Trust Board
There will be a meeting of the Trust Board on Thursday 11 February 2021 at 10:00. It will be held virtually and live streamed on You Tube.

Sir David Nicholson
Chairman

Agenda			Enclosure
1	**Welcome and apologies for absence:** Vikki Lewis (Rebecca Brown attending)		
2	**Patient Story**		
3	**Items of Any Other Business** *To declare any business to be taken under this agenda item.*		
4	**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.*		
5	**Minutes of the previous meeting** *To approve the Minutes of the meeting held on **14 January 2021** as a true and accurate record of discussions.*	*For approval*	**Enc A** **Page 3**
6	**Action Log**	*For noting*	**Enc B** **Page 10**
7	**Chairman's Report**	*Verbal*	
8	**Chief Executive's Report**	*For noting*	**Enc C** **Page 11**
9	**Strategy**		
9.1	**COVID -19 Longer View Update** Chief Operating Officer	*For assurance*	**Enc D1** **Page 14**
9.2	**Update on ICS and Trust Action Plan** Director of Strategy and Planning	*For approval*	**Enc D2** **Page 27**
9.3	**Update on Annual Planning 2021/22** Director of Clinical Strategy/Chief Finance Officer	*For noting*	**Enc D3** **Page 47**
10	**Performance**		
10.1 10.1.1	**Integrated Performance Report** **Executive Summary/SPC Charts/Infographic** Chief Executive/Executive Directors	*For assurance*	**Enc E** **Page 54**

10.2.2	**Committee Assurance Reports** Committee Chairs		**Appendix 3** **Page 113**
11	**Governance**		
11.1	**Nursing and Midwifery staffing report – October – November 2020 with a situation report 13/01/2020 of the response for the Covid 19 third wave** Chief Nursing Officer	*For assurance*	**Enc F1** **Page 118**
11.2	**Ockenden Report – Review Gap Analysis** Chief Nursing Officer	*For assurance*	**Enc F2** **Page 136**
11.3	**Maternity Serious Incident Report Quarter 3 (September – December 2020)** Chief Nursing Officer	*For assurance*	**Enc F3** **Page 145**
11.4	**Audit and Assurance Committee Report** Audit and Assurance Committee Chairman	*For assurance*	**Enc F4** **Page 151**
	Any Other Business *as previously notified*		
	Date of Next Meeting *The next public Trust Board meeting will be held on 11 March 2021, virtually.*		

Enc A

Worcestershire Acute Hospitals NHS Trust

MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON THURSDAY 14 JANUARY 2021 AT 10:00 AM VIRTUALLY

Present:

Chairman:	Sir David Nicholson	
Board members: (voting)	Waqar Azmi	Non-Executive Director
	Paul Brennan	Deputy Chief Executive/Chief Operating Officer
	Mike Hallissey	Chief Medical Officer
	Matthew Hopkins	Chief Executive
	Dame Julie Moore	Non-Executive Director
	Vicky Morris	Chief Nursing Officer
	Robert Toole	Chief Finance Officer
	Mark Yates	Non-Executive Director
Board members: (non-voting)	Richard Haynes	Director of Communications and Engagement
	Colin Horwath	Associate Non-Executive Director
	Richard Oosterom	Associate Non-Executive Director
	Jo Newton	Director of Strategy and Planning
	Tina Ricketts	Director of People and Culture
	Sharon Thompson	Associate Non-Executive Director
In attendance	Simon Adams	HealthWatch
	Nigel Parsons	Patient *item 119/20 only*
	Anna Sterckx	Head of Patient, Carer and Public Engagement *item 119/20 only*
	Marsha Jones	Head of Improvement *item 119/20 only*
	Rebecca Brown	Deputy Chief Digital Officer
	Martin Wood	Deputy Company Secretary
Public	12	Via YouTube
Apologies	Anita Day	Non-Executive Director
	Vikki Lewis	Chief Digital Officer
	Bill Tunnicliffe	Non-Executive Director

118/20 **WELCOME**

Sir David welcomed everyone to the meeting, including those viewing via YouTube. He particularly welcomed Waqar Azmi and Sharon Thompson, Non Executive Director and Associate Non-Executive Director respectively to their first Board meeting. He also welcomed Mrs Brown who was attending for Mrs Lewis and Mr Wood who was covering the Company Secretary role.

Sir David explained that the agenda for the meeting had been minimised to enable the Executive Team to focus on the enormity of dealing with COVID-19. Nonetheless, every effort had been made for the Board to be assured over the quality of services provided with proper governance arrangements

119/20 **PATIENT STORY**

Sir David explained that each Board meeting starts with a patient story. He was pleased to welcome Mr Nigel Parsons, Ms Anna Sterckx, Head of Patient, Carer and Public Engagement and Mrs Marsha Jones, Head of Improvement to explain the story of patients as partners: driving forward quality improvement together.

Mr Parsons explained that during his five days in hospital in September 2020, he observed multiple opportunities for capacity and quality improvement, including "getting the best use out of the MRI and the radiology department" which in turn would support a positive improvement in patient care and experience. He approached the Trust, initially as a complaint, to share his experiences and this was subsequently taken forward. Mr Parsons has volunteered "lean methodology expertise" and has been working with Mrs Jones on the development of the Single Improvement Methodology and how the Trust could address "waste", resulting in the ability to gain better value from some of the services we offer.

Whilst in the MRI unit Mr Parsons saw "a strong tool for process improvement". He questioned what the capacity is and how many patients can be seen; "how the hospital can ensure best value for the precious resource". Mr Parsons explained the actual time in MRI is very short, relative to the total elapse time from the start to the end of the process. He was in and out within less than 30 minutes but was not discharged from hospital until 43 hours later. During this time he was waiting for results. He was distressed, not knowing why he could not have a result and what the result might be. Nobody would make a decision and he just wanted to go home.

Mr Parsons suggested that with a lean manufacturing approach improvements to capacity constraints such as CT scans and MRI can be overcome. He referenced the research undertaken in Japan entitled "Iceberg of Ignorance" which related to teams being provided with equipment in terms of skills, time and capacity to resolve issues and make improvements on a daily basis and that they are aware that they are empowered to do this.

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

- Mrs Sterkx commented on seeing complaints as an opportunity to make improvements. Mrs Jones said that Mr Parson's observations had come at an opportune time as we develop our single improvement methodology.
- Mr Yates asked if it was lack of communication or the lack of seven day working which caused Mr Parson's frustration over the wait for the MRI. In response Mr Parsons said that the reasons for the MRI were make clear but the specifics of what was trying to be achieved were not made clear. Ward staff had no information. Mrs Morris added that there is a Radiologist on call seven days per week.
- Mr Oosterom enquired whether individual teams have sufficient information to manage the scarce scanning resources and, if so, how can they help make improvements. Mr Hopkins responded that with regard to scans, teams did not have this information; however, this approach was being used in other parts of our Trust such as Radiology and we need to extend this approach as part of the single improvement methodology.
- Sir David said that it is important to use complaints to improve our culture. There are benefits to the approach advocated by Mr Parsons which are evident in other health organisations which need to be replicated here. Mr Parson's input has come at the right time and a patient story is a powerful message to make this happen. He apologised for Mr Parson's poor experience. He thanked Mr Parson's for attending the meeting.

120/20 **ANY OTHER BUSINESS**
There were no items of any other business.

121/20 **DECLARATIONS OF INTERESTS**
The Board noted the Declarations of Interest submitted by Mr Waqar Azmi and Ms Sharon Thompson following their respective Non-Executive Director and Associate Non-Executive Director appointments.

The Board noted that the full list of declarations of interest were on the website.

122/20 **MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON 10 DECEMBER 2020**
RESOLVED THAT the Minutes of the public meeting held on 10 December 2020 be confirmed as a correct record and signed by the Chairman.

123/20 **MATTERS ARISING/ACTION SCHEDULE**
Mr Wood reported that he would liaise with Mrs Lewis over the first action relating to training for staff on iPads. The second action was for a future meeting.

124/20 **CHAIRMAN'S REPORT**
Sir David presented his report requesting ratification of the Vice Chairman's action taken in accordance with Standing Orders to approve the PAS Re-implementation and the award of the trauma products contract where respectively current licence and contract arrangements expired at the end of December 2021. The proposal was recommend for approval by the Finance and Performance Committee.

RESOLVED THAT : The Vice Chairman's action undertaken since the last Trust Board meeting in December 2020 be ratified.

125/20 **CHIEF EXECUTIVE'S REPORT**
Mr Hopkins presented his report. He said that Rebecca O'Connor has been appointed to the post of Company Secretary and will start on 1 March 2021. Mrs Gardner will start as Chief Nursing Officer on 15 March 2021. The system response to the Government's consultation document on the future ICS governance arrangements will be shared at the next Trust Board meeting.

Mr Hopkins paid tribute to all staff for continuing with their huge collective effort to respond to the strains that the pandemic is putting on our teams, our services and our community. He explained the huge burden placed on staff to deliver the vaccination programme. The guidance to issue the second dose of the vaccine had changed quickly necessitating the re-scheduling on thousands of second dose appointments and scaling up first dose appointments for staff and patients. There is both anger and frustration amongst both staff and patients over this change where second dose appointments had been changed without their consent to deliver as many first dose vaccinations as possible. Staff are responding to the pandemic with patients requiring urgent care and those with high levels of acuity. Staff are being re-deployed and it important they feel supported. The Incident Command Structure objectives have been refreshed. Difficult decisions will need to be taken on the priority of treatment. Respiratory and cancer teams are engaged in discussions and are concerned over the implications of capacity required for COVID patients. Mr Hopkins referred to the unacceptable behaviour of those who filmed themselves, without masks, in our hospitals (and several other hospitals) to support their agenda of denying the impact of COVID which is demoralising. The Police have intervened. Finally, Mr Hopkins paid tribute to his Executive Team and health and social care colleagues for their considerable efforts in

dealing with the pandemic. Sir David added that it is a privilege to be part on our Trust with such a dedicated workforce. The system is pulling together remarkably well.

RESOLVED THAT: The report be noted.

126/20 **STRATEGY**

126/20/1 **COVID- 19 Longer View Update – 31 December 2020**

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

- The last seven day average is 31 COVID patients admitted per day, 17 discharges per day and, unfortunately, 9 deaths per day. There has been an overall increase of 5 COVID patients per day. Today there are 250 COVID positive patients compared to a maximum of 140 in wave 1, 24 of whom are in ITU where we are operating at super surge level. Endoscopy is being prepared as the next surge area. Overall there are 24 COVID beds on the Worcester site and 14 at the Alex. 25 beds at level 3 are currently staffed. Approximately 60 staff have been redeployed to support ITU.
- Since the beginning of wave 1, 1,748 COVID positive patients have been admitted, 1,209 discharged with 539 deaths. The death rate is 30% which is in line with expectations. Out of the total bed base of 740, 324 are for COVID positive patients.
- Of the 500 staff off sick, 300 are COVID related. There is an increase in staff absences due to shielding, isolating and COVID positive.
- With regard to declared patient ethnicity, the admission rate to white is 90%, BAME 5% and undeclared 5%. The death ratio for white is 92%, 3% BAME and 5% not declared.
- The number of community cases has increased significantly over the last ten days and yesterday stood at 600 per 100,000 population with hospital admissions running at about 11 days after identified community cases. The predicted peak has been pushed back to around 29 January 2021 with a plateau of around 20 days before a significant decline which was not the case in wave 1.
- All non-urgent elective activity has ceased due to CIVID and only two major cancer cases have been undertaken in the last week. We are negotiating with the independent sector to increase colorectal and urology surgery with expectations that this will commence next week. We are looking to undertake major inpatient cancer cases on the Worcester site.
- To date 4,667 vaccinations have been undertaken at the Alex site of which 2.096 are our staff. Last weekend PCN sites administered 5,4400 vaccinations for our staff, health and social care and WMAS staff.

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

- Mr Oosterom echoed the appreciation to the Executive Team and staff for their considerable efforts. He asked for information on Hospital Acquired Infections (HCIAs), the plans should ICU capacity become full and whether there are any alternative stepdown arrangements to reduce length of stay.
- With regard to the first point, Mrs Morris said that swabbing is undertake at point of entry and then on day 3,5 and 13 which determines HCIAs, The definitions of HCIAs are undetermined, probable and definite. We are clear on lessons learnt.
- In response to the second point Mr Brennan said that the original ITU capacity was 12 beds which has been increased in stages and is now 26 beds. NHSE/I have said that Trusts are to increase ITU capacity to 200% of the original beds from 18 January 2021 and we have already surpassed that figure. There are plans to further increase ITU beds to 36. If further beds are required Aconbury 2 will become a COVID ward providing a total of 49 beds, then theatre recovery

will be used for green ITU patients. Staffing is already stretched and we will need to move further into a blended staffing model. In line with the regional initiative, we have taken 2 patients form elsewhere due to capacity constraints and one patient has been transferred from the Alex. Regional networks are in place to deploy staff when hospital capacity is reached and we are not yet at that level.

- With regard to the third point, Mr Brennan explained that we are working with the County Council and the Health and Care Trust to increase discharges. The Health and Care Trust has increased community capacity. County Council has secured nursing home beds for stepdown patients when social care is not immediately available and when COVID patients have been admitted from a nursing home who are not able to return to their original home. We are working as a system to maximise stepdown.
- Mr Brennan confirmed to Mr Yates that oxygen supply is sufficient to meet demand. There had been distribution issues at the Alex which are being resolved. The oxygen supply to Aconbury 2 is being reviewed.
- Mr Azmi suggested that the information on BAME staffing should be expanded to include age and gender. He asked for information on the support for BAME staff. In response, Ms Ricketts said that occupational health risks assessments are undertaken for all staff. To date compliance is 92% overall and 85% for BAME staff. HR are contact by telephone those staff whose risk assessment remains outstanding. Completed forms help in identifying reasonable adjustments to maintain staff safety which are individually reviewed by Occupational Health. 28% of staff have been identified at risk. Our Trust has a well-being programme which feedback has identified as comprehensive. The issue is that staff are not accessing the programme at the earliest opportunity and we are working to raise awareness that it is “OK not to feel OK”. Ms Thompson echoed the benefits of the support programme and asked if there is any patient experience to provide enhanced feedback. Mrs Morris said in response said that during wave 1 we supported relatives with communications regarding access to relatives in line with the compassionate visiting policy. iPads were also provided. A patient story relating to COVID was presented to the Trust Board in November 2020. A family liaison service has been established during wave 2. Mr Haynes said that the communication focus is on staff. BAME colleagues are raising awareness with messaging, particularly the vaccination programme. Public messages have been issued with the support of the CCG and Health and Care Trust. Mr Hopkins noted that many staff are also local residents and there are opportunities for them to speak up.
- Sir David said that we are committed to providing local people with the best possible service. We are working well with system partners to make this happen. There is a concern over those who remain silent who may not be getting the service they need and this must be recognised. We are undertaking as much cancer activity as we can.
- Sir David expressed on behalf of the Trust Board appreciation for the remarkable Executive Team their effort, commitment and time expended in responding to the pandemic.

RESOLVED THAT The Trust Board received the report for assurance.

127/20 **PERFORMANCE**

127/20/1 **Integrated Performance Report**

127/20/1/1 **Executive Summary**

Mr Hopkins introduced the report for month 8, November 2020. Three areas of challenge have been identified namely the impact of COVID-1, workforce demand v

supply and our financial position. Additionally he drew attention to the improvements in our staff vacancy, turnover and mandatory training performance. There has been an improvement in stroke performance and we had made progress with electivity activity which had now dropped during wave 2. EAS performance was 82.1% due to bed pressures. Ambulance handovers are challenging. There has been no increase in patients waiting in the corridor.

Action: Mrs Brown to provide more detail for the next meeting on long waiting patients.

The current financial regime is likely to continue for the foreseeable future. Our focus is on reducing the cost of providing services and agency spend despite the pressures with demand for staff outstripping supply.

Mrs Morris said that MSSA infections were above trajectory in November 2020 and we are building on the actions already in place by Divisions. Cdifficile infections are above trajectory and actions agreed via TIPCC are being managed at Divisional level. A review has been undertaken of carbapenem consumption for the last 12 months with actions to be agreed at Antimicrobial Stewardship Steering Group. Mr Hallissey added that the review has indicated that COVID-19 wards have a high usage rate of carbapenem which might be as expected. For the remaining wards usage is appropriate.

Mr Hallissey said that there has been a small improvement in Sepsis 6 performance. The e-learning module was launched in October 2020; however, the impact will not been seen for the next three to four months. We are focusing on obtaining real time data with one mechanism for recording data.

RESOLVED THAT: The report be received for assurance.

127/20/1/2 **Committee Assurance Reports**

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

128/20 **ASSURANCE REPORTS**

128/20/1 **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 September and October 2020.

RESOLVED THAT the report be received for assurance.

129/20 **DATE OF NEXT MEETING**

The next Public Trust Board meeting will be held on Thursday 11 February 2021 at 10:00. The meeting will be held virtually.

The meeting closed at 11.37 am.

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

Sir David asked Mr Adams to comment and ask questions if he wished.

Mr Adams thanked staff for the outstanding work which they are undertaking. He offered the support of Healthwatch in dealing with those who are denouncing the pandemic. He referenced a family member who is now working for the Trust who considered that it an outstanding organisation to work for.

Enc C

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

PUBLIC TRUST BOARD ACTION SCHEDULE – FEBRUARY 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
12-11-20	Patient story	82/20	Review training for staff on iPads	VL	Jan 2020	March 2021		
12-11-20	Patient story	82/20	Consider the use of volunteers for breast feeding support	VM	Mar 2020			
14-01-21	Integrated Performance Report	127/20/1/1	Provide more detail for the next meeting on long waiting patients.	RB	Feb 2021		Information included in the report. Action completed.	

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
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Chief Executive Officer's Report

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

Accountable Director	Mathew Hopkins Chief Executive Officer		
Presented by	Mathew Hopkins Chief Executive Officer	**Author /s**	Martin Wood Deputy 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: • Peter Pinfield, Chair of Healthwatch • Healthwatch Worcestershire Public Board Meeting • Wave 2 COVID Pandemic • Support for our Staff • Weekly MP Briefings with Worcestershire County Council • Lucy Pugh from MSSU wins University of Worcester's Exceptional Care Award • ICS System Response • West Midlands Ambulance Service Thank You Letter

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	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						

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
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Introduction/Background

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

Issues and options

Peter Pinfield, Chair of Healthatch: It is with great sadness that I have to report the death on 29 January 2021 of Peter Pinfield, Chair of Healthwatch. Peter had been Chair of Healthwatch since its inception in April 2013 and was instrumental in setting up Healthwatch with the support of colleagues in the voluntary and community sector, NHS and local Councils, following his long and successful careers as a children's social worker and local politician. We have expressed our sympathy to Peter's wife during this difficult period.

Healthwatch Public Board Meeting: I was delighted to attend the virtual meeting on 21st January 2021 to provide an update on our response to the Covid Pandemic and answer questions from Board members.

Wave 2 COVID Pandemic: The pandemic continues to cause significant mortality and morbidity in the county, and since the last Trust Board meeting the number of patients requiring our care in hospital continues to rise to a peak of 269 inpatients on the 22nd January. As the report in the meeting will show, our teams have continued to care for significantly higher numbers of sick patents than at the peak of Wave 1 in April 2020. I would like again to pay tribute to all of our staff for their passion, resilience and fortitude at this most difficult of times.

I would also like to acknowledge the likely lasting psychological effects that the Covid 19 Pandemic will have on our frontline staff; including post traumatic and moral injuries that the reality of caring for very sick and rapidly deteriorating patients will bring. We must redouble our efforts to support our staff at all levels as the pandemic's spread is curtailed by the vaccination programme.

Our COVID vaccination hub based at the Alexandra Hospital delivered approximately 8,000 vaccinations since being established in mid December 2020,. The hub has now closed with vaccinations being undertaken at the Artrix Centre, Bromsgrove and St Peter's Baptist Church, Worcester. Further detail is included in the Integrated Performance Report. I would like to express my appreciation to staff for their incredible efforts in delivering the vaccine.

Sadly, I must also report to the Board an increase in the level of verbal abuse experienced by our staff from some relatives, patients and members of the public, who are unwilling to comply with Government guidance on our premises. Unlike in the first wave of the Pandemic, we are seeing high levels of anger and frustration being unfairly projected onto our staff during the course of their work caring for our patients. Verbal abuse of our staff can never be tolerated and I know I can rely on Board members to once again support our leadership teams in taking firm action when such incidents arise.

Support for our Staff: It is now more than ever vital that we look after each other and starting last Wednesday on our Staff Facebook Group and every week we will be focussing on a 'Wellbeing Wednesday' to help support all staff during this difficult time.

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A new pathway launched specifically for staff who could be struggling with stress, anxiety, low mood or depression is now available through the local Heathy Minds service.

My regular virtual meetings with staff have continued with Meet the Chief, Staffside sessions and a cross section of frontline staff sharing their lived experience of working in our organisation at this challenging time.

Weekly MP Briefings: Since our last Board meeting I have been attending the weekly briefings of the Worcestershire Members of Parliament (MPs) led by Simon Geraghty, Leader of the Worcestershire County Council to provide an update on the Covid Pandemic response within our health and care system and our hospitals in particular.

Lucy Pugh from MSSU wins University of Worcester's Exceptional Care Award: Lucy Pugh, a student nurse form MSSU, has won the University of Worcester's Exceptional Care Award for her tireless dedication to providing outstanding care, including during the pandemic. Lucy is studying for a BSc in Adult Nursing having recently graduated from a Foundation Degree in Mental health at the University of Worcester.

ICS System Response: National guidance entitled “Next steps to building strong and effective integrated care systems across England” (published in November 2020) sought views on the next stage development of ICS’s, with a view to placing them on a more statutory footing. Engagement included views on the future role of the CCG, with the new focus on system and collaboration, rather than the commissioner and provider framework (including PbR).The system has agreed a joint response, to recommend that some CCG functions would be retained.

West Midlands Ambulance Service: I was delighted to receive a letter from Mark Docherty, Executive Director of Nursing and Clinical Commissioning, thanking our staff and our health and care system partners for: ‘the valiant efforts they have made to ensure that we are able to get patients handed over in a timely manner and thereby not delay our response to other patients. The performance at your two hospitals (Worcestershire Royal Hospital, The Alexandra Hospital) has been significantly improved compared to previous years and this is a tremendous achievement.

Conclusion

Recommendations

The Trust Board is requested to

- Note this report

Appendices - None

NHS
Worcestershire Acute Hospitals NHS Trust

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Covid-19 Longer View - Update

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, Senior Information Specialist/ 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

Recommendations	Trust Board is invited to note this report for assurance.
Executive summary	Covid continues to put the Trust under pressure but with some indications that we may be at a fragile peak/plateau in patient numbers. ▪ The current number of beds required for Covid-19 patients is slightly reduced on last week. ▪ Community-onset and symptomatic cases continue to be the main source of new inpatients. There are some signs that these may be reducing in line but delayed with those trends in community data. ▪ Hospital acquired and non-symptomatic cases whilst smaller in number are not decreasing. ▪ Crude mortality has worsened during the early part of 2021 but is showing some more recent signs of improvement. ▪ The demand for beds for Covid inpatients continues to be mitigated by ability to discharge treated patients. Our performance in this regard has been maintained over much of the last seven days. ▪ However, pressures on ITU and respiratory care have seen a slight reduction over this reporting period.

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		
Financial Risk			

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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						

NHS
Worcestershire
Acute Hospitals
NHS Trust

Meeting	Trust Board
Date of meeting	11th February 2021
Paper number	Enc D1

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	1107	12436	687	317	1004	31.6%	10.6	11.7
WRH	1180	12773	825	240	1065	22.5%	10.2	11.6
Trust	**2287**	**25209**	**1512**	**557**	**2069**	**26.9%**	**10.4**	**11.6**

As the pandemic ensues our crude mortality rate appears to have stabilised at 26.9%. Similarly the average LOS for both treated and deceased patients has also stabilised at 10.4 and 11.6 days respectively.

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**

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Wave 2 (23 September 2020 to date of report)

Site	Total No. inpatients	Combined LOS	Discharged (treated)	Died (in hospital)	Combined discharges	Crude mortality rate	Avg LOS (treated)	Avg LOS (died)
ALX	706	7805	429	174	603	28.9%	9.9	12.3
WRH	820	8769	565	140	705	19.9%	9.7	12.2
Trust	**1526**	**16574**	**994**	**314**	**1308**	**24.0%**	**9.8**	**12.2**

Observations:

- Our current crude mortality rate (wave 2) has increased slightly (was 23.7%). This reflects the same trend as previously reported which would suggest that, more recently, we have seen increasing levels of acuity.
- Nevertheless, the crude mortality rate for patients admitted during wave 2 is still much improved on those admitted during the earlier phase of the pandemic.
- The average LOS for those treated and deceased patients appears unchanged and is lower than we experienced during wave 1.

At the time of writing we have reported 260 inpatients across the Trust who have tested positive for Covid-19 (was 269 last week). There are a further 31 patients who have not yet had a positive PCR sample but are being treated as though they are positive (as these are symptomatic).

This represents a slight reduction in Covid bed numbers since the previous report (averaging at just under one fewer bed required each day). However, in this plateau-like period, this metric can be quite volatile. In the last week we have seen this range from a reduction of 10 beds to an increase of 5.

Even accounting for any changes in clinically suspected patient numbers (which are stable) the slow-down we previously reported has led to a levelling off in our total number of Covid beds.

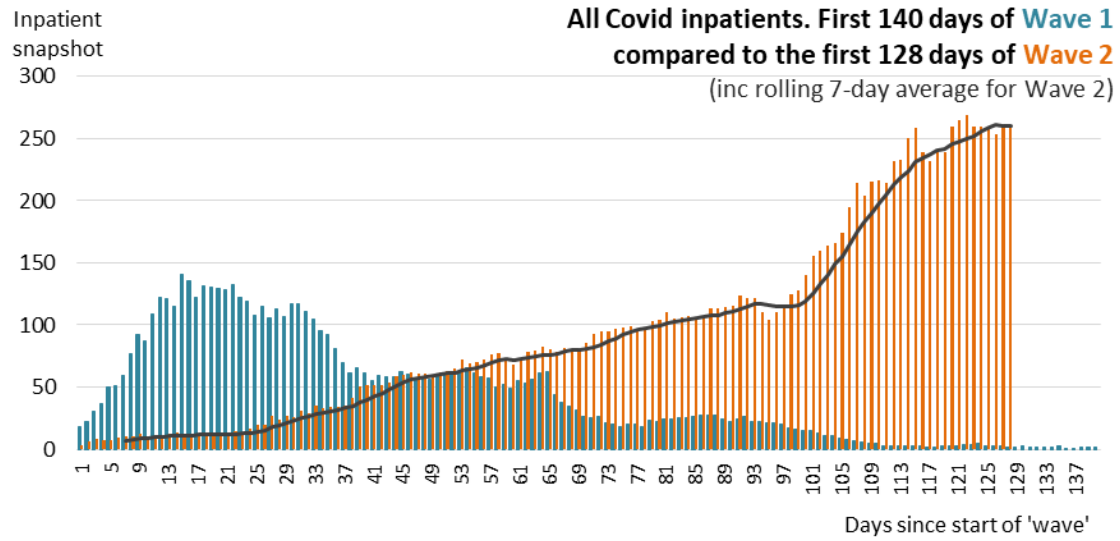
Again, this is something of a fragile balancing act between the daily number of new positive inpatients and our ability to discharge treated inpatients. In this regard the number of new positive inpatients appears to be slowing down and is currently 27 new cases each day (based on a rolling 7-day average). This same metric was over 35 and had peaked at an average of 57 new cases for the week up to 08 January.

Against this we have managed to maintain our daily discharge rate of treated patients at or around 20 discharges per day.

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 28 January) with the first 140 days of **wave 1**. It also includes a **rolling 7-day average** for wave 2.

Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	11th February 2021
Paper number	Enc D1

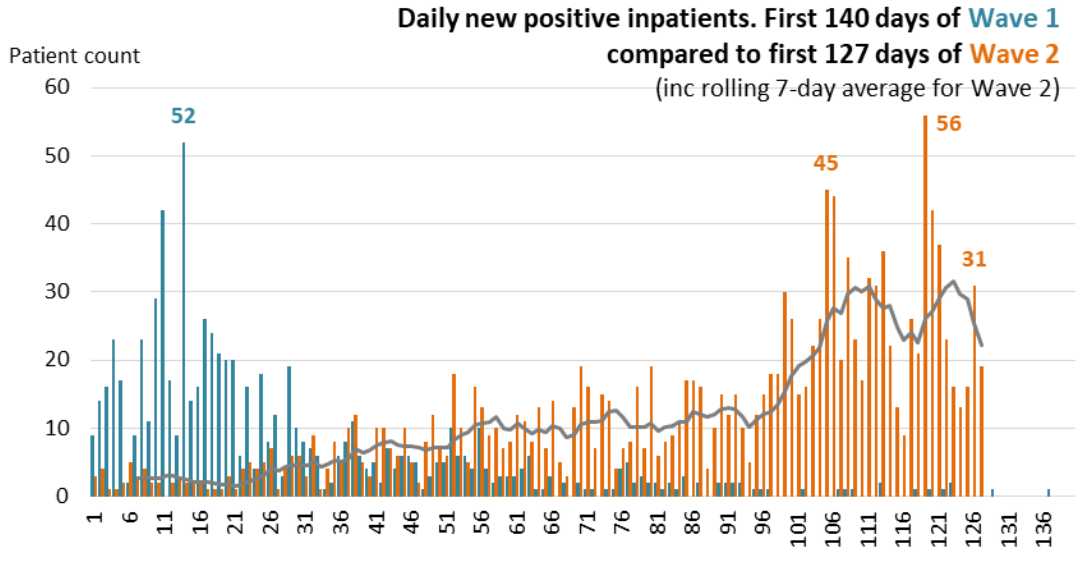


Information provenance: This data is taken directly from our daily snapshot returns, it is what is outlined in the bronze meeting each day. It is just a longer view.

Observations:

- Our requirement for Covid beds appears to be plateauing.

The following chart shows the *daily* new positive inpatients. As before, this compares **wave 2** (up to 27 January) with the first 140 days of **wave 1**. It also includes a **rolling 7-day average** for wave 2.



Observations:

- Our number of new Covid inpatients appears to be stabilising.
- This could be early signs of the reduction in community cases translating into a reduction in those requiring hospital treatments.

Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
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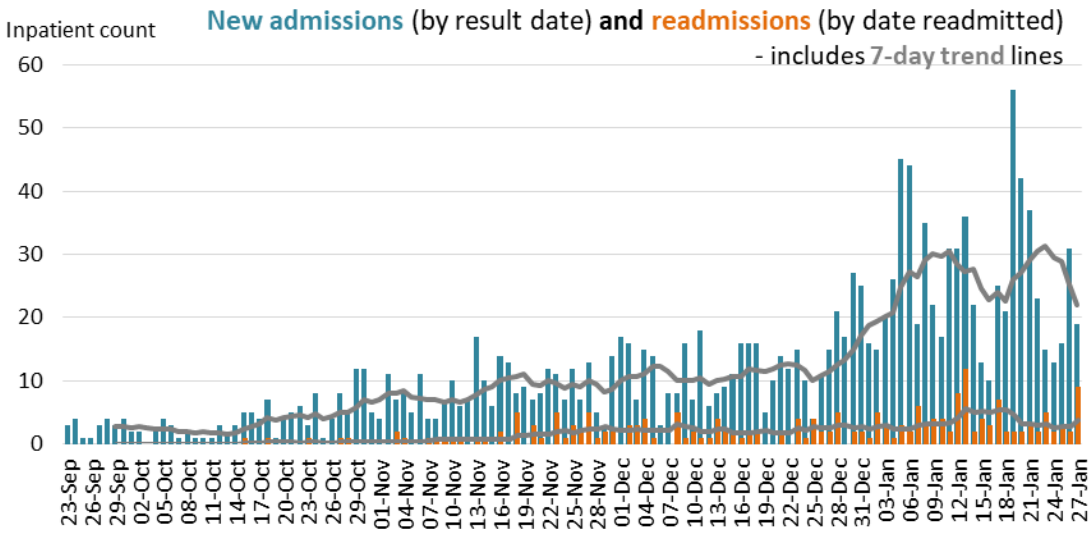
Readmissions

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).

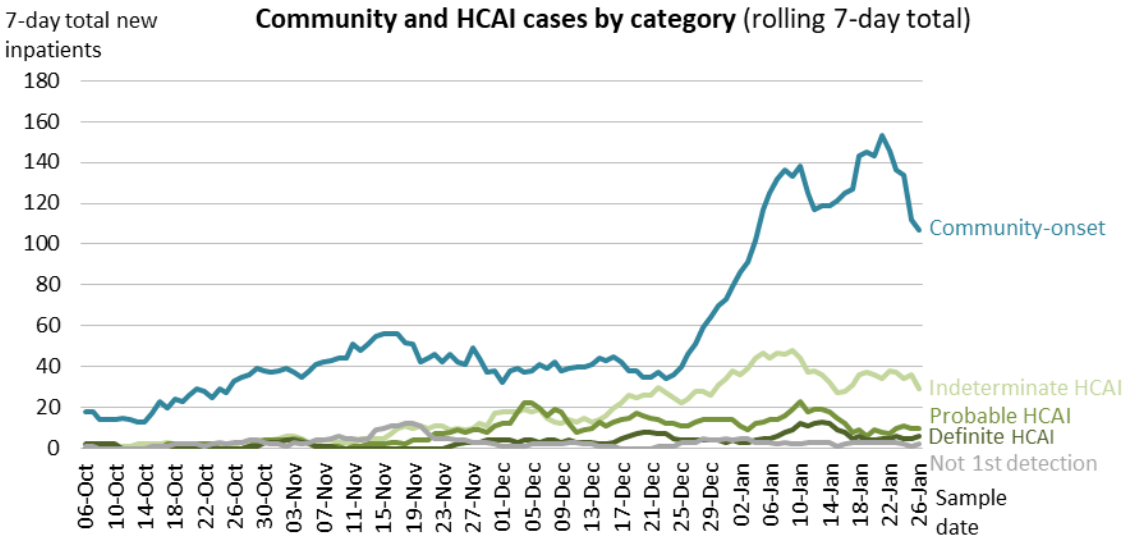


Observations:

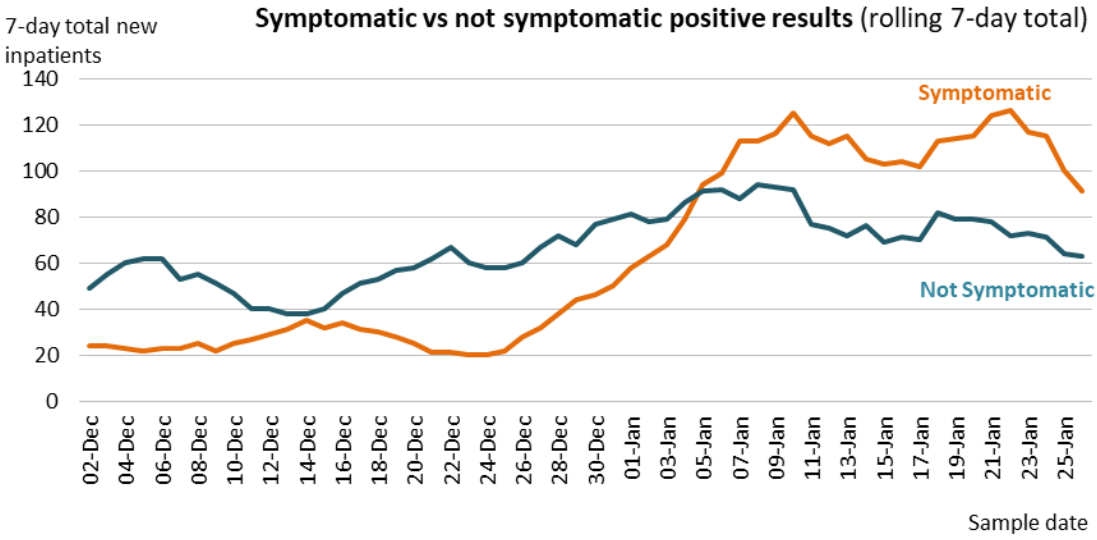
- New admissions appear to be falling slightly whereas readmissions are stable if not rising (slightly).
- Given increased patient numbers this month, the reduced length of stay and increased discharges, it is not surprising that we might see a rise in the number of readmissions.

The following two charts show the breakdown of our new positive cases by the HCAI category and whether the inpatient is described as symptomatic or not (at the point at which the resulting positive test is taken).

Please note: The Trust has now moved to two pathways (Covid and NON Covid). Analysis has commenced to look at any pre and post implementation effects this has on HCAI cases. Currently we do not have enough data points to confirm that there is a direct correlation. The process will be repeated over the coming weeks and analysis included in this report.



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.



Observations:

- We are starting to see reductions in community/symptomatic cases. Although these remain the predominate source/type of new Covid inpatients.
- Hospital acquired and non-symptomatic cases are relatively stable and, whilst not increasing, are exacerbating the current high number of Covid inpatients.

Mortality

At the time of writing we are averaging 6 deaths of Covid inpatients per day. This is an improvement on the last report where this figure was 9.4 deaths per day (based on a rolling 7-day average)

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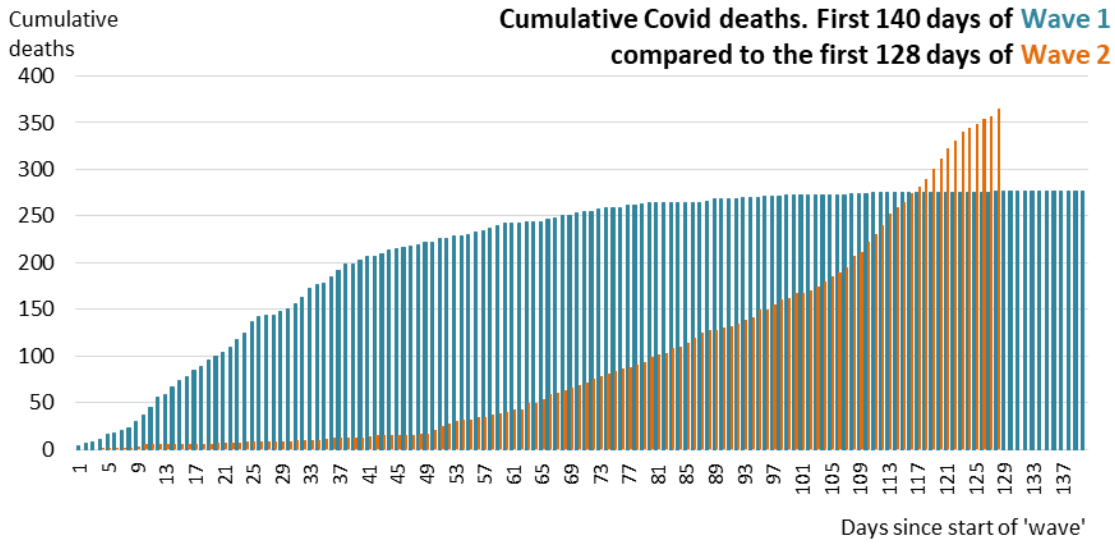
The following chart shows the cumulative deaths for the first 140 days of **wave 1** against the first 128 days of **wave 2**.



Observations:

- Last week saw the number of Covid deaths for wave 2 exceed those recorded during the first wave.
- Having risen at a noticeably sharper rate during recent weeks, it would appear that this too is starting to slow down.

The following chart shows a wider view of inpatient mortality (Covid and non-Covid) for the period January 2020 to January 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.

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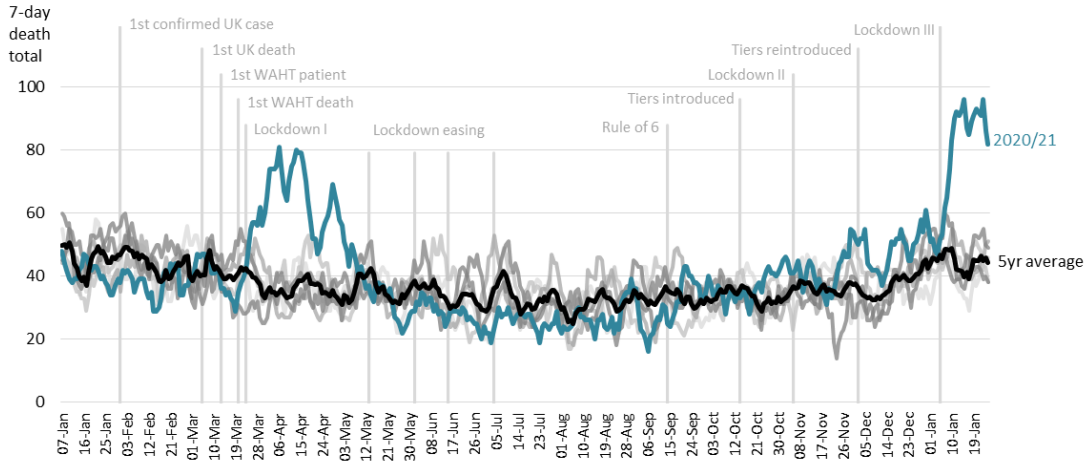
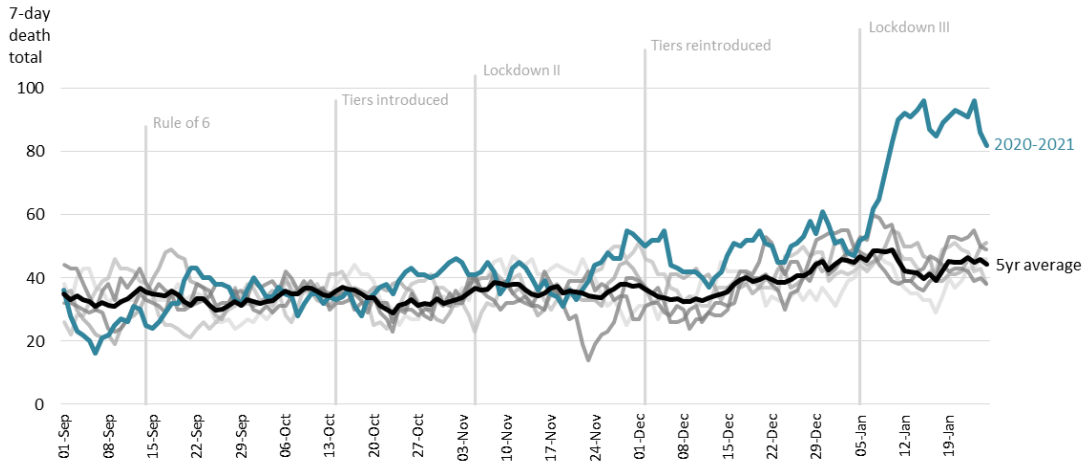
Inpatient deaths Jan 2020 to Jan 2021 (so far) **compared to 5yr average**
Based on rolling 7-day inpatient deaths



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



Observations:

- The impact of the pandemic on inpatient mortality is clear for the period 23 March to 12 May (the peak of wave 1) and also from January this year to the present date.
- The impact on mortality from the start of wave 2 (23 September) to January is reduced compared to these periods.
- Despite the pandemic, there have been periods between the two waves where reported inpatient mortality has actually been below the 5yr average for that time of year.

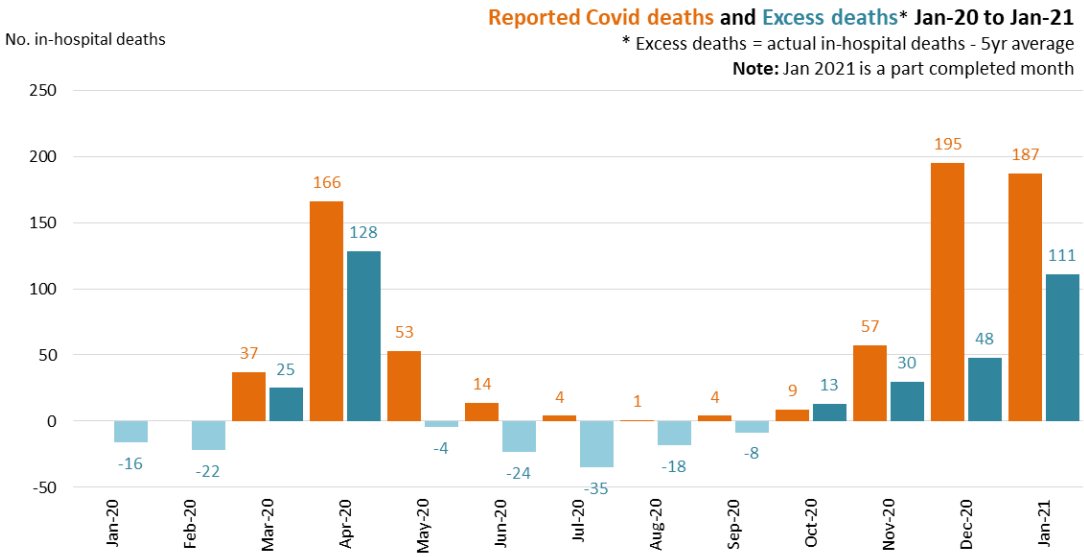
If we reduce this to a monthly view and plot the aggregated difference between the blue (current year) and black (5yr average) lines we get an indication of the number of 'excess

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:

- We started 2020 (calendar year) with fewer inpatient deaths than we might have expected.
- Covid-19 clearly changed this and our excess deaths rose to 128 in April 2020. During the same period we recorded 166 deaths of Covid-19 inpatients.
- For the period May through September we reverted back to fewer deaths than expected. Throughout this period we recorded noticeably fewer Covid deaths.
- As wave 2 started in September 2020 we started to see a corresponding increase in excess deaths.
- Whilst reported Covid deaths (inpatients) in December 2020 and January 2021 are higher than they were at the peak of wave 1, the number of excess deaths did not rise in a similar manner. This is because we would ordinarily expect a subtle but nonetheless meaningful increase in inpatient mortality during this period.
- The data for January 2021 is incomplete at this point in time. Subsequent reports will be able to establish the impact on excess mortality of the sudden rise in patient numbers during the first part of 2021.

The following chart shows the gender and age distribution of all Covid inpatients (treated or deceased). The lighter bars show the total (treated and deceased) the darker bars show the deaths only.

Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
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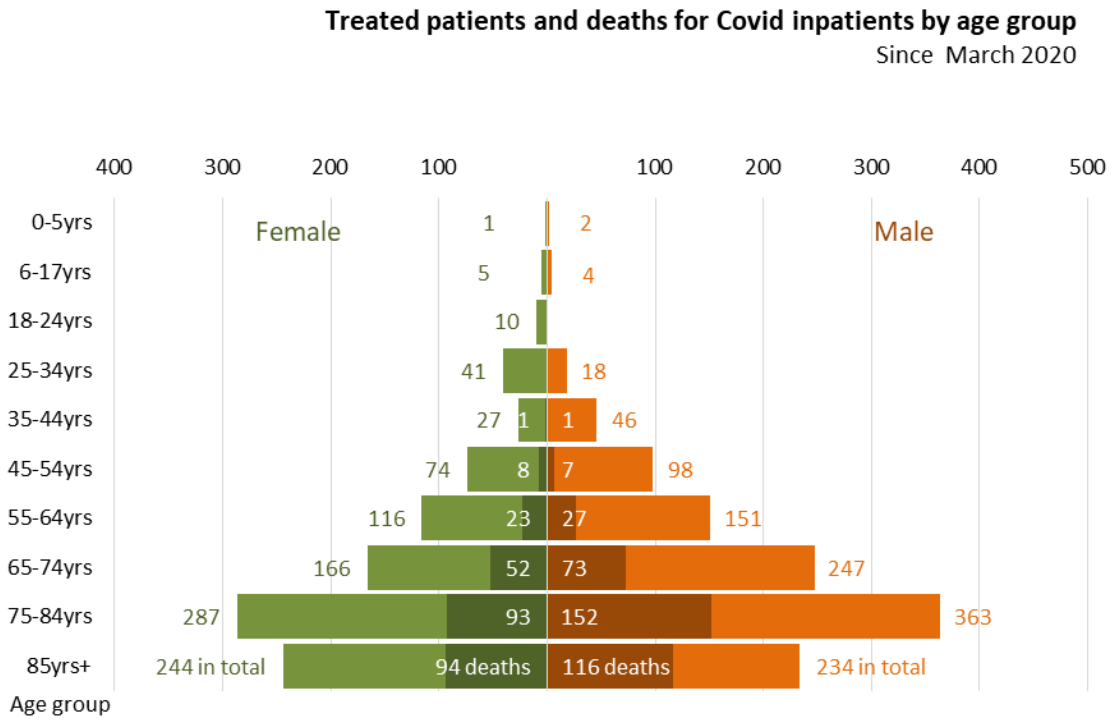
Paper number	Enc D1



Observations:

- There have been around 20% more male Covid inpatients. This is relatively stable for Waves 1, 2 and the most recent and sudden increase since January 2021.
- Deaths of male patients further skew towards male inpatients. There are approximately 40% more deaths of male Covid inpatients than female. If anything this is increasing (albeit slightly) during the current wave.
- The percentage of Covid inpatients aged 65yrs or older is 71.7% for females and 72.5% for males. Notably, whilst the female cohort of patients appears to be aging (slightly) the male cohort appears to be getting slightly younger.
- Crude mortality rates range from 0% for those in the youngest age groups (regardless of gender) to 49.6% for males aged 85yrs or older. This compares to a crude mortality rate of 38.5% for the same age group of female Covid inpatients.

There are some recent shifts in this data. The next chart is just for patients who have been treated or died since 01 January 2021.

Worcestershire Acute Hospitals NHS Trust

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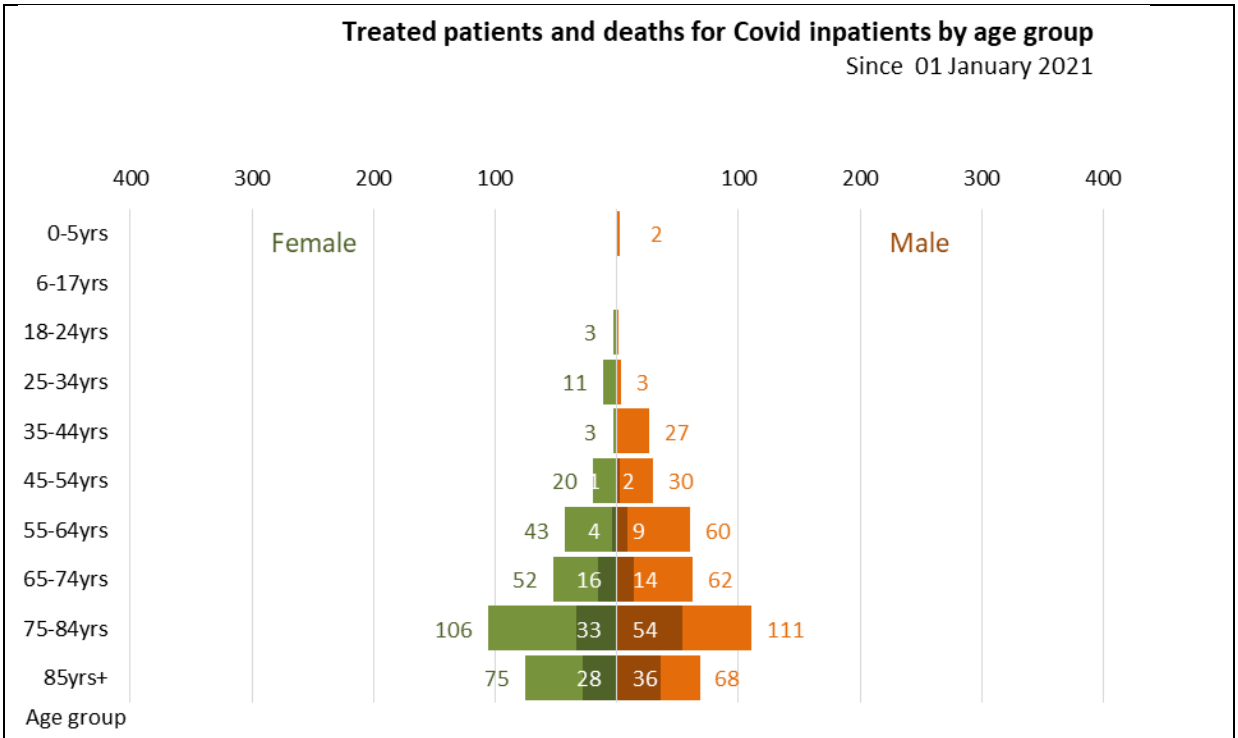

Observations

- The mortality rate for males aged 75yrs or older appears to be worsening. This same effect is not evident for female patients.
- The mortality rate for those aged under 65yrs is improving for both males and females.
- Some of these effects are quite small and involved relatively small numbers. But , whilst these figures might be a bit volatile, there appear to be shifts in the ages, gender and acuity of Covid-19 inpatients since 01 January.

Conclusion

Covid continues to put the Trust under pressure but with some indications that we may be at a fragile peak/plateau in patient numbers.

- The current number of beds required for Covid-19 patients is slightly reduced on last week.
- Community-onset and symptomatic cases continue to be the main source of new inpatients. There are some signs that these may be reducing in line but delayed with those trends in community data.
- Hospital acquired and non-symptomatic cases whilst smaller in number are not decreasing.
- Crude mortality has worsened during the early part of 2021 but is showing some more recent signs of improvement.
- The demand for beds for Covid inpatients continues to be mitigated by ability to discharge treated patients. Our performance in this regard has been maintained over much of the last seven days.
- However, pressures on ITU and respiratory care have seen a slight reduction over this reporting period.

Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	11th February 2021
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Recommendations
Trust Board is invited to note this report for assurance.
Appendices

NHS
Worcestershire Acute Hospitals
NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	11 February 2021
Paper number	Enc D2

Update on ICS and Trust Action Plan

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

Accountable Director	Jo Newton, Director of Strategy & Planning		
Presented by	Jo Newton	**Author /s**	Jo Newton Lisa Peaty/Jane Ball

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
CETM	3/2/21	Noted with amendments

Recommendations	The Board are asked to: • Note the update on ICS development • Endorse the Trust internal action plan

Executive summary	Implementation of the ICS action plan continues whilst awaiting the outcome of the designation process. Unless further national guidance is provided it is assumed that the target date for full implementation remains April 2022. Following a board development session in December 2020, the executive have reviewed the outputs to produce an eight point action plan aligned to our latest understanding of ICS development and timings.

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	BAF 2 Engagement BAF 3 Clinical Services Strategy BAF 4 Quality & safety

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	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	**March 2021**					

Introduction/Background

Meeting	Trust Board
Date of meeting	11 February 2021
Paper number	Enc D2

The paper outlines current ICS developments which have continued despite the Wave 2 COVID surge to implement the ICS development plan approved by Board in December.

Given the risks and opportunities identified by the Trust Board at the development session in December, a specific eight point action plan has been developed by the executive team for endorsement. (see Appendix 1).

Issues and options

Designation decision
Collectively as STP partners, we submitted our application to be formally recognised as an ICS in December 2020 and are currently awaiting news on the next steps. We were originally expecting to hear the outcome of the application in February, but have been advised that the decision will not be announced until the middle of March. In the mean time we will continue to work with the ICS partners on delivering the action plan that was included in the application.

Statutory guidance
There have been more that 8,000 responses submitted to the National Team on the "Next steps" for integrating care document. We have been advised that the team are going through the responses and will share an update as soon as possible. With the absence of concrete news to the contrary, we are assuming that the original timeline for statutory change will be pursued – ie new legislation impacting from April 2022.

Regional Commissioning Collaborative
The regional NHSEI team are currently conducting a review of their commissioning operating model. Locally the system is contributing to this work through a forum which a CCG director attends. The work is looking at developing joint/collaborative commissioning arrangements between ICS's and NHSE/I commissioned services (Specialist, Health and Justice, Primary Care - Dentistry, Optometry, Pharmacy). Shadow arrangements for new ways of working will be tested from April 2021, with a view to moving fully to new ways of working from April 2022. It is likely that this will involve an ICS level Joint Commissioning Board feeding into two Regional Boards (East and West) with ICS Strategic Commissioner and Provider membership.

National ICS Implementation Programme
Our ICS has been nominated by Regional Team to join the National ICS Implementation Test programme, along with only 6 other emerging ICS's nationally. This programme will provide us with the opportunity to help shape the next steps guidance and benefit from being able to test ideas and plans with regional and national support. We will also have the opportunity to work with and learn from the other sites, all of which are from other NHS regions.

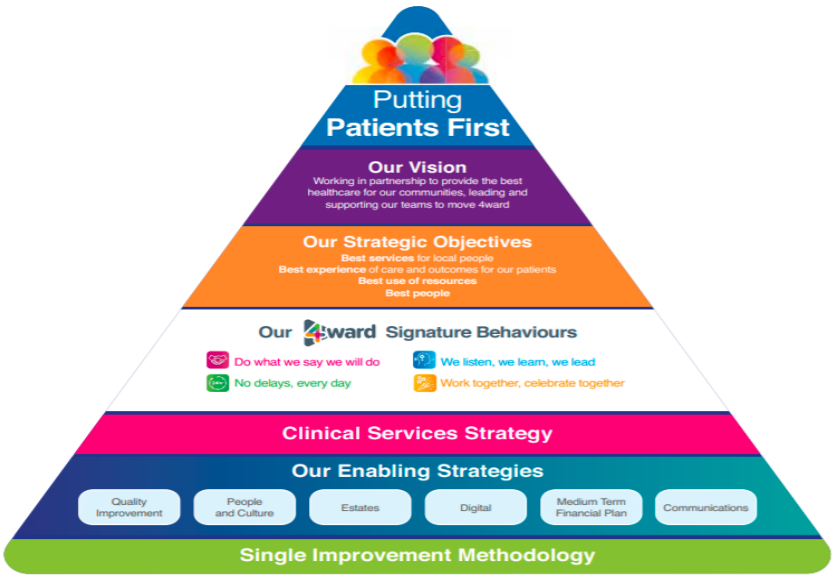
ICS Service Development Plans
As part of the work on the National ICS Implementation Programme, ICS partners are in the early stages of developing a plan for changing the way in which services are organised within the ICS. The first programme on the work plan is to explore ways to join up commissioner and provider functions for Mental Health Services in an integrated team. Within this arrangement, the "ICS" will develop an agreed outcomes framework that

the chosen provider is expected to work towards with an integrated budget that amalgamates funding streams into a single pot.

This approach will improve patient care by joining up services in a way that puts more ability to ***"do what's right for the person"*** in the hands of local clinicians and clinical leaders. Whilst initial developments will be focused on services that aren't directly commissioned from our Trust (ie all age mental health services), we are in conversations with ICS partners about exploring similar arrangements for some aspects of our planned care services. In order to take any developments forward, a Programme Board will be established on a "task and finish" basis to oversee the development and delivery of the work. Further details will be provided in due course when the development timelines are clear.

Leadership development / changes
Mike Farrar has been commissioned to support development of the PLACE (Worcester Place Alliance) collaboration, and further work to support PCN leadership development
A new ICS Programme Director, Dave Mehaffey has started to replace Jo-Anne Alner in leading system working.

The overarching ICS plan aligns to the Trust strategic objectives and the Clinical Services Strategy for our 42 sub-specialities.



The ICS development plan, approved by Board in December, outlines a significant amount of work at system level to achieve the deliverables outlined. Development work continues despite the current Wave 2 surge, with input from the corporate executive whilst the operational focus continues on responding to COVID-19. Clinical engagement by the Trust, as well as the wider system, remains a challenge during this phase.

WAHT ICS Action Plan

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	11 February 2021
Paper number	Enc D2

Following a Board development session in December 2020, the executive have reviewed the outputs to produce an action plan aligned to the ICS application action plan and our latest understanding of ICS designation timings (see Appendix 1). This eight point plan provides a summary of key areas of involvement with indicative timings.

The eight key objectives are built around the adopted 4ward behaviours approach which the themes of which also underpin the people and culture strategy.

EIGHT POINT PLAN:

1. Extend *Putting Patients First* approach to system working to support delivery of the ICS strategy

2. Lead system workforce transformation & OD agenda

3. Prioritise visible clinical leadership to drive patient centred delivery of care

4. Provide executive leadership to influence Use of Resources for System Sustainability within the Financial Framework

5. Lead system approach to transform elective (planned) care at PLACE (*vertical integration*)

6. Proactively influence and develop provider collaborations for acute & specialist care (*horizontal integration*)

7. Optimise the power of digital across all ICS providers, and embed and intensify the use of Population Health Management across the ICS

8. Use role as anchor institution to develop and host core corporate functions at PLACE

Conclusion

The Trust continues to work with system partners to develop and implement the ICS plan in line with national guidance.

The internal action plan seeks to reinforce our role as good system partners.

Recommendations

The Board are asked to:

- Note the update on ICS development
- Endorse the Trust internal action plan

Appendices

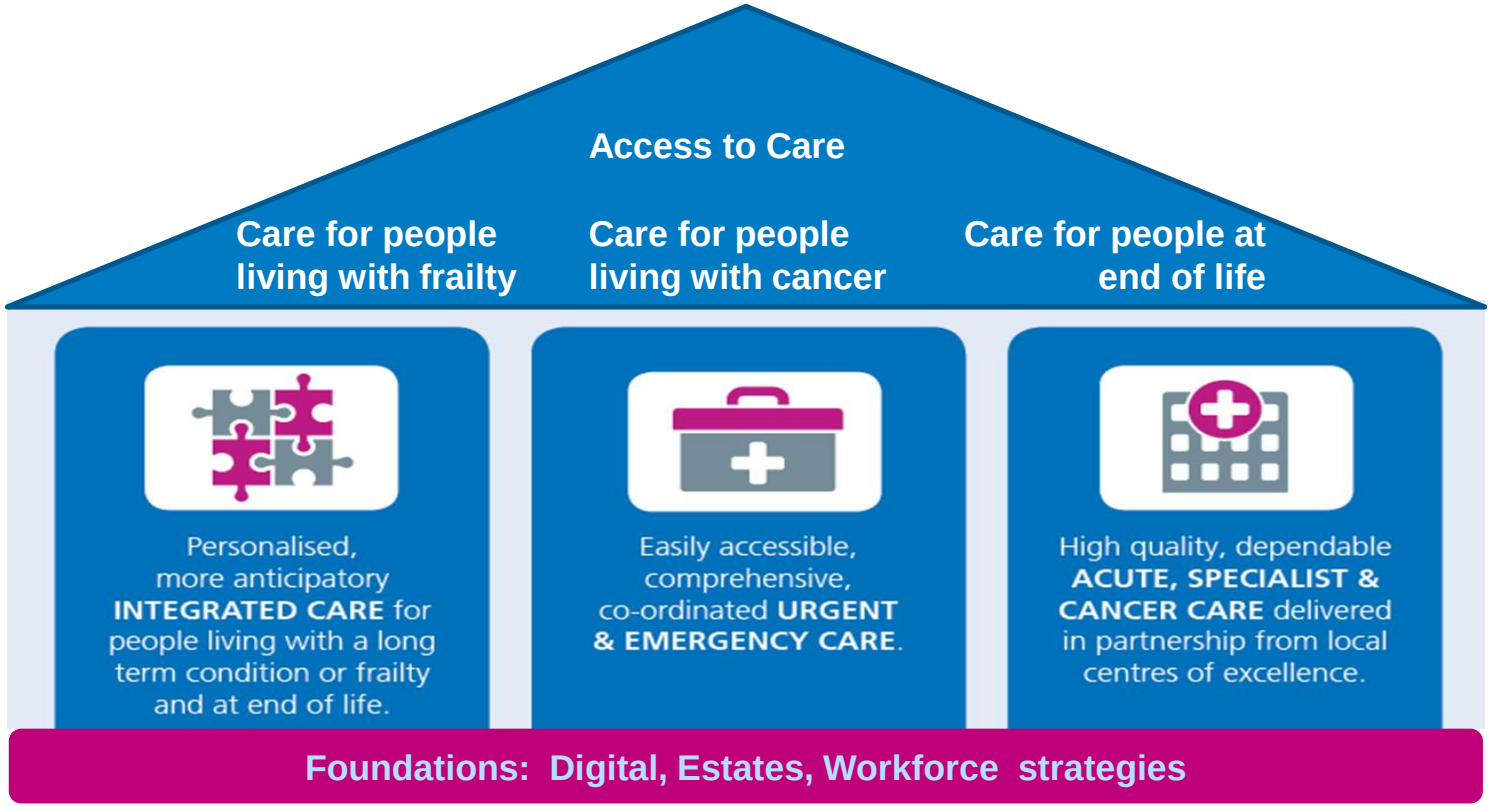
Appendix 1 – ICS Eight Point Action Plan

ICS Action Plan

following Board Workshop December 2020

Worcestershire Acute Hospitals NHS Trust

Aligned to H&W ICS and WAHT Clinical Services Strategy



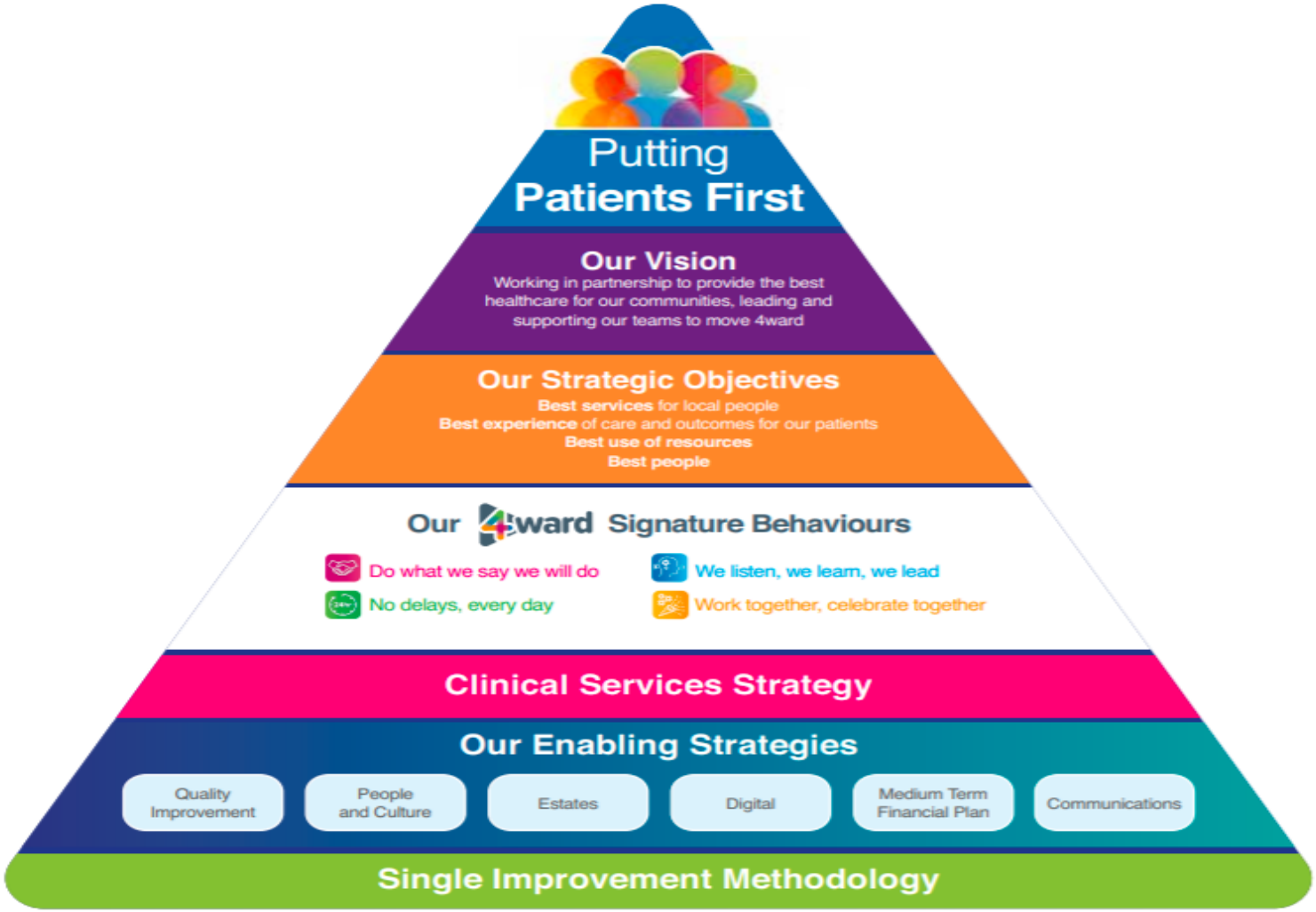
ICS 8 Point Plan

Worcestershire Acute Hospitals NHS Trust

Objectives *(underpinned by Clinical Services Strategy)*	Exec Lead(s)	When
1. Extend *Putting Patients First* approach to system working to support delivery of the ICS strategy	ALL	ongoing
2. Lead system workforce transformation & OD agenda	TR	ongoing
3. Prioritise visible clinical leadership to drive patient centred delivery of care	MiHa / JN	Feb -
4. Provide executive leadership to influence Use of Resources for System Sustainability within the Financial Framework	CFO - RDT	ongoing
5. Lead system approach to transform elective (planned) care at PLACE (*vertical integration*)	JN / PB	Feb - Oct
6. Proactively influence and develop provider collaborations for acute & specialist care (*horizontal integration*)	MiHa / JN	Feb -
7. Optimise the power of digital across all ICS providers, and embed and intensify the use of Population Health Management across the ICS	VL	Apr -
8. Use role as anchor institution to develop and host core corporate functions at PLACE	RT / TR / VL / RH / JN	May -

1. Extend *Putting Patients First* approach to system working to support delivery of the ICS strategy

Worcestershire Acute Hospitals NHS Trust



1. Extend *Putting Patients First* approach to system working to support delivery of the ICS strategy

Worcestershire Acute Hospitals NHS Trust

Objective	How
1.1 Do what we say we will do *Accountability*	Demonstrate commitment to building a successful ICS; plan, develop and deliver services collaboratively with our system partners Ensure our leaders are proactive, reaching out to colleagues across the ICS Put the greater good of the system ahead of organisational self interest
1.2 We listen, we learn, we lead *Empowerment and Leadership*	Respect and value the views of our ICS partners Embrace a population health-based approach to service planning and resource allocation Focus on partnership working to ensure that patients receive the right care in the right place at the right time, regardless of who delivers that care
1.3 No delays, everyday *Performance Improvement, linked to Single Improvement Methodology*	Ensure that governance and decision making processes are a catalyst for increased partnership working Contribute to agile and responsive ICS governance arrangements Move quickly to ensure health and care resources are deployed to the areas of greatest need
1.4 Work together, celebrate together *Collective Achievement*	Celebrate collectively as an ICS to recognise the contribution that our partners make Take as much pride in being a part of our ICS as we do in being a part of our own Trust Act as ambassadors for the ICS in our own organisation, across our ICS and beyond

2. Lead system workforce transformation & OD agenda

Worcestershire Acute Hospitals NHS Trust

Objectives	Exec Lead(s)	By when *(tbc)*
2.1 Lead development and implementation of People & Culture STP strategy and NHS People Plan to deliver 3 aims of an Engaged (culture/OD) Skilled (workforce transformation) and Supported (Great Place to Work) workforce	TR	ongoing
2.2 To develop an internal communication and engagement strategy for all staff which is aligned with ICS narrative	RH	End March 21
2.3 To establish how our board members engage with the system (e.g. making links with HWHACT, PCNs and LAs) and develop an accountability framework	TR	Early April 2021 onwards
2.4 To engage clinical staff in the identification of priority areas for system or place based working	MiHa/CNO	Ongoing

3. Prioritise visible clinical leadership to drive patient centred delivery of care

Worcestershire Acute Hospitals NHS Trust

Objective	Exec Lead(s)	By when *(tbc)*
3.1 To define the leadership role and competencies required of clinicians and identify system champions from Clinical Directors	JN/MiHa/CNO	End Feb 21
3.2 To co-design a model for engagement with PLACE clinicians consistent with the governance framework	MiHa/JN/Sarah Dugan	Mid Mar 21
3.3 To align senior clinicians to PLACE / district / PCN consistent with emergent operating model	JN/MiHa/CNO	Early Apr 21 onwards
3.4 To support and engage clinicians in outcome-based approaches to service development	JN/VL	Early Apr 21 onwards
3.5 Recommend and appoint to a Clinical Services Strategy lead clinician role	JN/MiHa	End Mar 21

4. Provide executive leadership to influence Use of Resources for System Sustainability within the Financial Framework

Worcestershire Acute Hospitals NHS Trust

Objective	Exec Lead(s)	By when *(tbc)*
4.1 Facilitate system wide review of recognised benchmarking tools and use that to inform discussions on the potential opportunities. Collaboratively determine with colleagues and lead on agreement on a small number of key areas and shared schemes that will focus on delivering Provider and System wide benefits. This aligned to an agreed benefits realisation methodology within the (to be issued) revised Financial Framework across the ICS and devolved to PLACE	RT	ongoing
4.2 To develop an agreed benefits realisation methodology within any ICS / RACI governance framework to support implementation and benefits delivery within assigned responsibilities, holding the system and partners to account.		
4.3 Influence capital investment programme to support UoR for the STP		
4.4 On an ongoing basis shared use of benchmarking to identify, sense check and drive opportunities.		

5. Lead system approach to transform elective (planned) care at PLACE (*vertical integration*)

Worcestershire Acute Hospitals NHS Trust

Objective	Exec Lead(s)	By when *(tbc)*
5.1 To influence the ICS/place approach to PHM so that a life course approach is adopted	JN/VL	ongoing
5.2 To repurpose approach and delivery of elective (planned) care bespoke to community needs	JN/PB	Q2
5.3 To review clinical services strategy to repatriate planned care closer to home	PB/JN	Q2
5.4 To work with neighbourhoods/districts and community leaders to understand the demand for secondary care using the outputs of PHM life course approach	JN/MiHa	ongoing
5.5 To establish the place of Children, young people and their families in this approach	JN/CNO	tbc

6. Proactively influence and develop provider collaborations for acute & specialist care (*horizontal integration*)

Worcestershire Acute Hospitals NHS Trust

Objective	Exec Lead(s)	By when *tbc*
6.1 To work with CCG to support devolvement of specialist commissioning functions to ICS level	PB/JN	Q3
6.2 To co-develop a pluralistic approach to ICS (STP) provider collaborations	MiHa / JN	Q1
6.3 To develop a Partnership strategy to affirm key partners to deliver clinical and diagnostic specialities	JN	Q1
6.4 To actively engage in clinical and diagnostic networks to ensure mutual aid and support ICS strategy	MiHa	Q1

7. Optimise the power of digital across all ICS providers, and embed and intensify the use of Population Health Management across the ICS

Worcestershire Acute Hospitals NHS Trust

Objectives	Exec Lead(s)	When
7.1 To act as Lead Intelligence Cell for the provider led aspect of the Population Health Management work	VL	Ongoing
7.2 Support the ICS delivery of the Integrated Care and Wellbeing Record System (Summary Care Record)	VL	April 2021
7.3 Implement an ICS level Patient Portal by combining and sharing provider data where legally permissible	VL	July 2021
7.4 Act as joint SRO for Data Lake & Insights Development Workstream to provide a framework for place-based strategies based on data analytics	VL	Ongoing

8. Use role as anchor institution to develop and host core corporate functions at PLACE

Worcestershire Acute Hospitals NHS Trust

Objectives	Exec Lead(s)	When
8.1 To review and agree what corporate services we could provide at place level	JN	March
8.2 To support ICS review of required enabling functions, co-designing a range of models for delivery of the services identified in 8.1	JN	End March
8.3 To continue to take a lead role in the development and provision of a digital hub at KTC	VL	Ongoing
8.4 To develop and propose approaches to organisation development and HR functions which could operate at place level	TR	Ongoing
8.5 To extend high impact change approach to place / system level	JN	Ongoing

People & Culture Strategic Framework 2021 to 2023

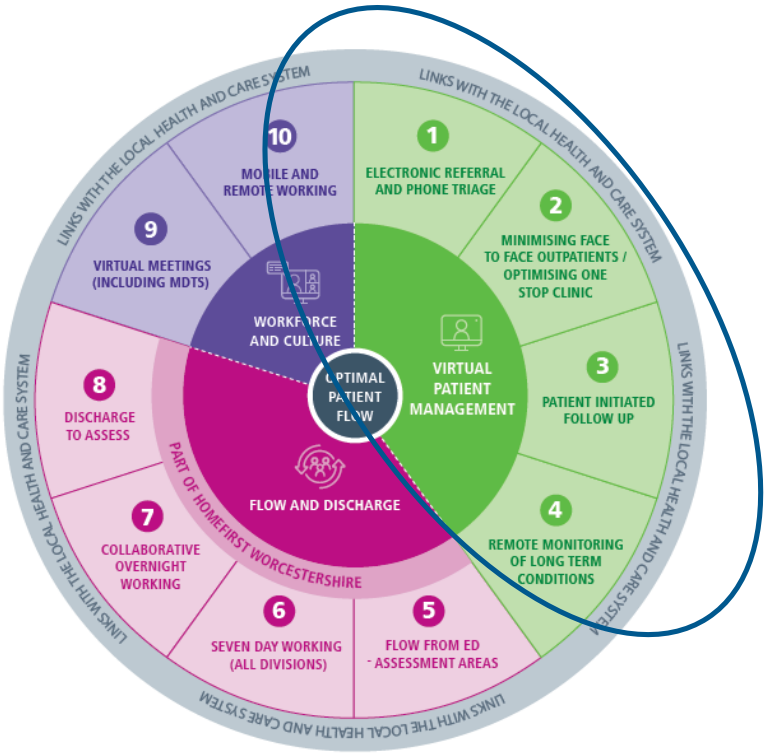
Worcestershire Acute Hospitals NHS Trust

STP Values and behaviours (To be defined)

Culture/ OD	Workforce Transformation	Great Place to Work
Equality & Diversity	Recruitment	Why Herefordshire & Worcestershire
Culture	Retaining staff	Flexible Working
Leadership	Workforce Planning	Health & Wellbeing
	Education, Learning and Development	
	New ways of Delivering Care	

LEADERSHIP BEHAVIOURS (To be defined)

Virtual Patient Management



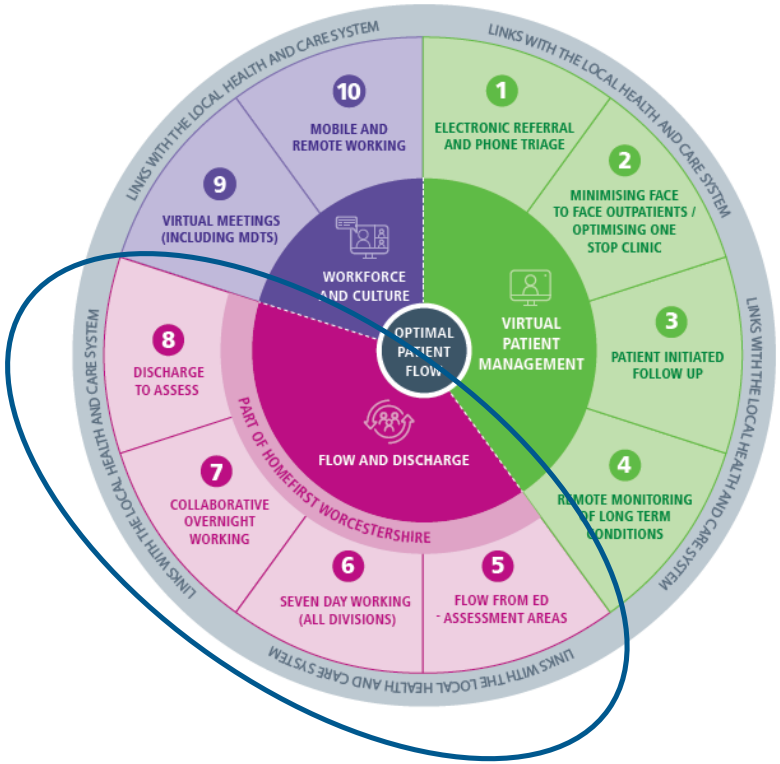
Existing system links:

- System working already in place.
- Updates on work within HICs 1-4 provided to STP via the GP and Acute Elective Care & Cancer Recovery Meeting.
- CCG PMs supported and provided system links.
- CCG PMs hosted within WAHT has proved to be an effective way of working.

Opportunities for system leadership:

- Potential to lead pathway and IT transformation – requires capacity across clinical teams, and system support for new ways of working

Flow and Discharge



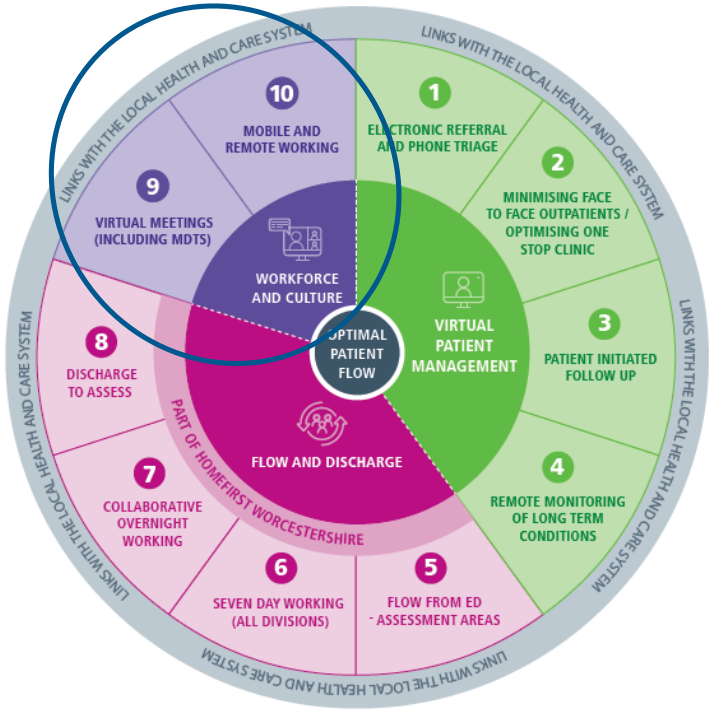
Existing system links:

- HomeFirst Worcestershire already embraces systemwide working to progress HICs 5 & 8.

Opportunities for system leadership:

- Potential to lead HICs 5 & 8 to strengthen systemwide approaches to flow and discharge to assess.
- HIC 6 – Seven Day Working could be widened across the system, in conjunction with the pathway transformation work from HICs 1-4, optimising patient access and use of resource across the system.

Workforce and Culture



Existing system links:

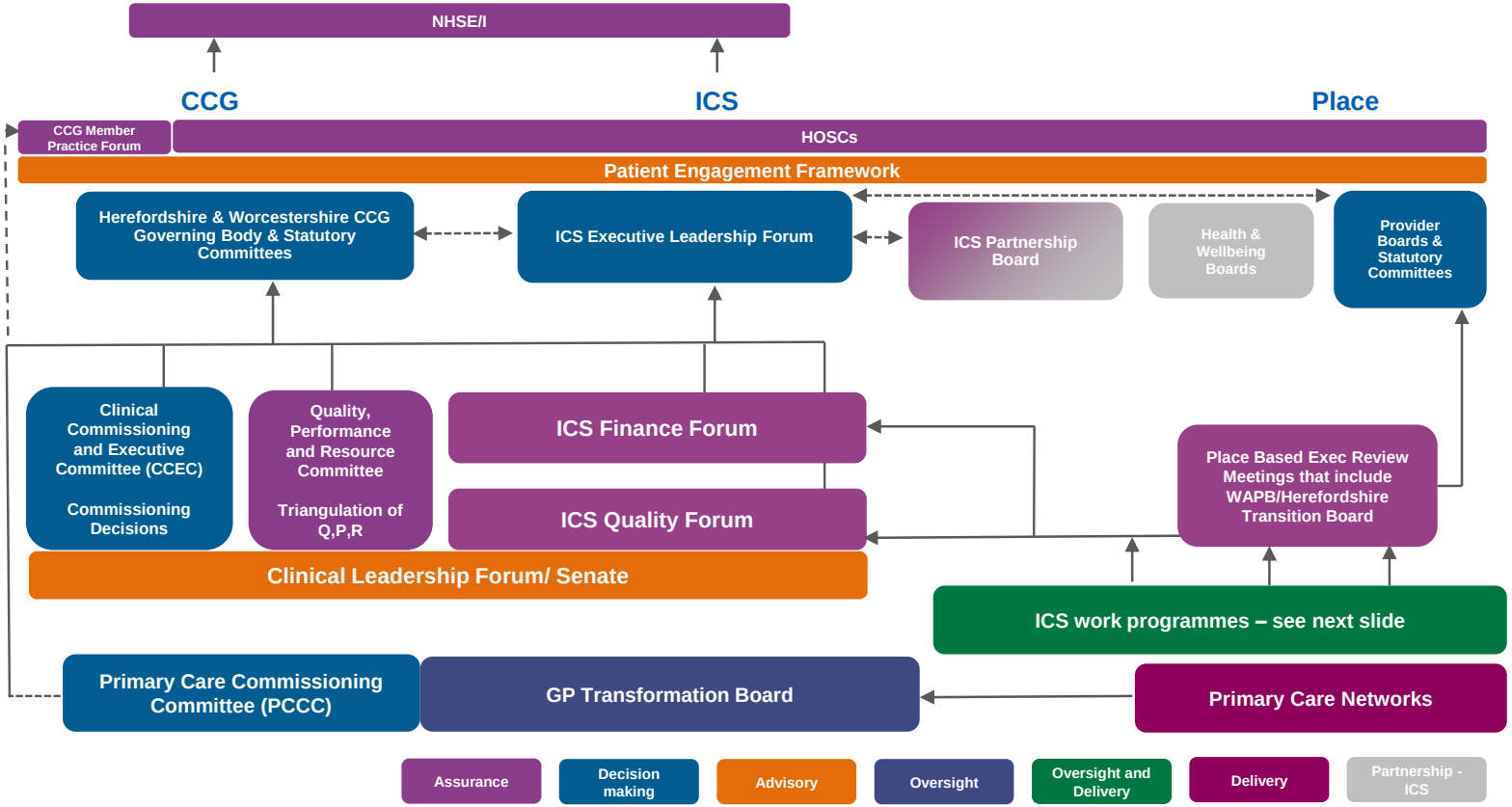
- Limited system working in place across HICs 9-10.

Opportunities for system leadership:

- Improved Virtual MDTs with wider system representation.
- GPs and community teams attending ward rounds.
- Aligned remote, mobile and flexible working policies and integrated hot-desking approaches, improving use of system estate.

Fully Draft ICS Governance by March 2021

Worcestershire Acute Hospitals NHS Trust



Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	11th February 2021
Paper number	Enc D3

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 Katie Osmond, Deputy Director of Finance Jo Kirwan, Assistant Director of Finance

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: • Note the changes to the timescale and approach for annual planning 2021/22 as a consequence of the surge in COVID-19 and recent national announcements • Acknowledge the complexity of annual planning given the need for restoration and recovery of services and because of the developing ICS

Executive summary	In January 2021, the national planning process was deferred due to COVID pressures and, consequently, a planning and contracting round will not be initiated before the end of March 2021. This paper presents our progress with annual planning to date, the proposed national approach to planning and its implications for the Trust.

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 x	4	5	6	7	N/A

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	11th February 2021
Paper number	Enc D3

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	**February 2021, following publication of national guidance**					

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	11th February 2021
Paper number	Enc D3

Introduction/Background

A paper describing our proposed approach to annual planning for 2021/22 was discussed at Finance and Performance Committee on 25th November 2020. It set out the context for the 2021/22 annual and financial planning process, and also proposed an approach and timeline for the development of plans. On 13th January 2021, NHSE/I announced that a planning and contracting round would not be initiated before the end of March 2021 because of COVID pressures and that the current financial arrangements will be rolled over to quarter 1. This paper describes the implications of this for the Trust and outlines our proposed response.

Issues and options

Work to date

Work to develop the Trust's annual plan commenced in November 2020. A timeline for the annual planning process was developed and by the end of December 2020, the following had taken place on time:

- A communication about commencing the development of service objectives, Productivity and Efficiency Plans (PEPs) and business cases was sent to operational and corporate divisions on 11th and 23rd December 2020 respectively.
- Activity data was sent to operational divisions on 24th December 2020. Divisions have reviewed and commented on the data and sent their comments to the Informatics and Contracts Teams in early January. Work is underway to adjust the activity data in light of the comments, but this is delayed due to COVID pressures.
- Discussions have taken place with those divisions which completed their draft strategic objective templates, lists of PEPs and lists of business cases. Divisions are continuing to develop and refine these.
- Pay budget working papers have been reviewed and updated to reflect staff in post and agreed rotas.
- Non pay and Directorate Income budget working papers have been reviewed and updated to align to 2019/20 outturn.
- Workforce planning and budget discussions have continued where practical and a list of cost pressures has been compiled.

In addition:

- The assumptions on which the 2021/22 plans will be based have been drafted, although these assumptions will need to be revised following publication of national and ICS assumptions.
- The 2021/22 Budget Setting Policy has been updated following feedback from Trust Management Executive.
- Model Hospital data has been provided to operational divisions and relevant corporate services as a basis for identifying potential PEPs.
- A risk register has been developed for the 2021/22 annual planning process.
- Annual planning and budget setting meetings with Corporate departments have taken place throughout December and January.
- The Trust has been represented at ICS system planning meetings.
- The Trust's Annual Planning Steering Group has met approximately weekly since October 2020.
- Creation of a Divisional draft of the underlying post COVID exit run rate from

2020/21.
- An assessment of cost impact of business cases agreed in 2020/21.
- An initial assessment of recurrent COVID costs in 2021/22, with consistent assumptions across the STP.

The following planned milestones were not met due to COVID pressures and the national announcement on 13th January 2021 that the planning round is suspended.

Action	Original timescale
Adjustments made by Informatics Team to activity data following comments from divisions and data resent to divisions – subsequent reviews and reiterations take place.	8th January
Submit paper on progress with annual planning to TME	13th January
Corporate teams collaboratively review and triangulate annual planning data	w/c 18th January
Submit paper on national guidance and progress with annual planning for CETM and F&P	20th January
Divisional sign off of data Finance to identify non pay fixed/variable cost base & derive costing tools for variable element HR Business Partners continue to work with Divisions on key areas of workforce plan Informatics to commence work on performance trajectories	22nd January
CETM discussion of paper on national guidance and progress F&P discussion of paper on national guidance and progress with annual planning with DDs present	27th January
Divisions to complete initial PIDs for PEPs Collate first draft capital programme for review at CPG and through ICS.	29th January

National planning approach
Following the NHSE/I announcement that the 2021/22 annual planning process will be deferred, the revised national approach to planning will be:

- To minimise the planning burden during quarter 4 2020/21 with the requirement for national returns minimised.
- To rollover the current financial framework into quarter 1 2021/22, although the

national total available quantum is still under negotiation at a national level.

- To defer the planning round to quarter 1 2021/22 with a focus on planning for quarters 2 to 4.

Quarter one 2021/22

Roll over of the quarter 1 financial framework will provide organisational level plans for months 1 – 3 of 2021/22. These are likely to be based on information generated by the national team on quarters 3 & 4 of 2020/21.

Regional planning work is already underway to look at the 2021/22 challenges and to identify the underlying positions post-COVID and non-recurrent pressures identified in 2021/22. Bridging is required from 2019/20 out turn to 2020/21 forecast and a view of the 2020/21 'where are we now' recurrent underlying position will be developed. In response to this regional work, we submitted a regional return on 29th January 2021. Our submission on the 29th was a high level top down approach that provides an initial assessment of what the Herefordshire and Worcestershire System financial position could look like in 2021/22. Our internal bottom-build planning / budget setting processes will refine this further and should also triangulate with the activity that can be delivered within the cost base.

Quarters 2 - 4 2021/22

Following quarter 1, the financial framework in quarters 2-4 will be based on:

- Continuation of the system envelope approach to financial planning.
- Reset of system envelopes being consistent with the Long Term Plan financial settlement and published CCG allocations and organisational Financial Recovery Fund which would have been available to systems in 2021/22.
- Additional non-recurrent funding being distributed from the spending review to systems to offset some of the lost efficiency opportunities from 2021/22.
- Baseline contracts being calculated to align with these envelopes.
- Blended payment being the default mechanism for most secondary healthcare services, including admitted elective pathways set out in the tariff engagement document issued on the 26th November.
- Funding for elective recovery being made available outside of system envelopes and funded from the additional ring-fenced resources identified in the spending review settlement.

Capital funding 2021/22

There will be a one year spending review national settlement for capital. The system capital envelope will be issued and system-level capital plans will be required for the year 2021/22 as a whole. The quantum nationally for system operational capital including emergency capital will be similar to 2020/21 and a similar method of allocation will be adopted. All available funding for backlog maintenance/critical infrastructure risk will be included into system envelopes for 2021/22. System capital envelopes are likely to be announced in February 2021 and system capital plans are likely to be required in April 2021. Work has commenced within the STP to understand pre commitments and priorities moving into 2021/22 and in the medium term.

Timescales and next steps

The indicative national timeline is set out below, although this is subject to the evolving

Meeting	Trust Board
Date of meeting	11th February 2021
Paper number	Enc D3

COVID situation:

Indicative date	Action
Early February	Guidance on quarter 1 rollover and associated requirements System capital envelopes announced
March	Final quarter 1 financial envelopes confirmed
Early April	Quarters 2 – 4 operational planning guidance issued Submission of system capital plans
End of June	Quarters 2-4 final operational plans submitted

Next steps January – February 2021 whilst awaiting national guidance

- Understand what roll forward of quarter one means for the Trust and how we are going to set budgets for quarter one.
- Corporate leads to continue to attend system-wide planning meetings and to meet internally on a weekly basis.
- Where possible, corporate annual planning leads to continue to work in the background on:
    - budget setting, including divisional and clinical meetings for those who wish to take up the opportunity
    - workforce plans
    - costing proposed PEPs
    - plans for corporate departments
    - capital plan
- Continue to address comments from divisions on activity and adjust activity data for 2021/22. Send back to division for review if division has the capacity to.
- Define the approach we will take for prioritising business cases.
- Define approach to divisional annual plan review meetings.

Post-COVID surge and following publication of national guidance

- Re-draft annual planning timeline to meet national and system deadlines and to align with our governance.
- Determine a work plan which will respond to these requirements, working with operational divisions to deliver this.
- Review annual planning assumptions.
- Develop and agree activity and workforce plans, budgets and cost pressures, performance trajectories and capital plans.
- Develop PEPs and business cases in required detail and prioritise business cases using agreed criteria.
- Divisional annual plan review meetings take place.

Conclusion
The 2021/22 annual planning process will be challenging given the environment in which we are setting our plans. The paper presents our revised approach, which is subject to further change in light of national guidance when it is published. We will work with our system

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	11th February 2021
Paper number	Enc D3

partners to support the development of the Herefordshire and Worcestershire STP/ICS plans and operating framework.

Recommendations

It is recommended that Trust Board:

- Note the changes to the timescale and approach for annual planning 2021/22 as a consequence of the surge in COVID-19 and recent national announcements
- Acknowledge the complexity of annual planning given the need for restoration and recovery of services and because of the developing ICS

Appendices

NHS
Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	11th February 2021
Paper number	Enc E

Integrated Performance Report – Month 9 2020/21

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

Accountable Director	Paul Brennan – Chief Operating Officer, Vicky Morris – Chief Nursing Officer, Mike Hallissey – Chief Medical Officer, Tina Ricketts – Director of People & Culture		
Presented by	Paul Brennan – Chief Operating Officer. Rebecca Brown – Deputy Chief Digital Officer	**Author /s**	Steven Price – Senior Performance Manager Nicola O'Brien – Associate Director – Business Intelligence, Performance and Digital

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	20th January 2021	Approved
Finance and Performance	27th January 2021	Assured
Quality Governance	28th January 2021	Assured

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

Executive summary	**The Impact of COVID-19** As noted in the IPR paper to January's Trust Board we recognise that the COVID-19 pandemic remains the most significant area of concern for the Trust; impacting bed capacity, staffing, surgery, front door activity, patient flow and cancer treatments. Decisions that have been made since the significant increase in COVID-19 positive patients (from 1st January) will not be identifiable in the December 2020, but will be visible in January 2021 data. In summary, where elements of the hospital pathway for patients have been put under additional pressure e.g. front door and patient flow, this has resulted in special cause variation for some of the associated metrics. Where the impact has not been as significant, in-month, most other metrics show no significant change in performance indicating that current processes were maintained. This reinforces the view that the balance achieved in Nov-20 was capable of being maintained in Dec-20 where we had the staff, beds, diagnostic capacity and pathways in place to focus on continuing to deliver care for non-COVID-19 patients. However, it must be highlighted now that the cancellation of elective treatments and redeployment of staff to support wards and the intensive care team will result in further fluctuations in performance, and specifically, will result in the number of patients waiting long periods of time for their treatment to increase. To put this in some

context, if we did 10% more activity a week, it would take us 10 weeks to catch up on 1 weeks missed activity.

Looking ahead to the eventual de-escalation from Covid Alert level 5, there will be a renewed focus on timely discharge and flow, in line with the good progress made in October / November 2020.

Looking forward at January, the Trust has cared for the highest number of COVID-19 inpatients since the start of the pandemic, at its peak 269, and 32 patients being cared for in our ITU's with 28 being COVID-19 positive. In addition, a range of category 2 elective surgery has been cancelled in January including cancer.

Long Waiters (Dec-20)

- There were 195 patients on a 62 day cancer pathway waiting over 62 days, and of those, 49 have been waiting over 104 days.
- There were 3,131 patients waiting over 52 weeks for their RTT related treatment, and of those, 381 have been waiting over 70 weeks.
- There were 3,163 patients waiting 6+ weeks for their diagnostic test and of those, 1,438 have been waiting 13+ weeks.

Quality and Safety

Infection Prevention & Control: Current work on the prevention of infection is focussed primarily on the management of COVID-19. The continued focus on both antimicrobial stewardship and MSSA bacteraemia has been impacted by the need to focus on the surge in cases in the second wave of the pandemic. The number of COVID-19 outbreaks and increased case numbers being admitted as part of the second wave of the pandemic have proved challenging but robust control measures are in place. The COVID-19 BAF self-assessment has been repeated and the recommended level of assurance has been reduced based upon the concerns noted in the Infection Prevention & Control Update to QGC.

Maternity – The Ockenden Report
Following the publication of the investigation into the safety of the maternity services at Shrewsbury and Telford NHS Trust, all Trusts were asked to provide assurance against 8 categories with 14 immediate safety actions. On review, Women's & Children Division were able to demonstrate compliance with 7 of the 14 immediate actions. In a further 6 areas a gap had been noted and actions identified to meet the standard outlined in the report. At the time of initially completing the gap analysis one action 'Perinatal Clinical Quality Surveillance Model' had not been launched nationally. This has now been received by the Trust and the Division is in the process of reviewing the model.

Worcestershire Acute Hospitals NHS Trust

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People & Culture

The top 3 people and culture risks during this period are:

- Maintaining a positive culture during the national pandemic
- Staff supply to meet the demand
- Staff health and wellbeing.

To mitigate these risks the people and culture directorate has organised itself around the following priorities during escalation level 5:

- Maintaining our 4ward culture change journey
- Enabling new staffing models to respond to operational priorities
- Ensuring the live recording and reporting of staff absence levels to support safe staffing
- To ensure staff are aware of and access health and wellbeing interventions at the earliest opportunity
- Maximising the Covid-19 vaccination for staff
- Maximising workforce supply
- Supporting staff with their welfare needs
- Supporting managers and staff with HR advice

These actions have contributed to a reduction in staff absence when compared to wave 1 and we continue to see improvement in our staff turnover and vacancy rates.

Our Financial Position

1. Internal Plan

Against the internal £(78.9)m operational deficit plan (Budget), the month 9 (December 2020) actual surplus was £0.5m vs Plan £(7.4)m, a £7.8m 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 £(1.2)m adverse. This position includes £1.0m of incremental COVID-19 costs.

The combined income position was £9.0m (Top-up £9.1m – Income variance £0.1m) favourable to budget in month recognising the interim funding regime. The revised payment mechanism remains in place until the end of March.

2. NHSI Financial Framework 20/21

NHSI Financial Framework submission - The Trusts Income & Expenditure position was £1.7m monetarily better than the Financial

Framework plan assumptions.

In December, Elective and Outpatient activity was reduced compared to November, whereas A&E attendances and Emergency admissions increased.

Income was £0.7m (2%) higher than plan due to additional income including COVID testing.

Pay costs were £1.0m (4%) 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 were lower than forecast. In addition, in December we have seen reduced levels of annual leave taken across our substantive workforce (particularly over the Christmas period). As a result temporary staffing and associated premium costs did not increase to the levels anticipated (£0.4m).
- 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. (£0.2m)
- Slippage in recruitment – in many cases this is deemed to be a timing difference, we would not expect this favourable variance to continue at this level. (c. £0.1m)
- Correction to Temporary Medics costs previously estimated M4-8 following receipt of M9 data from NHSP. At a Trust level this resulted in a marginal positive swing of c.£0.2m. Finance teams are validating this data with booking teams during January to provide further assurance.

Non Pay costs were £0.2m lower than the financial framework plan. The plan assumed additional spends driven by increases in activity with the assumption that all beds would be open in December 2020. Ward 10 remains closed and incremental variable non-pay costs associated with the number of beds open and occupied are lower than anticipated. Oncology and Respiratory Drugs costs increased in month reducing the overall variance from plan.

Financing costs are £0.1m adverse to plan following a reforecast in the PDC (Public Dividend Capital).

In M9 December we have performed a further and in-depth risk assessment of the Forecast Out Turn. This has moved the position by £(1.2)m from an estimated at M8 - £(1.3)m deficit to a forecast of £(2.5)m. This results in a remaining positive year end variance of £4.8m

Worcestershire Acute Hospitals NHS Trust

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	against the revised Financial Framework Plan of £(7.3)m deficit. At the end of M9 year to date we are £6.1m positive against this NHSI Financial Framework Plan, note though, Q4 activity and cost is expected to be impacted by 2nd wave COVID impact against Phase 3. Key items that have arisen in January that have been reflected within this refresh include the recent notification of the deployment of student nurses to support this 3rd wave c. £0.5m, a change to the personal injury discount rate c. £0.3m, PDC Dividend change £0.2m and other non-pay.

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	5	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**		**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 (Dec-20 data) • WAHT December 2020 in Numbers infographic • Committee Assurance Statements

Integrated Performance Report

NHS Worcestershire Acute Hospitals NHS Trust

Trust Board

11th February 2021

December 2020
Month 9

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

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Operational Performance

Operational Performance Report - Headlines

Operational Performance	Comments
Urgent care and patient flow including Home First Worcestershire	• 4 hour EAS, 12 hour breaches and 60 minute ambulance handover breaches are all showing special cause concern for December; there is a direct correlation with the pressure on both hospital sites to manage bed capacity, patient flow and, towards the end of the month, the surge in COVID-19 positive patients requiring a bed. • The in-month pressure on the sites is also evident in the other SPC graphs for this section of operational performance e.g. total time (95th percentile) in A&E, aggregated patient delay, the capacity gap and average length of stay in AMU; all of which also show special cause concern. • More beds have had to be allocated to COVID-19 pathways which has significantly reduced our capacity to undertake elective procedures. Redeployment is being actioned as part of our surge and super surge response plan but this does not offset the increase in staff absence related to COVID-19 or the recommended ratio of patients to staff required for intensive care treatment.
Cancer	• Cancer two week waiting times have not changed significantly in the last two months. This process is currently unlikely to achieve the 93% target whilst Breast Services continues to not be able to see the majority of their patients within two weeks. Overall performance may be expected to vary between 73% and 98%. • Cancer two week waits for Breast Symptomatic remains a concern with the majority of patients still not being seen within 14 days. Although the target of 93% can be, and has been met, it is unlikely to be achieved with variance between 22% and 100%. • Cancer 62 day waits have not changed significantly since Aug-19. This process will not achieve the 85% target but may be expected to vary between 60% and 80%. • **Long Waits:** The backlog of patients waiting over 62 days remains below the phase 3 trajectory; and there has been an increase in patients waiting. Of this cohort, those waiting over 104 days has not changed significantly; however our internal target of zero patients cannot be met at this time.
RTT	• RTT remains a cause for concern; a direct result of the impact of COVID-19 on elective treatment and surgery. The waiting list has grown for 6 of the last 7 months, but December is the first month since July where the number of patients waiting longer than 18 weeks has increased. With the cancellation of elective surgery and outpatient appointments, it is to be expected that the profile of the waiting list will show an increase in breaches. • **Long Waits:** 3,131 patients (7.53% of the RTT waiting list) are now waiting over 52 weeks for their treatment, with T&O and Urology each having over 500 patients. 381 of those patients waiting 52+ weeks have been waiting over 70 weeks and approximately 80% remained undated. As previously reported, 50% of those very long waiters are for orthodontic treatment or oral surgery.
Outpatients	• Although not entirely reflected in the Dec-20 totals, the requirement to cease elective activity, particularly on the WRH site, and redeploy clinical staff to support the care of COVID-19 patients has had, and will continue to have an impact on the Trust's capacity to undertake outpatient appointments. Consultant led (first) remote and Consultant led (follow up) face to face appointments were above the phase 3 forecast. Where possible, activity has continued at KTC but will be expected to flex as patients are prioritised.
Theatres	• Theatre utilisation was at 80% in Dec-20; highlighted as significant due to 7 months in a row of improving utilisation. The utilisation will be being impacted by the availability of recovery beds for patients having surgery, due to the increasing requirement for COVID beds.
Diagnostics	• Diagnostic testing remains a cause for concern; the impact of wave 1 of the majority of activity and subsequent increasing backlog is still being addressed. The process is currently not capable of achieving the 1% target. CT, non-obstetric ultrasound and flexi sigmoidoscopy activity was higher than phase 3 forecast. • **Long Waits:** 3,163 patients are waiting over 6 weeks for their diagnostic test, with echocardiography contributing the most waiters from a single modality. Of the total number of breaches, 1,438 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				
32	908	327	365	WRH	88.86%	ALX	60.93%

What does the data tell us?

- **EAS** - The overall Trust EAS performance which includes KTC and HACW MIUs is 76.15% in Dec-20, compared to 82.10% in Nov-20. The EAS performance at WRH decreased by 7.96 percentage points with 33 **more** ED attendances and 462 **more** 4 hour breaches than Nov-20 (Dec-20 breaches were 5,676). The ALX EAS decreased by 7.28 percentage points, with 367 **more** attendances and 342 **more** 4 hour breaches (Dec-20 breaches were 784). Total Type 1 attendances across ALX and WRH was 9,780; a 4% **increase** on the previous month and a 17% **decrease** on Dec-19.
- **EAS Type 1:** Our performance across the two sites, from Apr-19 to Dec-19, was 64.02% with 37,180 patients breaching 4 hours. Our performance for Apr-20 to Dec-20 is 81.72% with 16,299 patients breaching; this is a 56% reduction in patients breaching 4 hours. We have had 14,143 fewer patients attend ED in the nine months of 20/21.
- **Ambulance Handovers** - There were 365 x 60 minute ambulance handover delays; with breaches at both sites.
- **12 hour trolley breaches –** There were 32 reported 12 hour trolley breaches in Dec-20; they occurred on 15 of the 31 days and the highest on a single day being 7 on the 15th. We have reported 38 12 hour trolley breaches in 20/21 compared to 678 by the end of December 19/20.
- **Specialty Review times** – Specialty Review times remain within normal variation; however this is under the target that has been set.
- **Discharges** – Both sites continue to have a wide variation in performance with the percentage of non-COVID discharges compared to admissions at the WRH between 44% and 148% and between 48% and 166% at the ALX. Before 10am discharges (on non-COVID wards) were above the mean from Jul-20 to Nov-10 and although there has been no significant change have dropped below the mean. 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 30 (at 30th November) to 50 with 13 being MFFD.
- **Total Time in A&E:** The 95th percentile for patients total time in the Emergency departments has increased from 600 minutes in Nov-20 to 855 minutes in Dec-20. This is special cause variation and this process is unlikely to consistently achieve our target of 380 minutes but may be expected to vary between 288 and 704 minutes.

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 (Oct-20)	Aggregated patient delay (APD) (Target – 0)	Discharges as a % of admissions – (Target >100%)			
855	28 Beds	1.9%	580	WRH	100.2%	ALX	100%

What does the data tell us?

- **Bed Capacity** - We have increased our bed base by opening previously closed wards at the ALX. Our G&A bed base is current 761; with closed wards and unused beds during December our average number of G&A beds occupied per day was 590, up from 517 the month before.
- **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 shows a significant change for Dec-20 and the process indicates we cannot achieve the target of zero.
- **Occupancy -** G&A bed occupancy averaged at 77.53% across the Trust, with WRH fluctuating week on week in November to as high as 92.45% and ending the month at 85.80%. The ALX also fluctuated week on week to 60.93% at month end although this mask going over 60% on 19 days in the month.
- **Conversion rates** – 3,092 Type 1 patients were admitted in Dec-20; a conversion rate of 32.29%. The conversion rate at WRH was 33.55% and the ALX was 30.60%. The conversion rate at WRH in Dec-20 compared to Dec-19 is 2.44 percentage points higher continuing the trend of higher acuity for patients attending the Emergency Department; on three days in the month the conversion rate was greater than 40% at WRH and one day at ALX.
- **15 minute time to triage –** The Trust performance is 87.6%, showing no significant change since Apr-20; the process will not achieve the target of 95% consistently. It is the same at site level, no significant change for WRH or ALX.

Current Assurance Level: 5 (Nov-20)	**When expected to move to next level of assurance: Q4 – depending on the management and impact of COVID-19 second wave and the development of the Worcestershire Royal AMU model**
Previous assurance level: 5 (Oct-20)	**SRO: Paul Brennan**

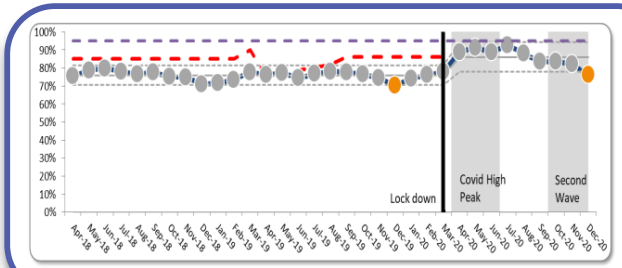
Month 9 [December] 2020-21 | Operational Performance: Urgent Care & Patient Flow

Responsible Director: Chief Operating Officer | Validated for Dec-20 as 07th January 2020

NHS Worcestershire Acute Hospitals NHS Trust

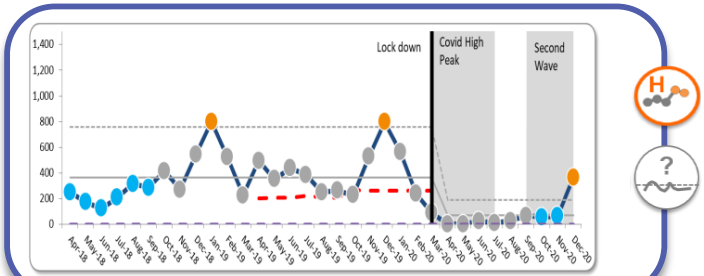
4 Hour EAS (all)

76.15%



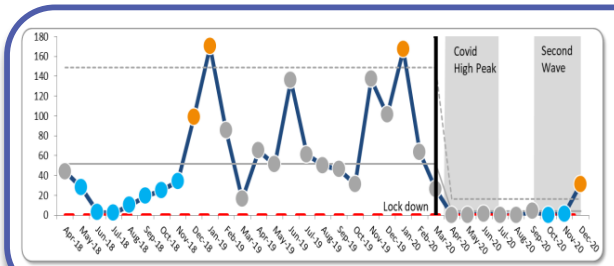
60 minute Ambulance Handover Delays

365



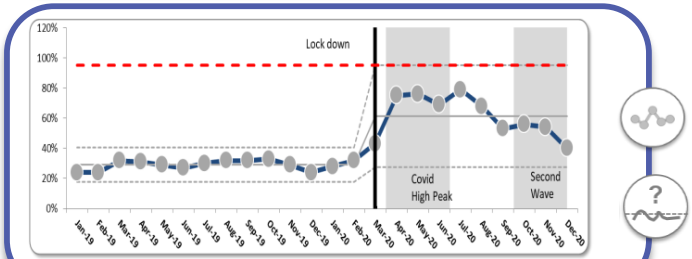
12 Hour Trolley Breaches

32



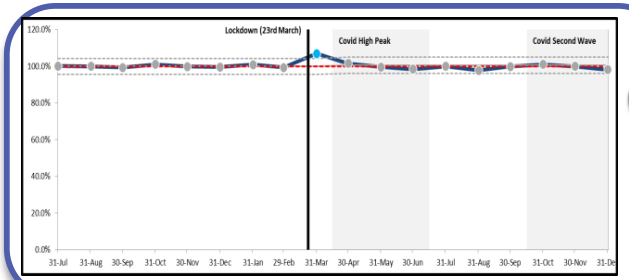
Specialty Review within 1 hour

40%



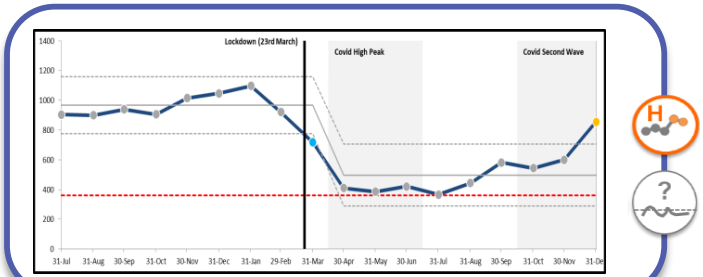
Discharge as a percentage of admissions

98.2%



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

855



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

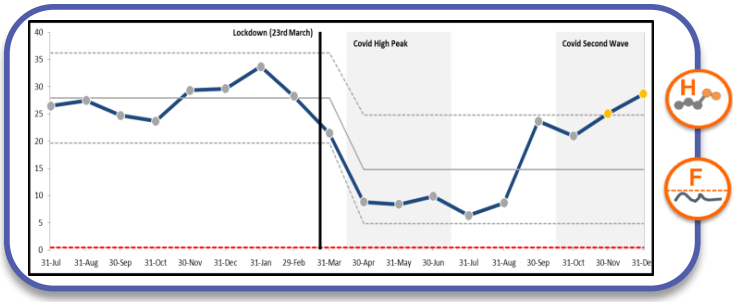
- Internal target
- Operational standard

Month 9 [December] 2020-21 | Operational Performance: Urgent Care & Patient Flow

Responsible Director: Chief Operating Officer | Validated for Dec-20 as 7th January 2020

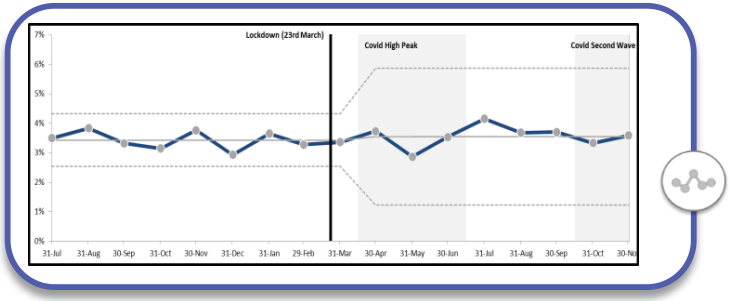
Capacity Gap (Daily avg. excl. EL)

28.2



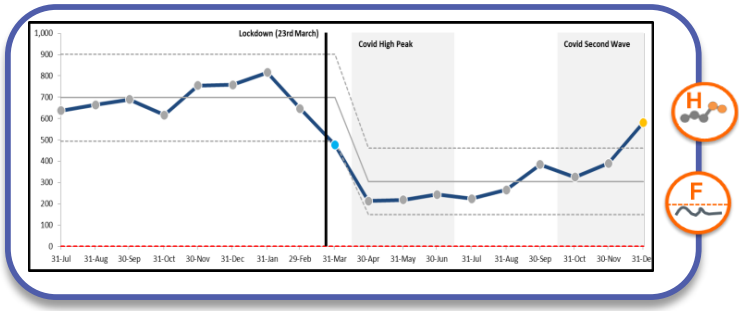
30 day readmission rate for same clinical condition (Oct-20)

3.26%



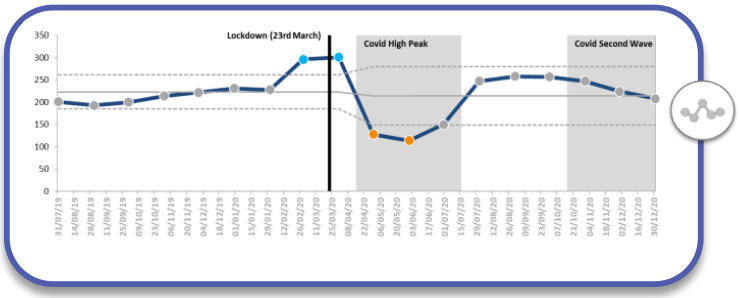
Aggregated Patient Delay (APD)

580



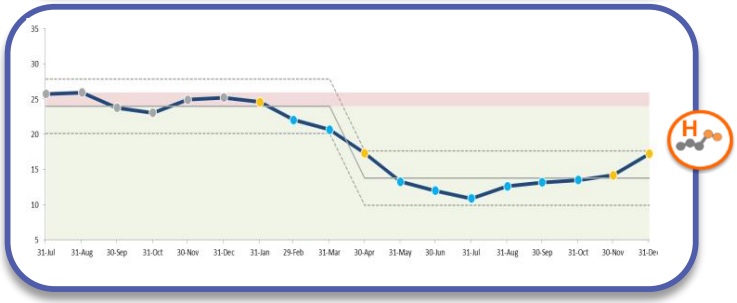
Discharges before 12pm (Non COVID-19 wards)

207



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

17.2



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 (December 2020)

EAS (All) - The Trust was one of 12 of the 13 West Midlands Trusts which saw a decrease in performance between November and December. This Trust was ranked 8th of 13; where we were 5th previous month. The peer group performance ranged from 65.83% to 84.55% with a peer group average of 73.95%; decreasing from 78.27% the previous month. The England average for December was 80.3%, a 3.8 percentage point decrease from 83.80%, in November.

EAS (Type 1) - The Trust was one of 12 of 13 West Midlands Trusts which saw a decrease in performance between November and December. This Trust was ranked 7th of 13; we were 3rd the previous month. The peer group performance ranged from 54.32% to 83.15% with a peer group average of 64.99%; decreasing from 68.88% the previous month. The England average for December was 72.1%, a 4.7 percentage point decrease from 76.8%, in November.

In December, there were 3,745 patients recorded as spending >12 hours from decision to admit to admission. 32 of these patients were from WAHT; 0.85% of the total.

EAS – % in 4 hours or less (All) – Dec-20

EAS – % in 4 hours or less (Type 1) – Dec-20

EAS – % in 4 hours or less (All) – Nov-20

EAS – % in 4 hours or less (Type 1) – Nov-20

WAHT — Operational Standard 95%

8

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	Backlog of patients waiting 63 days or more	Of which, patients waiting 104 days or more
2,127	80.09% (1,911 total seen)	9.91% (111 total seen)	94.38% (240 total treated)	70.21% (153 total treated)	195	57

What does the data tells us?

- **Referrals**: there has been no significant change in referrals since Jun-20, although the last four months have been above the mean. There are no **significant** changes in referrals at specialty level; the reduced demand on Breast services has been offset by increases in other specialties (Lower GI, Upper GI and Urology).
- **2WW:** The Trust saw 95 fewer patients in Dec-20 than Nov-20 and 80.09% were within 14 days. Further improvements to the Upper GI pathway has increased the number of patients seen within 14 days to 84.13%; it was as low as 6.17% in Sep-20. The Breast service saw 284 patients but only 8.10% were within 14 days; additional capacity continues to be made available to address the backlog but the wait remains in excess of 20 days.
- Of the 456 breaches, 261 (71%) were attributable to Breast Service (inc. Breast Symptomatic). Across all tumour sites, only 45 2WW breaches were due to patient choice.
- **2WW Breast Symptomatic:** The Trust saw no significant change in patients referred for breast symptoms but the waiting time performance has decline to 9.91%from 13.59% in Nov-20. The waits have increased significantly in the last two months and the process is very unlikely to achieve the 93% target.
- **31 Day:** Of the 267 patients treated in Dec-20, 252 waited less than 31 days for their first definitive treatment from receiving their diagnosis. There is no change in variation; the process is likely to achieve the target but not consistently.
- **62 Day:** There have been 169.5 recorded first treatments in Dec-20 to date-and 70.21% are 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. However, this is the second highest number of treatments in 20/21.
- **Backlog:** The number of patients waiting 62+ days for their diagnosis and, if necessary, treatment has increased from 181 in Nov-20 to 195 in Dec-20; this is still tracking under our December phase 3 forecast of 235. Of that cohort, the number of patients waiting 104 days or more is 57; despite the increase this is within normal variation, however this metric cannot currently meet the target of zero.
- **Conversion rates:** In 2019 the Trust's conversion rate from referral to positive diagnosis was 9.39% across all specialties. In 2020, to Sep-20, our conversion rate is 10.75%, however this is in the context of fewer total referrals and, fewer positive cases.

Current Assurance Level: 4 (Nov-20)	**When expected to move to next level of assurance: Phase 3 modelling is focussing on delivering the 62 day waiting time standard by Mar-21**
Previous Assurance Level: 4 (Oct-20)	**SRO: Paul Brennan**

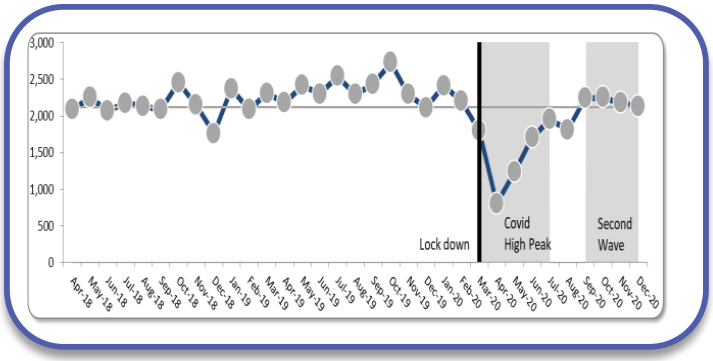
Month 9 [December] 2020-21 | Operational Performance: Cancer

Responsible Director: Chief Operating Officer | Unvalidated for Dec-20 as 9th January 2021

NHS Worcestershire Acute Hospitals NHS Trust

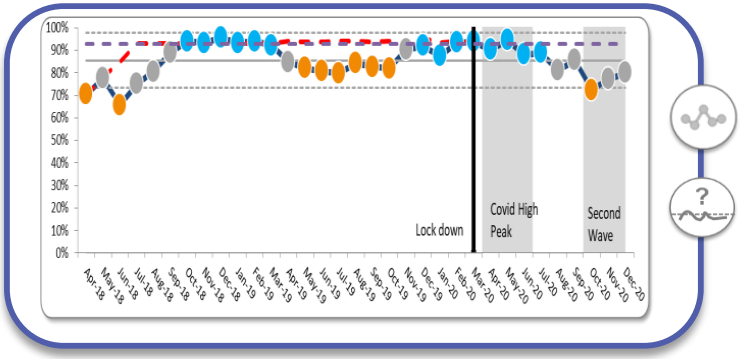
2WW Referrals

2,127



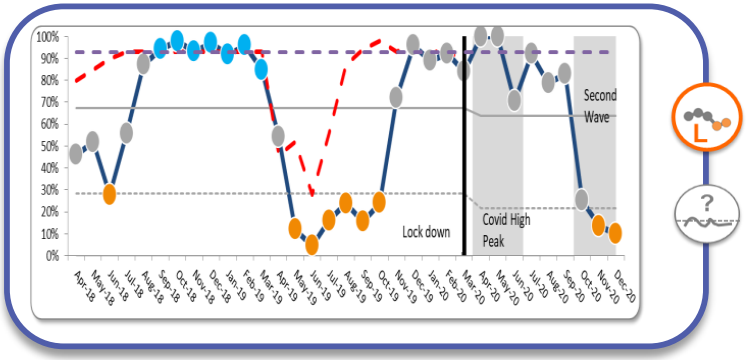
Cancer 2WW All

80.09%



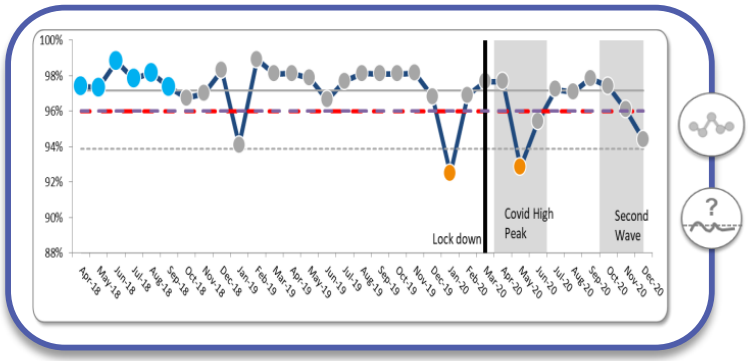
Cancer 2WW Breast Symptomatic

9.91%



Cancer 31 Day All

94.38%



Key

- Internal target
- Operational standard

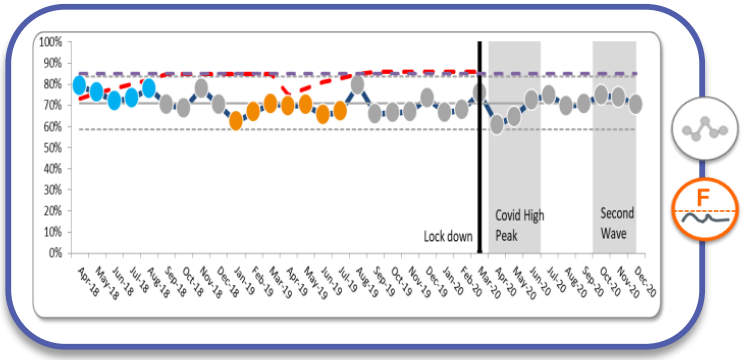
Please note: The **2WW Breast Symptomatic** SPC chart has been re-based to evidence if any changes in performance, post the initial COVID-19 high peak, are now common or special cause variation.

Month 9 [December] 2020-21 | Operational Performance: Cancer

Responsible Director: Chief Operating Officer | Unvalidated for Dec-20 as 7th January 2021

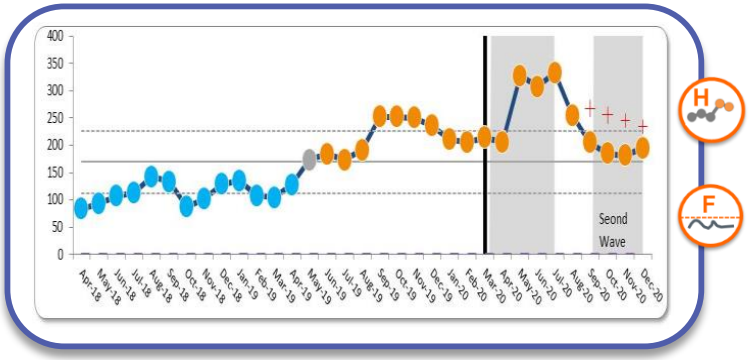
Cancer 62 Day All

70.21%



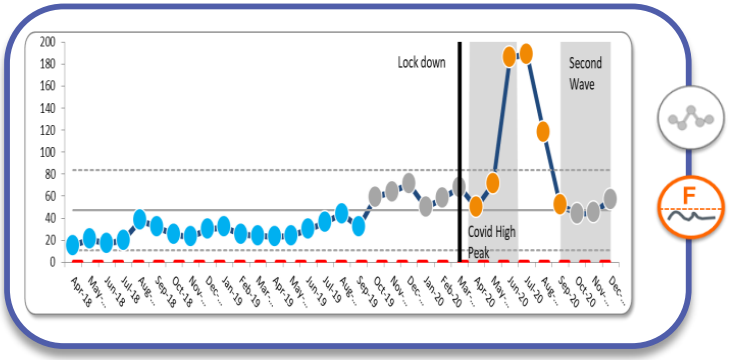
Backlog Patients waiting 63 days or more

195

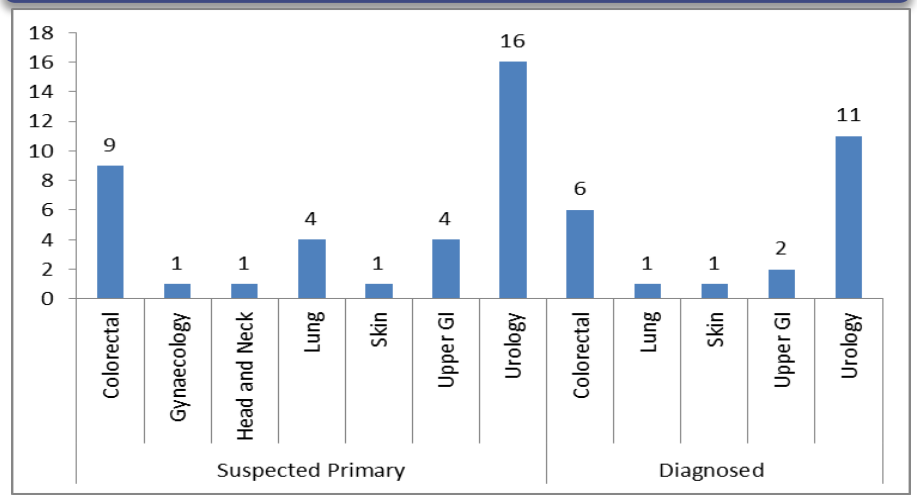


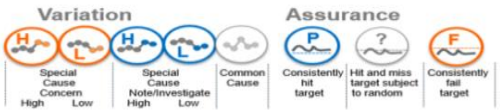
Backlog Patients waiting 104 day or more

57



104+ Day Backlog profile by specialty





Key

+ phase 3 target
- Internal target
- Operational standard

Operational Performance: Cancer Benchmarking

National Benchmarking (November 2020)

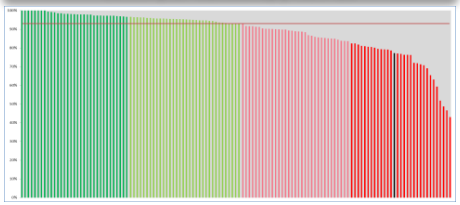
2WW: The Trust was one of 3 of the 13 West Midlands Trusts which saw a increase in performance between October and November. This Trust was ranked 10th out of 13. The peer group performance ranged from 46.64% to 98.21% with a peer group average of 82.46%; increasing from 82.36% the previous month. The England average for November 2020 was 87%, a 0.77 percentage point decrease from 87.88% in October.

2WW BS: The Trust was one of 11 of the 12 West Midlands Trusts who saw a decrease in performance between October and November. This Trust was ranked 10th of 12. The peer group performance ranged from 3.41% to 100% with a peer group average of 44.96%; increasing from 49.86% the previous month. The England average for November 2020 was 67.83%, a 9.16 percentage point decrease from 76.99%, in October.

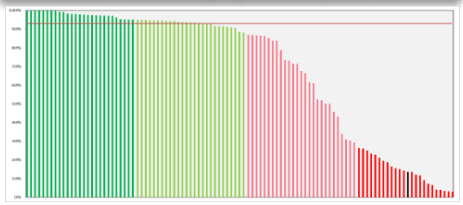
31 days: The Trust was one of 10 of the 12 West Midlands Trusts who saw a decrease in performance between October and November. This Trust was ranked 5th of 12. The peer group performance ranged from 84.23% to 100% with a peer group average of 92.21%; increasing from 91.80% the previous month. The England average for November 2020 was 95.21%, a 0.53 percentage point decrease from 95.74%, in October.

62 Days: The Trust was one of 7 of the 13 in the West Midlands Trusts who saw an in increase in performance between September and October. This Trust was ranked 6th of 13. The peer group performance ranged from 34.19% to 82.26% with a peer group average of 66.50%; increasing from 66.32%; the previous month. The England average for November 2020 was 75.55%, 1.05 percentage point increase from 74.5% in October.

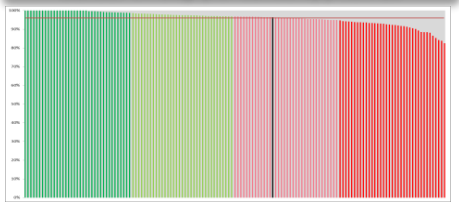
2WW (All cancers) | Nov-20



2WW Breast Symptomatic | Nov-20

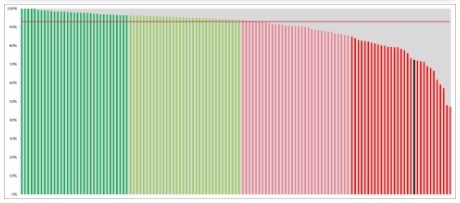


Cancer 31 Day (All cancers) | Nov-20

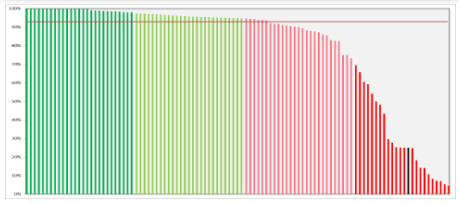


Cancer 62 day (All cancers) | Nov-20

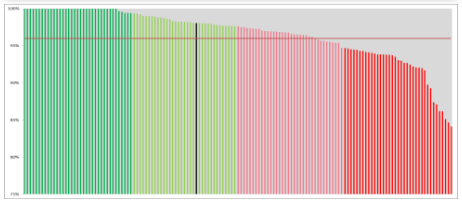
2WW (All cancers) | Oct-20



2WW Breast Symptomatic | Oct-20



Cancer 31 Day (All cancers) | Oct-20



Cancer 62 day (All cancers) | Oct-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
41,572	18,009	56.68%	6,149	3,131	381	4,488

What does the data tells us?

- The Trust has seen a 0.73% increase in the overall wait list size in Dec-20 compared to Nov-20; from 41,271 to 41,572. This is currently +1,436 more patients on our waiting list than the phase 3 forecast.
- The number of patients over 18 weeks who were unable to be treated has increased, for the first time since Jun-20 to 18,009. This is 455 more patients than Nov-20's snapshot. As a result of this RTT performance is validated at 56.68% compared to 57.47% in Nov-20. 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 now 6,149, and those patients waiting over 52 weeks which is now 3,131; this is currently +1,406 more patients waiting 52+ weeks than on our phase 3 forecast. Both metrics continue to show a significant increase in the number of patients waiting.
- Of the 3,131 patients waiting over 52 weeks, 381 have been waiting over 70 weeks with 193 patients requiring oral surgery / orthodontics treatment.
- Seven specialties have over 1,000 patients waiting over 18 weeks; this is 73% of all our 18 week breaches. Three of those specialties now have over 2,000 patients breaching. The same 7 specialties contribute 73% of all patients waiting over 52 weeks.
- RTT referrals (urgent and routine) have decreased by 6% from Nov-20 to Dec-20 and by 36% compare to Dec-19.
- **Referral Assessment Services (RAS)**: In Dec-20, 3,949 referrals were received through this service to be triaged, 3,819 (96.7%) of all Dec-20 referrals have been outcomed, and 44% of those were outcomed within 5 working days. 3,012 appointments have been booked, 133 referrals were cancelled but there remains 685 referrals awaiting action.

Current Assurance level: 4 (Nov-20)	**When expected to move to next level of assurance: Q4 – depending on the management and impact of COVID-19 second wave**
Previous Assurance Level: 4 (Oct-20)	**SRO: Paul Brennan**

13

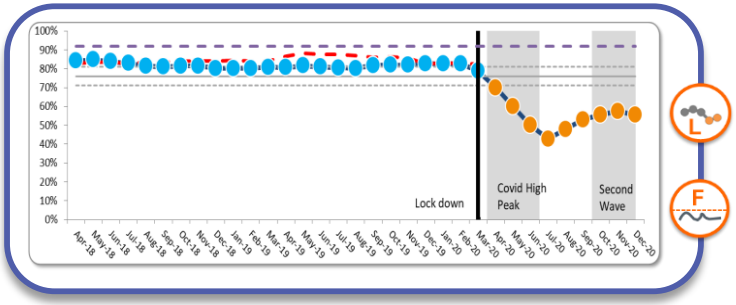
Month 9 [December] 2020-21 | Operational Performance: RTT

Responsible Director: Chief Operating Officer | Validated for Dec-20 as 21st January 2021

NHS Worcestershire Acute Hospitals NHS Trust

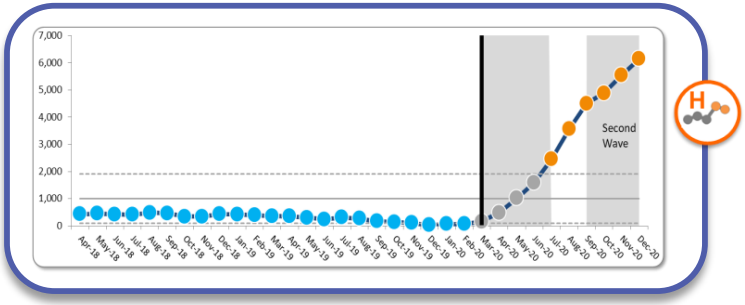
RTT % within 18 weeks

56.68%



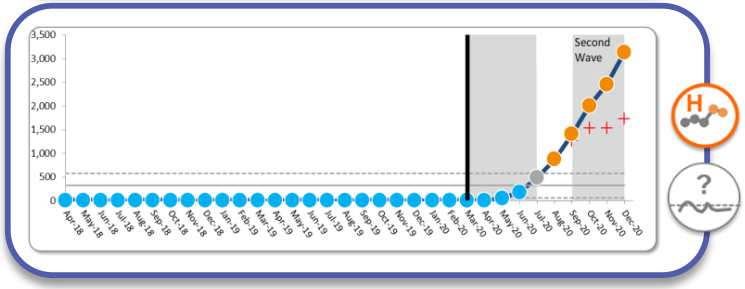
40-52 week waits

6,149



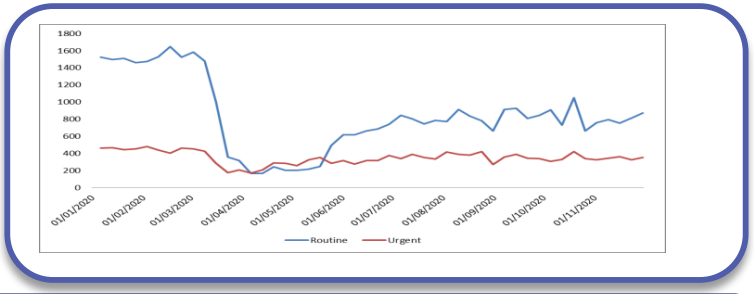
52+ week waits

3,131

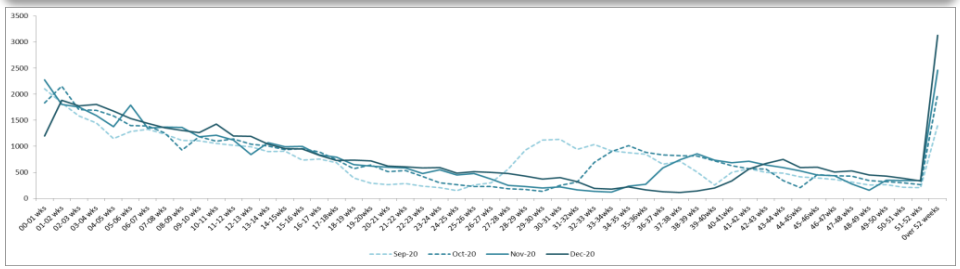


RTT Referrals Profile

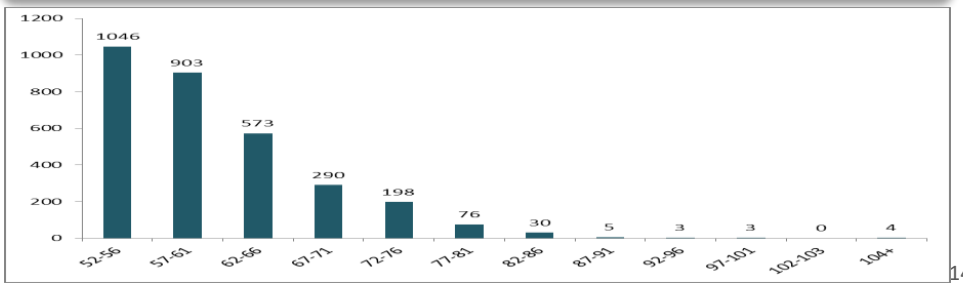
4,488



RTT waiting list profile (Aug-20 to Dec-20) by weeks waiting



RTT waiting list profile (Dec-20) | 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

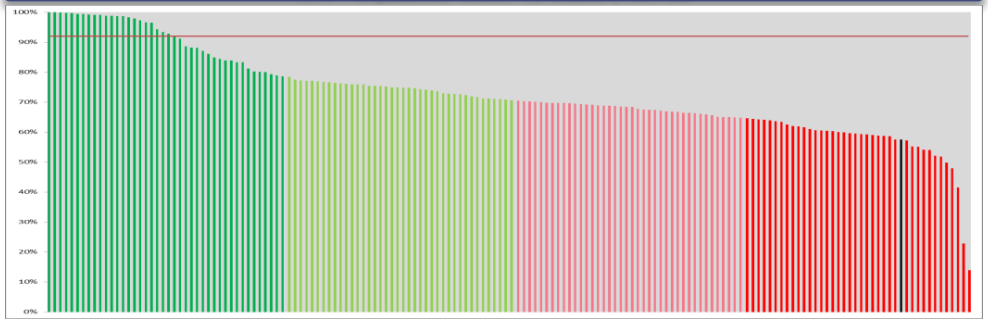
Operational Performance: RTT Benchmarking

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

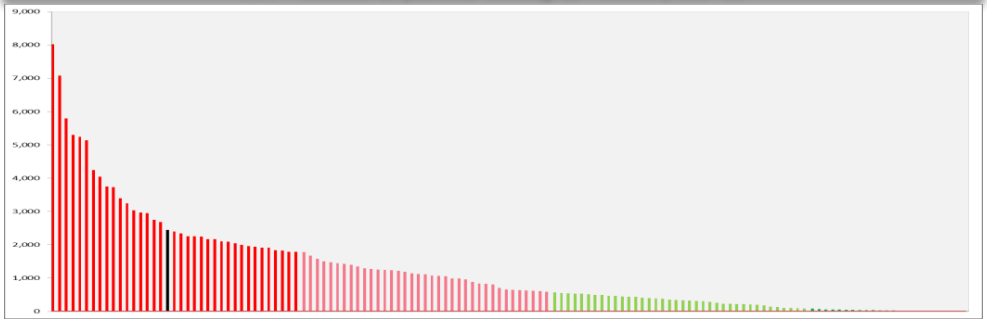
National Benchmarking (November 2020) | The Trust was one of 12 of the 12 West Midlands Trusts who saw a increase in performance between October and November. This Trust is still ranked at 12 of 12. The peer group performance ranged from 57.49% to 83.88% with a peer group average of 63.07%; increasing from 59.38% the previous month. The England average November 2020 was 68.20%, a 2.7 percentage point increase from 65.5%, in October.

Nationally, there were 192,169 patients waiting 52+ weeks, 2,449 (1.27%) of that cohort were our patients.

RTT - % patients within 18 weeks | Nov-20

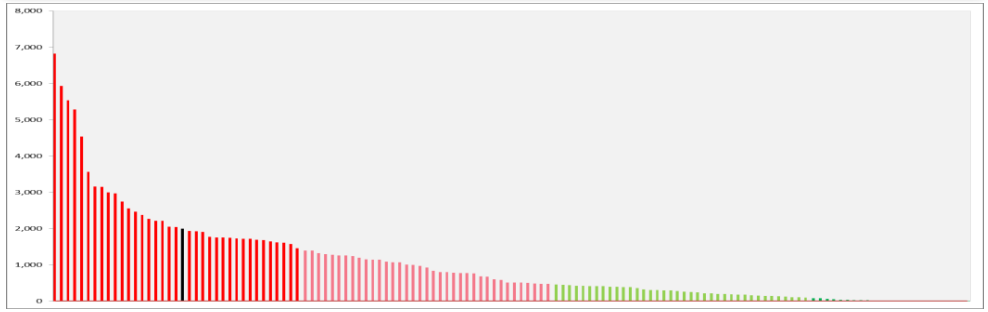


RTT – number of patients waiting 52+ weeks | Nov -20



RTT - % patients within 18 weeks | Oct -20

RTT – number of patients waiting 52+ weeks | Oct -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
9,443	2,385	20.16%	15,728	10,577	40.21%	33.99%

Outpatients - what does the data tell us?

- The Trust undertook 38,133 outpatient appointments in Dec-20. This is 2,155 fewer appointments than Dec-19 (95% of Dec-19 activity), and 4,722 less than Nov-20. When looking specifically at consultant led activity, in line with phase 3 restoration monitoring expectations we achieved 92% of our submitted plan activity.
- In Dec-19, 1,870 non-face-to-face appointments took place which increased to 12,962 in Dec-20. Of all appointments in the month, 33.99% (both new and follow-up) were non-face-to-face.
- As at 15th January the outpatient backlog for **new** outpatients was 44,347 with 17,750 on an RTT pathway and 26,597 on a non-RTT pathway. 6,755 patients had been dated which leave 37,592 not yet dated. 35,694 patients of the total new outpatient waiting list are deemed to be routine.
- Looking specifically at our phase 3 plan (slide 19), we undertook 20,614 appointments against a target of 22,213. Our area of success continues to be Consultant-led first outpatient attendances (telephone/video) where we were +835 to plan. We were +350 above plan for Consultant-led follow-up outpatient attendances (face-to-face), but 1,593 appointments under our target for Consultant-led follow-up outpatient attendances (telephone/video).

Planned Admissions - what does the data tell us?

- On the day cancellations shows no significant change since Jun-20.
- Theatre utilisation has achieved an upwards trend of 7 consecutive months, and this is highlighted by the special cause indicator (slide 17).
- Day cases were showing a positive upwards trend on the SPC chart (slide 17) however this was not continued. The performance is within the process limits
- From our inpatient elective monitoring, day Case spells were +334 above and ordinary spells were +221 above our phase 3 forecasts.

Current Assurance Level: 4 (Nov-20)	**When expected to move to next level of assurance: Q4 – depending on the management and impact of COVID-19 second wave**
Previous Assurance Level: 4 (Oct-20)	**SRO: Paul Brennan**

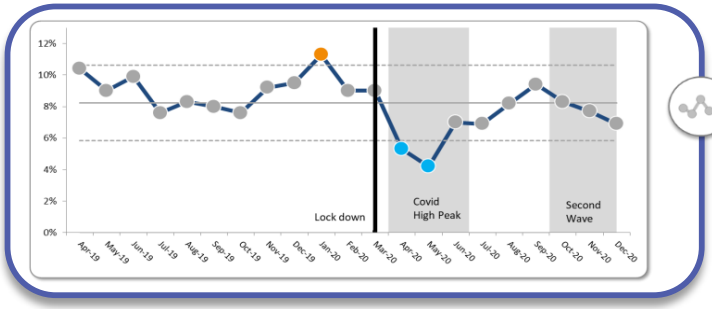
Month 9 [December] 2020-21 | Operational Performance: Theatre Utilisation & Outpatients

Responsible Director: Chief Operating Officer | Unvalidated for Dec-20 as 7th January 2021

NHS Worcestershire Acute Hospitals NHS Trust

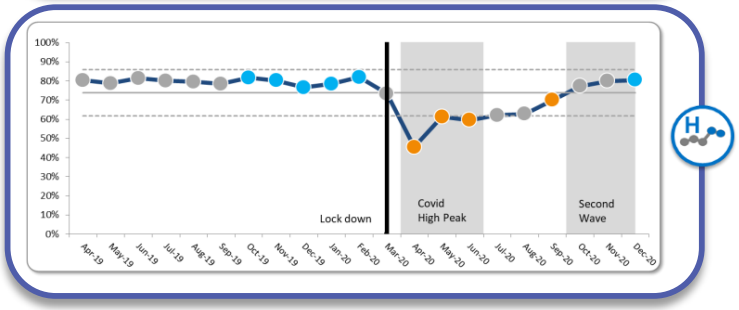
On the day cancellation as a percentage of scheduled procedures (%)

6.90%



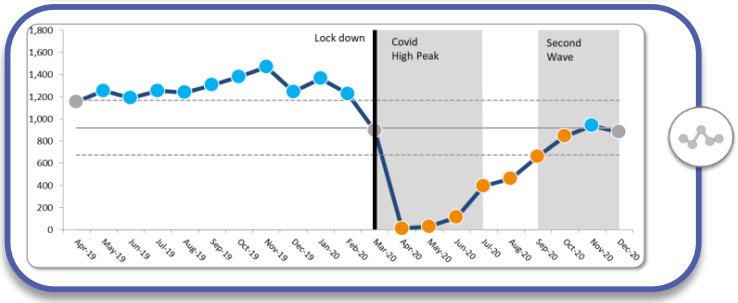
Actual Theatre session utilisation (%)

80.50%



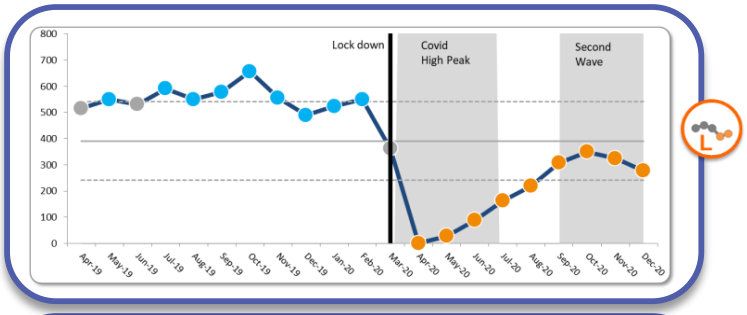
Day cases on elective theatre sessions (n)

882



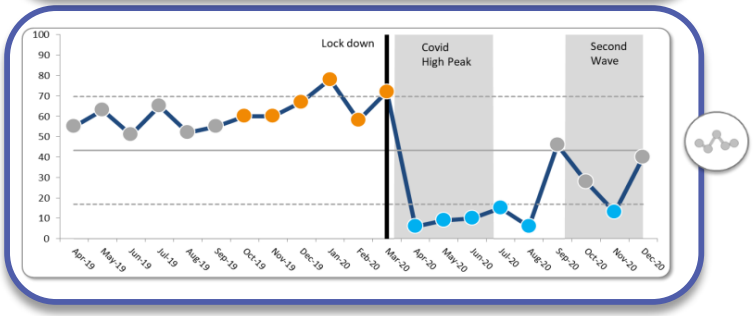
Electives on elective theatre sessions (n)

277

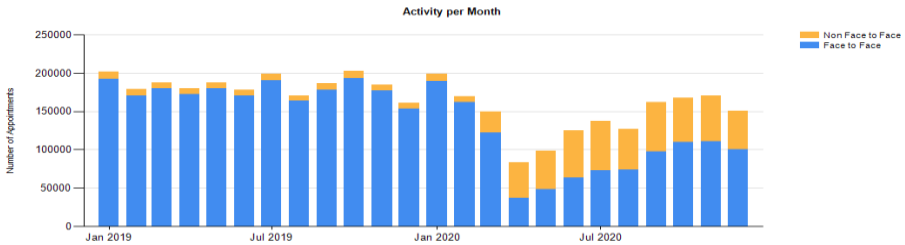


Non-electives & emergencies on elective theatre sessions (n)

40



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



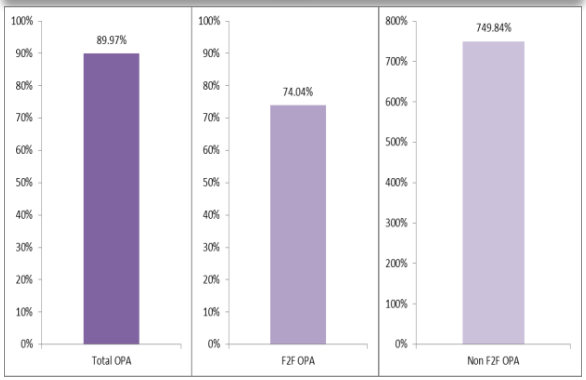
*Phase 3 restoration is based on consultant-led activity only that has been submitted via SUS. This graph is reflective of **all** the Outpatient activity that has been delivered by the Trust.

Month 9 [December] 2020-21 | Operational Performance: Outpatients

Responsible Director: Chief Operating Officer | Unvalidated for Dec-20 as 7th January 2021

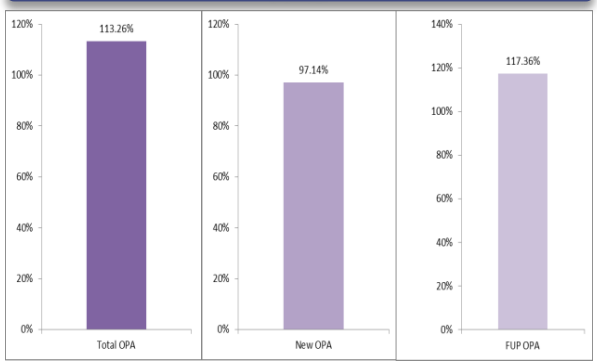
Outpatients Activity | Dec-20 activity as a percentage of Dec-19 activity (all activity apart from excluding OP+)[1]

New

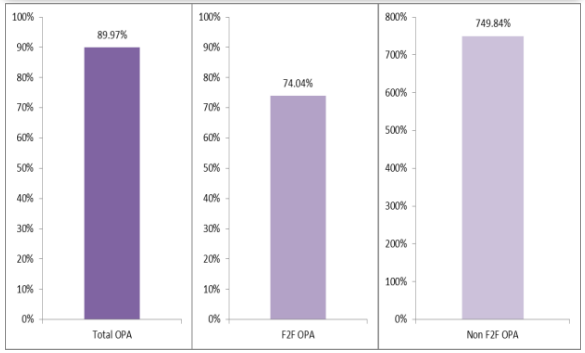


Emergency

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.

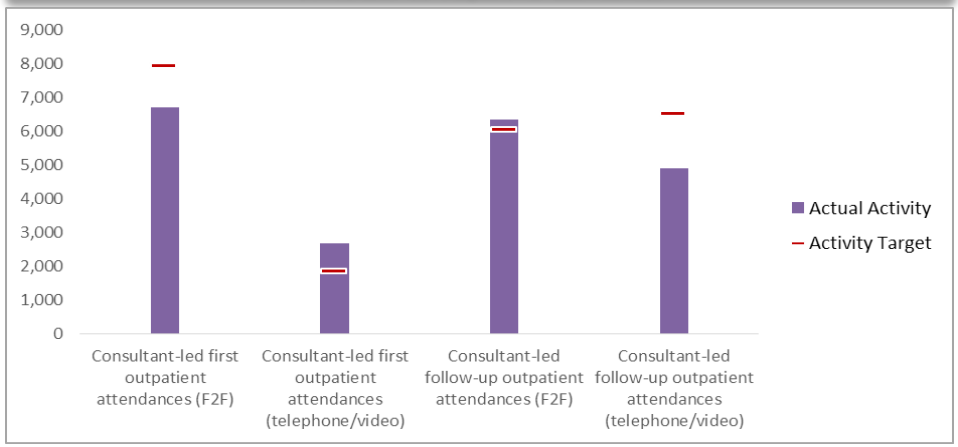
Month 9 [December] 2020-21 | Operational Performance: Outpatients

Responsible Director: Chief Operating Officer | Unvalidated for Dec-20 as 7th January 2021

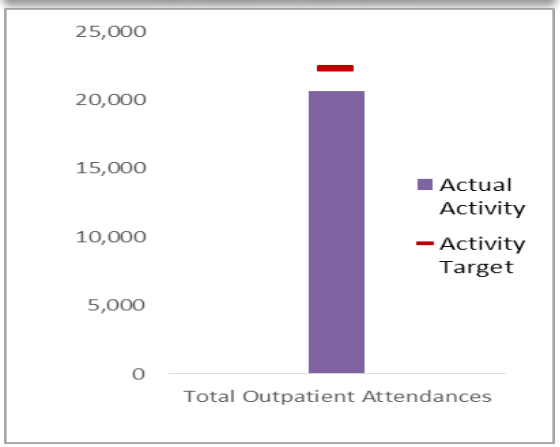
NHS Worcestershire Acute Hospitals NHS Trust

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

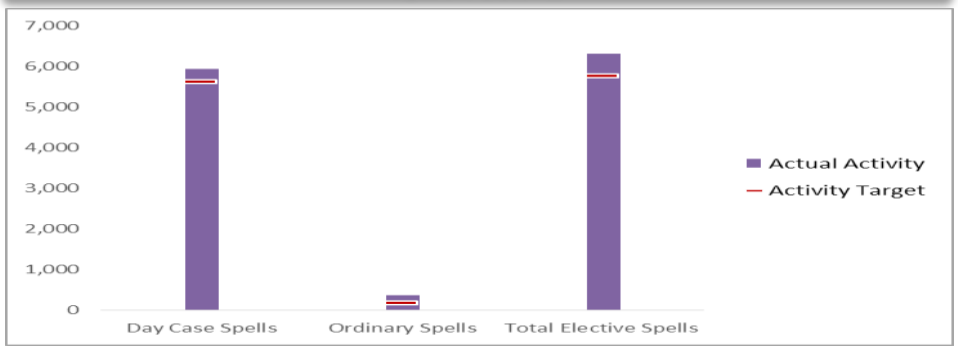
Consultant-led outpatients attendances



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

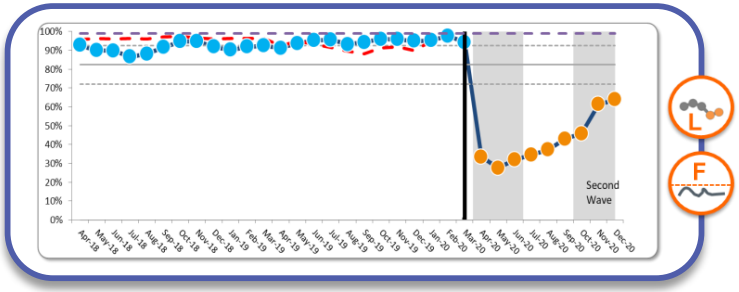
The total waiting list, the number of patients waiting more than 6 weeks for a diagnostic test, and % of patients waiting less than 6 weeks											
Trust Total			Radiology			Physiology			Endoscopy		
8,755	3,163	63.87%	4,876	1,262	74.12%	2,231	1,045	53.16%	1,648	856	48.06%

What does the data tell us?

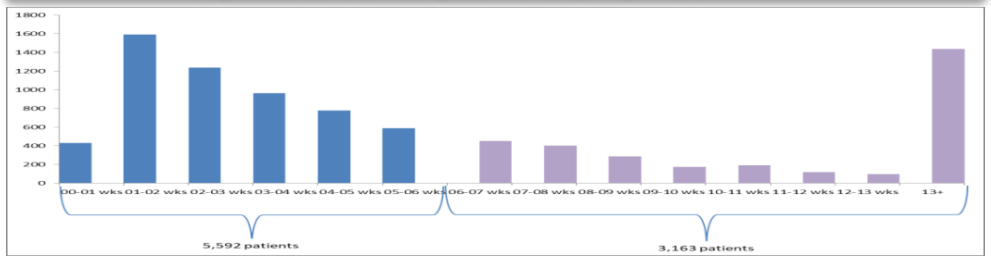
- The DM01 performance is unvalidated at 63.87% of patients waiting less than 6 weeks for their diagnostic test, no significant change from the previous month and consistent with the sustained underperformance since the cessation of elective diagnostic tests due to COVID-19 created a backlog of patients.
- The diagnostic waiting list has increased with the total waiting list currently at 8,755 patients, an increase of 512 patients from the previous month.
- The total number of patients waiting 6+ weeks has decreased by 25 patients and there are now 1,438 patients waiting over 13 weeks (1,617 in Nov-20).
- Radiology has the largest number of patients waiting at 4,876 but has reduced those waiting over 6 weeks by 25 between Nov-20 and Dec-20 to 1,262.
- 14,023 diagnostics tests were undertaken in Dec-20, 7.28% less than Nov-20 and 1.92% lower than Dec-19.
- Radiology undertook 934 fewer tests in Dec-20 compared to Nov-20. Comparing to our phase 3 activity target, CT and non-obstetric ultrasound were above the forecast and MRI was below it.
- Endoscopy completed 137 fewer tests in Dec-20 than Nov-20 with only flexi sigmoidoscopy above the phase 3 forecast.
- Physiology completed 1,235 tests in Dec-20, no significant change from the previous month's activity.

DM01 Diagnostics % patients waiting <6 weeks

63.87%



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



Current Assurance Level: 5 (Nov-20)	When expected to move to next level of assurance: 18 Weeks increased capacity at Malvern by end of Nov-20
Previous assurance level: 5 (Oct-20)	SRO: Paul Brennan