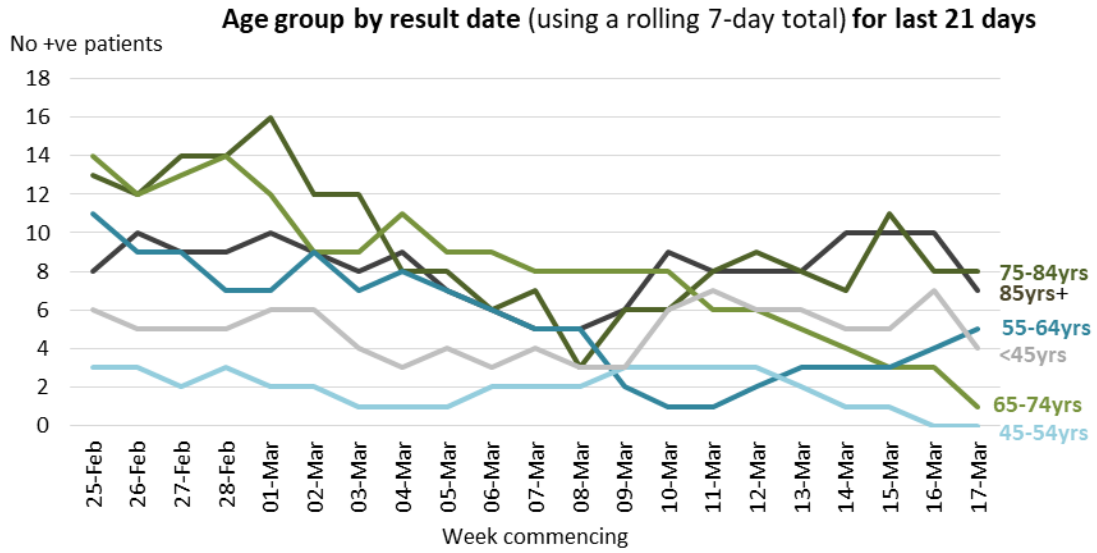
- Although all positive cases are much reduced, those that are not symptomatic are tending to be more prevalent.

Age Groups

We continue to see shifts in the influence of age on new Covid inpatients. The following two charts show the rolling 7-day total new inpatients (based on result date) by a broad age grouping.



Again, the next chart is the same data, focussing on a more recent period.



Observations:

- Broadly speaking, all age groups have seen reductions and those older age groups have seen the largest reductions. This has noticeably lessened the age effect on our patient cohort.
- However, there are a few of exceptions. We have recently seen increases in those patients aged 85 years or older and (to a lesser extent) those patients aged 55-64yrs.
- Attributing this to the vaccination programme is problematic but the biggest reductions have been in those age groups most likely to have received a vaccination.
- Similarly, it would be wrong at this point in time to attribute the rise in cases of those aged 85 years or more to be a consequence of the delay between first and second vaccinations. Given the small numbers, such increases could simply be attributable to a similarly small number of care home cases/outbreaks.

Mortality

As of 17 March, the rolling 7 day average number of Covid inpatient deaths was just 1. This is slightly improved on 1.9 as previously and remains much reduced over recent weeks and significantly reduced from the peak figure of 9.1, which occurred on the week ending 21 January.

The following chart shows the actual numbers of daily Covid deaths for the last 30 days. Along with a 7-day average.

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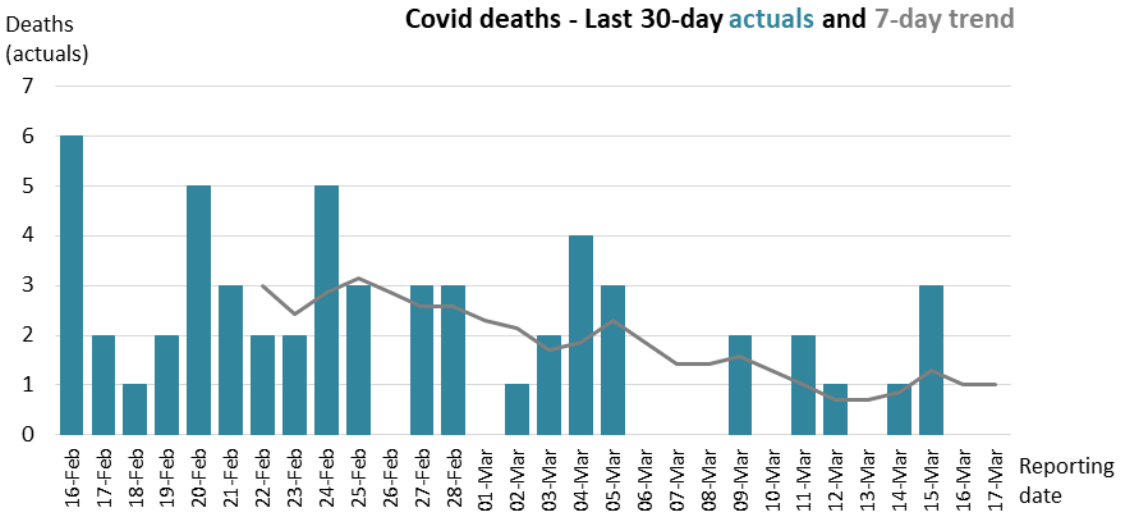
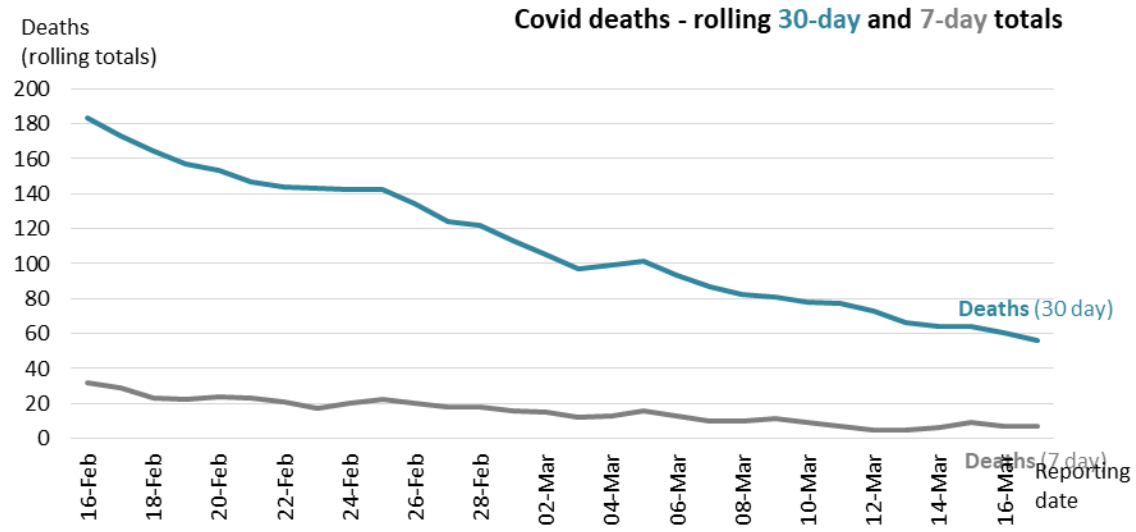


This can be viewed in light of the next chart which shows the longer, 30-day trend against the shorter, 7-day trend.



The following chart shows the cumulative deaths for **wave 1** against the first 175 days of **wave 2**.

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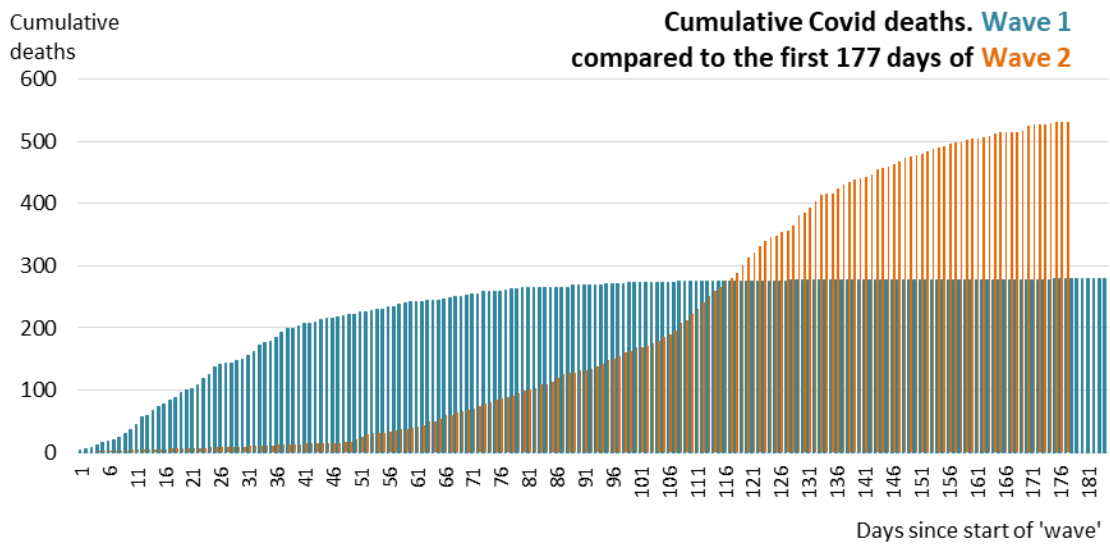
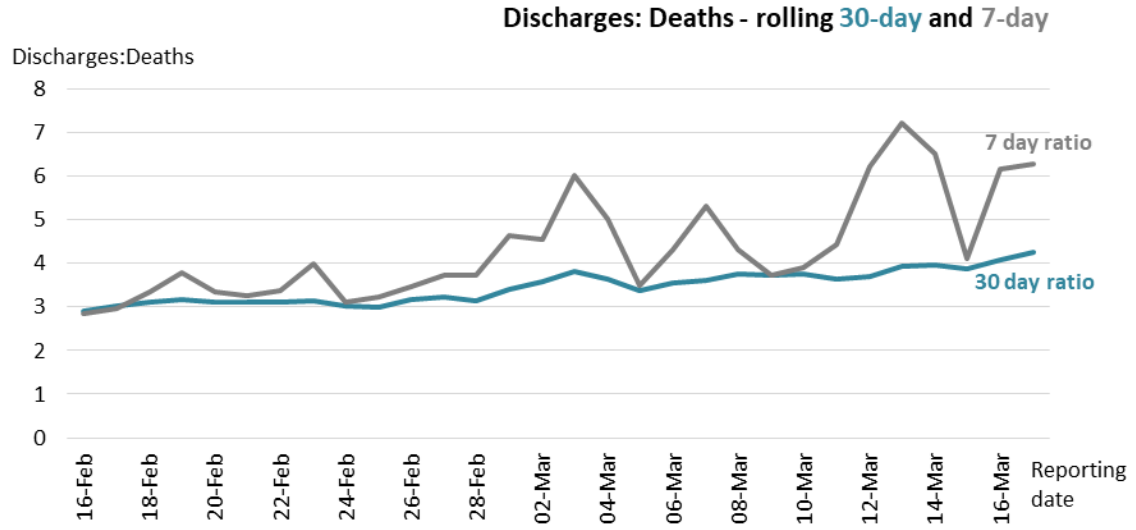


The following chart shows the ratio of discharged treated patients to deceased patients, over the last 30 days, for both 30 and 7-day rolling averages.



Observations:

- Our mortality rate is continues to improve as is the daily number of reported deaths.
- Over the last seven days the number of daily reported deaths has been zero on three occasions. The periodicity of days when we are reporting zero deaths is increasing.
- Although wave 2 has resulted in more deaths than the first wave, the crude mortality rate remains improved.
- We are continuing to see improvements in the ratio of treated to deceased patients. This suggests greater treatment success rates and also lessening of the acuity of patients over time.

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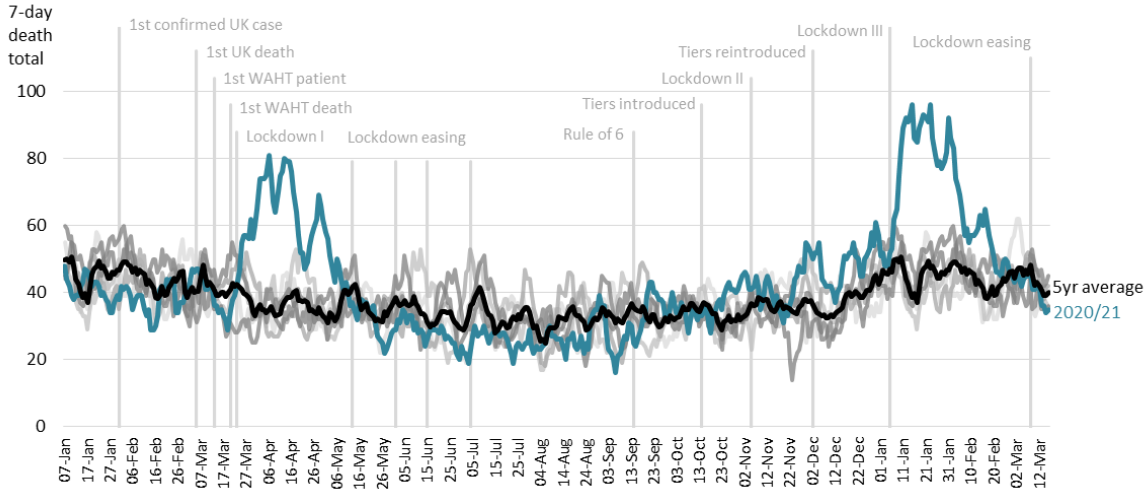
The net effect of this, in terms of its impact all inpatient deaths can be viewed in the following three charts.

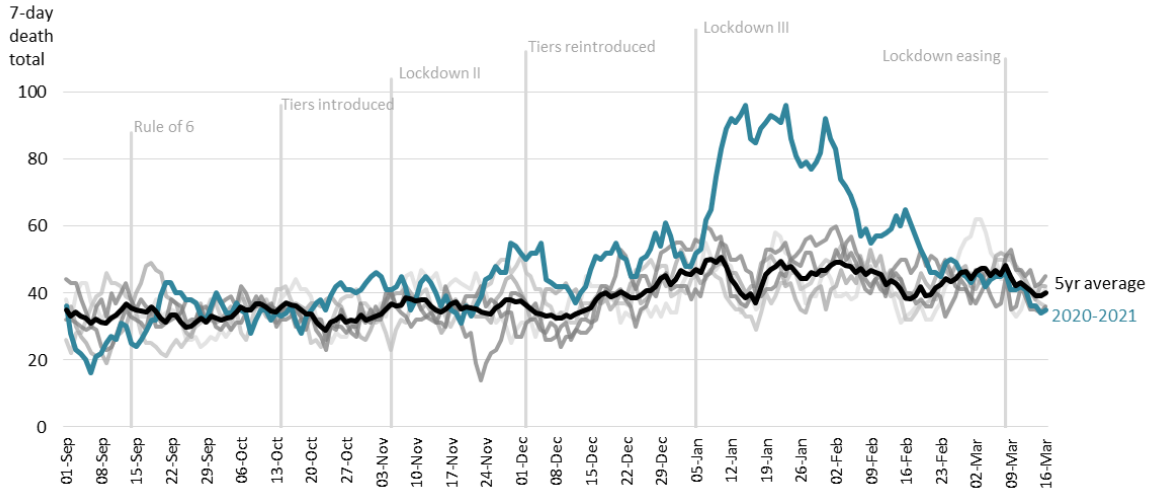
The first shows a wider view of inpatient mortality (Covid and non-Covid) for the period January 2020 to March 2021. This is set against the previous five years inpatient mortality and the 5yr average. The chart uses a rolling 7-day total to smooth out the natural volatility in our daily crude mortality. Several key milestones in the pandemic have also been introduced to provide reference points across the 13 months.

Inpatient deaths Jan 2020 to March 2021 (so far) **compared to 5yr average**
Based on rolling 7-day inpatient deaths



The next chart shows the same information only for the most recent wave.

Inpatient deaths for Wave 2 compared to 5yr average
Based on rolling 7-day inpatient deaths



Both of these charts show the periods where Covid-19 has resulted in markedly more

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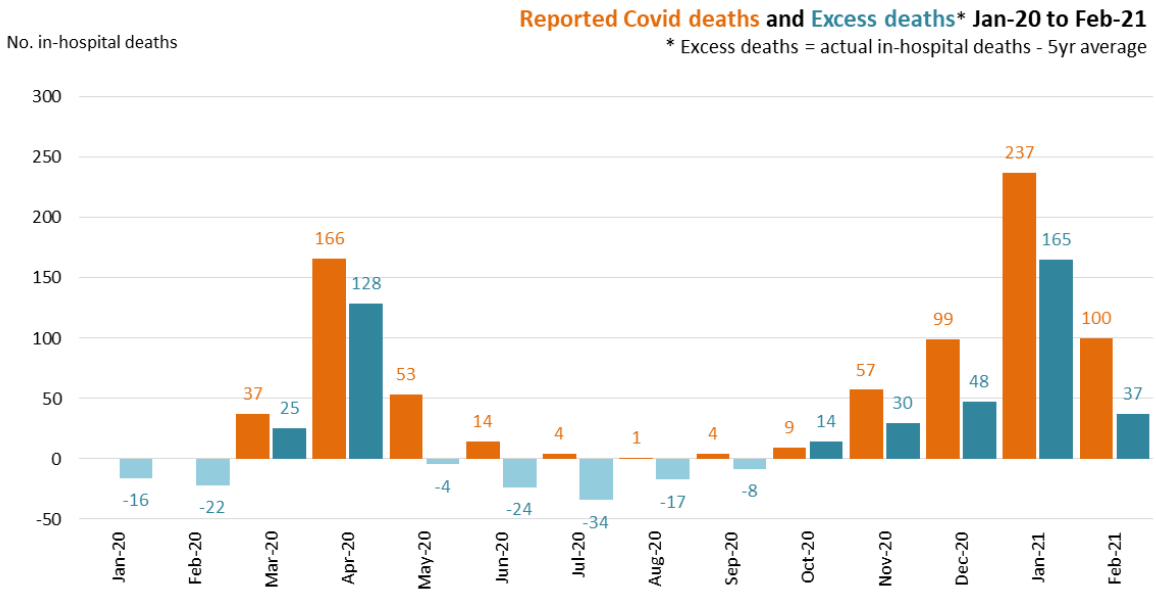
inpatient deaths. Both of these periods coincide with the peaks of wave 1 and wave 2 respectively. On both occasions it is noticeable that our inpatient deaths have quickly dropped to, or even below, that which we might normally expect (in the absence of Covid-19).

If we reduce this to a monthly view and plot the aggregated difference between the blue (current year) and black (5yr average) lines we get an indication of the number of 'excess deaths'.

Please note: This methodology to compute excess deaths is used by the likes of John Hopkins University in the US and also by the Financial Times and BBC.

The following chart shows the excess deaths by month compared to the reported Covid deaths for the same period.



Please note: Covid deaths refers to those that have been or will be reported to nationally to CPNS .

Observations:

- Covid-19 has resulted in somewhere in the region of 153 excess deaths in the first wave and 294 excess deaths for wave 2 (up to and including February 2021).
- The combined total of positive excess deaths (447) is substantially less than the figure reported nationally (781 up to February 2021).
- Since the start of the pandemic in March 2020 there have been five months (out of 12) where we have not experienced inpatient deaths greater than expected.
- We are not seeing additional, non-Covid 'excess deaths'. This is supported by the published Summary Hospital-level Mortality Indicator (SHMI).

Conclusion

- Now that the Covid numbers are reducing we are reviewing the re-start of elective

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surgery. There will be some changes to ward structure at the Alex in the coming weeks to accommodate the restart of some complex elective surgery on that site.

- More communications will be sent to provide more information on the vaccine in relation to pregnancy and fertility.
- Lateral Flow testing will commence for our Maternity services in line with national guidance.

Recommendations

The Committee are invited to note this report for assurance.

Appendices

Worcestershire Acute Hospitals NHS Trust

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Update on Annual Planning 2021/22

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

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 and Director of Strategy and Planning Jo Kirwan, Assistant Director of Finance Nikki O'Brien Assistant Director of Business Intelligence, Performance and Digital Felicity Davies, Deputy Director of People and Culture Katie Osmond, Deputy Director of Finance Zoe Scott-Lewis, Head of Transformation and PMO

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

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

Recommendations	It is recommended that Trust Board notes: • the key themes from the national annual planning guidance published by NHSE/I on 25th March 2021 • the progress with annual planning at ICS and Trust level

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	• the plans in place to further develop the Productivity and Efficiency Programme

Executive summary	This paper provides an outline of the national annual planning guidance and an update on progress with annual planning at both ICS and Trust level. It sets out our approach (including the proposed approach to the development of PEPs and attendant business cases), progress and timescales.

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

Assurance Level (x)	0		1		2		3		4		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	**May 2021, following submission of draft plans to NHSE/I**					

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Acute Hospitals
NHS Trust

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Introduction/Background

Prior to release of national guidance, work to develop our annual plans has been underway with a particular focus on budget setting, with divisional budget setting review meetings which took place in mid-March. The meetings provided a perspective on the financial baseline position which enables the establishment of a credible financial plan and established the scale of additional work required to identify and develop PEPs and to prioritise business cases for 21/22. NHSE/I published national planning guidance on 25th March 2021 which has been reviewed within the trust and with colleagues from our system partners. This paper summarises the national guidance, outlines our approach, progress to date and timescales.

Issues and options

National annual planning guidance

NHSE/I issued national annual planning guidance on 25th March 2021. The guidance sets the priorities for the year ahead against a backdrop of the challenges of restoring services, meeting new care demands and reducing the care back logs that are a direct consequence of the pandemic. This is set in the context of the need to support staff recovery and to take further steps to address inequalities in patient access, experience and outcomes. The guidance expects ICSs to articulate how services will be restored, backlogs addressed and how staff are supported to recover. The following system-wide priorities for 2021/22 are set out:

- Supporting the health and wellbeing of staff and taking action on recruitment and retention
- Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19
- Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services
- Expanding primary care capacity to improve access, local health outcomes and address health inequalities
- Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay
- Working collaboratively across systems to deliver on these priorities.

Whilst these priorities are set for the year, the technical guidance recognises that the NHS enters the new financial year with uncertainty and therefore focuses to the first half of the year (H1) for which fully triangulated activity, workforce and financial plans now need to be developed.

The current block payment arrangements will remain in place. For H1, the system funding envelope, including top-up and COVID-19 fixed allocation will be based on the H2 2020/21

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envelope adjusted for known pressures and policy priorities. This includes an efficiency requirement of 0.28% for the six month period which is expected to increase through the second quarter. Dates for provider capital and cash plan submission was by 12th April. There is also an expectation that elective activity will be maintained during any future COVID surges.

ICS approach

We have reviewed the guidance with our system colleagues and the Trust continues to be represented at a range of system-wide planning meetings which are focusing on the development of plans. A time-limited Herefordshire and Worcestershire Operational Planning Forum has been established which will meet for the first time on Wednesday 21st April. It will:

- oversee all elements of the annual planning round across the system
- unlock any issues raised by groups responsible for specific work streams
- triangulate across finance, workforce and delivery/operations

There will be a particular system-wide focus on requirements associated with elective recovery, reduction in health inequalities, financial sustainability and best use of resources. It is estimated that it will take 2.5 – 3 years to resolve recovery issues relating to elective care and the priority areas which have been identified are summarised in Appendix One. Our trust-level activity, workforce and financial plans will contribute to a triangulated system-wide plan which will be submitted to NHSE/I on behalf of Herefordshire and Worcestershire ICS (summary plan by 6th May and a final plan by 3rd June).

Trust approach

A series of operational division budget setting meetings took place between 12th and 16th March which focused on budget setting (including cost pressures), including a stocktake of business cases and productivity and efficiency plans (PEPs). The meetings provided a perspective on the financial baseline position which will enable the establishment of a credible financial plan and established the scale of additional work required to identify and develop PEPs and to prioritise business cases for 2021/22.

Following publication of the national guidance, a detailed timeline for developing our annual plan submission was developed which aligns the work required with the deadlines for submission of our trust-level information for ICS triangulation. A high level summary of the detailed timeline is presented in Appendix 2. The internal annual planning process will be overseen by Annual Planning Steering Group.

The guidance states that H1 plans should be based on 2020/21 quarter 3 actuals. Quarter 3 activity data was reviewed by divisions in December 2020 and revised by the Business Intelligence Team in light of divisional comments in January 2021. The revised data was resent to division on 1st April for further review by 12th April 2021. A series of meetings to triangulate different elements of the plan will be held the fortnight commencing 12th April.

These meetings will also assess capacity for and affordability of delivery.

A further series of annual planning review meetings for operational divisions chaired by the Chief Operating Officer will take place fortnight commencing 29th April to consolidate their operational plans and budgets and to review progress on the identification and development of PEPs. Delivery will be tracked through divisional Performance Review Meetings from May 2021. Budget setting review meetings chaired by the Chief Executive will take place in early May 2021 for Corporate, Estates & Facilities and Digital divisions.

NHS England and NHS Improvement have nationally calculated default organisational plans based on Q3 2020/21 actuals in a bid to minimise the extent of local planning. Our system approach effectively restates our underlying 2020/21 financial plan having adjusted for agreed non recurrent items, cost pressures and business cases. As a result, Divisional budgets will reflect this bottom build approach.

Given that our underlying cost base position (irrespective of financial frameworks) remains at a significant deficit and income levels remain uncertain, this position has continued focus and requires ongoing attention and action irrespective of the six month interim funding regime.

This action will likely include:

- Setting realistic though stretching Productivity Improvement / PEP targets aimed at ensuring reduced cost per unit of activity
- Targeted Divisional Focus on GiRFT and reducing clinical variation
- Specialty Service Line Management deep dives developing understanding of cost buckets and cost drivers for action
- Slippage against agreed business cases / developments
- Further targeted high cost / high volume agency usage areas
- Transfer of activity across patient pathways to value for money areas (e.g. community or domiciliary settings) and making better use of system resources.
- Planned slippage against any reserve

Development of PEPs

Four phases of PEP development are proposed.

Phase 1 focuses on divisional level schemes, along with carry forward schemes from 2020/21 and workforce schemes. Following the initial operational division budget setting meetings in March, a small number of divisional PEP schemes were identified (see below), for which the divisional leads are assessing deliverability and developing plans which will enable more accurate costing, with a project initiation document (including Quality Impact Assessment) where necessary.

PEP idea	Approximate FYE value (£k)
Closure ward 1 (Specialist Medicine)	£1,700
Pharmacy CMU (SCSD)	£300
Biochemistry analysers (SCSD)	£75
Radiology WLI conversion (SCSD)	£31
Endoscopy Malvern drying cabinets	£23
Pathology analyser platform	£17
Radiotherapy maintenance contract	£13
Urgent care medical workforce (Urgent Care) Urgent care nurse workforce (Urgent Care) Procurement (All) Move of day case from SCSD to Surgery Division (SCSD/Surgery) Car parking/remote working (Trust wide)	To be scoped

There are also a number of schemes that could not be delivered in 20/21 which are being considered for carry forward in 2021/22.

	Scheme Name	*TOTAL PLANNED SAVINGS FOR YEAR £K*	*Comments*
Schemes from 20/21 which will carry forward			
SCSD	Replacement of analysers	17	
SCSD	Radiology WLI conversion	31	
Urgent Care	Closure of Corridor (WRH)	439	Division have agreed this scheme should carry forward to 21/22, however savings profile for 21/22 not yet determined
E&F	Consumables purchased through ISS/PFI (not directly by the Trust)	13.8	The opportunity within this scheme for 21/22 is being scoped by the division
E&F	Energy Usage and Sustainability	75	This is yet to be approved by the division

In addition, workforce and procurement schemes are currently being reconsidered and reprofiled for 2021/22 and there are some partially delivered non-recurrent schemes (e.g. Pharmacy CMU) which could continue delivery into 2021/22.

PEP maturity levels for these schemes are being tracked weekly at the Annual Planning Steering Group and gateway meetings have been arranged (x3 per week) for corporate annual planning leads to review and formalise the progression of schemes through the maturity levels. Each scheme will be approved by a panel of executive directors before delivery commences.

Phase 3 of PEP development will focus on cross divisional/cross trust PEPs and on schemes which increase value at the same, or reduced, cost. This requires a shift in thinking in terms of our approach to PEPs which should form the keystone for service improvement. Given the scale of recovery required for elective services, it is proposed that such PEPs are prioritised to a small number which are done well. A cross divisional workshop which will focus on cross-divisional schemes is being planned for May in conjunction with the Chief Operating Officer and is likely to focus on clinical variation. Other areas for discussion and potential scoping may include:

- Learning from Independent Sector re theatres throughput
- Quantification of hot/cold site productivity benefits
- Adoption of procurement traffic light system for consumables
- Review of stock management processes

- Review of SLAs
- Use of high cost items

In addition, system level PEP schemes are being explored with the work being led by WAHT's Chief Finance Officer and the CCG Head of PMO on behalf of the system. A system-wide GiRFT event focusing on elective recovery delivered by national GiRFT leads took place on 30th March, following which there is a commitment to focus at system level on developing interventions to improve productivity through standardisation of Urology, Orthopaedics and Gynaecology pathways.

Business cases

All divisions presented their 'long list' of business cases to a meeting of the Strategy & Planning Group held on 8th March 2021 and identified which they would prioritise for 2021/22. As part of the development of a standard operating procedure for business cases, a business benefits realisation matrix has been developed which will be completed for the prioritised business cases and used to inform 'red pen' exercises in late April/early May. This exercise will determine which of these business cases should be developed for consideration in 2021/22. The principles adopted to guide the red pen exercise are:

- Business cases will not be considered unless they contribute to improving our financial position. There has to be a clear financial 'pay back' or a genuine quality[1] issue or statutory need.
- Therefore, all business cases must be focused on improvement (i.e. deliver a productivity or efficiency benefit)
    - Identification and removal of waste
    - Removal of non-value-adding activities
    - Improved timeliness/optimise process
    - Eliminate process variation
    - Improve process capability
- All business cases must demonstrate how the proposal impacts on recovery/restoration of services/reduction of the backlog aimed at a reduced cost per unit of activity.
- Where a business case is not self-funding or pay back is beyond an acceptable time period (e.g. invest to save business cases), alternative funding would normally have to be identified. Exceptions in limited circumstances, may include if it is a statutory, critical infrastructure or other key BAF risk.
- If a case is not self-funding, we would always seek to find an offset funding / to identify additional PEP, but we would not necessarily always be able to hold off implementing until that had been secured.
- We will focus on a small number of business cases which will be done well (end to end) so that we can get the basics right (i.e. scope, process and benefits realisation)

[1] Quality includes effectiveness, safety, patient and staff experience

and ensure delivery of the benefits identified.

Capital Planning

System capital envelopes were confirmed week commencing 22nd March. The Capital Prioritisation Group and work stream leads are progressing a review of business as usual / rolling replacement priorities for assets as well as considering potential strategic investment priorities ahead of a system prioritisation process.

Staff Recovery

In March 2021 Trust Management Executive (TME) and People & Culture Committee (P&C) approved the development of our 'post COVID staff offer', this will be developed under 6 headings:-

- Appreciation and recognition
- Rest and recovery
- Safe and secure at work
- Staff experience
- Creating capacity
- Healing

The immediate priorities will be to review flexible working options for all staff and contractual and policy arrangements which enable staff to take a break from work. This is alongside the implementation of our Health and Wellbeing Plan also approved at March TME and P&C.

Top 3 Risks for annual planning process

Risk	Mitigation
Operational demands mean that managers and clinicians are unable to engage fully in annual planning process and consequently timescales are not met	Prioritisation of requests made of divisions As much work as possible undertaken corporately Ensure that annual planning discussed at existing meetings
Requests and timeline for ICS level annual planning triangulation and discussion further reduces the time we have to ensure we have robust internal plans meaning work is not complete for ICS deadlines	Complete as much work as possible up front Keep system partners updated on progress over time and provide early alert of potential issues Deprioritise other work to focus resource on annual planning
Internal triangulation of plans identifies capacity issues which impact on deliverability and/or affordability of activity	Early triangulation of plans to give sufficient time to discuss and address any issues identified Unresolved issues escalated internally

	and in system discussions
Compressed timelines compromise ability to identify transformational PEP opportunities and implementation and embedding of new benefits realisation tools	Phased approach to PEP discussion, understanding of capacity and / or capability gaps and consideration of focus on H2 for full reset

Conclusion

The timescale for undertaking annual planning is ambitious and planning is taking place against a challenging backdrop of COVID and recovery/restoration of services. Our work to date places us in good stead to respond to national guidance for H1, although further focus on PEPs and business cases is required. In addition, an assessment of the activity that can be delivered within the financial envelope available is required and is integral part of triangulation discussions and those relating to productivity and efficiency. Whilst PEPs that focus on income generation and cost reduction will be difficult to identify in a non-payment by results environment, there is potential to generate PEP through business benefits associated with existing transformation schemes and proposed business cases through a focus on improvements in productivity and efficiency as outlined in this paper. An update will be provided at the 13th May Board meeting by which time work will be sufficiently progressed to be able to present key headlines from the operational plan.

Recommendations

It is recommended that Trust Board notes:

- the key themes from the national annual planning guidance published by NHSE/I on 25th March 2021
- the progress with annual planning at ICS and Trust level
- the plans in place to further develop the Productivity and Efficiency Programme

Appendices

Appendix One - Draft ICS 2021/22 priority areas
Appendix Two – High level timeline

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Appendix One: Herefordshire and Worcestershire priority areas

	Cross-cutting priority areas		
Area	Elective care recovery programme (demand management, outpatients, waiting list management, personalised care)	Diagnostics (Community Diagnostics Hub Programme)	Cancer (specific issues in H&N)
Planned next steps	**National GIRFT team event, 30th March, 12.30 – 14.00.** Covering Orthopaedics, ENT, Ophthalmology, General Surgery, Urology, Gynae, Spinal.	CDH group expanded to include broader diagnostics work.	Continued area of focus

	H&W 21/22 Priority clinical pathways				
Pathway	Orthopaedics	Urology	Respiratory	Diabetes	Neurology
Rationale	• Total waiting list • Over 52+ weeks wait	• Total waiting list • Over 52+ weeks wait	• Post COVID • Uncertain demand • Rapid access to tertiary services • Rehab capacity	• Potential fragility • Disjointed pathway across providers • Left shift (£ potential) • Unknown future demand	• Fragile service • Unclear cancer pathways • Staffing issues
Planned next steps	**Orthopaedic engagement 20th April, 12.30 – 14.00**	Urology engagement event required	Review capacity gaps Reflect on national guidance i.e. BTS	Review capacity gaps Review current pathways	Review capacity gaps Review current pathways

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Appendix Two: Summary of annual planning timeline

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Meeting	Trust Board
Date of meeting	22nd April 2021
Paper number	Enc F1

Integrated Performance Report – Month 11 2020/21

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

Accountable Director	Paul Brennan – Chief Operating Officer, Paula Gardner – Chief Nursing Officer, Mike Hallissey – 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	24th March 2021	Approved
Finance and Performance	31st March 2021	Assured
Quality Governance	1st April 2021	Assured

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

Executive summary

The Impact of COVID-19

February 2021 has been a month of transition in our management of the demands of COVID-19 on our core and surge capacity and the deployment of our staff. The impact of the national vaccination programme and lockdown began to have the desired effect on reducing hospitalisation; reducing our in-month average for positive patients in a bed from 230 in Jan-21 to 160 in Feb-21, and, by the end of the month there were 105 positive patients in the hospital.

However, this reduction in patients did not correspond with increases in elective and ambulatory activity on the WRH and ALX sites as the Star Chamber continued to review patients to determine if surgery could take place and whether ambulatory services could be restarted.

This approach stabilised our capacity to undertake similar volumes of activity seen in Jan-21; the seasonal "half-term effect" was not as apparent either. As would be expected, reduced elective activity had the knock-on effect of increasing the numbers of patients waiting:

- 5,608 patients waiting over 52 weeks for their RTT related treatment, and of those, 1,014 have been waiting over 70 weeks.
- 4,684 patients waiting 6+ weeks for their diagnostic test and of those, 1,800 have been waiting 13+ weeks.

Conversely, our focus on our cancer patients has seen a reduction in the number of patients waiting for their diagnoses and treatments:

- 238 patients on a 62 day cancer pathway waiting over 62 days, and of

those, 93 have been waiting over 104 days.

An average of 160 people a day attended A&E during the month and the conversion rate remained high at 35%. This continued to put pressure on our capacity and whilst discharging COVID-19 patients remained an important component of managing the bed demands, the Trust saw increases in the number of long length of stay patients and those deemed medically fit for discharge but remained in a bed.

Quality and Safety

Infection Prevention and Control
In Feb-21, 6 more cases of C. Diff were recorded taking our year to date total to 54, 1 more case than our end of year target of no more than 53.

2 more MSSA cases were recorded taking our year to date total to 25, 15 cases above our target of no more than 10.

There were 3 E. Coli cases bringing us to a total of 30; this is 20 cases below our end of year target of no more than 50 cases.

Finally, although there were no MRSA cases recorded in Feb-21, 1 unvalidated case have been recorded in Mar-21 and, if validated, this would take our 20/21 total cases to 2.

The patient with MRSA had significant risk factors for MRSA colonisation, though was screened and negative on admission. Following detailed review it is not clear if this MRSA was a contaminant or a true infection. Practice issues have been identified relating to peripheral cannula documentation and care, and skin integrity. Learning and actions relating to these are being progressed, and will also be fed into the Staphylococcus aureus BSI quality improvement project work.

Given the continuing concerns on anti-microbial stewardship, the sustained level of assurance for MSSA BSI, and current performance the overall recommended level of assurance for non-COVID-19 issues is recommended to reduce to level 3.

To date during the pandemic we have detected and managed 33 outbreaks; 3 of these are being actively managed, and the other 30 have been closed.

Sepsis
The audit process for Sepsis 6 completion has been revised in recent months with a coded form which has allowed a greater number of cases to be identified. In addition, the reporting mechanism reflects base ward designation not the actual use during the COVID-19 pandemic. New ESR based training has been implemented and it is hoped that now COVID-19 pressures are reduced there will be increased compliance with training and consequent changes in data completion.

Antibiotic delivery within an hour was achieved in 94% of cases with

every Division achieving over 90%. After 5 consecutive months improvement, the sepsis 6 bundle completed within one hour compliance has dropped in Jan-21 due to drop in one metric, urine output measurement. Completion of the bundle is subject to a QI project to be delivered with the support of the Chief Registrar to revise the data collection tool to make it the sole documentation used in these cases. It is hoped this reduction in documentation will improve both delivery and data accuracy.

People & Culture

The total hours worked for substantive, bank and agency staff increased from 6,303 to 6,360 whole time equivalents in February which is higher than the funded establishment of 6,321. This has been driven by winter pressures and the response to wave 2 of the COVID-19 pandemic. We have also seen an increase in tier 2 agency costs due to workforce demand.

Absence due to stress and anxiety has increased by 0.17% to 1.32% this month and is closely monitored through the incident control structure. Health and wellbeing interventions have been targeted to high risk staff groups which are underpinned by individual occupational health referrals to ensure appropriate support is put in place.

As we come out of level 5 escalation focus is needed on getting the basics right as both appraisal and job planning compliance have seen further deterioration.

Our Financial Position

Internal Plan

Against the internal £(78.9)m operational plan (Budget), the month 11 (February 2021) actual surplus was £1.7m vs Plan £(8.6)m, a £10.3m positive variance. This is against a very different activity, income and resource plan.

The combined pay and non-pay expenditure variance against our internal budget is £ (1.5)m adverse. This position includes £1.5m of incremental COVID-19 costs.

The combined income position was £11.7m favourable to budget in month recognising the interim funding regime. This revised payment mechanism has been extended into H1 2021/22.

Note Year to date Income top-up of £83.5m including £16m COVID-19 Related.

Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	22nd April 2021
Paper number	Enc F1

NHSI Financial Framework 20/21

NHSI Financial Framework submission - The Trusts Income & Expenditure position was £3.1m better than the Financial Framework plan assumptions.

As we continued to respond to COVID-19 In February, Elective and Outpatient activity remained low compared to December, and Emergency admissions increased.

Income was £0.7m above plan mainly due to additional funding from the LDA for Education and Training following notification at the end of January 21 regarding a revision to the tariff.

Pay costs were £0.7m (2%) lower than plan as a result of the following key items:

- Forecast assumed that all beds would be open in December 2020 and that we would incur significant additional temporary staffing costs for heightened levels of sickness / absenteeism. Ward 10 remains closed and absenteeism levels have been lower than forecast. As a result temporary staffing and associated premium costs did not increase to the levels anticipated (£0.6m).
- Fill rates for temporary staff to perform patient temperature checks in Outpatients and Radiology and Theatres roles such as runners for RED theatres are low. In the main, these tasks have been completed by utilising the goodwill of our substantive workforce, stretching existing staff. Workforce colleagues have been working closely with Directorate leads. (£0.1m)

Non-Pay costs were £0.8m (5%) lower than the NHSI financial framework plan. The key items driving this position include:

- Lower than anticipated patient activity delivered in the private sector, this is offset by lower income (£0.2m)
- Incremental variable costs driven by bed capacity and activity lower than anticipated (£0.5m)
- Cleaning costs have not increased to the levels anticipated. (£0.1m)

In M11 we have revised the full year forecast to the Phase 3 Financial Framework Plan submission of £(7.3)m deficit from a £(2.5)m deficit to a £2m surplus against the separately allocated system funding allowance. Income has increased significantly since we submitted the initial forecast as a result of additional Education and Training funds, pass through High Cost Drugs and further COVID-19 support. In addition, our variable cost base aligned to activity and our productivity outputs have reduced given the wave 2 COVID-19 impact.

NHS
Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	22nd April 2021
Paper number	Enc F1

Risk															
Which key red risks does this report address?		**What BAF risk does this report address?**	1,2,3,4,5, 7,8,10, 11, 12 and 13												
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 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						

Recommendations
▪ The Board is asked to note this report for assurance.
Appendices
▪ Trust Board Integrated Performance Report (Feb-21 data) ▪ WAHT February 2021 in Numbers Infographic ▪ Committee Assurance Statements

Integrated Performance Report

NHS Worcestershire Acute Hospitals NHS Trust

Trust Board

21st April 2021

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

Operational Performance

Operational Performance Report - Headlines

Operational Performance	Comments
Urgent care and patient flow including Home First Worcestershire	• 4 hour EAS continues to show special cause concern for Feb-21; however ambulance handover and 12 hour breaches are showing normal variation. Although there has been a slow, steady decrease in the number of COVID-19 patients over the course of the month, the pressure on both hospital sites to manage bed capacity, patient flow and COVID-19 positive patients requiring beds has remained. • Although we were successful in discharging our COVID-19 patients at an average of 13 per day in Feb-21, discharging patients with a long length of stay and those deemed medically fit has not been as successful, reducing the timeliness of our patient flow for admissions. There is still work to do to ensure more patients are discharged before 10am and 12pm to offset surges in ED attendances that occur later in the day.
Cancer	• Cancer two week waiting times have not changed significantly in the last four months. This process is currently unlikely to achieve the 93% target whilst Breast Services continues not to be able to see the majority of their patients within two weeks, hindered in Feb-21 by additional demand and the requirements of the national screening programme on the services capacity. However, Urology did achieve the operational standard for the first time since Nov-20. • Although now normal variation, cancer two week waits for Breast Symptomatic remains a concern with the majority of patients still not being seen within 14 days. • Cancer 62 day waits is showing special cause concern as a result of more of our breaching patients received their first treatment in Feb-21. Performance will not improve to the operational standard whilst we rightly focus on the cohort of patients requiring treatment. • **Long Waits:** The backlog of patients waiting over 62 days has decreased to 238; this is still above the phase 3 trajectory. Of this cohort those waiting over 104 days has also decreased below 100; our internal target of zero patients cannot be met until more services and pathways are restored.
RTT	• RTT remains a cause for concern; although the number of COVID-19 inpatients decreased in Feb-21, elective treatments and surgery were still limited. The waiting list has grown for 8 of the last 9 months, and there are now more patients waiting 52+ weeks than between 40 and 52 weeks. The inpatient waiting list was over 11,000 at the end of Feb-21; this is the group of patients we are planning to target first as part of the recovery plan. 18,205 patients are waiting for the first outpatient appointment. • **Long Waits:** 5,608 patients (13% of the RTT waiting list) are now waiting over 52 weeks for their treatment. 1,012 of those patients waiting 52+ weeks have been waiting over 70 weeks and approximately 82% remained undated. The profile of the very long waiters hasn't change with 34% of patients requiring orthodontic treatment or oral surgery. We remain on track to our forecast of 6,500 patients over 52+ weeks at the end of Mar-21.
Outpatients	• Feb-21 saw the continuation of cancelled outpatient activity at WRH and ALX, and utilising KTC as much as possible. Although we undertook fewer appointments in Feb-21 than Jan-21, the adjustment in the forecast for half term meant that we were a similar number of appointments, 6,124 compared to 6,130, below the phase 3 forecast for the month. Similarly to Jan-21, the lost activity in Feb-21 was primarily face to face appointments. Non-face to face first appointments exceeded the Phase 3 forecast by 597 appointments; this is consistent with previous months. Non-face to face follow-up appointments were 1,467 below plan, but this remains consistent with previous months.
Theatres	• Although non-elective and cancer surgery theatre procedures were maintained through Feb-21, many routine day case and elective surgery procedures were cancelled, particularly on the WRH and ALX sites. The Independent Sector undertook some day case and elective activity, but only at the level of Jan-21.
Diagnostics	• Diagnostic testing remains a cause for concern; the process is currently not capable of achieving the 1% target. Increases in endoscopy activity, even with ICU surge capacity held at the ALX and 16 lost lists, was offset by reductions in imaging and physiology tests; e.g. WLIs were not carried out for non-obstetric ultrasound, routine OP activity was ceased for neurophysiology and only urgent echocardiography patients were seen by the service. • **Long Waits:** 4,684 patients are waiting over 6 weeks for their diagnostic test and of the total number of breaches, 1,800 have been waiting over 13 weeks.

Operational Performance: Urgent care and patient flow including Home First Worcestershire

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

12 Hour Breaches	Ambulance Handover Delays (Home First Programme metric)			Average Occupancy			
	15-30 mins	30-60 mins	60+ mins				
12	817	251	170	WRH	88.86%	ALX	60.93%

What does the data tell us?

- **EAS** - The overall Trust EAS performance which includes KTC and HACW MIUs was 75.99% in Feb-21, compared to 73.35% in Jan-21. The EAS performance at WRH increased by 0.44 percentage points with 172 **fewer** ED attendances and 86 **fewer** 4 hour breaches than Jan-21 (Feb-21 breaches were 4,939). The ALX EAS increased by 2.75 percentage points, with 139 **fewer** attendances and 125 **fewer** 4 hour breaches (Feb-21 breaches were 643). Total Type 1 attendances across ALX and WRH was 8,412; a 3.5% **decrease** on the previous month.
- **EAS Type 1:** Our performance across the two sites, from Apr-19 to Feb-21, was 70.71% with 41,299 patients breaching 4 hours. Our performance for Apr-20 to Jan-21 is 80.62% with 18,974 patients breaching; this is a 54% reduction in patients breaching 4 hours. We have had 16,330 fewer patients attend ED in the ten months of 20/21.
- **Ambulance Handovers** - There were 170 x 60 minute ambulance handover delays with breaches at both sites.
- **12 hour trolley breaches –** There were 12 validated 12 hour trolley breaches in Feb-21; we have reported 78 12 hour trolley breaches in 20/21 compared to 908 by the end of Feb-20.
- **Specialty Review times** – Specialty Review times remain within normal variation; however this is under the target that has been set.
- **Discharges** – Before 12pm discharges (on non-COVID wards) is showing no significant change however the process will not achieve the target of 33%. The number of patients with a length of stay in excess of 21 days increased from 57 (at 31st January) to 73 with 16 being MFFD.
- **Total Time in A&E:** The 95th percentile for patients total time in the Emergency departments has decreased from 742 in Jan-21 to 830 in Feb-21 . This metric has returned to normal variation and the process is unlikely to consistently achieve our target of 380 minutes but may be expected to vary between 315 and 749 minutes.

What have we been doing?

Clinical Site Management

- Discharge Group now in place with appropriate stakeholders to address any pathway issues
- Nursing team are trialling use of first iteration of the new electronic referral / handover system
- Commenced 3 times per day surgical huddles to discuss electives, discharges and outliers, and commenced daily meetings with Theatres .

Acute Patient Flow

- Three times weekly review for all patients over 19 days on WRH combining the R2G/ SAFER focus with LLOS
- White Board audits continue twice weekly to review compliance which is improving on both sites.
- Golden Discharge 'form' given to all wards to identify one Golden discharge to be completed by 4pm daily

Acute Front Door

- CCG agreement confirmed to extend funding for ANP role until end April
- Virtual clinics team have received technical equipment allowing a trial of virtual AEC review clinics
- Daily capacity huddle meetings ensuring daily focus on the need for 22 spaces to be emptied on MAU before 12pm
- Trialled separation of ED and IP scanning by using the new WRH CT scanner in Oncology.

Frailty

- Attendance at the ICWR Programme Board Patient Portal & Care Plans Workstream to progress ReSPECT as part of the Integrated Care Wellbeing Record (ICWR)
- ED to start recording CFS Scores – a Nurse Champion has been identified to develop a consistent model of service and will audit CFS recording and manage non-compliance

Operational Performance: Urgent care and patient flow including Home First Worcestershire

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

Total time in A&E – 95th percentile (Target – 360 mins)	Overnight Bed Capacity Gap (Target – 0)	30 day re-admission rate (Dec-20)	Aggregated patient delay (APD) (Target – 0)	Discharges as a % of admissions – (Target >100%)			
830	23 Beds	3.82%	556	WRH	102.3%	ALX	99.3%

What does the data tell us?

- **Bed Capacity** - Our G&A bed base is 761; with closed wards and unused beds during Feb-21 our average number of G&A beds occupied per day was 561, up from 551 the month before; the average occupancy was 73.72%.
- **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.
- **Aggregated patient delay (total time in department for admitted patients only per 100 patients – above 6 hours) –** this indicator now shows special cause variation for Feb-21 and the process indicates we cannot achieve the target of zero.
- **Conversion rates** – 2,946 Type 1 patients were admitted in Feb-21; a Trust conversion rate of 35.90%. The conversion rate at WRH was 37.80% and the ALX was 33.31%. The conversion rate at WRH in Feb-21 compared to Feb-20 is 8.67 percentage points higher continuing the trend of higher acuity for patients attending the Emergency Department; on 11 days in the month the conversion rate was greater than 40% at WRH, and includes one day at 46% and 5 days at ALX.
- **15 minute time to triage –** The Trust performance is 90.4%, showing no significant change; the process will not achieve the target of 95% consistently but may be expected to vary between 88% and 97%. It is the same at site level, with no significant change for WRH or ALX.

What are we doing next?

Clinical Site Management

- Identify root causes of complex discharge delays at the weekend and ensure Discharge Group agree actions to address them
- Identify the challenges around capturing accurate and timely EDD's and provide update to HFW Board regarding problems/achievements/solutions
- Work stream objectives to be confirmed at the first Transformation Group meeting to ensure all stakeholders are aware of roles and responsibilities to achieve objectives

Acute Patient Flow

- Therapy Flow Team to work with wards to establish prioritization of patients
- Review ward rounds following the introduction of Modern Ward Round paper which has been devised by RCN and Royal College of Physicians
- Flow Team to collect Golden discharge information and work with wards and divisions to book transport and complete EDS/TTO's the day prior to discharge

Acute Front Door

- PDSA trial Progress Chaser escalation process within the ED departments across both sites and monitor Progress Chasers compliance with their new escalation role
- Commence collaborative work with ED Progress Chasers and Radiology CT Helpdesk to improve management, prioritisation and escalation of Radiology referrals from ED
- Explore opportunities around public health funding to support ED / SDEC and social prescribing

Frailty

- Clinical Service Improvement Lead Frailty presenting at Worcestershire Health and Wellbeing Board 30th March with CCG Exec Strategy and Transformation re the Health and Wellbeing Strategy - Theme Champions 'Living Well in Later Life'
- WAHT ICOPE Worcestershire Collaborative, next meeting 4th April, with a focus on the delivery of frailty in H&W Integrated Care System

Current Assurance Level: 5 (Feb-21)	**When expected to move to next level of assurance:** This is dependent on the on-going management of COVID-19 second wave and achieving operational standards.
Previous assurance level: 5 (Jan-21)	**SRO: Paul Brennan**

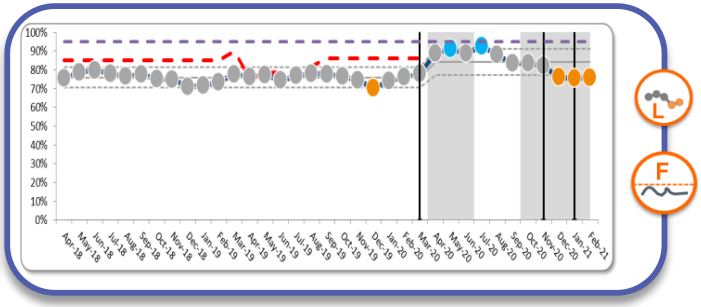
Month 11 [February] 2020-21 | Operational Performance: Urgent Care & Patient Flow

Responsible Director: Chief Operating Officer | Validated for Feb-21 as 4th March 2021

NHS Worcestershire Acute Hospitals NHS Trust

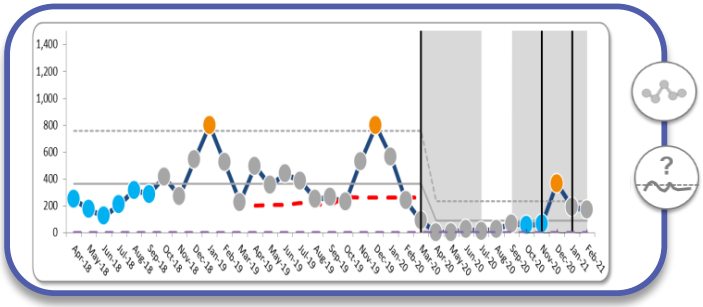
4 Hour EAS (all)

75.99%



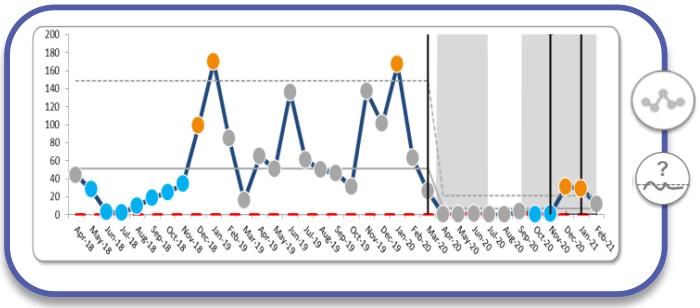
60 minute Ambulance Handover Delays

170



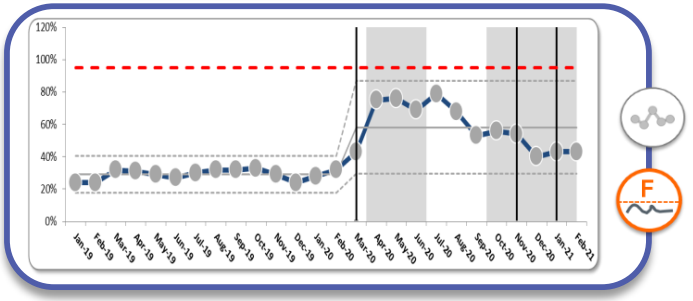
12 Hour Trolley Breaches

12



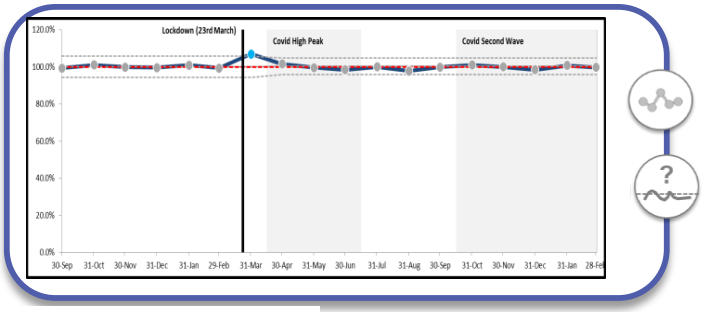
Specialty Review within 1 hour

43%



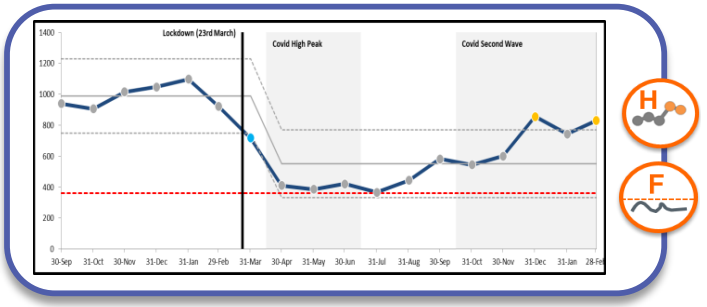
Discharge as a percentage of admissions

99.64%



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

830



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

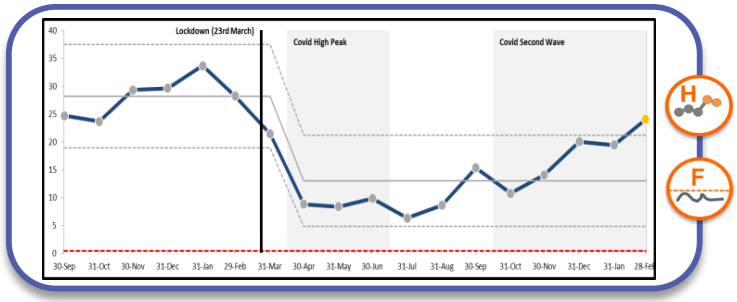
- Internal target
- Operational standard

Month 11 [February] 2020-21 | Operational Performance: Urgent Care & Patient Flow

Responsible Director: Chief Operating Officer | Validated for Feb-21 as 4th March 2021

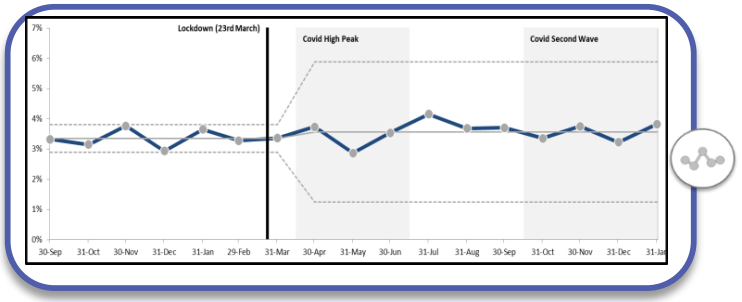
Capacity Gap (Daily avg. excl. EL)

23.6



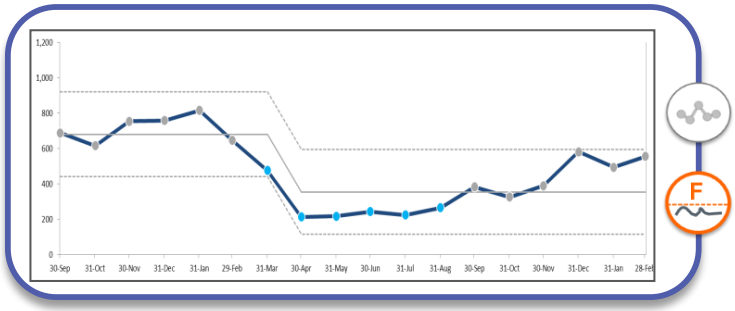
30 day readmission rate for same clinical condition (Jan-21)

3.82%



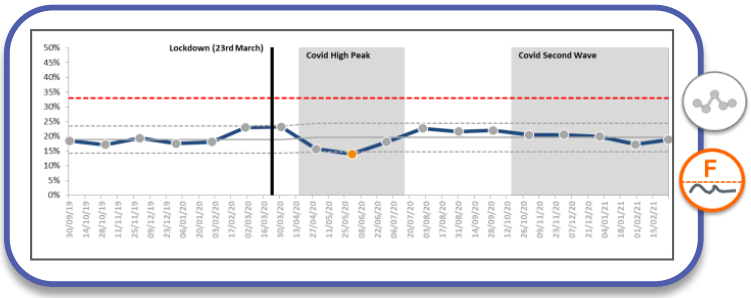
Aggregated Patient Delay (APD)

556



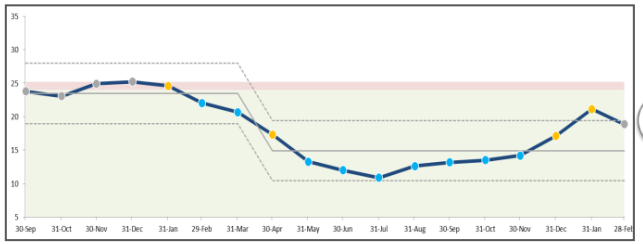
% Discharges before midday (non-COVID wards)

18.90%



Average LOS in hours in AMU – Zone 2 (in hours) (Trust)

18.9



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 (February 2021)

EAS (All) - The Trust was one of 13 of 13 West Midlands Trusts which saw a improvement in performance between January and February. This Trust was ranked 9th of 13; where we were 6th previous month. The peer group performance ranged from 65.73% to 89.11% with a peer group average of 77.57%; improving from 70.34% the previous month. The England average for February was %, a 5.4 percentage point increase from 78.50%, in January.

EAS (Type 1) - The Trust was one of 13 of 13 West Midlands Trusts which saw an improvement in performance between January and February. This Trust was ranked 8th of 13; where we were 6th previous month. The peer group performance ranged from 60.44% to 88.16% with a peer group average of 70.55%; improving from 61.98% the previous month. The England average for February was 70%, a 1.1 percentage point decrease from 71.10%, in January.

In Jan-21, there were 1,038 patients recorded as spending >12 hours from decision to admit to admission. 12 of these patients were from WAHT; 1.15% of the total..

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

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

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

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

WAHT — Operational Standard 95%

Operational Performance: Cancer

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

Cancer Referrals	Patients seen within 14 days (2WW) (All Cancers)	Patients seen within 14 days (2WW) Breast Symptomatic	Patients treated within 31 days	Patients treated within 62 days	Total Cancer PTL	Backlog of patients waiting 63 days or more	Of which, patients waiting 104 days or more
1,982	85.97% (1,689 total seen)	38.46% (91 total seen)	94.74% (228 total treated)	61.41% (155.5 total treated)	1,990	238	93

What does the data tells us?

- **Referrals:** there has been no significant change in referrals since Jun-20, although the we have dropped below the mean. There are no significant changes in referrals at specialty level; although Breast, Gynaecology, Skin Upper GI and Urology have seen increases in their referrals this month.
- **2WW:** The Trust saw 115 fewer patients in Feb - 21 than Jan -21 and 85.97% were within 14 days. The Breast service saw 298 patients but only 39.3% were within 14 days. Of the 241 breaches, 182 (75%) were attributable to Breast Services. Across all tumour sites, only 37 2WW breaches were due to patient choice.
- **2WW Breast Symptomatic:** The Trust saw no significant change in patients referred for breast symptoms and the waiting time performance is 38.46%. The waits have decreased to between 15 and 19 days however, the process is very unlikely to achieve the 93% target.
- **31 Day:** Of the 228 patients treated in Feb-21, 216 waited less than 31 days for their first definitive treatment from receiving their diagnosis. This showing normal variation and the process is still likely to achieve the target but not consistently. The decision to halt cancer (and all elective) surgery at WRH and the ALX is impacting waiting times.
- **62 Day:** There have been 155.5 recorded first treatments in Feb-21 to date and 61.41% within 62 days. This does continue the trend of no significant change in variation since Aug-19 and, currently, the 85% target is not achievable.
- **Cancer PTL:** As at the 1st March there were 1,990 patients on our PTL with 122 having been diagnosed and 994 still suspected. The remaining 874 patients were between 0-14 days.
- **Backlog:** Of the 1,990 patients, the number waiting 62+ days for their diagnosis and, if necessary, treatment decreased from 282 in Jan-21 to 238 in Feb-21; this is still tracking above our February phase 3 forecast of 212. Of that cohort, the number of patients waiting 104 days or more is 93, 27 diagnosed and 66 suspected; this metric cannot currently meet the target of zero.
- **Conversion rates:** In 2019 the Trust's conversion rate from referral to positive diagnosis was 9.40% across all specialties. In 2020, to Dec-20, our conversion rate is 10.49%, however this is in the context of fewer total referrals and, fewer positive cases.

What have we been doing?

- The increase in 2WW performance for February 2021 was driven by improvements in both Urology and Breast, which saw the former deliver the 2ww standard for the first time since November 2020. Unfortunately the predicted improvement in Breast has not been continued into March 2021 due to another spike in demand.
- Continued use of the independent sector (IS) to provide some operating capacity (though significantly less than during the first wave) and of Star Chamber to risk assess and prioritise cancer patients for their surgery at both the WRH and ALX sites.
- Continued to work collaboratively with the PCN that sees all cancer patients offered a Covid-19 vaccination ahead of starting their cancer treatment (surgery, chemotherapy and radiotherapy) to protect against increased mortality risks.
- Reopening of Aconbury 1 at WRH as a true purple pathway / ward

What are we doing next?

- Reopening of the ALX from w/c 15th March 2021 in a phased manner over the next 4 weeks, which will see increases in both the number and complexity of cases delivered week on week. This includes reopening of the UIC at the ALX which will greatly help to reduce the diagnostic backlog within Urology.
- Prioritisation of available theatre lists / elective beds to be via the established Restoration Group to allocate on a service priority as opposed to individual patient basis going forwards.
- Reinstatement of Performance Management Group (PMG) meeting with focus of producing Remedial Actions Plans (RAPs) by speciality for recovery of the cancer performance standards
- Working with primary care to deliver earlier second vaccinations for the most vulnerable of cancer patients, where treatment pathways safely allow.

Current Assurance Levels (Feb-21)	Previous Assurance Levels (Jan-21)
2WW - Level 5	2WW - Level 5
31 Day Treatment - Level 5	31 Day 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

SRO: Paul Brennan

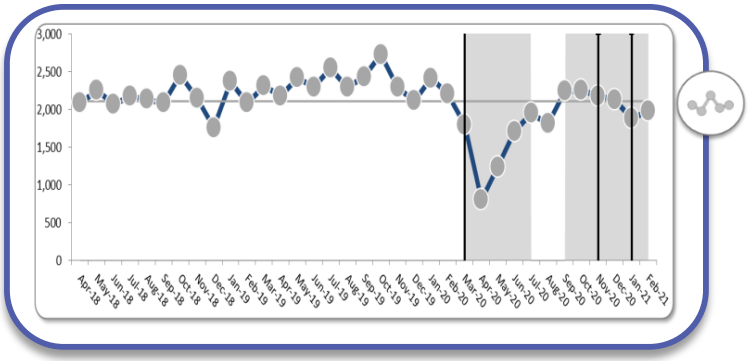
Month 11 [February] 2020-21 | Operational Performance: Cancer

Responsible Director: Chief Operating Officer | Unvalidated for Feb-21 as 9th April 2021

NHS Worcestershire Acute Hospitals NHS Trust

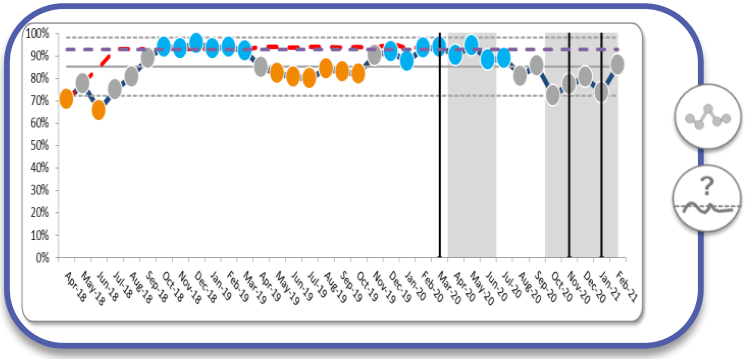
2WW Referrals

1,982



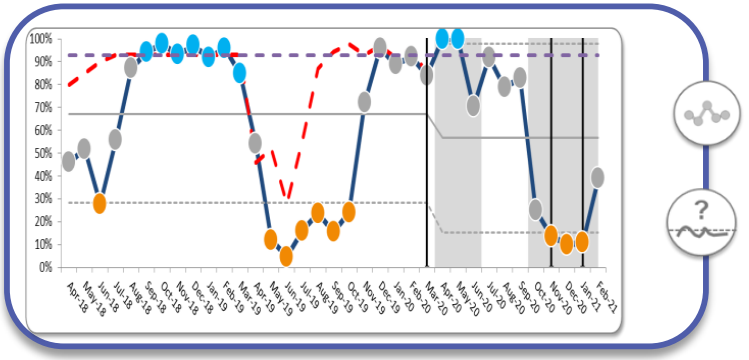
Cancer 2WW All

85.97%



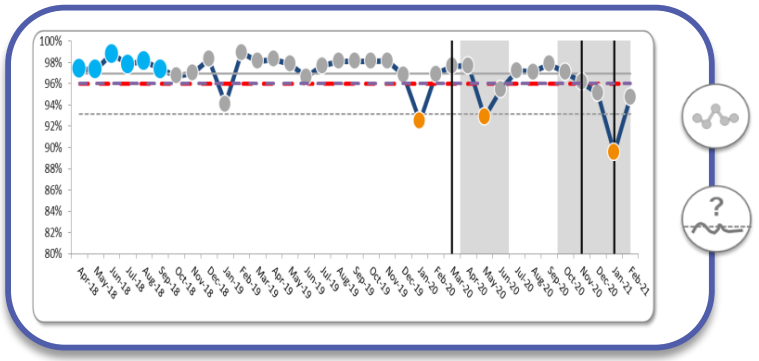
Cancer 2WW Breast Symptomatic

38.46%



Cancer 31 Day All

94.74%



Key

- Internal target
- Operational standard

Lockdown Period

COVID Wave

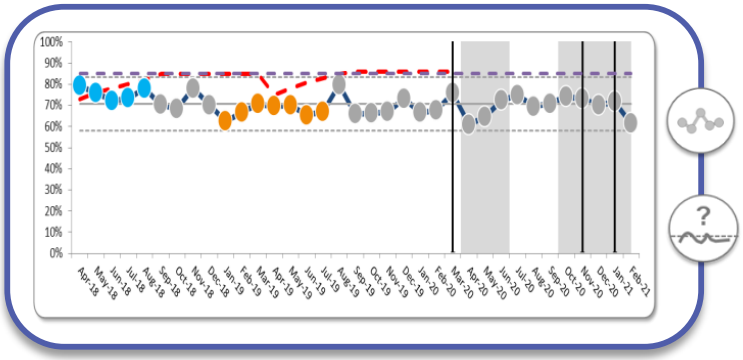
Please note: The **2WW Breast Symptomatic** SPC chart has been re-based to evidence if any changes in performance, post the initial COVID-19 high peak, are now common or special cause variation.

Month 11 [February] 2020-21 | Operational Performance: Cancer

Responsible Director: Chief Operating Officer | Unvalidated for Feb-21 as 9th April 2021

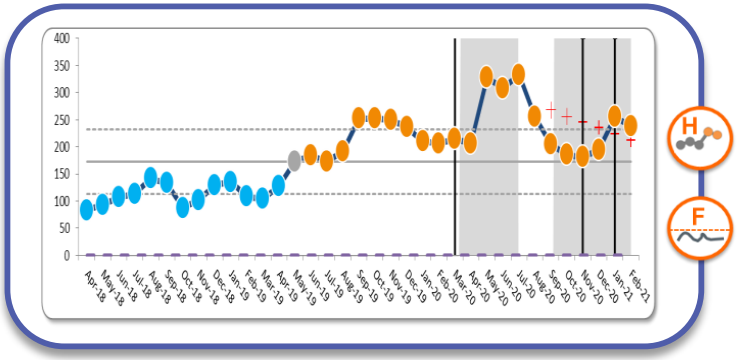
Cancer 62 Day All

61.41%



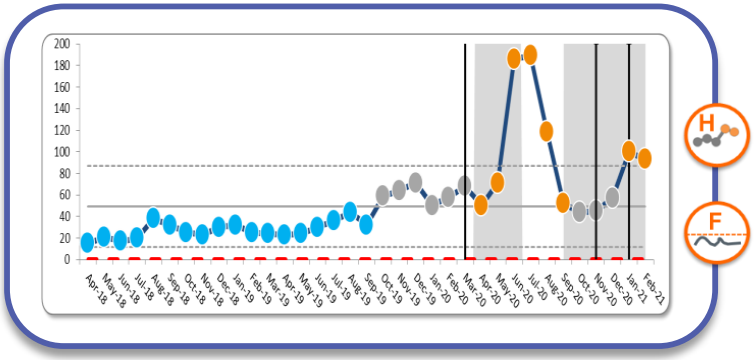
Backlog Patients waiting 63 days or more

238

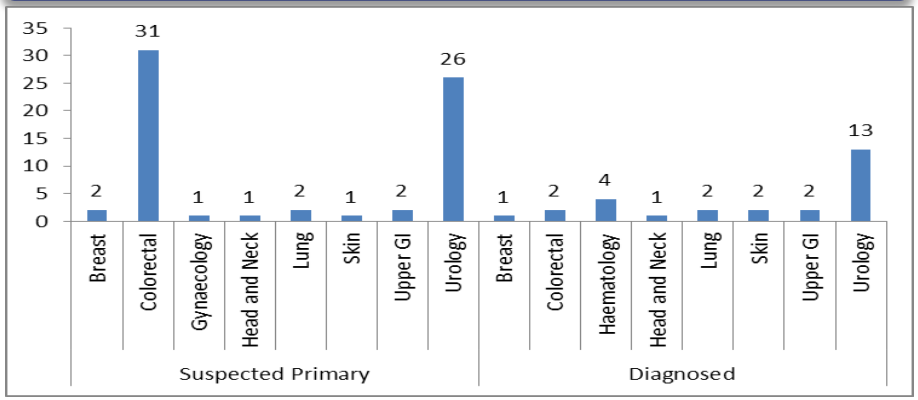


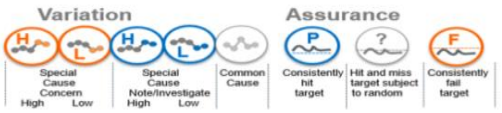
Backlog Patients waiting 104 day or more

93



104+ Day Backlog profile by specialty





Key

\+ phase 3 target

\- Internal target

\- Operational standard

Lockdown Period

COVID Wave

Operational Performance: Cancer Benchmarking

National Benchmarking (January 2021)

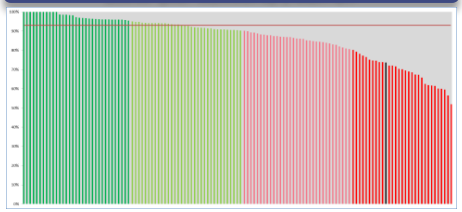
2WW: The Trust was 12 of the 13 West Midlands Trusts which saw an decline in performance between December and January. This Trust ranking is 10 out of 13. The peer group performance ranged from 33.64% to 96.98% with a peer group average of 73.76%; declining from 81.97% the previous month. The England average for January 2021 was 83.39%, a 4.15 percentage point decrease from 87.54% in December.

2WW BS: The Trust was one of 07 of the 13 West Midlands Trusts who saw a improvement in performance between December and January. This Trust was ranked 10 of 13. The peer group performance ranged from 2.13% to 100% with a peer group average of 40.31%; declining from 46.68% the previous month. The England average for January 2021 was 62.67%, a 4.38 percentage point decrease from 67.05%, in December.

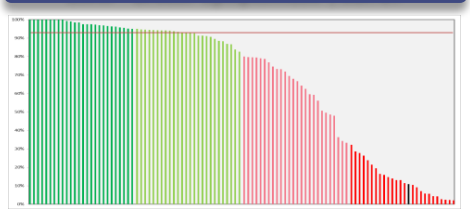
31 days: The Trust was one of 10 of the 13 West Midlands Trusts who saw a decline in performance between December and January. This Trust was ranked 9 of 13. The peer group performance ranged from 82.10% to 100% with a peer group average of 92.23%; declining from 94.16% the previous month. The England average for January 2021 was 94.01%, a 1.99 percentage point decrease from 96%, in December.

62 Days: The Trust was one of 4 of the 13 in the West Midlands Trusts who saw an in improvement in performance between December and January. This Trust its position is 4 of 13. The peer group performance ranged from 32.16% to 77.34% with a peer group average of 61.47%; declining from 64.68%; the previous month. The England average for January 2021 was 71.18% 3.99 percentage point decrease from 75.17% in December.

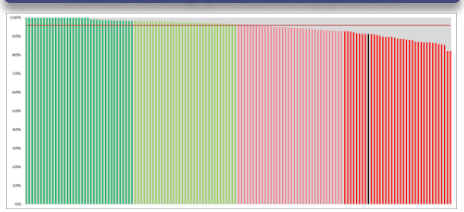
2WW (All cancers) | Jan-21



2WW Breast Symptomatic | Jan-21

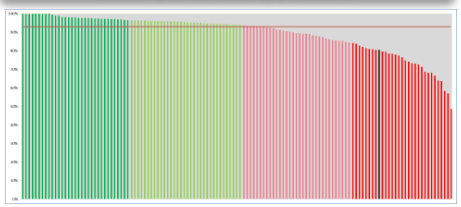


Cancer 31 Day (All cancers) | Jan-21

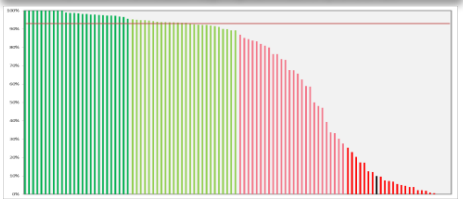


Cancer 62 day (All cancers) | Jan-21

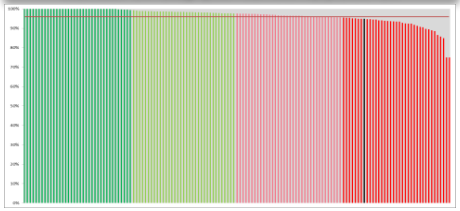
2WW (All cancers) | Dec-20



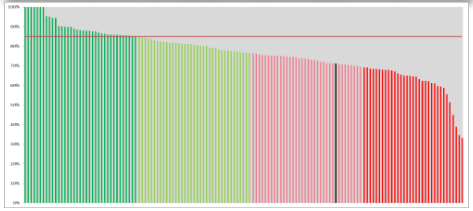
2WW Breast Symptomatic | Dec-20



Cancer 31 Day (All cancers) | Dec-20



Cancer 62 day (All cancers) | Dec-20



WAHT — Operational Standard 93%

WAHT — Operational Standard 93%

WAHT — Operational Standard 96%

WAHT — Operational Standard 85%

Operational Performance: RTT

2.4 - Maintain access to all emergency surgery (inc trauma) and triage elective waiting list to prioritise access for those at greatest risk of harm from delay

Total Waiting List	Number of patients waiting over 18 weeks	Percentage of patients on a consultant led pathway waiting less than 18 weeks for their first definitive treatment	Number of patients waiting 40 to 52 weeks or more for their first definitive treatment	52+ weeks	Of which, waiting 70+ weeks	RTT Referrals (Routine and Urgent) received
43,726	20,434	53.27%	2,887	5,608	1,012	3,527

What does the data tells us?

- The Trust has seen a 3.7% increase in the overall wait list size in Feb-21 compared to Jan-21; from 42,169 to 43,726. This is currently +2,162 more patients on our waiting list than the phase 3 forecast.
- The validated Feb-21 snapshot of the waiting list can be broken down as follows:
  - 11,298 patients on the inpatient waiting list, 3,365 are waiting for an endoscopy.
  - 23,806 outpatients; 18,205 are waiting their first appointment and 5,601 are waiting for a follow-up
  - 883 patients waiting on a diagnostics waiting list (for a test other than endoscopy)
  - 7,739 patients are not on an active waiting list, 1,799 with no previous appointment
- The number of patients over 18 weeks who were unable to be seen or treated has increased to 20,434. This is 1,534 more patients than Jan-21's snapshot. RTT performance for Fe-21 is validated at 53.27% compared to 55.18% in Jan-21. This remains sustained, significant cause for concern from Apr-20 and the 92% waiting times standard cannot be achieved.
- The number of patients waiting between 40-52 weeks for treatment is 2,887, and those patients waiting over 52 weeks which is now 5,608; this is currently +3,434 more patients waiting 52+ weeks than on our phase 3 forecast. The reduction in referrals during wave 1 of the pandemic accounts for the shift in the number of patients waiting over 52 weeks being more than the 40-52 weeks cohort.
- Of the 5,608 patients waiting over 52 weeks, 1,012 have been waiting over 70 weeks with 341 patients requiring oral surgery / orthodontics treatment, 205 requiring T&O treatment and 187 requiring urology treatment.
- Seven specialties have over 1,000 patients waiting over 18 weeks; this is 76% of all our 18 week breaches. Three of those specialties continue to have over 2,000 patients breaching. Those seven specialties contribute 82% of all patients waiting over 52 weeks.
- **Referral Assessment Services (RAS)**: In Feb-21, 3,424 referrals were received through this service to be triaged, 3,055 non-2WW referrals have been outcomed, and 69% of those were outcomed within 14 working days. 2,589 appointments have been booked, 124 referrals were cancelled but there remains 199 referrals awaiting action.
- **Advice and Guidance:** The Trust received 2,140 requests and 90.5% of them were responded to within 2 working days. We have been receiving over 2,000 requests a month since Oct-21 and have been consistently achieving the 80% response within 2 days target since May-20.

Current Assurance level: 4 (Feb-21)	**When expected to move to next level of assurance:** This is dependent on the on-going management of COVID-19 second wave, the restoration of elective activity and reduction of long waiters
Previous Assurance Level: 4 (Jan-21)	**SRO: Paul Brennan**

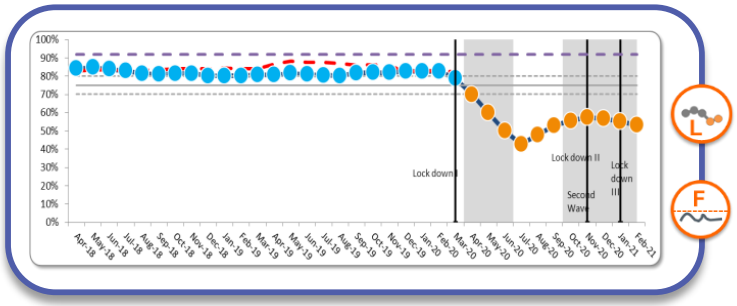
Month 11 [February] 2020-21 | Operational Performance: RTT

Responsible Director: Chief Operating Officer | Validated for Feb-21 as 17th March 2021

NHS Worcestershire Acute Hospitals NHS Trust

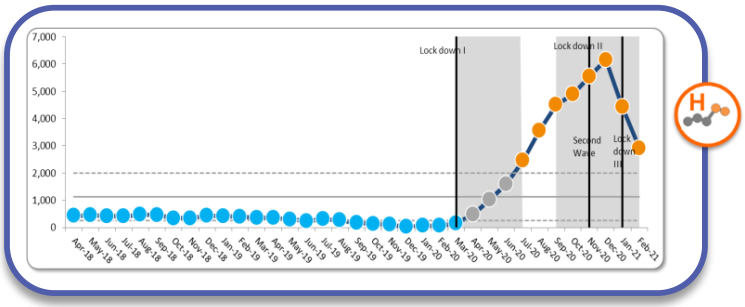
RTT % within 18 weeks

53.27%



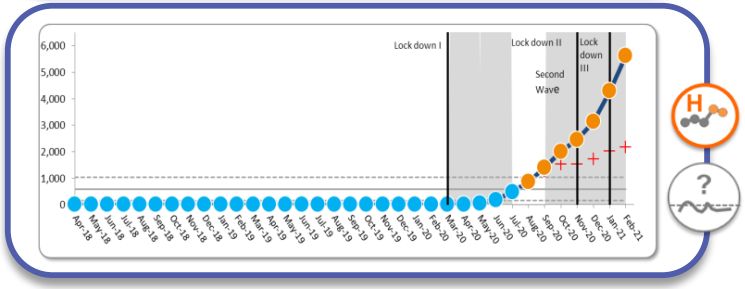
40-52 week waits

2,887



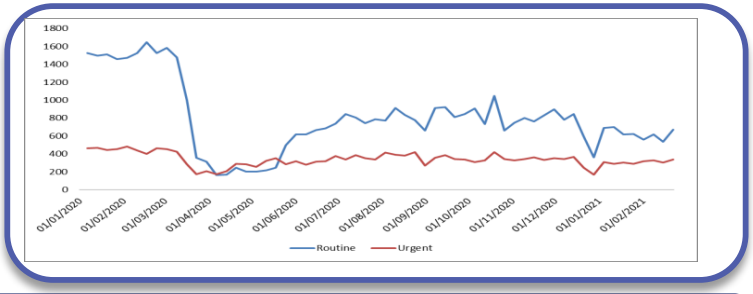
52+ week waits

5,608

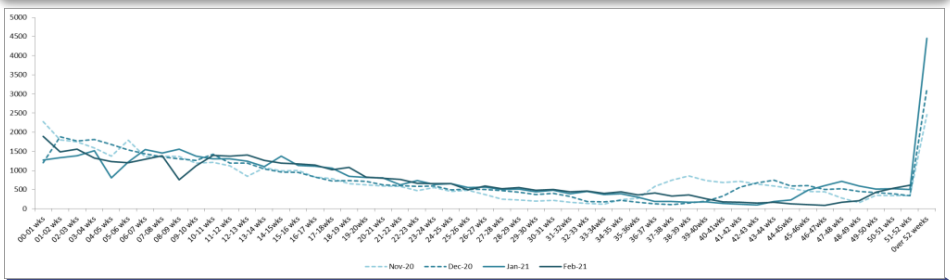


RTT Referrals Profile

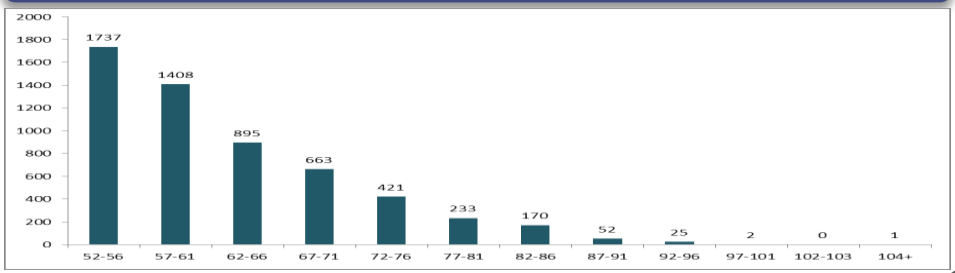
3,670



RTT waiting list profile (Nov-20 to Feb-21) by weeks waiting



RTT waiting list profile (Feb-21) | 52+ weeks



Variation: Special Cause Concern High/Low; Special Cause Note/Investigate High/Low; Common Cause

Assurance: Consistently hit target; Hit and miss target subject to random; Consistently fail target

Key

\+ phase 3 target

\- Internal target

\- Operational standard

Operational Performance: RTT Benchmarking

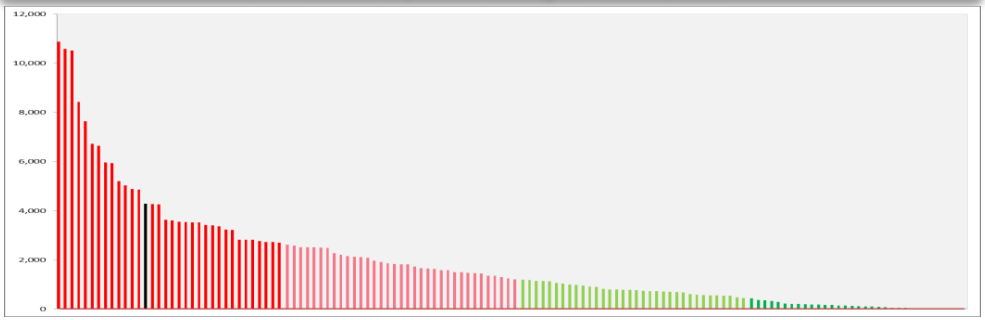
2.4 - Maintain access to all emergency surgery (inc trauma) and triage elective waiting list to prioritise access for those at greatest risk of harm from delay

National Benchmarking (January 2021) | The Trust was one of 12 of the 13 West Midlands Trusts who saw a decline in performance between December and January. This Trust is now ranked at 13 of 13.The peer group performance ranged from 55.21% to 80.56% with a peer group average of 68.08%; declining from 66.29% the previous month. The England average January 2021 was 66.2%, a 1.3 percentage point decrease from 67.8%, in December.

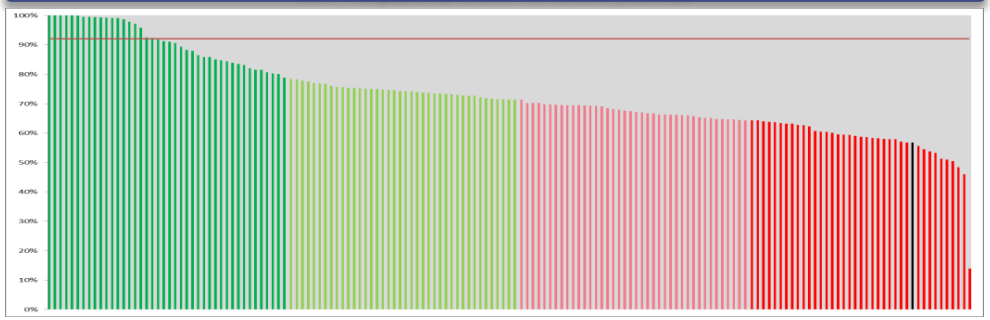
Nationally, there were 304,044 patients waiting 52+ weeks, 4,273 (1.4%) of that cohort were our patients.

RTT - % patients within 18 weeks | Jan-21

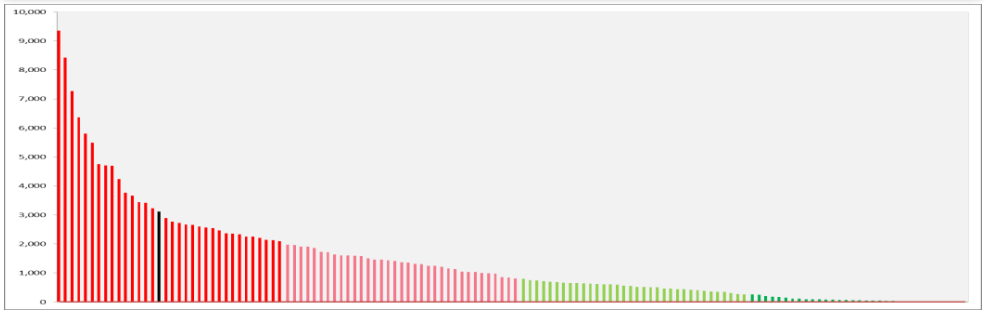
RTT – number of patients waiting 52+ weeks | Jan-21



RTT - % patients within 18 weeks | Dec-20



RTT – number of patients waiting 52+ weeks | Dec-20



WAHT — Operational Standard 92%

Operational Performance: Outpatients and Planned Admissions (including Phase 3)

2.4 - Maintain access to all emergency surgery (inc trauma) and triage elective waiting list to prioritise access for those at greatest risk of harm from delay

News Face to Face (excl OP+ – all other activity)	News Non Face to Face (excl OP+ – all other activity)	News % Non Face to Face	Follow ups Face to Face (excl OP+ – all other activity)	Follow ups Non Face to Face (excl OP+ – all other activity)	Follow ups % Non Face to Face	Total % Non Face to Face
7,322	2,376	24.41%	10,352	10,501	50.36%	42.15%

Outpatients - what does the data tell us?

- The Trust undertook 30,551 outpatient appointments in Feb-21. This is 11,981 fewer appointments than Feb-20 (72% of Feb-20 activity), and 2,969 fewer appointments than Jan-21. When looking specifically at consultant led activity, in line with phase 3 restoration monitoring expectations, we achieved 73% of our submitted plan activity.
- In Feb-20, 2,001 non-face-to-face appointments took place which increased to 12,877 in Feb-21. Of all appointments in the month, 42.15% (both new and follow-up) were non-face-to-face.
- As at 17th March the outpatient backlog for all **new** outpatients was 49,456 with 21,401 on an RTT pathway and 28,055 on a non-RTT pathway. 6,651 patients had been dated which leave 42,805 not yet dated. 40,164 patients of the total new outpatient waiting list are deemed to be routine.
- Looking specifically at our phase 3 plan, we undertook 16,356 appointments against a target of 22,480. Our area of success continues to be Consultant-led first outpatient attendances (telephone/video) where we were +597 to plan.

Planned Admissions - what does the data tell us?

- On the day cancellations shows no significant change since Jun-20
- Theatre utilisation has returned to the mean, at 71.9%; noting that 92% of the day case and elective activity (on elective theatre sessions) took place at KTC.
- From our inpatient elective monitoring, day case spells were -724 below and ordinary spells were -268 below our phase 3 forecasts as we limited our elective activity across our sites.
- We maintained a similar number of non-elective (447) and cancer (104) theatre activity in Feb-21 when compared to Jan-21.
- The Independent Sector undertook 105 day cases and 14 electives; this was only 3 more elective admissions compared to Jan-21.

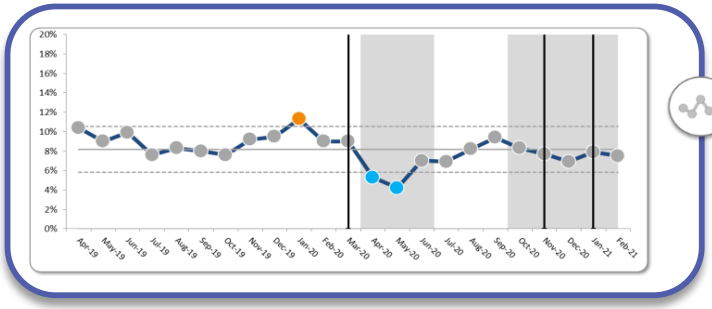
Current Assurance Level: 4 (Feb-21)	**When expected to move to next level of assurance:** This is dependent on the on-going management of COVID-19 second wave allowing for the restoration of outpatient appointments and planned admissions for surgery
Previous Assurance Level: 4 (Jan-21)	**SRO: Paul Brennan**

Month 11 [February] 2020-21 | Operational Performance: Theatre Utilisation & Outpatients

Responsible Director: Chief Operating Officer | Unvalidated for Feb-21 as 4th March 2021

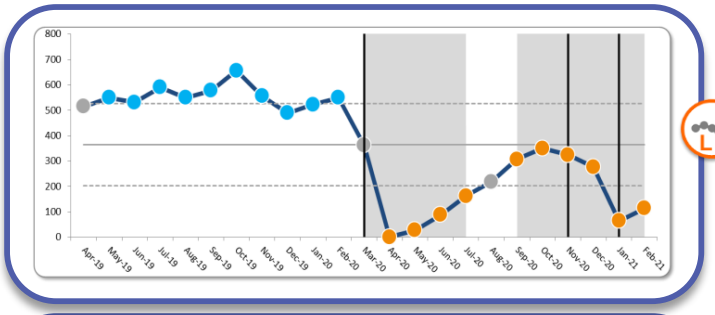
On the day cancellation as a percentage of scheduled procedures (%)

7.50%



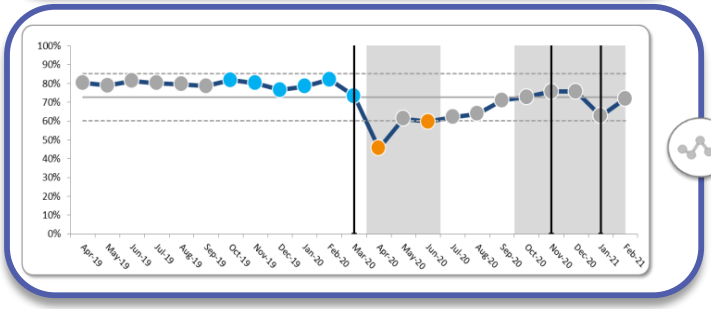
Electives on elective theatre sessions (n)

114



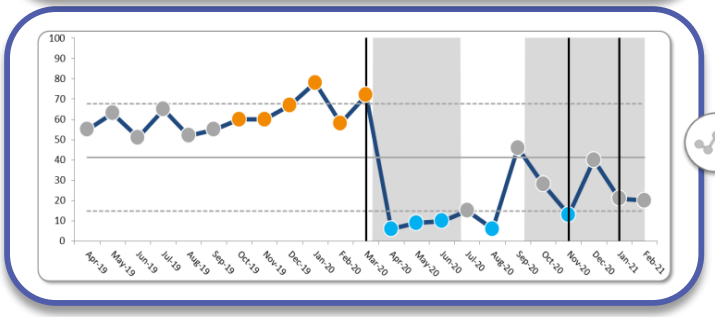
Actual Theatre session utilisation (%)

71.90%



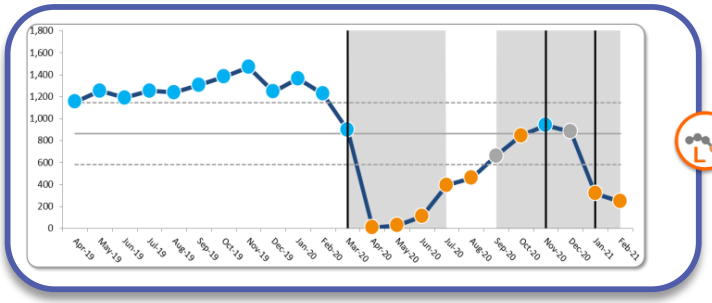
Non-electives & emergencies on elective theatre sessions (n)

20

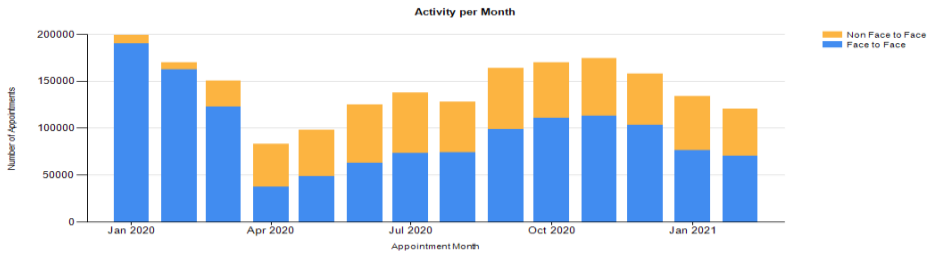


Day cases on elective theatre sessions (n)

247



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



*Phase 3 restoration is based on consultant-led activity only that has been submitted via SUS. This graph is reflective of **all** the Outpatient activity that has been delivered by the Trust.

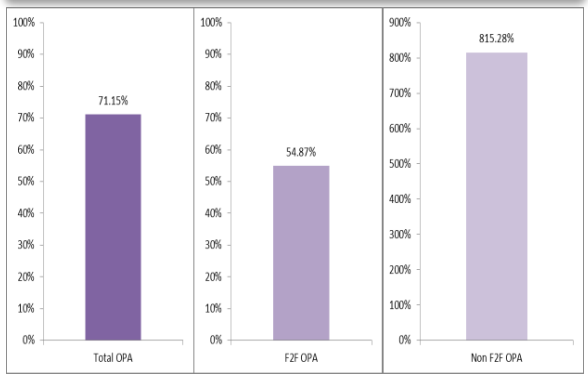
Month 11 [February] 2020-21 | Operational Performance: Outpatients

Responsible Director: Chief Operating Officer | Unvalidated for Feb-21 as 17th March 2021

NHS Worcestershire Acute Hospitals NHS Trust

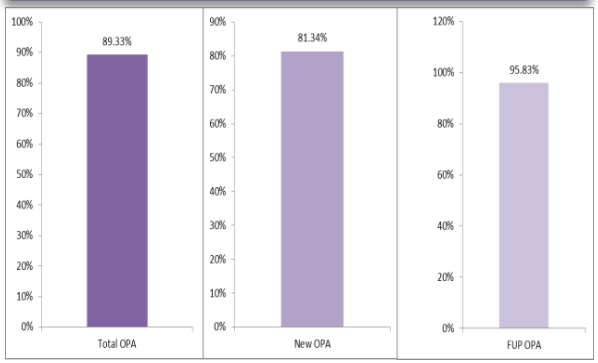
Outpatients Activity | Feb-21 activity as a percentage of Feb-20 activity (all activity apart from excluding OP+)[1]

New

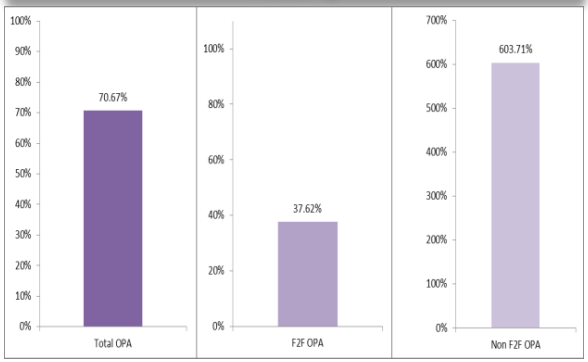


Emergency

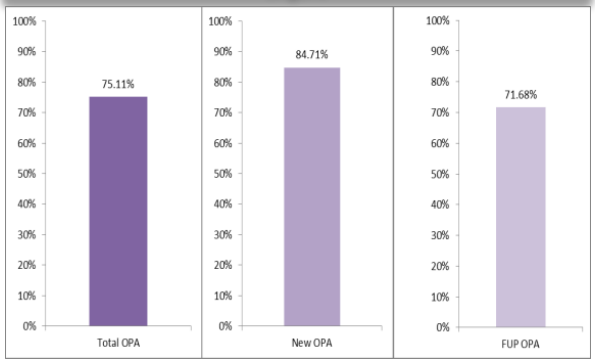
Cancer



Follow up



Urgent



Routine

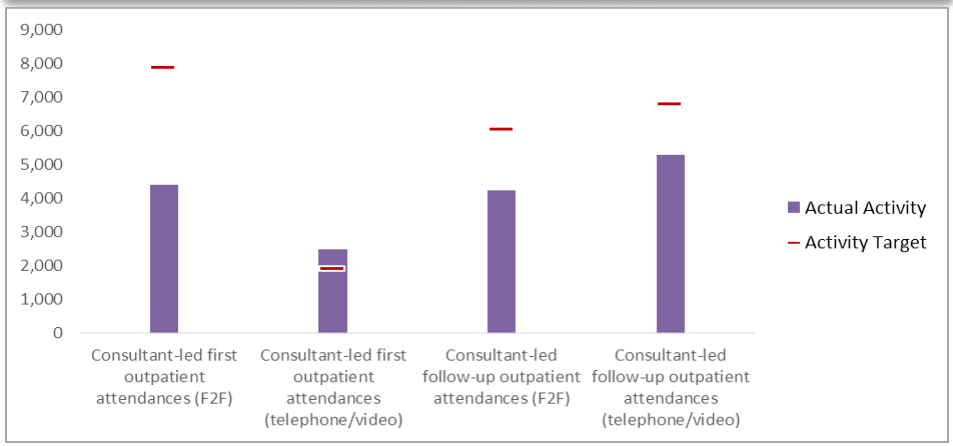
1. These graphs are reflective of all the OPA activity that has been delivered by the Trust - phase 3 restoration is based on consultant-led activity only that has been submitted via SUS.
2. Please note the 1000% scales on the New and Follow non face-to-face activity graphs., This is due to the significant increase in non face-to-face appointments in 2020.

Month 11 [February] 2020-21 | Operational Performance: Outpatients

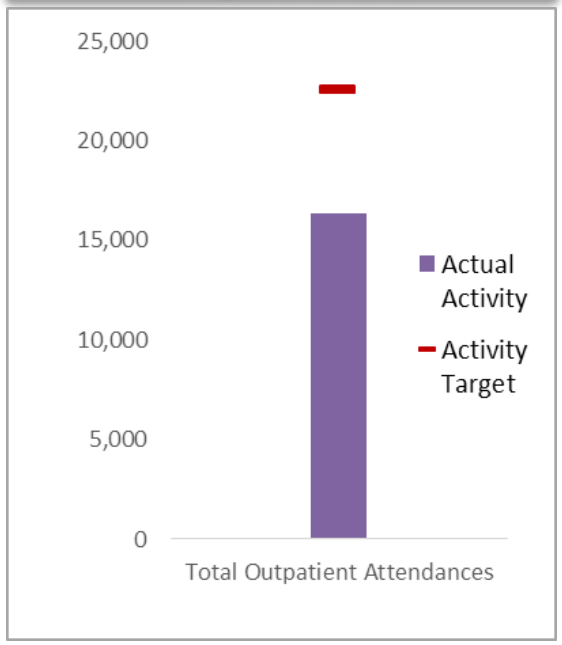
Responsible Director: Chief Operating Officer | Unvalidated for Feb-21 as 17th March 2021

Outpatient attendances and Inpatient Elective activity compared to Phase 3 restoration plan | Jan-20

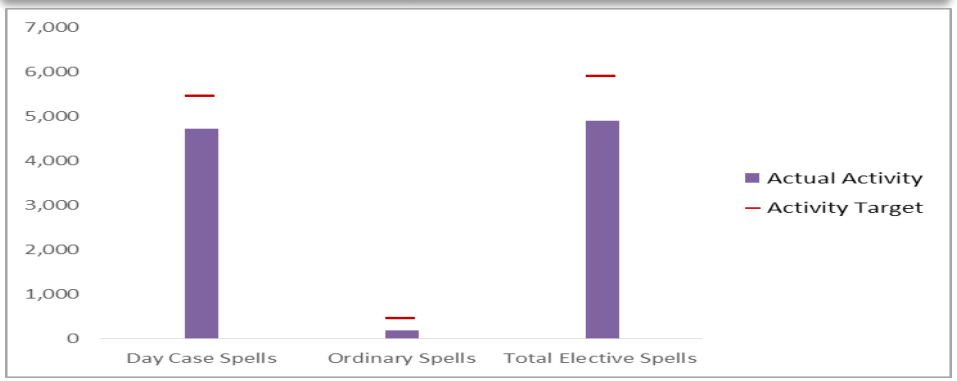
Consultant-led outpatients attendances



Total outpatients attendances



Inpatient Electives



These graphs represent phase 3 restoration only, as submitted in the plan.

Operational Performance: DM01 Diagnostics

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

NHS Worcestershire Acute Hospitals NHS Trust

The total waiting list, the number of patients waiting more than 6 weeks for a diagnostic test, and % of patients waiting less than 6 weeks

Trust Total			Radiology			Physiology			Endoscopy		
8,947	4,684	47.65%	5,132	2,415	52.94%	2,286	1,436	37.18%	1,529	833	45.52%

What does the data tell us?

- The DM01 performance is validated at 47.65% of patients waiting less than 6 weeks for their diagnostic test, no significant change from the previous month and consistent with the sustained underperformance since the cessation of elective diagnostic tests due to COVID-19 created a backlog of patients.
- The diagnostic waiting list has increased with the total waiting list currently at 8,947 patients, an increase of 488 patients from the previous month.
- The total number of patients waiting 6+ weeks has increased by 254 patients (4,430 in Jan-21) and there are now 1,800 patients waiting over 13 weeks (1,533 in Jan-21).
- Radiology has the largest number of patients waiting at 5,132 and has the largest number of patient waiting over 6 weeks at 2,415; an increase of 276 in Feb 21 compared to Jan-21.
- 11,273 diagnostics tests were undertaken in Feb-21, 1.03% more than Jan-21 but 29% fewer test than Feb-20.
- Radiology undertook 292 fewer tests in Feb-21 compared to Jan-21. Comparing to our phase 3 activity target, CT, MRI and MRI non-obstetric ultrasound were all below phase 3 target.
- Endoscopy completed 668 more tests in Feb-21 than Jan-21. Comparing to our phase 3 activity, Flexi Sigmoidoscopy achieved the forecast but colonoscopy and gastroscopy were below.
- Physiology undertook 15 more tests in Feb-21 compared to Jan-21.

RADIOLOGY

What have we been doing?

- Continued utilisation of mobile CT at KTC site
- Continued WLI sessions countywide, staff permitting.
- CT3 installed, used as additional capacity for 2 week period as fifth countywide scanner in between replacement program.
- Continued discussion with CCG re DEXA referral review- continued to provide DEXA appointments

Issues

- Mobile CT at AGH did not materialise as planned on 1st March
- USS breaches are mostly due to being unable to staff WLI as no willingness to carry out sessions on peripheral sites

What are we going to do next?

- Agree contract for continued mobile on KTC site, will be for 16 days per month.
- Continue WLI session in CT, MRI and US.
- Continue DEXA review with CCG
- Staff and utilise CT3 from Jan 2022 following installation of CT1 and KTC replacement
- Reviewing option to increase US at MCH, potential requirement of investment for equipment
- Commence routine CT activity on 15th March 2021 in main CT at AGH following star chamber approval

ENDOSCOPY (inc. Gynaecology & Urology)

What have we been doing?

- Continuing the use of IS at BMI and Spire for SPOT patients; increased numbers of patients being sent over to BMI for scoping
- Continuing with weekend WLI sessions
- Continuing use of 18 Week Support insourcing team providing 18 sessions at ECH and 2 sessions at MCH
- Commenced 'green' lists to capture previously covid-19 positive patients in a timely manner
- Adjusted Urology template to better utilise sessions

What are we going to do next?

- Exploring ways to increase therapeutic capacity
- Working from a risk-stratified PTL for booking patients
- Planning for the re-start of ambulatory services across ALX and WRH sites

Issues

- Total of 16 lists lost throughout February; due to sickness, annual leave and unable to backfill sessions, and/or COVID-19 related absences (re-deployment, shielding)
- Unisoft issues; requiring upgrade to Solus to resolve
- Lack of capacity for therapeutic procedures

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Operational Performance: DM01 Diagnostics

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

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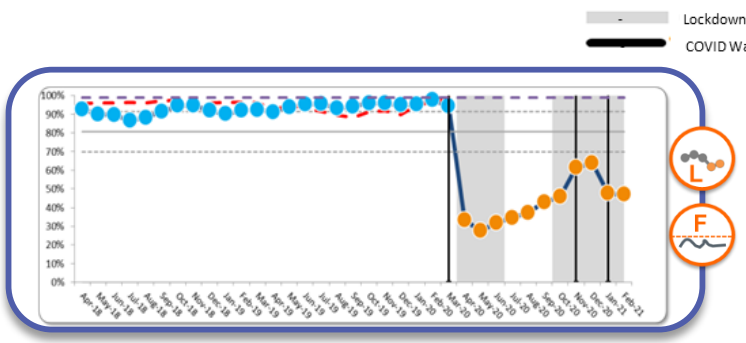
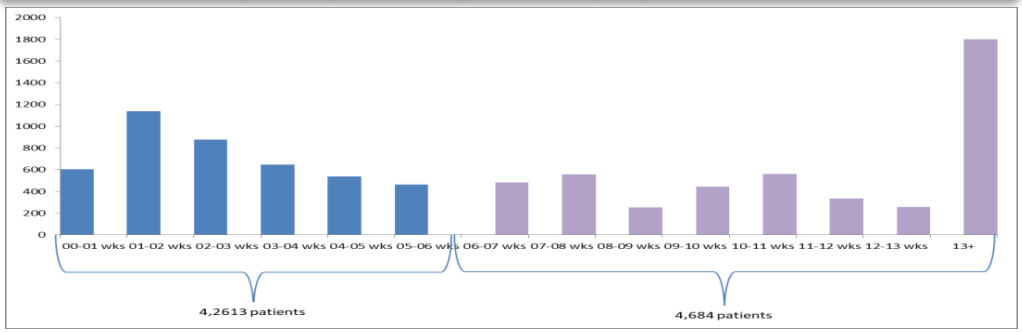
DM01 Diagnostics % patients within 6 weeks

47.65%



Diagnostics (DM01) Waiting List Profile split by 0-6 and 6+ week



NEUROPHYSIOLOGY

What have we been doing?

- All routine outpatient activity has been stopped since the 18th Jan. Only urgent work as approved by the star chamber has continued. This has led to over 1,000 patients sitting on a waiting list with a predicted waiting time of 16 weeks.
- Patients have been receiving well being calls throughout the closure.

What are we going to do next?

- Need approval for clinics to re-start. Once this has been agreed Clinics will resume under the COVID-19 secure restrictions. Future plans will be to look at and get approval for waiting list initiative clinics.

CARDIOLOGY – ECHO

What have we been doing?

- Service currently open to urgent patients only due to second COVID-19 wave
- Restoration of services had been previously approved
- Workloads for all sites currently working on priority through KTC
- Backlog is increasing due to reduced capacity
- WLI clinics are continuing at KTC

What are we going to do next?

- Awaiting approval for restart of activity on all sites
- WLI clinics to continue where possible

Assurance Level: 4 (Feb-21)

Previous assurance level: 4 (Jan-21)

When expected to move to next level of assurance: This is dependent on the on-going management of COVID-19 increasing our capacity for routine activity

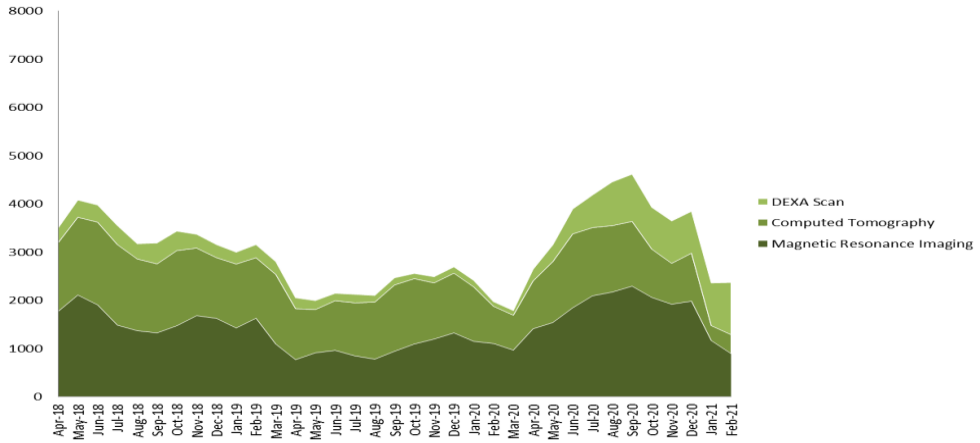
SRO: Paul Brennan

Month 11 [February] 2020-21 | Operational Performance: DM01 Diagnostics

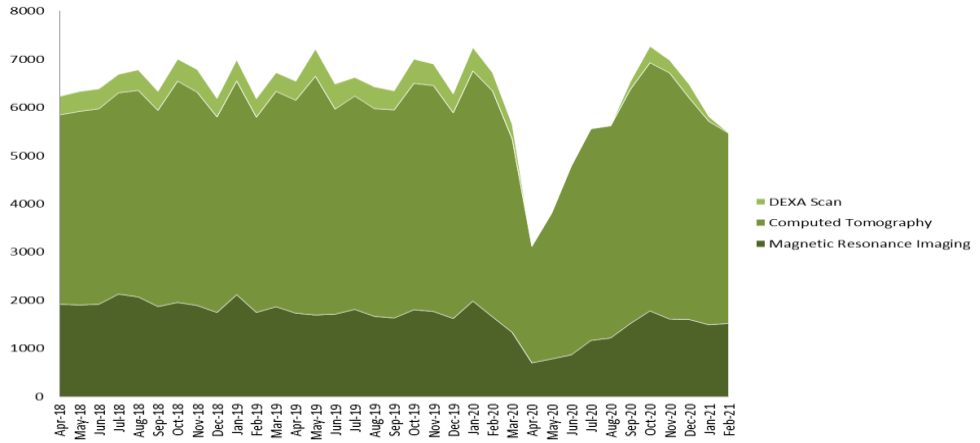
Responsible Director: Chief Operating Officer | Validated for Feb-21 as 17th March 2021

Worcestershire Acute Hospitals NHS Trust

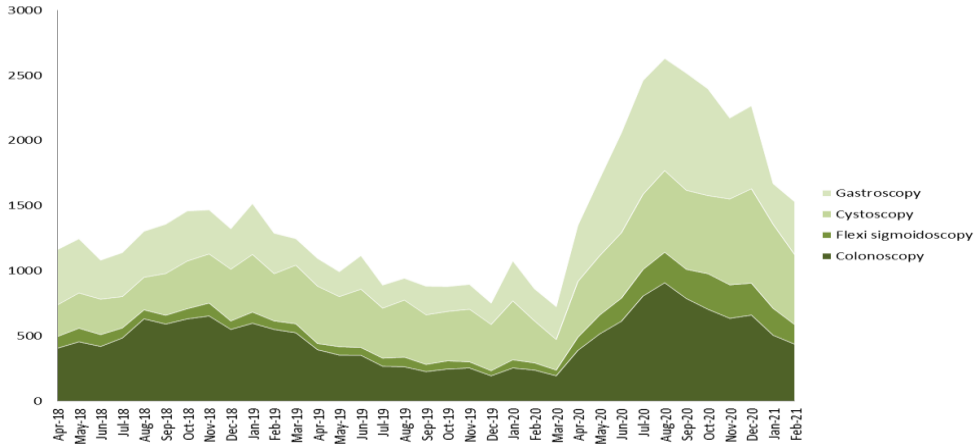
Radiology DM01 waiting list size - Monthly snapshot



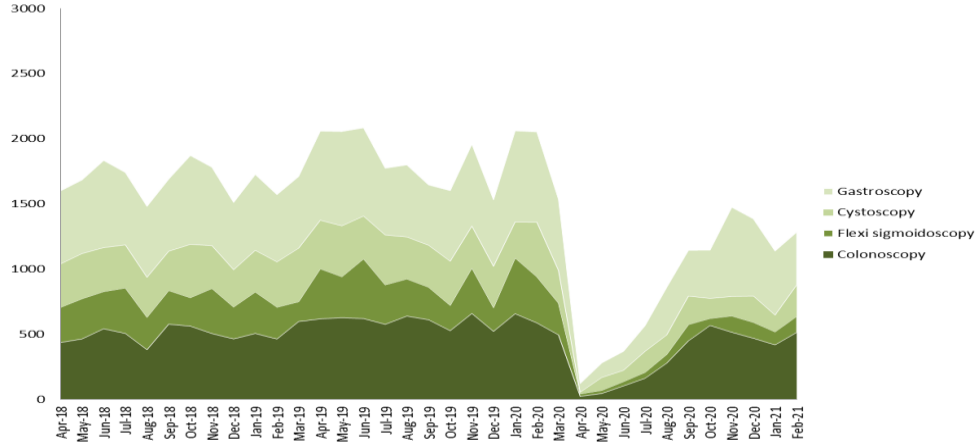
Radiology DM01 Activity - Monthly snapshot



Endoscopy DM01 waiting list size - Monthly snapshot



Endoscopy DM01 Activity - Monthly snapshot



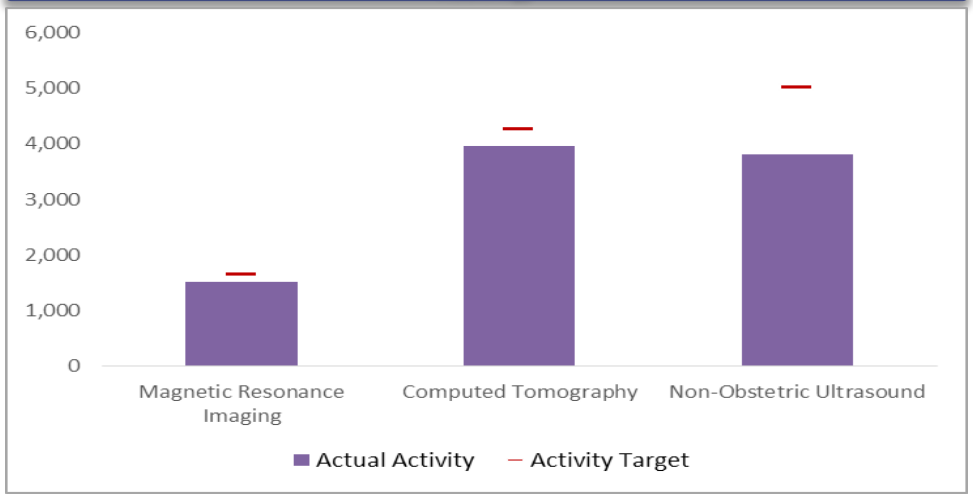
Note the different scaled axis on the graphs when comparing them

Month 11 [February] 2020-21 | Operational Performance: DM01 Diagnostics

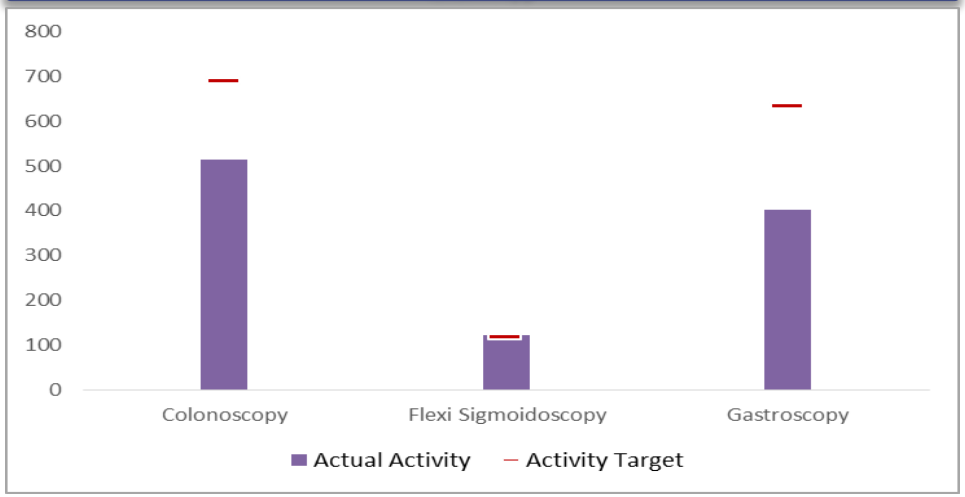
Responsible Director: Chief Operating Officer | Validated for Feb-21 as 17th March 2021

DM01 Diagnostics Activity | Jan-20 Diagnostic activity compared to Phase 3 restoration plan

Radiology



Endoscopy



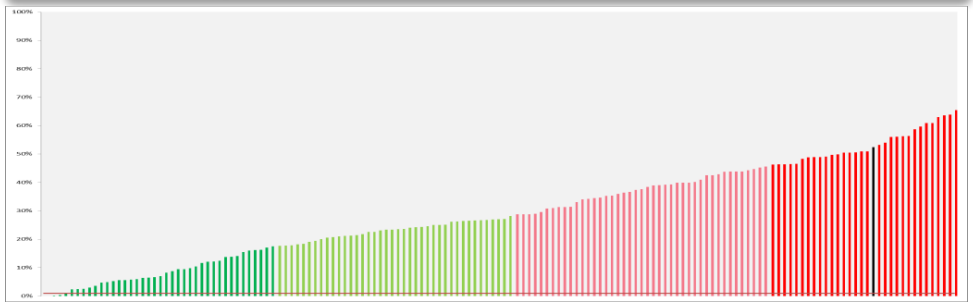
These graphs represent phase 3 restoration only, as submitted in the plan. All physiology tests, DEXA and cystoscopy were not included in the request from NHSEI

Operational Performance: Diagnostics (DM01) Benchmarking

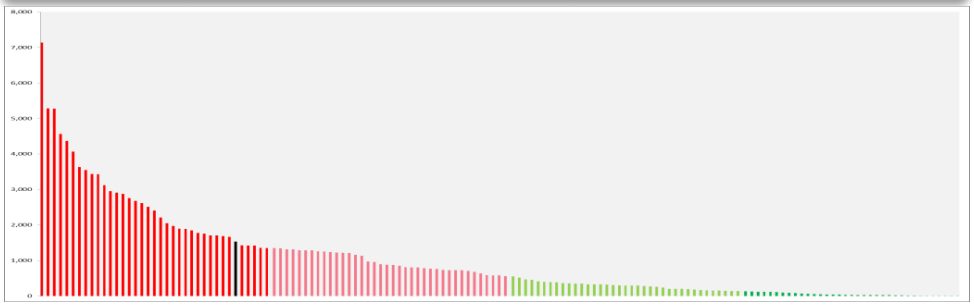
National Benchmarking (January 2021) | The Trust was one of10 of the 13 West Midlands Trusts which saw a increase in patients waiting over 6 weeks. This Trust was ranked 12 of 13 in December 2020. The peer group performance ranged from 2.44% to 54.01% with a peer group average of 30.79%; decreasing from 28.06% the previous month.

The England average for January 2021 was 33.3%, a 4.1 percentage point decrease from 29.2% in December.
In December, there were 154,099 patients recorded as waiting 13+ weeks for their diagnostic test; 1,532 (0.99%) of these patients were from WAHT

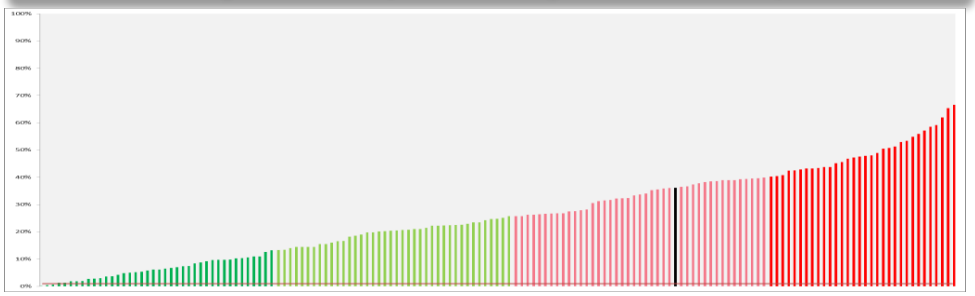
DM01 Diagnostics - % of patients waiting more than 6 weeks | Jan-21



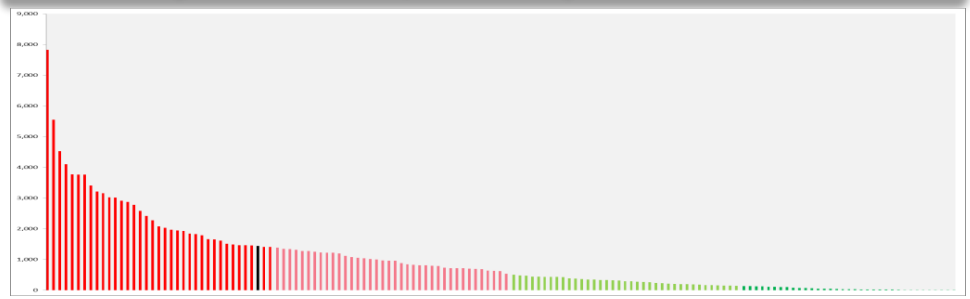
DM01 Diagnostics - number of patients waiting more than 13 weeks | Jan-21



DM01 Diagnostics - % of patients waiting more than 6 weeks | Dec-20



DM01 Diagnostics - number of patients waiting more than 13 weeks | Dec -20



Operational Performance: Stroke

% of patients spending 90% of time on a Stroke Ward	% of patients who had Direct Admission (via A&E) to a Stroke Ward	% patients seen in TIA clinic within 24 hours	% of patients who had a CT within 60 minutes of arrival	SSNAP Q3 Oct-20 to Dec-20			
78.85%	44.23%	97.22%	46.15%	Score	59.6	Grade	D

What does the data tell us?

Main Metrics

- All four main stroke metrics show performance that has not changed significantly.

SSNAP

- The overall SSNAP score for Q3 has been finalised at 59.6, this is a grade D. This compares to a score of 74, grade B, in quarter 2.
- There are 10 clinical domains and overall we scored 66; however, being graded a B for Case Ascertainment and Audit Compliance reduces our overall score to 59.6 and were therefore 0.4 short of being graded level C.
- The main changes in domain scoring / grading are:
- Domain 1 Scanning – reduced to a grade C from a grade B
- Domain 2 Stroke Unit – reduced from a grade D to a grade E
- Domain 3 Thrombolysis – reduced from a grade D to a grade E
- Domain 4 Specialist Assessment - reduced from a grade B to a grade C
- Domain 9 Standards by Discharge – reduced from grade B to a grade D
- Domain 10 Discharge process – improved from a grade D to B and score from 75 to 91.

- During Covid, the Stroke SOP was relaxed and the team is keen on reinforcing the SOP again from as the Covid numbers continue to reduce.
- Restoration – Request has been made to restart face to face activity including urgent TIA and some follow –up patients.
- Stroke Patients on MAU - Stroke patients on Medical Assessment Unit (MAU) to be transferred to the Stroke unit while waiting investigations when capacity allows. This will ensure improvement in Stroke patients receiving appropriate care in a timely manner.
- Stroke Registrar & Consultant Vacancy – Approval to recruit (ATR) has been raised for a permanent consultant and interview is arranged for Stroke Registrar on 22nd of March.
- Radiology – Stroke and Radiology Clinical lead met this week to discuss current imaging challenges mainly concerning TIA patients. The plan is to develop a criteria list to improve appropriate triaging of patients needing MRI scans, which to be discussed and seen as a step forward in achieving a reasonable resolution.
- Have received confirmation from the CCG that funding is available now for a Stroke co-ordinator to work with both Community and Acute. This has been received well by the team and see it as an great opportunity to work closely with the community team to improve flow.

Please see point's below with regards to COVID-19 impact

- Lack of MRI capacity often increasing length of stay for Stroke patients - Scanning has been delayed during Covid as it takes an extended period of time to clean the scanner after potential Covid patients. LOS has been increased for patients awaiting PEG MDT'S as there were a delay in discussing these patients, particularly on Covid wards.
- Lack of non-Covid bed capacity – non ring-fencing of Stroke beds impacted direct admission. Increased numbers of non-stroke admissions to the acute stroke unit impacted on ability to directly admit stroke patients. Covid positive stroke patients were admitted onto non stroke wards. This has had a negative impact on the metrics for direct admission to a stroke unit and spending 90% of their stay on such.
- Lack of Community Rehabilitation beds; the flow out of the Acute Stroke Unit to community rehab beds has been significantly compromised. Evesham Community Hospital have opened a ward to assist in the flow of these patients although some patients are still experiencing delays. The Community Stroke team now in-reach on a daily basis to the stroke unit to facilitate discharges and support flow through the stroke pathway.
- Patients requiring the Onward Care Team for pathway 2 and 3 wait extended periods of time. This impacts greatly on capacity and the ability to directly admit to the ward. ASU has also been an outbreak ward which significantly impacted on the ability of patients to be accepted into community beds
- TIA clinics are being completed virtually, thereby improving the ability to have a consultant review within 24 hours.

Current Assurance Level: 4 (Feb-21) | Agreed at QGC

When expected to move to next level of assurance: This is dependent on the on-going management of COVID-19 allowing for the ring-fencing of (non-COVID-19) stroke beds and increased availability of MRI scanning.

Previous assurance level: 5 (Jan-21)

SRO: Paul Brennan