Trust Board
There will be a meeting of the Trust Board on Thursday 14 January 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:** Bill Tunnicliffe, Anita Day		
2	**Patient story**		
3	**Items of Any Other Business** *To declare any business to be taken under this agenda item.* **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.* Waqar Azmi, newly appointed Non-Executive Director has submitted the following Declarations of Interest:- • Chairman of Remembering Srebrenica (a genocide education charitable initiative) • Director & Trustee of Ummah Help Charity (a humanitarian aid & development charity) • Birmingham & Solihull Mental Health NHS Trust (partner works as a Senior Community Engagement Manager at this Trust) Sharon Thompson, newly appointed Associate Non-Executive Director, has submitted a nil return.		
4	**Minutes of the previous meeting** *To approve the Minutes of the meeting held on **10 December 2020** as a true and accurate record of discussions.*	*For approval*	**Enc A** **Page 3**
5	**Action Log**	*For noting*	**Enc B** **Page 11**
6	**Chairman's Report**	*For approval*	**Enc C** **Page 12**
7	**Chief Executive's Report**	*For noting*	**Enc D** **Page 13**

8	**Strategy**		
8.1	COVID -19 Longer View Update – 31 December 2020 Chief Operating Officer	*For assurance*	**Enc E** **Page 16**
9	**Performance**		
9.1	**Integrated Performance Report**	*For assurance*	**Enc F**
9.1.1	**Executive Summary/SPC Charts/Infographic** Chief Executive/Executive Directors		**Page 29**
9.2.2	**Committee Assurance Reports** Committee Chairs		**Appendix 3** **Page 96**
10	**Assurance Reports**		
10.1	**Trust Management Executive Report** Chief Executive	*For assurance*	**Enc G** **Page 100**

Any Other Business *as previously notified*

Date of Next Meeting
The next public Trust Board meeting will be held on 11 February 2021, virtually.

Enc A

Worcestershire Acute Hospitals NHS Trust

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

Present:

Chairman:	Sir David Nicholson	
Board members: (voting)	Paul Brennan	Deputy Chief Executive/Chief Operating Officer
	Anita Day	Non-Executive Director
	Mike Hallissey	Chief Medical Officer
	Matthew Hopkins	Chief Executive
	Dame Julie Moore	Non-Executive Director
	Vicky Morris	Chief Nursing Officer
	Robert Toole	Chief Finance Officer
	Bill Tunnicliffe	Non-Executive Director
	Stephen Williams	Non-Executive Director
	Mark Yates	Non-Executive Director
Board members: (non-voting)	Richard Haynes	Director of Communications and Engagement
	Colin Horwath	Associate Non-Executive Director
	Vikki Lewis	Chief Digital Officer
	Richard Oosterom	Associate Non-Executive Director
	Jo Newton	Director of Strategy and Planning
	Tina Ricketts	Director of People and Culture
	Kimara Sharpe	Company Secretary
In attendance	Jo Ringsall	HealthWatch – vice chair
	David Hill	System Improvement Director *until item 108/20*
	Dean Eales	AccessAble *item 101/20 only*
	Anna Steryx	Head of Patient Engagement *item 101/20 only*
Public	17	Via YouTube

100/20 **WELCOME**

Sir David welcomed everyone to the meeting, particularly those viewing via YouTube.

101/20 **PATIENT STORY**

Sir David explained that each Board meeting starts with a patient story. He was pleased to welcome Mr Dean Eales and Ms Anna Steryx to explain about the work that has been undertaken on AccessAble within the Trust. He asked Mrs Morris to introduce the item.

Mrs Morris introduced Mr Eales from AccessAble and Ms Steryx, Head of Patient Engagement who have been working together on introducing AccessAble to the Trust. She asked Ms Steryx to present the work.

Ms Steryx welcomed Mr Eales who has been working with Trust staff to enable patients to be empowered when entering the Trust premises.

Mr Eales shared a presentation which gave more information about AccessAble. The

company was formed in 2000 by Gregory Burke who had been disabled due to encephalitis. He began to use a wheelchair and only discovered the meaning of 'being disabled' when he went out and about in his community. He felt that there was a 'death of spontaneity' when wanting to visit places outside his home. As a result, he created an online profile of places which disabled people could access prior to going out to see what facilities were available. The ultimate aim was to empower disabled people to be able to access the community and be more independent.

Currently AccessAble works with 350 different partners and 60 NHS trusts. Over 125000 places have been surveyed. The website is free to use and 250m people access it each year.

He then turned to the work with hospital trusts. He stated that people were anxious when attending hospitals and if they were disabled, they were even more anxious, not knowing what facilities were available. AccessAble provides the information online so people can do a virtual visit prior to the appointment.

Mr Eales then went through the guide for the Alexandra Hospital, Redditch. The guide on the website contained many detailed photographs e.g. the number and place of blue bays and how big they are plus giving the distance from blue bays to the entrance including the position of the dropped curbs. When looking at the entrance, ramps were detailed and the type of glass in the doors as well as floor patterns, glazed surfaces, reception desk and whether the height was user friendly for wheelchair users. He then went through the detail of the information contained for access to the Children's clinic at Worcestershire Royal.

Mr Eales stated that the most detail was for the accessible toilets for example the transfer side – if someone has had a stroke and the transfer side is on the weaker side, then they will not be able to use the toilet. Commentary was also made about the lighting levels and contrasts.

Mr Eales concluded his presentation by thanking the Trust staff involved in the project. He stated that the project had been incredibly smooth. All researchers felt safe on site. He was looking forward to launching the project in the New Year.

Sir David thanked Mr Eales for his very interesting presentation. The work was extraordinarily valuable. He invited comments and questions from the Board members.

Mr Yates welcomed the work. He specifically thanked Ms Steryx and Mrs Edwards for their support. He urged members to download the app which gave the details of the work.

Mr Oosterom also thanked Mr Eales. He wondered whether any feedback had been given to the estates department in relation to the improvements that could be made. Mr Eales confirmed that there was formal feedback to the Trust and this showed the improvements that could be made. These were ranked in order of importance.

Ms Day added her thanks. She wondered whether how different types of physical disability and people with learning disabilities were managed within the work. Mr Eales stated that a lot of work had been undertaken on people on the autistic spectrum, but this work was challenging. He described the easy read version of the guide, but the use of photographs was essential for people with learning disabilities.

Dr Tunnicliffe wondered why such a guide was not available for all patients. Ms Steryx confirmed that work was being undertaken with other groups of people for example the

Youth Forum.

Mrs Morris thanked Mr Eales for his presentation and work with the Trust.

Sir David also thanked Mr Eales as well as Ms Steryx and Mrs Edwards. He wished to see the concept extended to a broader range of patients and felt that this should be part of what the Trust does for patients.

102/20 **ANY OTHER BUSINESS**
There were no items of any other business.

103/20 **DECLARATIONS OF INTERESTS**
There were no additional declarations of interest. The Board noted that the full list of declarations of interest were on the website.

104/20 **MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON 12 NOVEMBER 2020**

RESOLVED THAT the Minutes of the public meeting held on 12 November 2020 be confirmed as a correct record and signed by the Chairman.

105/20 **MATTERS ARISING/ACTION SCHEDULE**
Mrs Sharpe reported that there no outstanding actions and all other actions had been completed. She drew members' attention to the new IPad stands that are now in place within the maternity wards.

106/20 **CHAIRMAN'S REMARKS**
Sir David commenced his remarks by congratulating Dr Tunnicliffe on his appointment for four years as a non-executive director.

He thanked Mr Williams for his work as he was leaving the Trust at the end of December. He has been a non-executive director for three years and has been chair of the Audit and Assurance Committee for that time. He paid tribute to the work which has been done during this time. He wished him well in his new life in London.

Sir David then thanked Mrs Sharpe for her work as she was also leaving the Trust at the end of December. He wanted to put on record the massive contribution she has made to the Board in the eight years that she has been with the Trust. He stated that she has ensured the safe operation of the Board ensuring the processes and systems were adhered to. He also thanked her for her personal support whilst he has been Chair, He concluded by stating that she always had the patient at the heart of her work.

Sir David concluded his remarks by stating that he has appointed one associate non-executive director and one non-executive director and details of these appointments would be forthcoming.

RESOLVED THAT The Trust Board

- Noted the report

107/20 **STRATEGY**

107/20/1 **System Resilience Plan**
Mr Brennan outlined the System Resilience Plan for 2020/21. He explained that the plan was drawn up when the effects of the second wave of COVID were not available. The plan covers the phase 3 resumption of elective activity.

He drew members' attention to pages 15 and 16 of the accompanying slide deck which gives the detail of the modelling undertaken. The work shows the number of general and acute beds across the trust which are modelled to be used for COVID. A range of scenarios were chosen and the best assessment was that 128 beds would be unavailable due to COVID. Access to the Independent Sector is due to end at the end of the month so a super clean pathway has been developed for elective patients. This has removed an additional 78 beds. As of the 10 December, 170 beds are dedicated to the COVID pathway. He stated that the number of beds for COVID is more than modelled which is proving a big challenge on a day to day basis.

Mr Brennan then turned to slides 19 and 20 which outline the main projects developed to address the shortfall in capacity. These projects can be outlined in three areas:

- System wide strategic for example THINK 111: This has had excellent feedback nationally but locally there is anecdotal evidence that suggests that more people are attending A&E as a result of contacting 111. The actual evidence will be available in the next few days.
- Community response such as neighbourhood teams and intravenous therapy
- Within the hospital: The development of the acute medical unit which has been implemented at the Alexandra Hospital and has resulted in a reduction in overall length of stay. The equivalent unit will be operational at the Worcestershire Royal on 24 December. Other internal initiatives include the continued implementation of Home First Worcestershire.

Slide 22 identifies the bed day deficit of 24000 (annual estimate). Part year (covering the winter period) is 13000. If the entire project identified operates at 100%, a bed day surplus would be generated. In 2019/20, the success of the projects was 24%.

Mr Brennan then turned to the monitoring of the Plan. This will be undertaken through the A&E Delivery Board. An early warning system will be in place to give real time data from the ambulance service, community, 111, admissions, discharges and waiting times in A&E.

Mr Brennan thanked all the partners for working together on the Plan. The joint working continues. There have been improvements with the Home First Worcestershire action plan being implemented, particularly with respect to long length of stay and the difference that the work of the onward care team is making with discharges. There is still some work to do, particularly with respect to the community 2 hour response. Mr Brennan remained concerned about the number of general and acute beds set aside for COVID patients.

Sir David asked for Mr Oosterom's comments, as Chair of the Finance and Performance Committee. Mr Oosterom stated that the preparation had been better than 2019/20 with better analysis. He remained concerned about the number of beds for COVID patients and the fact that the projects only realised 24% in 2019/20.

Sir David was pleased with the continued reduction in inpatient length of stay. He wondered what the impact would be of the Ambulatory Emergency Centre opening at Worcester. Mr Brennan stated that the new AEC is double the capacity of the previous one and he would be working with the ambulance service to ensure that patients went to the AEC and bypassed the emergency department. He also stated that there had been support from the clinical commissioning group to extend the opening hours of the surgical clinical decision unit. He remained concerned about the number of beds aligned to the COVID pathway.

Sir David wondered whether the COVID activity was decreasing. Mr Brennan stated that the number of COVID patients presenting with COVID symptoms was in double figures and the number of positive patients was at its highest since 25 April. He felt that the activity was increasing rather than decreasing. Local Public Health officials have predicted that there would be a decrease within the next 2-3 weeks as the effect of the lockdown was felt. There would be no reduction in the number of beds for COVID patients until at least the middle of January.

Dr Tunnicliffe expressed concern about the possible effect of the relaxation of restrictions at Christmas. He wondered whether there were any further actions that should be taken to mitigate this effect. Mr Brennan confirmed that the Public Health team were cascading messages to try to minimise the mixing. He also stated that beds for positive patients have been commissioned within a local nursing home and these will be operational from 11 December. These will be for patients who have been admitted to the Trust from a nursing home and remain positive.

Dame Julie was disappointed with the anecdotal feedback that THINK 111 was generating attendances to the emergency department. She wondered how the service was being audited. Mr Brennan confirmed that there was a steering group and the Trust was a member of this. The A&E Delivery Board will receive the data in following week.

Mr Hopkins thanked Mr Brennan for his leadership during this very challenging period. He reminded members that not only was the Chief Operating Officer managing the COVID pathway, but also the elective surgery patients and there also had been a reasonable 4 hour A&E performance.

Mr Hopkins went onto state that NHS E/I (Midlands) were concerned about the performance of 111 as well as the 2 hour community response. At a recent meeting, NHS E/I undertook to implement a number of actions to work with the ambulance service to ensure there was an operational change. NHS E/I supported the System Plan.

Mr Hopkins also informed the board that the post of lead manager for intermediate care (system based) had been appointed to and this post worked across the whole system and was able to hold staff to account in all organisations in respect of the discharge of patients into intermediate care.

He also confirmed that there was a refresh of the modelling. System leaders met weekly to discuss progress. The view of NHS E/I was that the system was in a good place. However there remained real concern that the community would relax now that there was a vaccine available. This was a bigger risk than the mixing at Christmas.

Sir David welcomed the plan, even though it was not completely robust. He was pleased that a further iteration of the modelling was being undertaken. If the numbers of beds for COVID patients continued to increase, there would be challenges for the whole health system and suggested that contingencies needed to be developed.

Finally, Sir David expressed his thanks to Mr Brennan for his continued work.

RESOLVED THAT The Trust Board received the report for assurance

108/20 **PERFORMANCE**

108/20/1 **Integrated Performance Report**

108/20/1/1 **Executive Summary**

Mrs Lewis introduced the report, month 7, October 2020. She stated that the report was

more concise than the previous month. The report has been considered by the Finance and Performance Committee and Quality Governance. Assurance levels were now applied. She stated that the only assurance level below 4 was for sepsis 6 which was a level 2.

Four areas of challenge have been identified:

- The impact of COVID-19 on elective activity
- Maintaining high quality care
- Demonstrating well-being for staff
- The financial position

Mr Hopkins asked Mr Hallissey to comment on the sepsis 6 bundle.

Mr Hallissey stated that the sepsis bundle compliance remains a challenge. A new electronic training system has been implemented. He has met with the Chief Registrar to understand more about the issues for junior doctors in completing the paperwork. He understands that the issues are documented in the notes but not on the sepsis 6 form. A quality improvement programme has been implemented. He gave assurance that the outcomes for sepsis were in line with the national figures. He would give a detailed report to the Quality Governance Committee in the New Year.

Sir David asked for more information on the outcomes. Mr Hallissey confirmed that the data showed that the outcomes were average when compared to other trusts. He felt that outcomes could be better. He confirmed that he was reviewing the recent coroner's report from Dudley.

Dr Tunnicliffe confirmed that he was expecting a deep dive to the January meeting of the Quality Governance Committee was would report back following that meeting.

Mr Hopkins then turned to the impact of covid on elective activity and asked Mr Brennan to comment. Mr Brennan confirmed that there had been a significant reduction in the number of people waiting 104 and 62 days or more for cancer treatment. His ambition was to reduce the numbers waiting to zero, recognising that there would always be a small number waiting over 62 days.

With respect to diagnostic performance, Mr Brennan confirmed that MRI and CT activity was now above the phase 3 plan. However people waiting over 52 weeks for outpatients is 11% below that within the plan. This was due to the use of outpatient accommodation for virtual consultations. Harm reviews were being undertaken and no patients have been identified as having been harmed due to the delay. He has worked with GP colleagues to determine the risk of patients being referred for their first outpatient appointment and the new system in place has had positive feedback from primary care colleagues.

Sir David asked about the use of the independent sector and Kidderminster Hospital. Mr Brennan confirmed that three out of the four theatres at Kidderminster were being utilised and from January (when alternative accommodation has been opened for chemotherapy patients), all four will be in use. Over 3200 patients have been seen in the independent sector and now he is negotiating the continued use. New guidance issued this week had given the steer to be able to use the facilities until the end of March 2021. There are good local discussions underway with the local independent sector providers.

Dr Tunnicliffe congratulated Mr Brennan on the work undertaken. He wondered why

more outpatient consultations were not held virtually. Mr Brennan confirmed that there had been some governance issues which have now been resolved. Also the ophthalmology clinics were now being held as nurse led clinics and this reassignment cannot be made to the national return. This has distorted the figures.

Mr Oosterom also added his thanks to Mr Brennan. There was good progress on length of stay and long length of stay; also progress with emergency department performance but he was concerned that more needed to be done to minimise the risk for people waiting a long time. Mr Brennan confirmed that the current capacity was focussed on category 2 and 3. Majority of long waiters are category 4 for which there was reduced capacity. He stated that the waiting list has increased and there are reduced beds and reduced theatre capacity.

Mr Horwath asked for information about the third CT scanner. Mr Brennan explained that resources have been received to provide a 3rd scanner. No additional staff are required as the scanner will be used (for the first 7 months) for decanting whilst one scanner at Worcestershire Royal and one at Alexandra Hospital are replaced. There is also a mobile scanner at Kidderminster which hopefully will be in place until the end of March (dependent on whether the Nightingale Hospital will become operational). There is also an additional scanner capacity at the Alexandra Hospital.

Mr Hopkins asked Mrs Morris to speak about infection control and the use of Carbenpine. Mrs Morris confirmed that the actions as agreed at the recent Quality Governance Committee were being actioned. There was a continued focus on the management of outbreaks.

Mr Hopkins then turned to the staff offer and asked Ms Ricketts to comment.

Ms Ricketts stated that absence was increasing due to the second wave but there as a lot of proactive work being undertaken to reduce this, particularly amongst staff who were shielding. The Trust continues to benchmark favourably against the peer group. She confirmed that the absence for mental health reasons was showing the normal run rate. The introduction of lateral flow tests have identified over 30 people who were asymptomatic. The second lockdown identified 150 people in the extremely clinical vulnerable group. About 70 continue work from home and 81 are being redeployed where possible within the system. Since lockdown ended, seven staff are not able to work. She praised her staff and managers for this work to date.

Ms Ricketts then turned to flu. The current figure was 76% uptake of the vaccine (figures taken the previous week). She reported that the COVID vaccine had an excellent uptake by staff and vaccination was beginning on the 16 December for 5 days.

Mr Hopkins asked Mr Toole to comment on the financial position.

Mr Toole confirmed that the regime for the first six months of the year (to breakeven) had now ceased. The financial allocation now covered the whole STP. The Trust was underspent by £2m in October but that was due to the lack of activity.

Mr Oosterom added that the Finance and Performance Committee was pleased with the controls in place in relation to bank and agency spend. He was also pleased to see the detail in relation to capital. The Committee remained concerned about the lack of information in relation to the financial regime for 2021/22.

Sir David referred to a letter from the CCG Chief Officer in relation to a commitment to break even for the STP. He asked Mr Toole to comment. Mr Toole stated that due to the

lack of activity both Wye Valley and the Trust were in the same position and this showed a financial advantage. However this was not the best for patients and he was concerned that patients were not being treated due to the lack of beds.

Mr Horwath asked whether NHS E/I were aware of the reason for the current financial situation and if not, urged Mr Toole to have dialogue with them. Mr Toole confirmed that there were quarterly reviews with NHS E/I.

Sir David also expressed concern about the financial position. The issue of the lack of capacity needed to be understood across the system and by NHS E/I.

RESOLVED THAT the report be received for assurance.

108/20/1/2 **Committee Assurance Reports**

RESOLVED THAT the Finance and Performance Committee, People and Culture and the Quality Governance Committee reports be noted for assurance.

109/20 **GOVERNANCE**

109/20/1 **Audit and Assurance Committee Report**

Mr Williams reported that the meeting had a good discussion about the ICS risks. This area needed to be picked up at the subsequent meetings in the New Year.

RESOLVED THAT the report be received for assurance.

DATE OF NEXT MEETING

The next Public Trust Board meeting will be held on Thursday 15 January 2021 at 10:00. The meeting will be held virtually.

The meeting closed at 12:02 hours.

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

Sir David asked Ms Ringsall to comment and ask questions if she wished.

Ms Ringsall thanked Sir David for the opportunity to comment. She was aware of the huge amount of work undertaken in respect of the System Resilience Plan and she was pleased to see the system collaboration and that some initiatives were delivering the outputs needed. She asked how assured the Board was about the delivery of the Plan. She also wondered how patients were aware of the situation.

Mr Brennan confirmed that all patients were written to by the end of October 2020 (part of a national initiative) and all will have had a phone call by the end of December.

Sir David acknowledge the huge pressures on the delivery of the Plan. He was pleased that there was another review planned and stated that the plans in place would mitigate the risks as far as possible.

Mr Hopkins asked that Ms Ringsall raise the issues at the A&E Delivery Board the following week.

Enc C

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

PUBLIC TRUST BOARD ACTION SCHEDULE – JANUARY 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			
12-11-20	Patient story	82/20	Consider the use of volunteers for breast feeding support	VM	Mar 2020			

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	14 January 2021
Paper number	Enc C

Chairman's Report

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

Accountable Director	Sir David Nicholson Chairman		
Presented by	Sir David Nicholson Chairman	**Author /s**	Martin Wood Deputy Company Secretary

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

Report previously reviewed by		
Committee/Group	Date	Outcome

Recommendations	The Trust Board are requested to ratify the Vice Chair's action undertaken since the last Trust Board meeting in December 2020.

Executive summary	Following the meeting of the Finance and Performance Committee on 23 December 2020, the Vice Chair undertook a Chairman's Action in accordance with Section 24.2 of the Trust 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 Chief Finance Officer supported this proposal.

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

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

Financial Risk	*State the full year revenue cost/saving/capital cost, whether a budget already exists, or how it is proposed that the resources will be managed.*

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

NHS
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: • Wave 2 COVID Pandemic • Healthwatch Worcestershire Question Time with the leaders of Worcestershire's NHS • Appointment of Chief Nursing Officer • Appointment of Company Secretary • Interim Chief Executive of Worcestershire Children First and Interim Director of Children's Services • Midlands Region Year of the Nurse and Midwife - celebratory e-book: • New integrated care systems

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

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

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Introduction/Background

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

Issues and options

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 has risen very sharply. As the report in the meeting will show, our teams have been caring for significantly higher numbers of sick patents than at the peak of Wave 1 in April 2020.

In addition, since the last meeting, the COVID vaccination programme has been launched through the Worcestershire hospital hub based at the Alexandra Hospital. The logistical challenge has been immense, but of course the vaccine offers the best chance of the minimising the impact of Coronavirus for our staff and patients alike.

I want to pay tribute once again to all of our staff for their passion, resilience and fortitude at this most difficult of times.

Healthwatch Worcestershire Question Time with the leaders of Worcestershire's NHS: I represented our organisation at this highly successful event in December with other system leaders, taking questions from the public about a range of issues including: the response to COVID-19, the waiting times for planned care, the plans for any expansion of services at the hospitals and our ambitions in developing more effective integrated care.

Appointment of Chief Nursing Officer: I am delighted to report that after a rigorous and competitive recruitment process, Paula Gardner has been appointed as our new Chief Nursing Officer. Paula will join us in mid-March 2021 for a two-week handover with Vicky Morris. This will be Paula's third Chief Nurse post, following her time most recently as Chief Nurse with Sandwell and West Birmingham Hospitals NHS Trust and previously as Chief Nurse with Burton Hospitals NHS Foundation Trust. It also sees Paula's nursing career come full circle after starting as a trainee nurse in Worcester and going on to her first role as a qualified nurse at theformer Ronkswood Hospital on Newtown Road.

Appointment of Company Secretary: I am pleased to report that we have appointed a new Company Secretary following the retirement of Kimara Sharpe. Details of the appointment will be announced once the recruitment process has been completed.

Interim Chief Executive of Worcestershire Children First and Interim Director of Children's Services: Tina Russell has been appointed Interim Chief Executive of Worcestershire Children First and Interim Director of Children's Services initially for a period of 9 months. The appointment follows the recent news that Catherine Driscoll will be leaving Worcestershire early in 2021 to become the new Director of Children's Services at Dudley. Tina is currently the County Council's Director of Social Care & Safeguarding

Midlands Region Year of the Nurse and Midwife - celebratory e-book: NHS England and NHS Improvement (Midlands) are incredibly proud to announce the Midlands Region Year of the Nurse and Midwife, celebratory e-book. The Year of the Nurse and Midwife 2020 is their

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opportunity to celebrate and champion our nursing and midwifery professions to showcase the incredible, life changing work we do for patients across our health and social care system. Whilst in ordinary times we would have celebrated together, the events of this year have meant we have had to do things differently – but we still wanted to do something fitting to mark this very special occasion. That's why they have compiled this commemorative e-book which includes stories and videos from nurses, midwives and care support workers from across our region and highlights their contribution and the difference they are making to patients and communities. This e-book is a celebration of you and everything we do. It's recognition of how diverse and vibrant our professions are and how we as nurses and midwives touch people's lives. The e-book can be downloaded from www.england.nhs.uk/midlands/youm-ebook

New integrated care systems: Sir Simon Stevens has confirmed that 11 more parts of the country will be formally designated "integrated care systems" (ICS) from 1 April 2021 serving 14 million people. Sir Simon has said that NHS organisations will need to intensify partnership working with local authorities and the voluntary sector to tackle health inequalities resulting from COVID-19.

Conclusion

Recommendations

The Trust Board is requested to

- Note this report

Appendices - None

NHS
Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

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Paper number	Enc E

Covid-19 Longer View - Update 31 Dec 20

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

Accountable Director	Paul Brennan, Deputy Chief Executive & Chief Operating Officer		
Presented by		**Author /s**	Gordon Stovin, Senior Information Specialist

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	This has been a landmark week. As wave 2 approached its 100th day, the number of patients treated during this current wave overtook the number treated during the entirety of wave 1. Current challenges are: ▪ This week's increase in community cases is now resulting in increased admissions. ▪ The current number of beds required for Covid-19 patients is likely to exceed the peak experienced during the first wave over the next few days. ▪ At our current rate we are increasing the number of beds required for Covid inpatients by almost three per day. This rate has accelerated over the past week. ▪ This is largely been driven by increases in community-onset and symptomatic cases (which reflects the increase in community cases). ▪ Indeterminate hospital acquired cases are also a significant factor in the daily number of new inpatients identified. ▪ The pressure on ITU beds required whilst less in this wave has increased in the last week. It has also been sustained at an elevated level (due to Covid-19) for >50 days. ▪ Crude mortality has risen over the last seven days and it would appear that patient acuity is increasing. Although this cannot be disentangled from increases in acuity attributable to 'winter pressures'.

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	However: ▪ The rate of growth in the number of newly detected Covid inpatients is being kept at its current level through the successful discharges treated patients and deceased patients. ▪ Despite increases in crude mortality our mortality rate and numbers of successfully treated patients remains improved on wave 1. This data and subsequent analysis supports: ▪ Discussions from this week regarding Lateral Flow testing in ED for patients who would be on a green pathway, to try to prevent potential HCAI infections from within the Hospital. ▪ The implementation of the ward plan changes that have been implemented on 30 December. ▪ The agreement *this week* to increase the capacity for ITU beds at WRH from *next week*.

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	*State the full year revenue cost/saving/capital cost, whether a budget already exists, or how it is proposed that the resources will be managed.*																	

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

NHS
Worcestershire
Acute Hospitals
NHS Trust

Assurance levels Nov 2020

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Introduction/Background

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

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

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

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

Issues and options

Current situation, inpatient numbers and trends

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

Combined (Since 23 March 2020)

Site	Total No. inpatients	Combined LOS	Discharged (treated)	Died (in hospital)	Combined discharges	Crude mortality rate	Avg LOS (treated)	Avg LOS (died)
ALX	782	8887	494	230	724	31.8%	11.1	11.8
WRH	772	8401	549	154	703	21.9%	10.3	11.3
Trust	**1554**	**17288**	**1043**	**384**	**1427**	**26.9%**	**10.7**	**11.6**

As the pandemic progresses the crude mortality rate continues to improve and the average length of stay is starting to lengthen.

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**

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	381	4256	236	87	323	26.9%	10.2	13.1
WRH	412	4397	289	54	343	15.7%	9.4	12.3
Trust	**793**	**8653**	**525**	**141**	**666**	**21.2%**	**9.8**	**12.8**

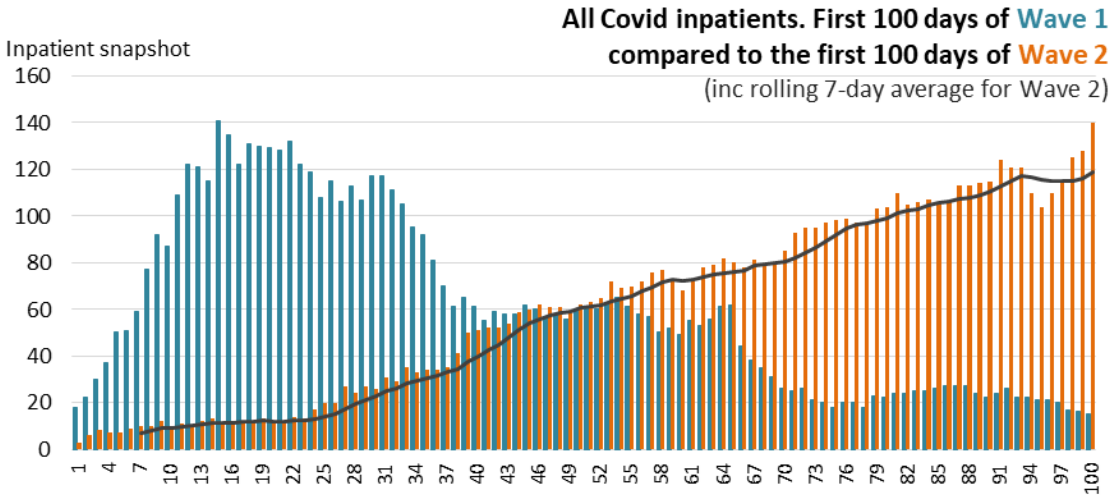
Observations:

- We have now dealt with more patients in wave 2 than we had in wave 1.
- The crude mortality rates for wave 2 remains better than those in wave 1 and has not changed noticeably.
- Length of stay for wave 2 is continuing to increase for treated patients.

At the time of writing we have reported 140 inpatients across the Trust who have tested positive for Covid-19. Please note: There are a further 35 patients who have not yet had a positive PCR sample but are being treated as though they are positive (as these are symptomatic).

The rise in this particular metric continues at the rate of almost 2.7 additional Covid 'beds' per day. This represents an accelerated rate than previously reported which also represented an increase on previous weeks. This is mostly due to the increases witnessed over the past five days (averaging >7 per day). There are no indications of this rise abating and we on track to exceed the high point of 143 Covid inpatients we witnessed during wave 1.

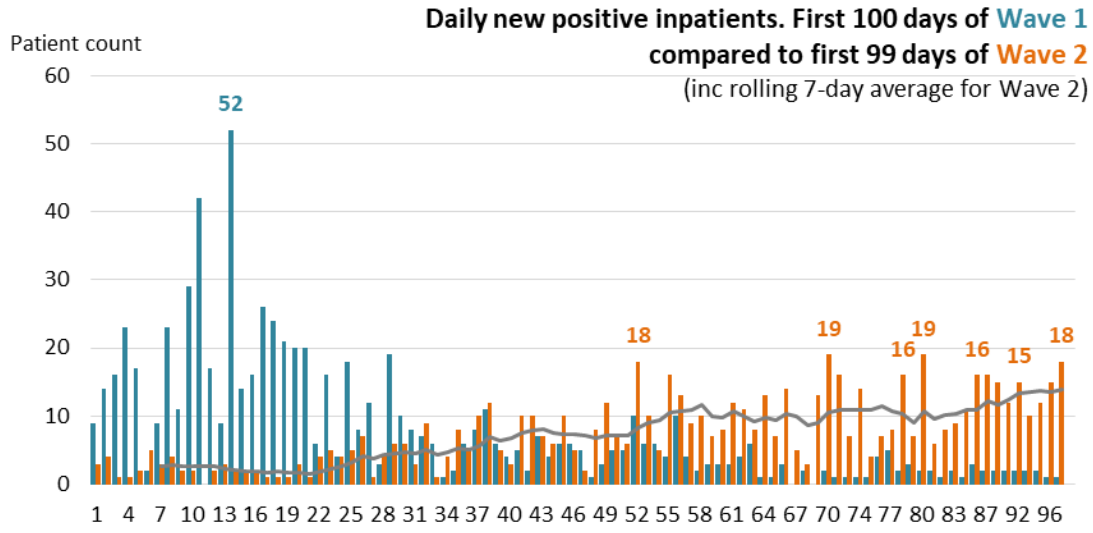
The impact on the number of beds required for Covid patients can be seen on the following chart. This shows the inpatient 'snapshot' as reported on a daily basis. It compares **wave 2** (up to 31 December) with the first 100 days of **wave 1**. It also includes a **rolling 7-day average** for wave 2.



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.

At this rate we will shortly exceed the previous high point for the number of beds required for confirmed Covid-19 inpatients (ie. this figure does not include suspected Covid inpatients).

The following chart shows the *daily* new positive inpatients. As before, this compares **wave 2** (up to 30 December) with the first 100 days of **wave 1**. It also includes a **rolling 7-day average** for wave 2.



Our number of Covid inpatients is massively dictated by our ability to successfully treat and discharge said patients. This is currently averaging at 8.3 discharges per day. This is fairly consistent with that reported last week and represents a sustained effort during the Christmas period.

Sadly, deaths have also decreased and we are currently averaging 4.3 Covid-related deaths per day. This is a marked jump on the number reported last week. This suggests there may have been an increase in acuity levels of recent inpatients.

The following two charts show our inpatient snapshot for **ITU** and **Other wards** for the first 100 days of wave 1 (top) and wave 2 (bottom).

Worcestershire Acute Hospitals NHS Trust

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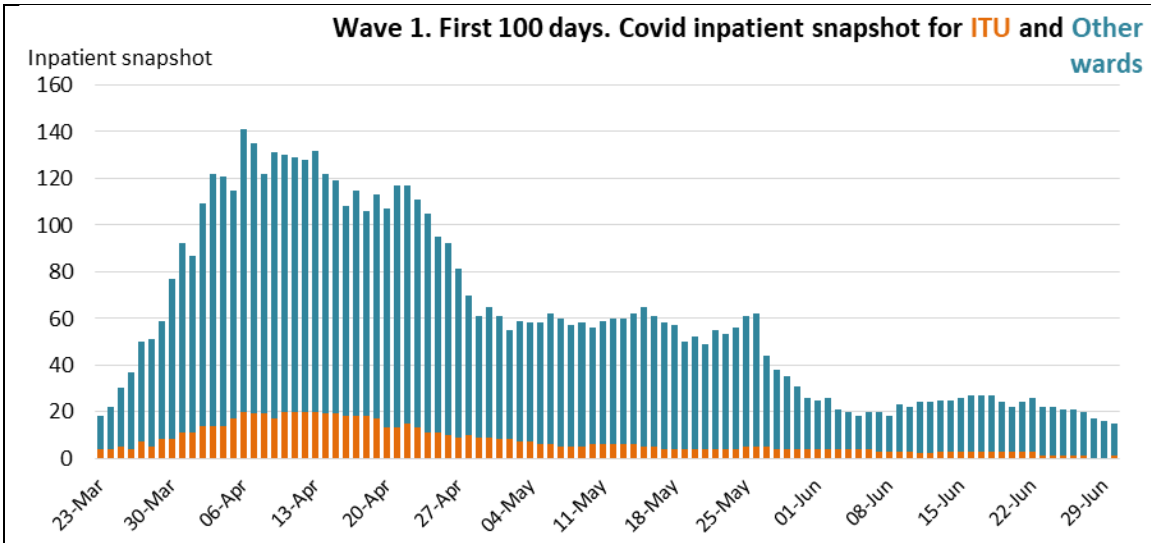
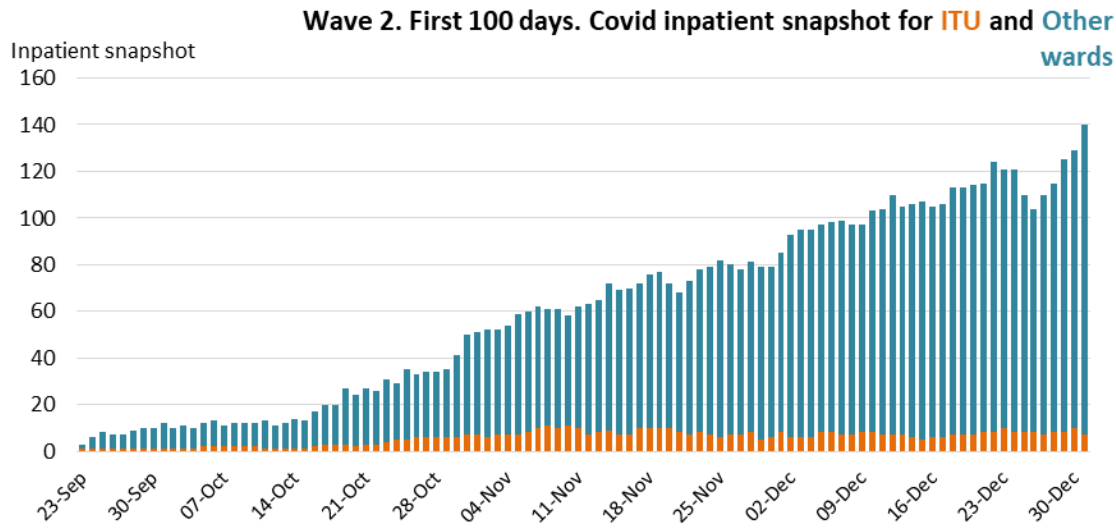
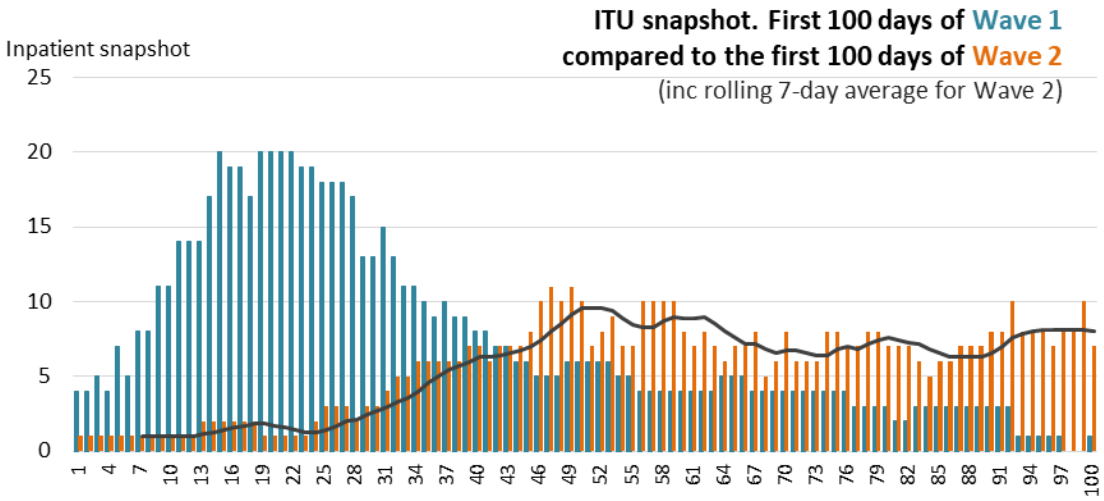


Note: These are drawn on the same scale to make them visually comparable with each other.



Whilst the predominant feature of the second wave (thus far) continues to be more about the number of inpatients and accompanying bed pressures there has been a consistent, elevated requirement for ITU beds (see next chart).

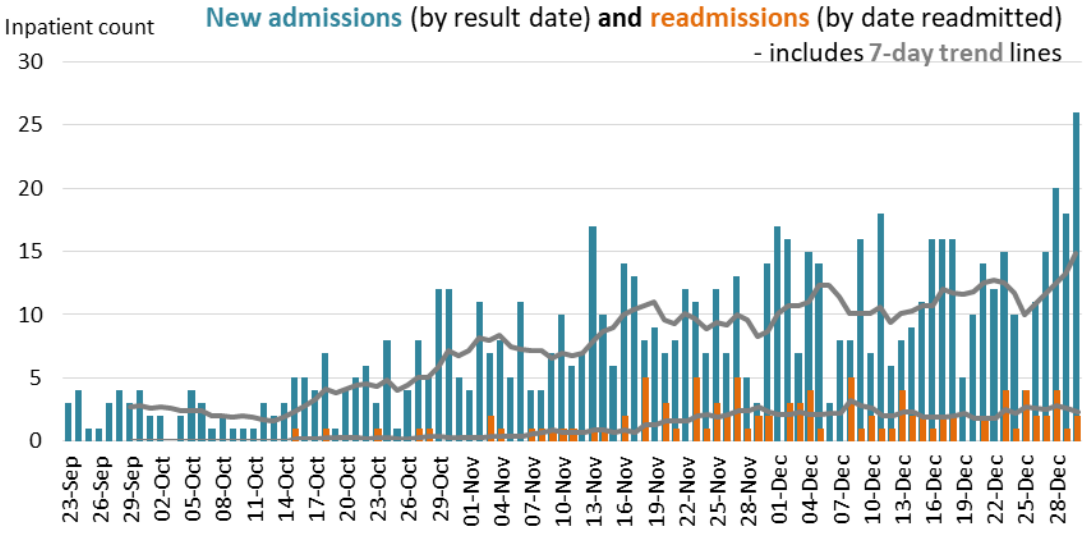


Pressures on ITU, whilst not at the levels experienced during wave 1, have now been at a heightened and sustained level for over 50 days.

Readmissions

Please note: This remains relatively new work and may be subject to change as we continue to understand this area.

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:

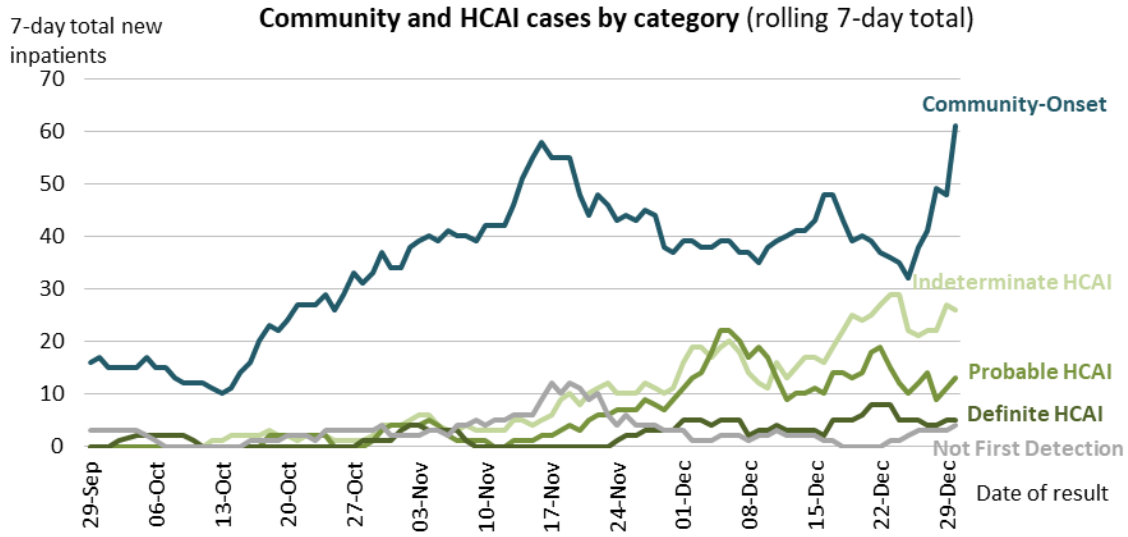
- Readmissions of previously treated patients have increased since early November

but now appear to be relatively stable.

- New admissions have increased over the past week. Our current increase in beds required for Covid inpatients is being driven by new admissions.

Hospital acquired cases

The following chart shows the rolling 7-day totals for community and hospital acquired cases. This is portrayed using the current HCAI categories and outlined by the date the result of the test was known.



Last week we reported that indeterminate hospital acquired cases had increased since the beginning of December. To the extent that the combined effect of hospital acquired cases (inc. indeterminate) exceeded the number of community onset cases and is rising. Compared to a recently reducing number of new community onset cases/admissions.

Most recently this is no longer the case and, in the past 7 days, we have seen a noticeable and sharp rise in the number of community-onset cases.

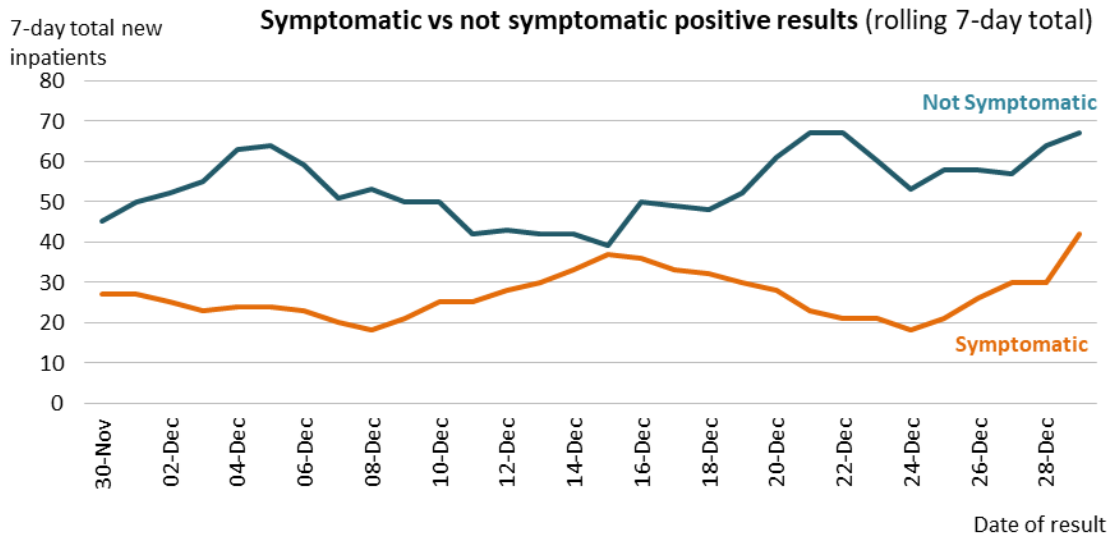
Note: The definition of an indeterminate case is a positive test taken within 3-7 days of admission.

The combined effect here is one of increasing community and hospital acquired cases. The number of indeterminate and community-onset cases reiterate the importance of testing all patients at the point of entry and shortly thereafter to limit in-hospital outbreaks.

Clinically suspected or 'asymptomatic' cases

The following chart shows the number of new positive results (based on day of result) for **not symptomatic** and **symptomatic** cases. Please note that this is based entirely on a single descriptive field/choice at the time the test was requested. It is not a clinical assessment of

the patient.

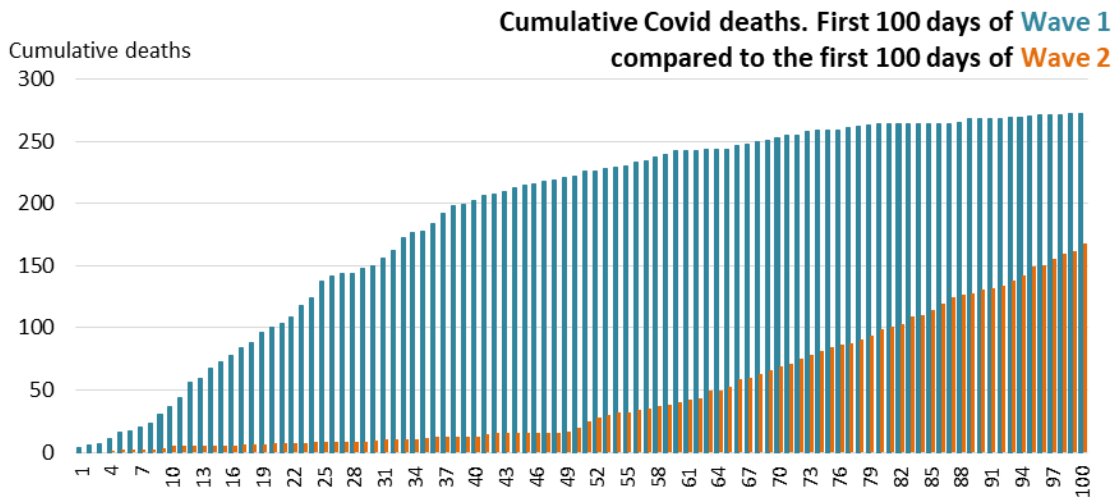


Potential data quality issues to one side, this shows a recent reversal in the trend of declining symptomatic cases. However, the number of not symptomatic cases also continues to rise.

This rise over the past week corresponds with a noticeable increase in new positive patients and to some extent corroborates the increase in community-onset cases and increased acuity levels within the community as a result.

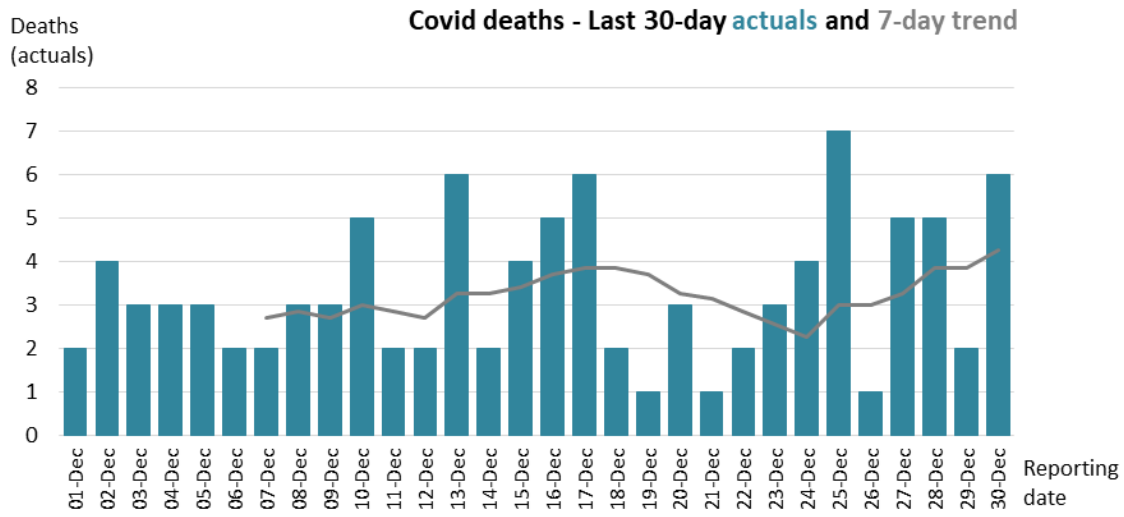
Mortality

The following chart shows the cumulative deaths for the first 100 days of **wave 1**against the first 93 days of **wave 2**.



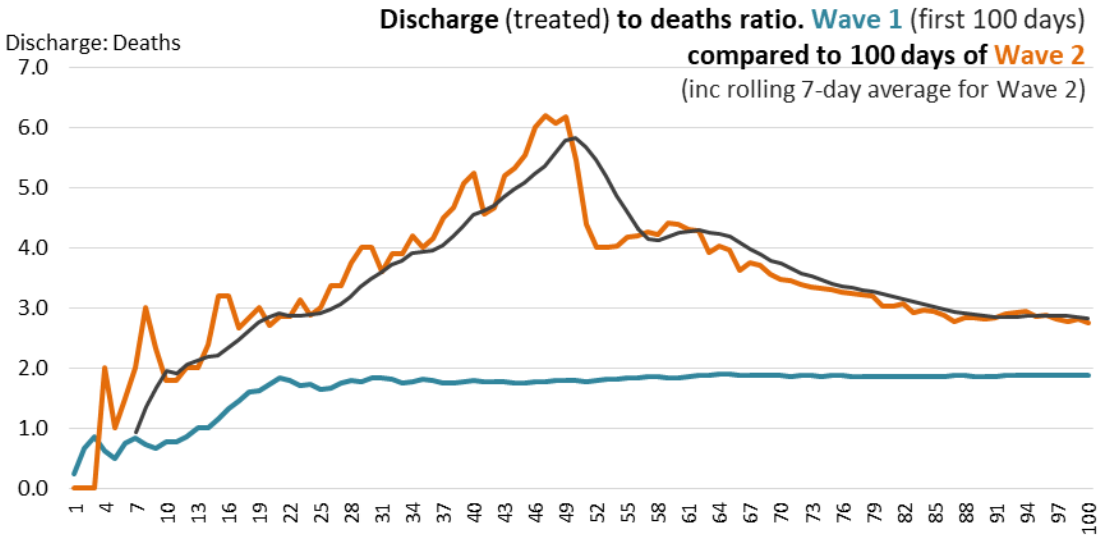
In the past week, our number of Covid deaths has accelerated.

The following chart shows the 7-day trend and the actual number of Covid deaths for the last 30 days.



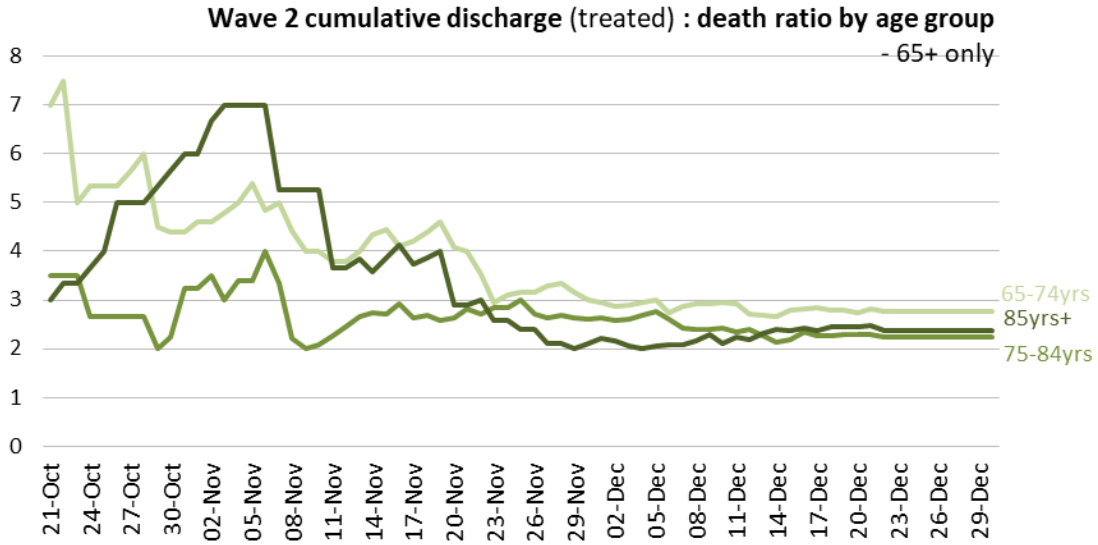
As the average LOS for deaths for wave 2 currently stands at around 13 days (see earlier tables) the increase witnessed this week we would expect that these are mainly from patients admitted/identified in the last 2-3 weeks.

However, an examination of the last seven days would suggest that the average LOS is just over nine days and an average time from identification as positive to death of 6.5 days. This would also suggest an increase in inpatient acuity corresponding with the increase in new cases over the past 7 days.



Although the ratio of treated:deceased inpatients for the current wave is much improved on that noted in wave 1(see above chart) this is being 'buoyed' by the treatment success for those patients under 65yrs.

The ratio for those age groups 65 or older has also stabilised having previously declined (see following chart).

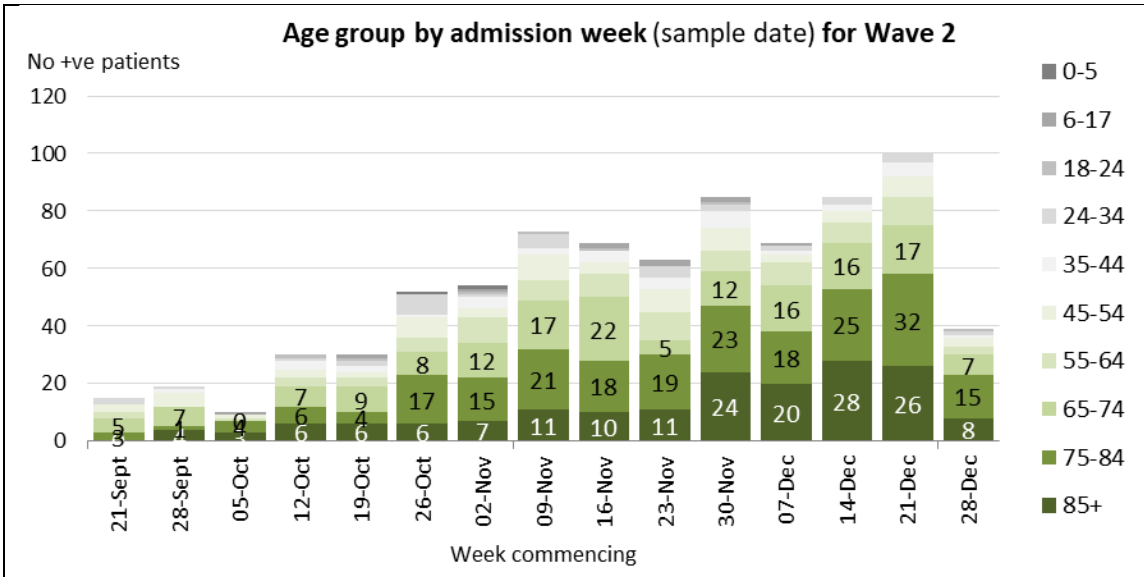


Observations:

- Our mortality rate continues to be improved.
- Our ability to successfully treat patients is maintaining above that in wave 1.
- However our crude mortality is currently increasing in line with increased patient numbers.

Inpatients by age group

The final chart in this week's report shows the gradual increase in patient numbers and corresponding increase in those aged 65+. Whilst the proportion of new admissions aged 65 or older has remained relatively consistent throughout (averaging <70%), this peaked at 81.2% for the week commencing 14 December and has been >75% for four consecutive weeks. This, in part would explain the recent increases in deaths.



If there is any good news here it is that our crude mortality rate is, if anything, improving and we continue to enjoy zero deaths for Covid inpatients <45yrs.

Conclusion

This has been a landmark week. As wave 2 approached its 100th day, the number of patients treated during this current wave overtook the number treated during the entirety of wave 1.

Current challenges are:

- This week's increase in community cases is now resulting in increased admissions.
- The current number of beds required for Covid-19 patients is likely to exceed the peak experienced during the first wave over the next few days.
- At our current rate we are increasing the number of beds required for Covid inpatients by almost three per day. This rate has accelerated over the past week.
- This is largely been driven by increases in community-onset and symptomatic cases (which reflects the increase in community cases).
- Indeterminate hospital acquired cases are also a significant factor in the daily number of new inpatients identified.
- The pressure on ITU beds required whilst less in this wave has increased in the last week. It has also been sustained at an elevated level (due to Covid-19) for >50 days.
- Crude mortality has risen over the last seven days and it would appear that patient acuity is increasing. Although this cannot be disentangled from increases in acuity attributable to 'winter pressures'.

However:

- The rate of growth in the number of newly detected Covid inpatients is being kept at its current level through the successful discharges treated patients and deceased patients.
- Despite increases in crude mortality our mortality rate and numbers of successfully treated patients remains improved on wave 1.

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This data and subsequent analysis supports:

- Discussions from this week regarding Lateral Flow testing in ED for patients who would be on a green pathway, to try to prevent potential HCAI infections from within the Hospital.
- The implementation of the ward plan changes that have been implemented on 30 December.
- The agreement *this week* to increase the capacity for ITU beds at WRH from *next week*.

Recommendations

Trust Board is invited to note this report for assurance.

Appendices

NHS
Worcestershire Acute Hospitals
NHS Trust

Meeting	Trust Board
Date of meeting	14th January 2021
Paper number	Enc F

Integrated Performance Report – Month 8 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 Rickets – Director of People & Culture		
Presented by	Paul Brennan – Chief Operating Officer. Vikki Lewis – 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	16th December 2020	Approved
Quality Governance	17th December 2020	Assured
Finance & Performance	23rd December 2020	Assured

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

Executive summary	**The impact of COVID-19** The Board will not be surprised to read 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. These areas have been affected by the increasing number of patients requiring hospital pathways and treatment that reflect the prevalence and acuity of their conditions. Although the IPR focuses on November 2020 metrics, in hindsight they highlight the fine balance that the Trust was achieving in November, and has since strived to maintain with more patients testing positive and therefore altering, again, our ratio of red and amber beds to enable cohorting of patients. The Trust has revised its operational framework to manage the significant increase of positive patients and reduce patient movement once in an inpatient bed. The necessary fluctuations between non-elective, COVID pathway and elective beds means that we have further reduced the level of elective surgery and have, for the first time since this pandemic started, cancelled cancer operations in addition to elective operations from the 4th January as the number of positive inpatients increased by 46% from 115 to 169 in the previous eight days. The total number of patients waiting longer than 52 weeks is now over

3,000.

Further improvements have been achieved in our diagnostic pathway activity and the focus on reducing the number of patients waiting over 62 days for their cancer treatment continues; however two week wait cancer time are being affected by the breast services demand and capacity gap that means patients are waiting over 20 days from referral for this particular service.

Workforce Demand vs Supply
Due to the second wave of COVID-19, winter pressures, the flu and COVID vaccination programmes we are seeing an increase in the use of bank and agency staff but also an increase in unfilled shifts.

Demand is outstripping supply with available bank staff preferring to work on the COVID-19 vaccination programme. To address this we have introduced a number of attraction strategies including increased bank rates, the ability for students to undertake bank shifts as healthcare assistants and winter incentive payments.

Staffing levels are monitored regularly throughout the day by the Clinical Site team with oversight by the Senior Nursing and Medical teams.

Our Financial Position
Against the internal £(78.9)m operational deficit plan (Budget), the month 8 (November 2020) actual surplus was £0.7m vs Plan £(6.2)m.

The combined pay and non-pay expenditure variance against our internal budget is £(1.3)m adverse. This position includes £1.7m of incremental COVID-19 costs.

The combined income position was £8.2m (Top-up £9.1m – Income variance £0.9m) favourable to budget in month recognising the interim funding regime. The revised payment mechanism will be in place until end of March.

Funds were to be withheld if the phase 3 activity targets are not met under Elective Incentive Scheme re: Phase 3 letter. The current guidance though requires Trusts to refer to the likely impact of the Elective Incentive Scheme in Board papers, but not to adjust the financial positions as a result of it. No adjustment is therefore included this month although it is estimated that the Trust activity levels would have resulted in a £1.3m penalty YTD, if applied.

The Trusts Income & Expenditure position was £2.0m better than the Financial Framework assumptions.

Pay costs were £1.0m (3%) lower than the Framework plan as a result of the following key items:

- Forecast assumed that all beds would be open in November 2020 and that we would incur significant additional temporary staffing costs for heightened levels of staff absenteeism. However, Ward 10 remains closed and temporary staffing resource and costs have not increased to the levels anticipated (£0.5m)
- 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. This is not deemed a sustainable solution and requires mitigation. Workforce colleagues are working closely with Directorate leads. (£0.1m)
- Lower than forecast usage of WLI in Endoscopy which may have an impact on waiting lists (£0.1m)
- Slippage in recruitment – in many cases this is deemed to be a timing difference and therefore we would not expect this favourable variance to continue at this level. (£0.1m)
- The August baseline included bank holiday enhancements. Due to the top town approach, no phasing was applied for future payments. Over the course of the remaining months this item will even itself out (£0.1m).

Non Pay costs were £0.6m (3%) lower than the framework plan. The key items driving this position include:

- The forecast assumed an additional £1.7m of additional spend driven by increases in activity with the assumption that all beds would be open in November 2020. Ward 10 remains closed and incremental variable non-pay costs associated with the number of beds open and occupied are lower than anticipated (c. £0.3m)
- Forecast had assumed additional touchpoint cleaning was to commence in October and continue throughout November. These services have not yet commenced. A paper has been submitted to Bronze and Silver meetings to update that the previously forecast £1.3m of additional cleaning costs will now be £0.4m (£0.1m)

Financing Costs are £0.1m adverse to plan following a reforecast in the PDC dividend.

As a result of the cumulative £4.3m positive to NHSI Finance Framework plan, mainly across temporary staffing and supplies and services we have adjusted the FOT to a forecast deficit of £(1.3)m based on the positive financial variances in M7 and M8 noting though impact on activity and patients into 21/22

NHS
Worcestershire Acute Hospitals NHS Trust

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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																		

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 (Nov-20 data) • WAHT November 2020 in Numbers • Committee Assurance Statements

Integrated Performance Report

NHS Worcestershire Acute Hospitals NHS Trust

Trust Board

14th January 2021

November 2020
Month 8

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

Operational Performance

Operational Performance Report - Headlines

Operational Performance	Comments
Urgent care and patient flow including Home First Worcestershire	• EAS Type 1 performance showed no significant variation even with fewer patients under the 4 hour target and an increase in aggregated patient delay. COVID-19 lockdown is thought to have been a contributing factor to a decrease in attendances, however the acuity of the patients remains high evidenced by a conversion rate still above 30%. • There was an increase in the number of 60 minute ambulance handover breaches from 58 to 63 and this month there was one 12 hour trolley breach. • In response to the increase in patients testing positive for COVID-19 we have had to increase our bed capacity, with over 200 G&A beds designated for COVID-19 pathways.
Cancer	• The surge in demand from Breast and Breast Symptomatic patients which our existing capacity has not been able to meet has resulted in our Breast 2WW waiting time performance, and 2WW Breast Symptomatic performance showing special cause concern. Additional capacity has been created through weekend clinics, however this has not achieved the operational standard of patients being seen within 14 days. • 31 Day wait for treatment is above the waiting times standard with 10 patients breaching of 255 patients treated, and this is within normal variation. • We have continued to reduce the backlog of patients waiting over 62 days for treatment so our cancer waiting times for 62 days remains below the operational standard. However, the backlog of patients over 104 days has gone up to 45 after three months of reducing the size of this cohort.
RTT	• Our RTT waiting list has grown again, although not at the same rate as previous months. Although the proportion of patients waiting over 18 weeks is currently lower than the previous month, now below 18,000, there are still growing number of patients waiting over 40 weeks with 2,457 patients waiting over 52 weeks. The number of patients waiting over 70 weeks now stands at 227 with those requiring oral surgery / orthodontic treatment making up nearly 50% of the cohort.
Outpatients	• Although there has been a further increase in our consultant-led outpatient appointments in-line with Trust plans to restore activity we have undertaken 10% fewer appointments than our forecast. • Consultant-led first outpatient attendances (telephone/video) and Consultant-led follow-up outpatient attendances (face-to-face) were positive to the phase 3 plan.
Theatres	• Of the available theatre capacity we have in the Trust we increased our utilisation to 76%. • Day case numbers have reached a point of significance with an increase for the 7 month in a row. • The pressure on beds at the end of November did result in the temporary suspension of elective surgery at the Alexandra Hospital and of the total number 172 elective cases booked across the Trust, 33 patients were cancelled giving a cancellation rate of 19.2%
Diagnostics	• A data validation exercise has reduced the number of patients recorded as waiting significantly. There was a reduction in diagnostic activity undertaken in Nov-20, and the proportion of patients waiting over 6 weeks has reduced and is now ~5,800 . There are 1,617 patients waiting 13+ weeks for their diagnostic test. CT, non-obstetric ultrasound, FlexiSig and gastroscopy activity were above their phase 3 trajectories.

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				
1	893	178	63	WRH	82.73%	ALX	51.12%

What does the data tell us?

- **EAS** - The overall Trust EAS performance which includes KTC and HACW MIUs is 82.10% in Nov-20, compared to 83.56% in Oct-20. The EAS performance at WRH decreased by 3.76 percentage points with 802 **fewer** ED attendances and 10 **fewer** 4 hour breaches than Oct-20 (Nov-20 breaches were 5,622). The ALX EAS increased by 1.08 percentage points, with 485 **fewer** attendances and 103 **fewer** 4 hour breaches (Nov-20 breaches were 443). Total Type 1 attendances across ALX and WRH was 9,539; a 12% **decrease** on the previous month and a 16% **decrease** on Nov-19.
- **EAS Type 1:** Our performance across the two sites, from Apr-19 to Nov-19, was 64.71% with 32,328 patients breaching 4 hours. Our performance for Apr-20 to Nov-20 is 83.26% with 13,291 patients breaching; this is a 59% reduction in patients breaching 4 hours. We have had 12,230 fewer patients attend ED in the eight months of 20/21.
- **Ambulance Handovers** - There were 63 x 60 minute ambulance handover delays; all but two of those were at WRH. These ambulance handover breaches occurred on 20 individual days
- **12 hour trolley breaches –** There was 1 reported 12 hour trolley breaches in Nov-20. We have reported six 12 hour trolley breaches in 20/21 compared to 577 by the end of November 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 have a wide variation in performance with the percentage of discharges compared to admissions at the WRH between 62% and 143% and between 37% and 152% at the ALX. Before midday discharges are above the mean from Jul-20 onwards, however the target of 33% cannot be met without a change to the process. The number of patients with a length of stay in excess of 21 days increased from 26 (at 31st October) to 30 (at 30th November) with 7 being MFFD.
- **Total Time in A&E:** The 95th percentile for patients total time in the Emergency departments has increased from 543 minutes in Oct-20 to 600 minutes in Nov-20. This metric is showing normal variation, but the statistical process chart indicates it is highly unlikely that we will achieve our target.

What have we been doing?

Clinical Site Management

- Approved posts are either out to advert or in the process of recruiting
- Twilight shift at Redditch on track to commence 1st December 2020
- CSM SOP and refreshed "Rhythm of the Day" has been circulated to CSM teams, nursing leads and Divisional leads for cascade and implementation
- Interim e-handover / referral form has been built and has had positive feedback
- Business case completed and will be submitted to COO for approval and due for TME review on 16th December

Acute Patient Flow

- Board Round Audit discussed at work stream meeting
- Action Cards with Board Round standards for different member of the MDT redistributed to all Divisions for comment
- Meeting with DDN for Urgent Care and requested all Urgent Care wards to provide Flow Team with patients who have had CCD set in assessment areas.

Acute Front Door

- Primary Care SOP for current service has been reviewed and approved until pilot ends in March
- Safety huddles continue, with escalation through EPIC and Divisional Teams to address delays
- Urgent access to radiology - a number of operational improvements have been tested in the last 8 weeks. An evaluation report was presented to Divisional Management Board with tests of change being maintained and, where appropriate, rolled out to WRH site.
- AEC in Mulberry and Acute Medicine business cases presented at, and approved by, Divisional Management Board
- Increase in surgical assessment spaces approved as part of winter plans and temporarily funded for 3.5 months through CCG

Frailty

- Planning meeting for MDT clinical review of ambulance conveyances of patients 65+ to ED to better understand the use of the Urgent Care 2-hour response service by 111/999 both during the test of change in North Worcs and since the countywide launch & inform the clinical model 2021-22
- Mapping of roles and competencies for Frailty – the learning module (to include HAFD) on Essential Training Matrix completed for upload, go live planned for beginning of December

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%)			
600	24 Beds	3.26%	389	WRH	100.7%	ALX	99.1%

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 November our average number of G&A beds occupied per day was 517.
- **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 no significant change since the re-base post COVID-19. However, the statistical process chart indicates we cannot achieve the target of zero without further intervention.
- **Occupancy -** G&A bed occupancy averaged at 72.07% across the Trust, with WRH fluctuating week on week in November to as high as 92.92% and ending the month at 82.74%. The ALX also fluctuated week on week to 57.80% at month end and only went over 60% on five days in the month.
- **Conversion rates** – 3,041 Type 1 patients were admitted in Nov-20; a conversion rate of 33.13%. The conversion rate at WRH was 35.24% and the ALX was 30.02%. The conversion rate at WRH in Nov-20 compared to Nov-19 is 1.7 percentage points higher continuing the trend of higher acuity for patients attending the Emergency Department.
- **15 minute time to triage –** The Trust performance is 92.6%, the target is 95%. Although the ALX achieved the target, both sites show no **significant** change in performance.

What are we doing next

Clinical Site Management

- Continue with the recruitment as planned and complete the induction and competency work which was delayed due to prioritisation of the management of the site
- Seek feedback on CSM SOP and refreshed "Rhythm of the day" and review impact in January
- PDSA test of the interim e-handover / referral form and process with one ward, pending development of CLIP module
- Ongoing review of transport issues at stakeholder group
- Launch Trust Escalation Management plan and ensure all post holders with role specific actions defined in EMS levels 1-4 are trained to undertake designated actions

Acute Patient Flow

- Divisions will be reporting back to next work stream meeting with action plans for improving afternoon Board Round compliance and quality of information discussed at Board Rounds.
- A repeat of the Board Round audit will be carried out week commencing December 7th 2020 to review if improvement has been made in quality of information discussed at Board Rounds.
- A R2G delay audit will be carried out on Aconbury 3, Beech B and Ward 11, to obtain ward level data for delays.
- Flow team to track CCD/ CLD patients from Urgent Care to demonstrate CLD usage once a patients has moved wards
- Training for Physician Associates on SAFER/ R2G principles and the importance of EDS/TTO completion the day before discharge to improve flow

Acute Front Door

- Reviewing the ANP evaluation report and agree actions to optimise role
- System-wide Stakeholder event regarding development of ED model between now and new build
- Ratify escalation process for Handover Delays and include in trust wide escalation document
- Document and implement a communications plan to ensure stakeholders are aware of and accessing SDEC services

Frailty

- ReSPECT to be added to EDS to include key information to enable effective system wide communication to address the challenge of 65+ attendances & admission conversion
- Monitor compliance with Frailty e –learning with a focus on Urgent Care
- Identification of Frail Patients on discharge CFS to be added to EDS on Mandatory field

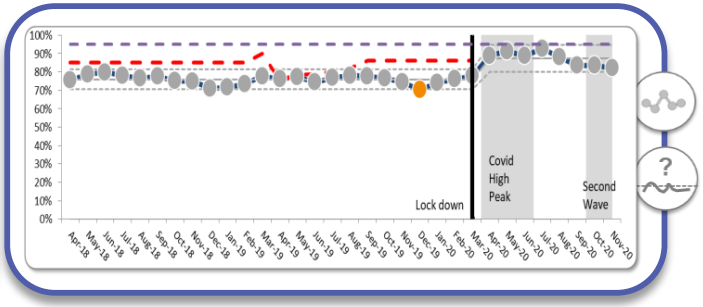
Assurance Level: 5 (Nov-20)	**When expected to move to next level of assurance: Q4 – depending on the management and impact of COVID-19 second wave and the development of the Worcestershire Royal AMU model**
Previous assurance level: 5 (Oct-20)	**SRO: Paul Brennan**

Month 8 [November] 2020-21 | Operational Performance: Urgent Care & Patient Flow

Responsible Director: Chief Operating Officer | Validated for Nov-20 as 9th December 2020

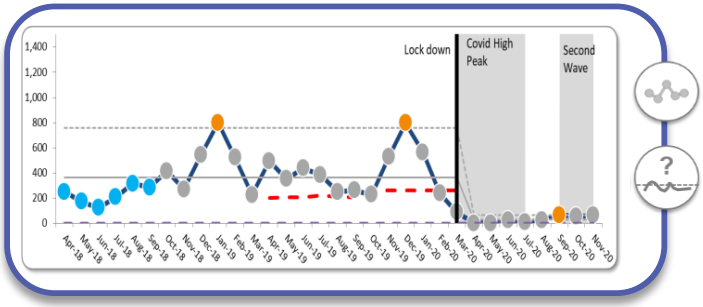
4 Hour EAS (all)

82.10%



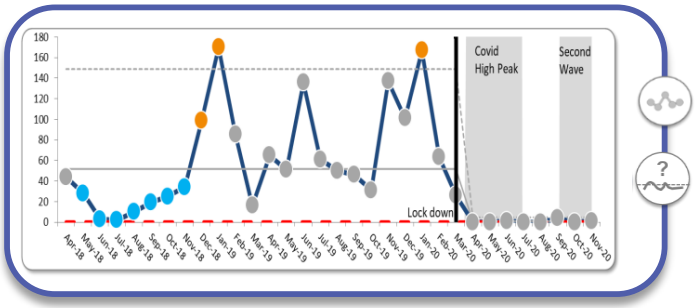
60 minute Ambulance Handover Delays

63



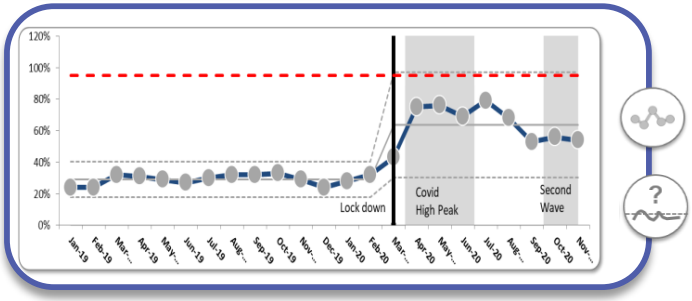
12 Hour Trolley Breaches

1



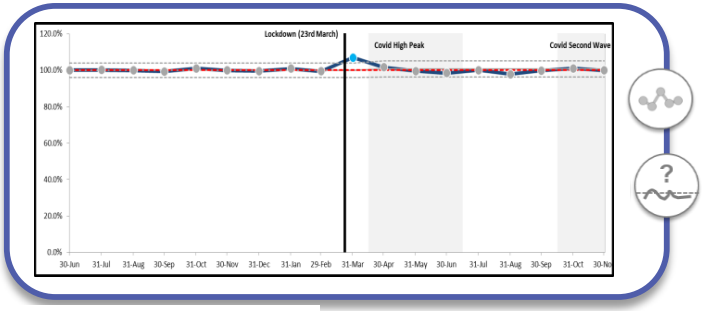
Specialty Review within 1 hour

54%



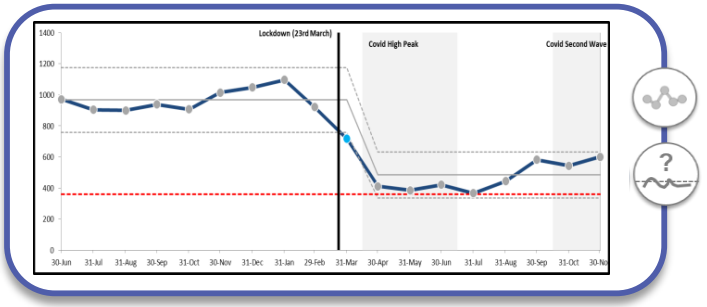
Discharge as a percentage of admissions

100.0%



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

600



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

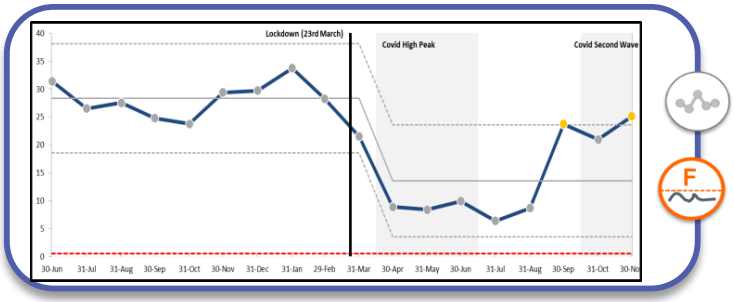
- Internal target
- Operational standard

Month 8 [November] 2020-21 | Operational Performance: Urgent Care & Patient Flow

Responsible Director: Chief Operating Officer | Validated for Nov-20 as 9th December 2020

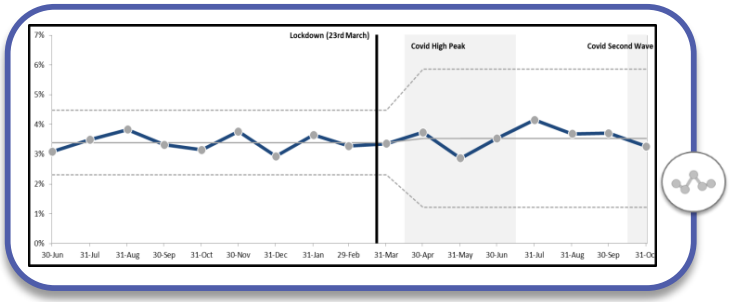
Capacity Gap (Daily avg. excl. EL)

24.6



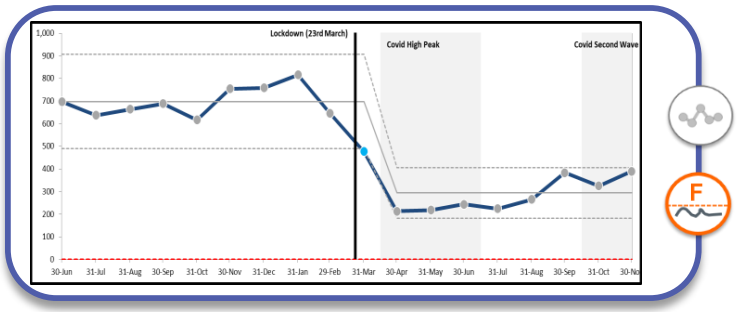
30 day readmission rate for same clinical condition (Oct-20)

3.26%



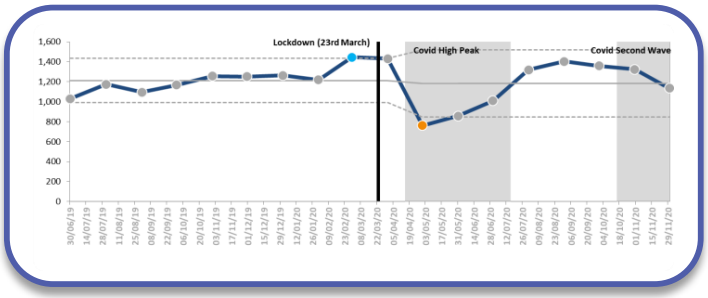
Aggregated Patient Delay (APD)

389



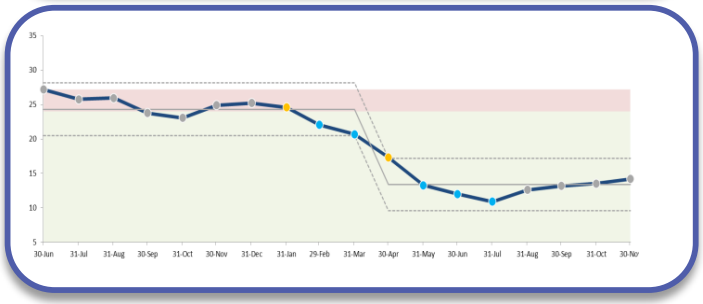
Discharges before 10am (Non COVID-19 wards)

1,134



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

14.2



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

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 (November 2020)

EAS (All) - The Trust was one of 10 of 13 West Midlands Trusts which saw a decrease in performance between October and November. This Trust was ranked 5th of 13; where we were 5th previous month. The peer group performance ranged from 68.93 % to 89.30% with a peer group average of 76.79%; decreasing from 78.27% the previous month.
The England average for November was 83.8%, a 1.1 percentage point decrease from 84.40%, in October.

EAS (Type 1) - All 13 West Midlands Trusts saw a decrease in performance between October and November. This Trust was ranked 3rd of 13; where we were 7th the previous month. The peer group performance ranged from 56.10% to 89.30% with a peer group average of 68.88%; decreasing from 76.38% the previous month.
The England average for November was 76.8%, a 0.8 percentage point decrease from 77.60%, in October.

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

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

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

EAS – % in 4 hours or less (Type 1) – Oct-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
2,167	77.22% (2,002 total seen)	13.59% (103 total seen)	96.08% (255 total treated)	73.83% (149 total treated)	181	45

What does the data tells us?

- **Referrals**: there has been no significant change in referrals since Jun-20, although the last three months have been above the mean. There are also no significant changes in referrals at specialty level; however the demand on the Breast service is sustained which is impacting seeing patients within 14 days.
- **2WW:** The Trust saw 14 more patients in Nov-20 than Oct-20 and 77.22% were within 14 days, a return to normal variation. Further improvements to the Upper GI pathway has increased the number of patients seen within 14 days to 64.56%. The Breast service saw 370 patients but only 12.16% were within 14 days; additional capacity continues to be made available to address the backlog but the current wait is in excess of 20 days. Despite the increase in referrals, the conversion rate for Breast has remained the same.
- Of the 456 breaches, 325 (71%) were attributable to Breast. Across all tumour sites, only 35 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 13.59% in Nov-20 from 25.00% in Oct-20 – this is now a point of special cause concern.
- **31 Day:** Of the 255 patients treated in Nov-20, 245 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 149 recorded first treatments in Nov-20 to date and 73.83% are within 62 days. This is continues the trend of no significant change in variation since Aug-19 and, currently, the 85% target is not achievable.
- **Backlog:** The number of patients waiting 62+ days for their diagnosis and, if necessary, treatment has decreased from 185 in Oct-20 to 181 in Nov-20; this is tracking under our November phase 3 target of 245. This does continue the sustained and significant trend of patients waiting over 62 days. Of that cohort, the number of patients waiting 104 days or more is 45; this has returned to 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 10.85%, however this is in the context of fewer total referrals and, fewer positive cases.

What have we been doing?

- Remedial action plan in place for Urology with weekly review with STP lead. Actively investigating use of the IS for complex surgery and potential to use Cancer Surgical Hub. Also exploring capacity outside of the Midlands (Cheltenham).
- FIT testing in place in primary care and for re-triage pathway of patients waiting + 90-days'.
- STP endoscopy steering group established to support / identify increases in capacity to meet demand for cancer patients requiring a scope.
- Breast Services ran 1 additional clinic at POWCH and ran 3 Saturday clinics in the month. They have also been running education events for GPs to encourage breast pain treatment and monitoring to remain in primary care.

What are we doing next?

- An STP Workforce Transformation Group has been established with a number of subgroups identified which include Cancer and Diagnostics.
- HEE data pack shared with system lead for workforce transformation to initiate the development of a workforce plan for cancer.
- Breast Services will not be running any Saturday clinics in Dec-20 due to staffing capacity but have already planned for additional clinics to run each Saturday in Jan-21.
- The Breast Surgery theatre list running at South Bank will return to ALX in Jan-21.

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

9

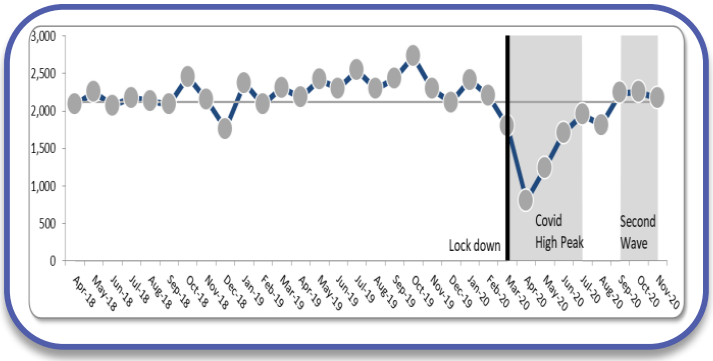
Month 8 [November] 2020-21 | Operational Performance: Cancer

Responsible Director: Chief Operating Officer | Unvalidated for Nov-20 as 4th January 2021

NHS Worcestershire Acute Hospitals NHS Trust

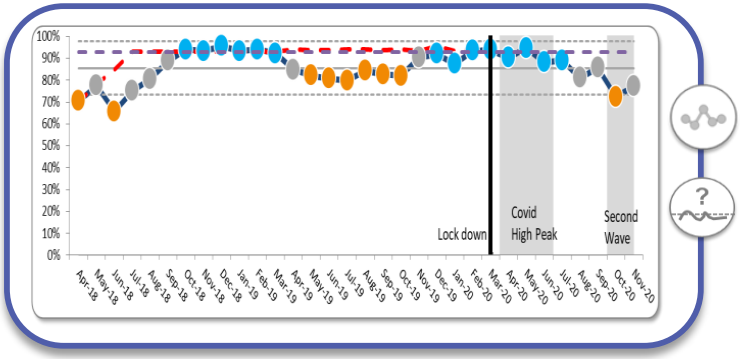
2WW Referrals

2,167



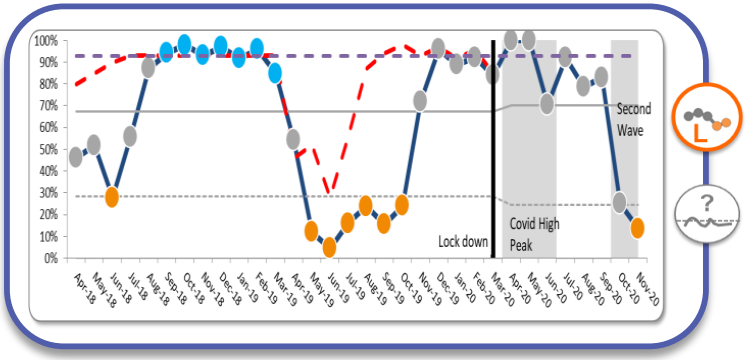
Cancer 2WW All

77.22%



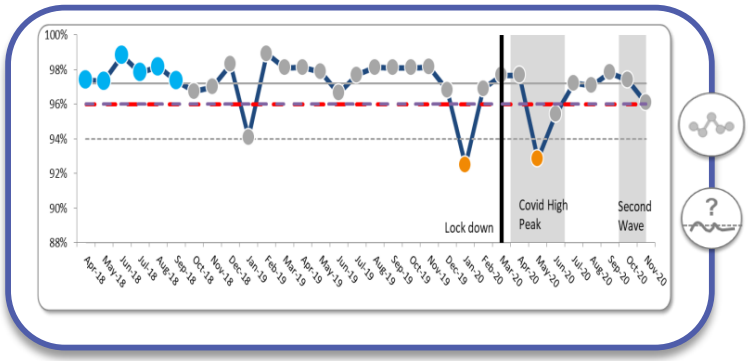
Cancer 2WW Breast Symptomatic

13.59%



Cancer 31 Day All

96.08%



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.

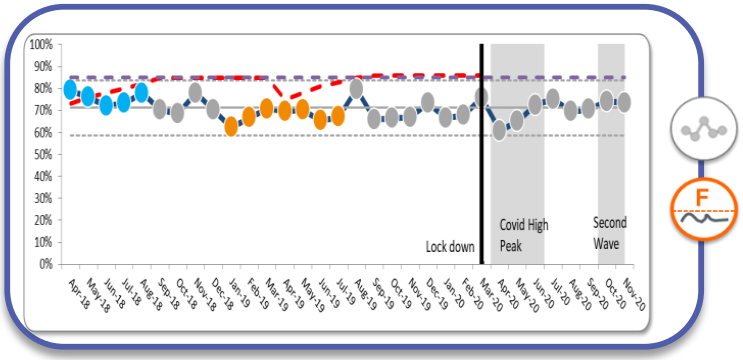
Month 8 [November] 2020-21 | Operational Performance: Cancer

Responsible Director: Chief Operating Officer | Unvalidated for Nov-20 as 4th January 2021

NHS Worcestershire Acute Hospitals NHS Trust

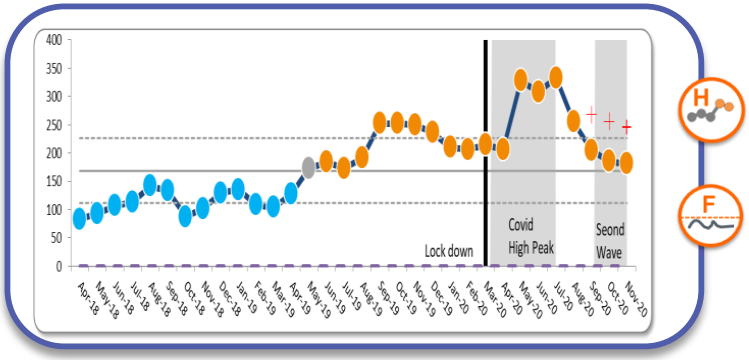
Cancer 62 Day All

73.83%



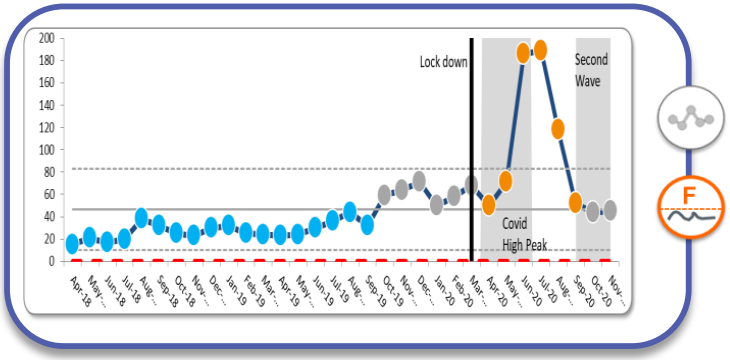
Backlog Patients waiting 63 days or more

181

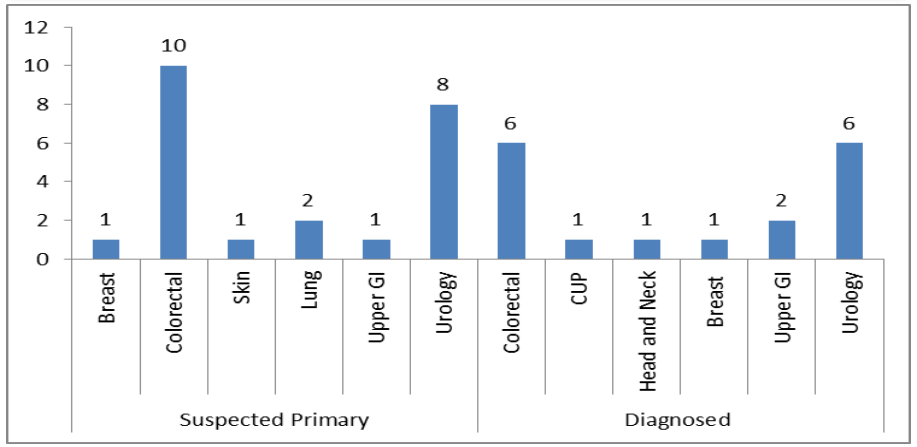


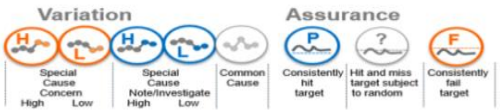
Backlog Patients waiting 104 day or more

45



104+ Day Backlog profile by specialty





Key

+ phase 3 target
- Internal target
- Operational standard

Operational Performance: Cancer Benchmarking

National Benchmarking (October 2020)

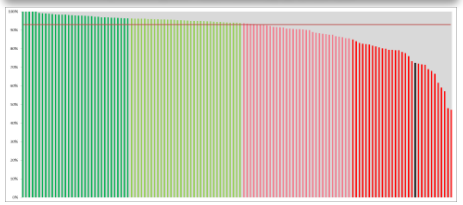
2WW: The Trust was one of 5 of the 13 West Midlands Trusts which saw a decrease in performance between September and October. This Trust ranking is 11th out of 13. The peer group performance ranged from 47.21% to 97.85% with a peer group average of 82.36%; increasing from 78.66% the previous month. The England average for October 2020 was 87.88%, a 1.68 percentage point increase from 86.20% in September.

2WW BS: The Trust was one of 12 of the West Midlands Trusts who saw a decrease in performance between September and October. This Trust was ranked 9th of 12. The peer group performance ranged from 7.14% to 100% with a peer group average of 49.86%; decreasing from 77.45% the previous month. The England average for October 2020 was 76.99%, a 0.16 percentage point decrease from 77.15%, in September

31 days: The Trust was one of 4 of the 12 West Midlands Trusts who saw a decrease in performance between September and October. This Trust was ranked 3rd of 12. The peer group performance ranged from 84.69 % to 100% with a peer group average of 91.80%; decreasing from 94.02% the previous month. The England average for October 2020 was 95.74%, a 3.42 percentage point increase from 92.05%, in September.

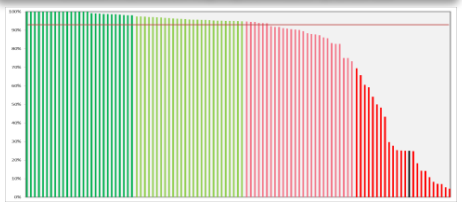
62 Days: The Trust was one of 9 of the 13 in the West Midlands Trusts who saw an in increase in performance between September and October This Trust its position is 7th of 13. The peer group performance ranged from 33.97% to 84.68% with a peer group average of 66.32%; increasing from 67.02%; the previous month. The England average for October 2020 was 74.5%, 3.44 percentage point decrease from 77.94% in September.

2WW (All cancers) | Oct-20



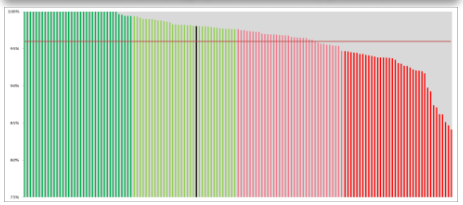
WAHT — Operational Standard 93%

2WW Breast Symptomatic | Oct-20



WAHT — Operational Standard 93%

Cancer 31 Day (All cancers) | Oct-20

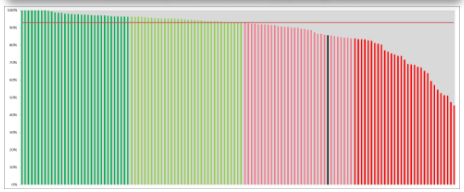


WAHT — Operational Standard 96%

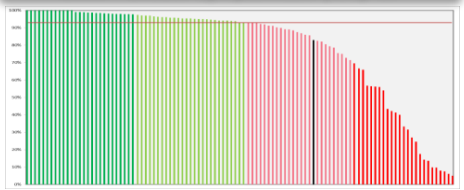
Cancer 62 day (All cancers) | Oct-20

WAHT — Operational Standard 85%

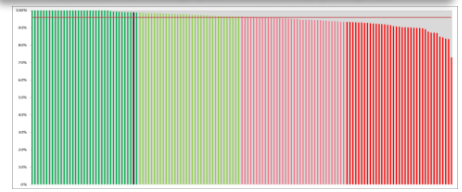
2WW (All cancers) | Sep-20



2WW Breast Symptomatic | Sep-20



Cancer 31 Day (All cancers) | Sep-20



Cancer 62 day (All cancers) | Sep-20

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
41,271	17,554	57.47%	5,537	2,457	227	4,411

What does the data tells us?

- The Trust has seen a 0.14% decrease in the overall wait list size in Nov-20 compared to Oct-20; from 41,332 to 41,271. This is currently +1,688 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 now reduced to 17,554, with a further reduction of 802 patients from Oct-20's snapshot. It is still the case that the combination of a larger waiting list with new patients being added to it and another reduction in the total number of patients above 18 weeks has seen RTT performance move from 55.83% in Oct-20 to 57.47% in Nov-20. However, 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 5,537, and those patients waiting over 52 weeks which is now 2,457; this is currently +925 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 2,457 patients waiting over 52 weeks, 227 have been waiting over 70 weeks with 109 patients requiring oral surgery / orthodontics treatment
- Seven specialties have over 1,000 patients waiting over 18 weeks; this is 70% of all our 18 week breaches. The same 7 specialties contribute 72% of all patients waiting over 52 weeks.
- RTT referrals (urgent and routine) have decreased by 15% from Oct-20 to Nov-20.
- **Referral Assessment Services (RAS)**: In Nov-20, 3987 referrals were received through this service to be triaged, 3936 (98.7) of all Nov-20 referrals have been outcomed, and 44% of those were outcomed within 5 working days. 3,254 appointments have been booked, 108 referrals were cancelled but there remains 723 referrals awaiting action.
- **Elective Planned:** This waiting list has 8,967 patients and the vast majority (6,549) are awaiting an endoscopy. Of the total waiting list, 6,297 are within their repeat date but they do not yet have a TCI. 455 patients have passed their repeat date with no TCI set and 420 patient have passed their repeat date and have a TCI.

What have we been doing?

- Due to the increase in oral surgery 70+ weeks waiters, NHSEI was attempting to source alternative providers; however this has been devolved to the system to explore. Although Trust is actively looking for alternatives, it is felt that system support is still needed.
- T&O patients have been identified as a potential group to go to Dudley for surgery. The CCG is calling these patients to review if this is acceptable with 37 agreeing to transfer, to date.

What are we doing next?

- Specialties will continue to work to, and adapt, their intervention plans to undertake as much activity as they can within current constraints.
- Interventions plans continue to be monitored to identify where specialties are on track or deviating from their plans to that any impact on achieving the phase 3 activity plans is understood.
- The review by the clinicians to ensure that we are maximising the opportunity for virtual appointments is on-going.

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**

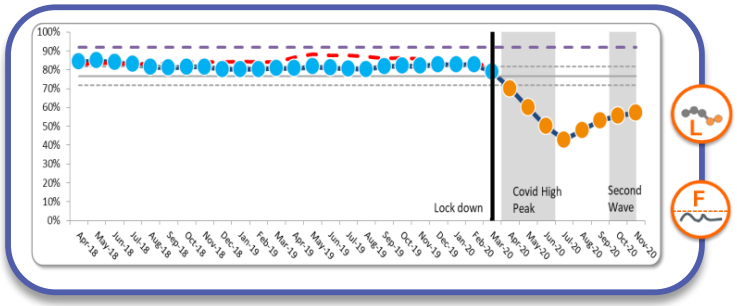
Month 8 [November] 2020-21 | Operational Performance: RTT

Responsible Director: Chief Operating Officer | Validated for Nov-20 as 4th January 2021

NHS Worcestershire Acute Hospitals NHS Trust

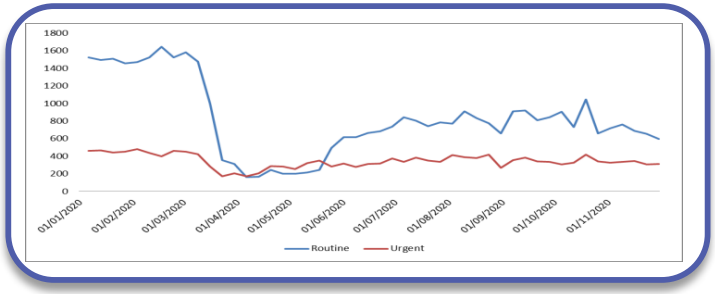
RTT % within 18 weeks

57.47%



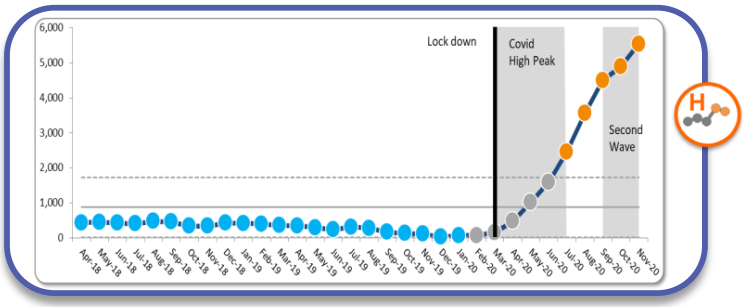
RTT Referrals Profile

4,411

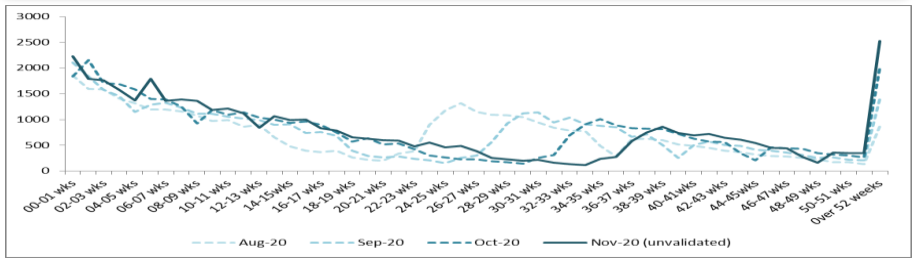


40-52 week waits

5,537

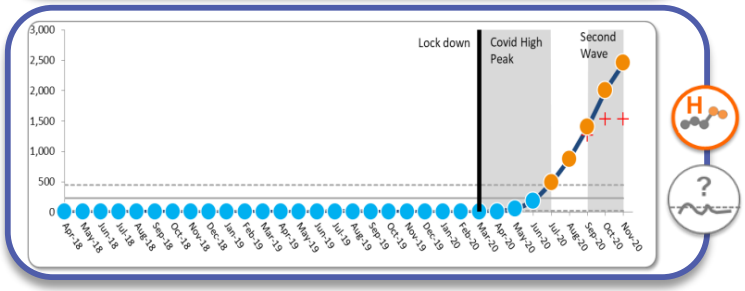


RTT waiting list profile (Aug-20 to Nov-20) by weeks waiting

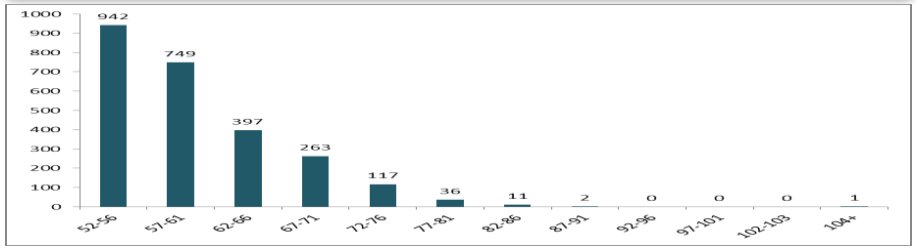


52+ week waits

2,457



RTT waiting list profile (Nov-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

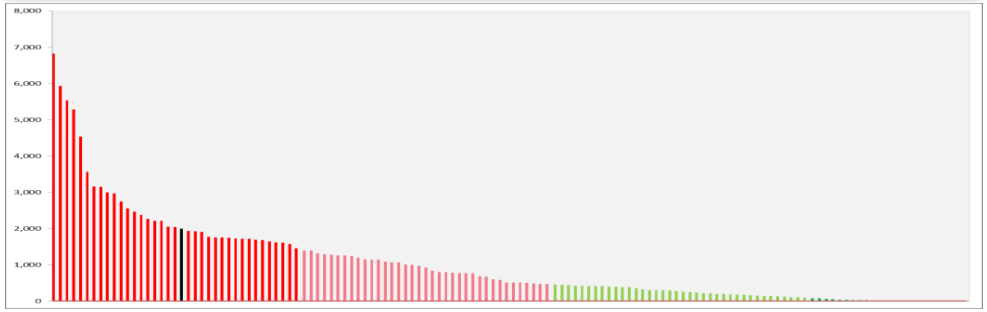
2.4 - Maintain access to all emergency surgery (inc trauma) and triage elective waiting list to prioritise access for those at greatest risk of harm from delay

National Benchmarking (October 2020) | The Trust was one of 12 of the 12 West Midlands Trusts who saw a increase in performance between September and October. This Trust is now ranked at 12th of 13 where the previous month we were ranked 10th. The peer group performance ranged from 55.61% to 82.85% with a peer group average of 59.38%; increasing from 54.96% the previous month. The England average October 2020 was 65.5%, a 4.9 percentage point increase from 60.6%, in September.

Nationally, there were 162,888 patients waiting 52+ weeks, 2,000 (1.23%) of that cohort were our patients.

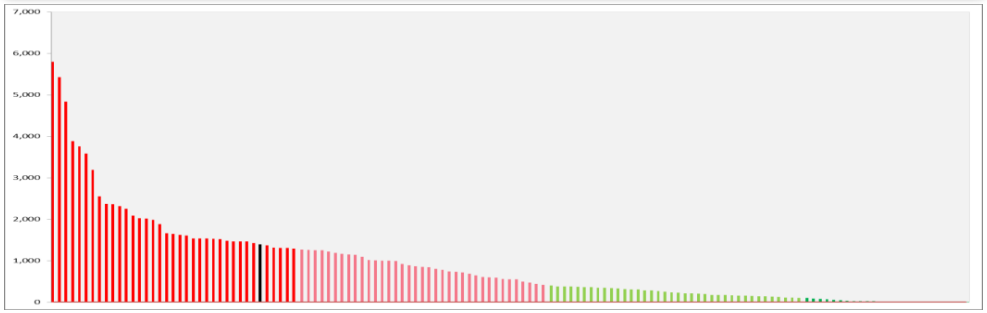
RTT - % patients within 18 weeks | Oct-20

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



RTT - % patients within 18 weeks | Sep-20

RTT – number of patients waiting 52+ weeks | Sep-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
10,384	2,545	19.68%	16,955	12,023	41.49%	34.76%

Outpatients - what does the data tell us?

- The Trust undertook 41,663 outpatient appointments in Nov-20. This is 4,461 fewer appointments than Nov-19 (90.33% of Nov-19 activity), and 591 more than Oct-20. When looking specifically at consultant led activity, in line with phase 3 restoration monitoring expectations, Nov-20 unvalidated activity is 77.3% of Nov-19 activity and we achieved 90% of our submitted plan activity.
- In Nov-19, 1,951 non-face-to-face appointments took place which increased to 14,568 in Nov-20. That is 12,617 more appointments, an increase of 646.69%. Of all appointments in the month, 34.76% (both new and follow-up) were non-face-to-face.
- As at 11th November the outpatient backlog for new outpatients was 43,308 with 17,388 on an RTT pathway and 525,920 on a non-RTT pathway. 8,756 patients had been dated but that does leave almost 35,000 not yet dated. Nearly 35,000 patients, of the total new outpatient waiting list are deemed to be routine.
- Looking specifically at our phase 3 plan (slide 19), we undertook 21,571 appointments against a target of 23,760. Our area of success continues to be Consultant-led first outpatient attendances (telephone/video) where we were +618 to plan. Although we were +251 above plan for Consultant-led follow-up outpatient attendances (face-to-face), this might have contributed to being -1,602 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 continue to show normal variation having been statistically lower for April and May and is now on the mean line for the period Apr-19 to Nov-20.
- Theatre utilisation remains within normal variation but it is clear that we have a long way to go to achieve pre-COVID-19 utilisation in-line with the phase 3 elective activity plan. Day cases show a positive upwards trend on the SPC chart (slide 17) as more day case surgery is undertaken , although not yet at the pre-COVID-19 levels.
- From our inpatient elective monitoring, day Case spells were +526 above and ordinary spells were -64 below our phase 3 plans.

What have we been doing?

- SMS texting for outpatients has restarted to reduce our DNA rate.
- There was a temporary suspension of elective surgery at the Alexandra Hospital and of the total number 172 elective cases booked across the Trust 33 patients were cancelled giving a cancellation rate of 19.2%. No further elective patients have been cancelled.
- An audit of all clinics has been undertaken to ensure we are making best use of capacity. One finding is that we don't currently need to use BHI Parkside in Bromsgrove, which had been offered for it's additional clinic space.

What are we doing next?

- Specialties will continue to work to, and adapt, their intervention plans to undertake as much activity as they can within current constraints.
- Interventions plans continue to be monitored to identify where specialties are on track or deviating from their plans to that any impact on achieving the phase 3 activity plans is understood.
- The review by the clinicians to ensure that we are maximising the opportunity for virtual appointments is on-going.
- Ophthalmology are reviewing a switch from consultant-led to nurse-led clinics

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**

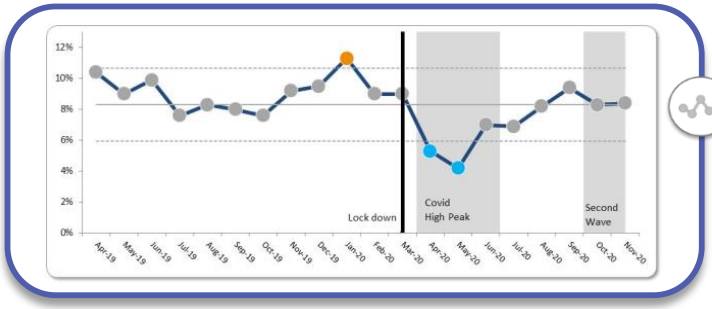
Month 8 [November] 2020-21 | Operational Performance: Theatre Utilisation & Outpatients

Responsible Director: Chief Operating Officer | Unvalidated for Nov-20 as 4th January 2021

NHS Worcestershire Acute Hospitals NHS Trust

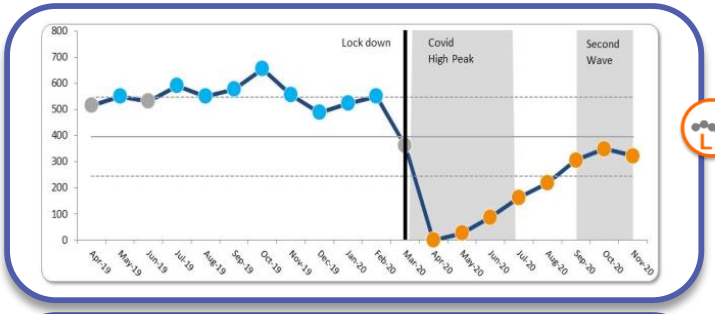
On the day cancellation as a percentage of scheduled procedures (%)

8.4%



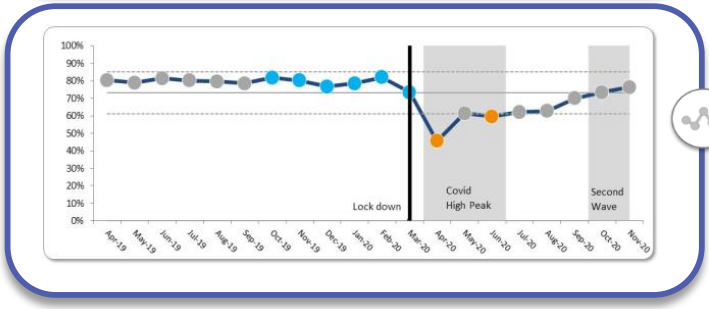
Electives on elective theatre sessions (n)

323



Actual Theatre session utilisation (%)

76.30%

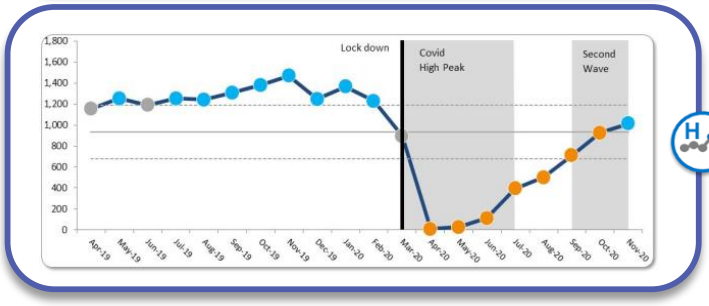


Non-electives & emergencies on elective theatre sessions (n)

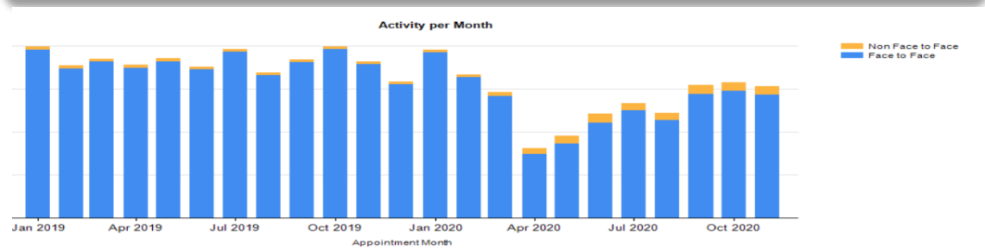
13

Day cases on elective theatre sessions (n)

1014



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



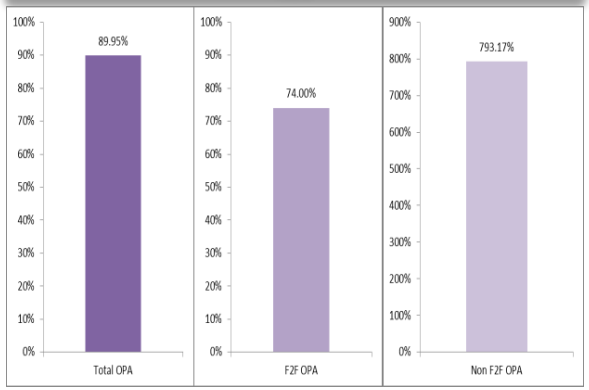
*Phase 3 restoration is based on consultant-led activity only that has been submitted via SUS. This graph is reflective of **all** the Outpatient activity that has been delivered by the Trust.

Month 8 [November] 2020-21 | Operational Performance: Outpatients

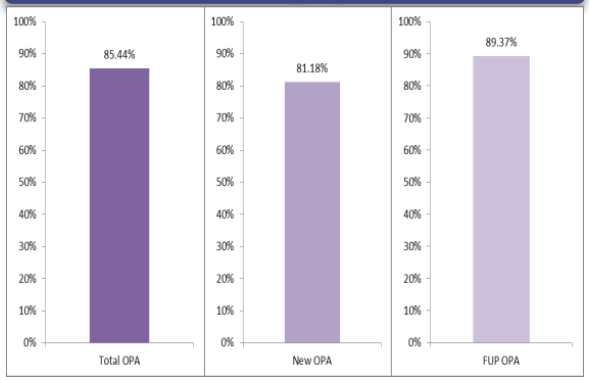
Responsible Director: Chief Operating Officer | Unvalidated for Nov-20 as 4th January 2021

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

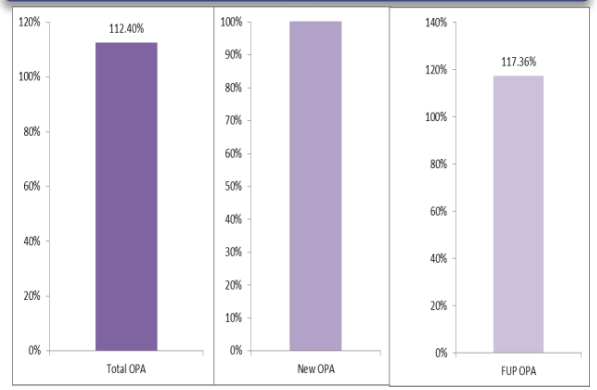
New



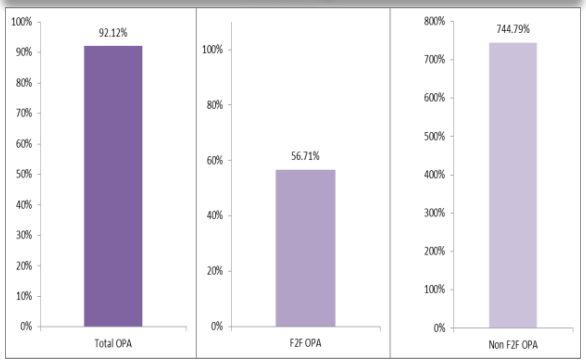
Emergency



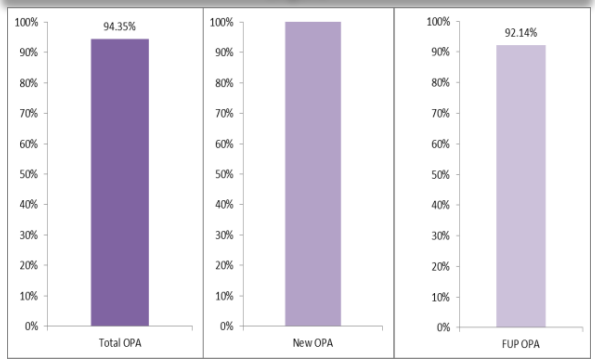
Cancer



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.

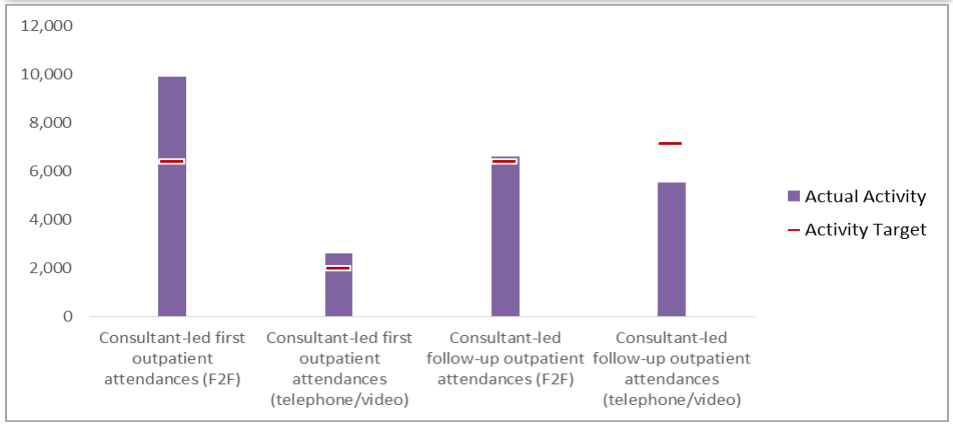
Month 8 [November] 2020-21 | Operational Performance: Outpatients

Responsible Director: Chief Operating Officer | Unvalidated for Nov-20 as 4th January 2021

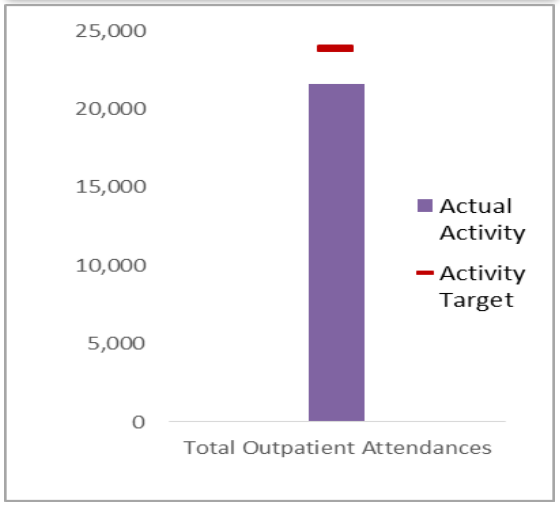
NHS Worcestershire Acute Hospitals NHS Trust

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

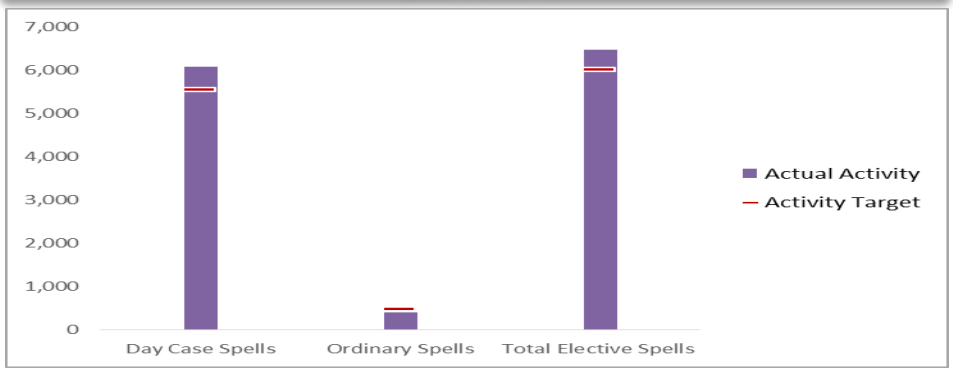
Consultant-led outpatients attendances



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

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		
8,243	3,188	61.32%	4,402	1,287	70.76%	2,186	931	57.41%	1,655	970	58.61%

What does the data tell us?

- A data validation exercise was undertaken which removed a cohort of patients who were on the waiting list after being cancelled due to COVID-19 in March and April, but have since been either seen or cancelled for clinical reasons.
- The DM01 performance is now validated at 61.32% 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 therefore reduced with the total waiting list currently at 8,243 patients, a decrease of 3,750 patients (-31.3%) from the previous month.
- The total number of patients waiting 6+ weeks has decreased by 3,322 patients (-51.0%); there are now 1,617 patients waiting over 13 weeks (4,376 in Oct-20).
- Radiology has the largest number of patients waiting at 4,402 but has reduced those waiting over 6 weeks by 2,589 between Oct-20 and Nov-20 (through activity and data validation).
- 15,213 diagnostics tests were undertaken in Nov-20, 1.01% less than Oct-20 and 8.78% lower than Nov-19.
- Radiology undertook 199 fewer tests in Nov-20 compared to Oct-20. Comparing to our phase 3 activity target, CT and non-obstetric ultrasound were above the plan.
- Endoscopy completed 44 more tests in Nov-20 than Oct-20 with gastroscopy and flexi sigmoidoscopy above their respective phase 3 activity plans.
- Physiology completed 1,353 tests in Nov-20, no significant change from the previous month's activity.

RADIOLOGY

What have we been doing?

- Maintained MRI and Ultrasound lists at full capacity across county to accommodate backlog of routine patients.
- Continuing with the additional capacity through WLI sessions in CT, MRI and Ultrasound
- Continued using independent sector for Cardiac CT, routine CT
- Mobile CT scanner extended until March 2021- reviewed booking protocols to try and increase daily throughput while adhering to social distancing

What are we going to do next?

- Continue with WLIs
- Discussing with independent sector extending support past December
- Risk of CT mobile being removed to support Nightingale, impact has been escalated.
- Trying to obtain resource via STP for Radiographers to staff 3rd CT scanner following installation in January.
- Reviewing continuity plans to establish where any services can be maintained in event of increased COVID-19.

ENDOSCOPY (inc. Gynaecology & Urology)

What have we been doing?

- Continuing the use of IS at BMI and Spire until 23/12/20
- Continuing with weekend WLI sessions
- Continuing use of 18 Week Support insourcing team providing 18 sessions
- Relocated Urology activity from ALX to KTC on 25/11/20
- Evening WLIs for Urology
- Increased upper GI procedures per list
- Appointed 2 new booking co-ordinators
- Commenced 18 Week Support list at MCH 09/12/20
- Utilised text messages service to identify patients that are available at short notice
- Text messaging service switched on for COVID-19 swab appointments with the hope to reduce DNAs

What are we going to do next?

- Urology activity relocates from ALX to KTC on 25/11/20
- Scoping increase of 18 Week Support activity at Malvern Community Hospital from January 2021
- Exploring in-Trust weekend theatre lists to capture patients requiring Endoscopy under GA

Issues

- Total of 27 lists lost throughout November; planned maintenance = 11, booking team unable to fill = 6, No backfill = 4, 6 IS sessions taken back
- BMI theatre lists no longer available to endoscopy GA patients – service to look at other options

Operational Performance: DM01 Diagnostics

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

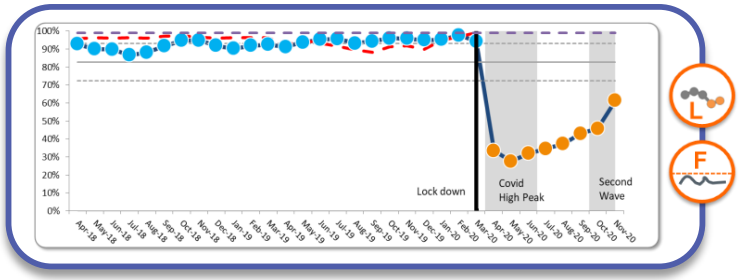
NHS Worcestershire Acute Hospitals NHS Trust

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

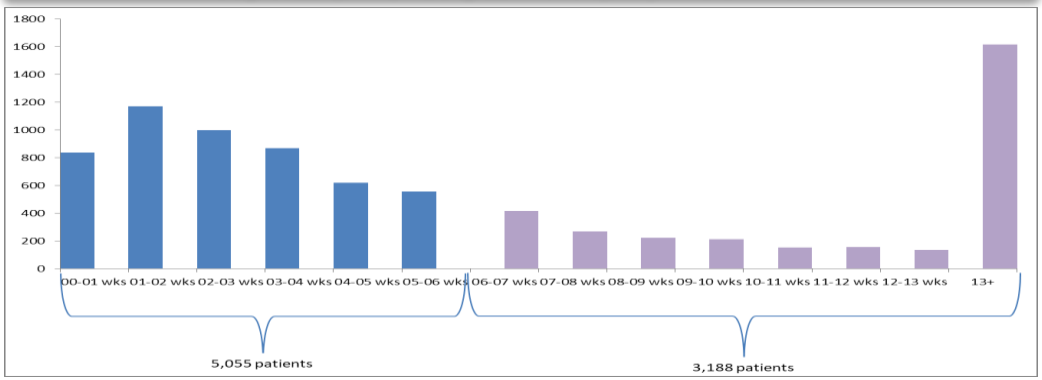
Trust Total			Radiology			Physiology			Endoscopy		
8,243	3,188	61.32%	4,402	1,287	70.76%	2,186	931	57.41%	1,655	970	58.61%

DM01 Diagnostics % patients within 6 weeks

61.32%



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



NEUROPHYSIOLOGY

What have we been doing?

- Continuing to undertake approximately 85% of clinics and increased working to 6 days
- Limitations are around capacity due to increased infection control and social distancing.
- Waiting lists have increased for consultant led diagnostics due to a period of sick and annual leave. This is now averaging around 12 weeks
- Waits for other investigations are around 10 weeks still. This is not reducing due to the increase in staff sickness this month. Small pool of staff with no bank/agency readily available staff for clinical scientists or medical consultant

What are we going to do next?

- Continuing to try and source off site capacity
- Need to look at WLI clinics for consultant investigations - will continue monitor over the next month. There is no capacity in the current staffing levels to offer WLI this month (Dec)

CARDIOLOGY – ECHO

What have we been doing?

- Service now open to routine patients
- Restoration of service has been approved, with reduced capacity
- To achieve 100% capacity additional rooms would be required on a permanent basis outside of the designated units due to waiting room limitations
- Approx. 12-16 week wait
- Service is being managed on a priority basis balancing the need for the backlog with urgent patients

What are we going to do next?

- Performing WLI clinics to reduce the backlog
- Looking at room solutions to full restore clinics

Assurance Level: 5 (Nov-20)

Previous assurance level: 5 (Oct-20)

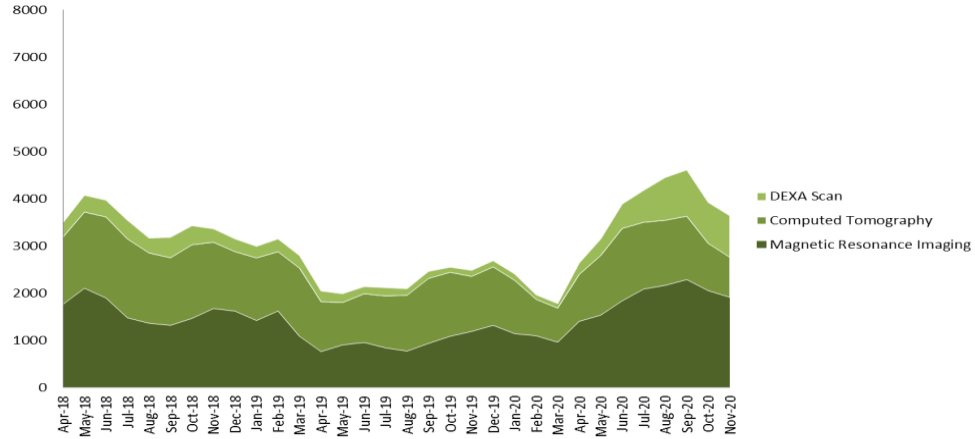
When expected to move to next level of assurance: 18 Weeks increased capacity at Malvern by end of Nov-20

SRO: Paul Brennan

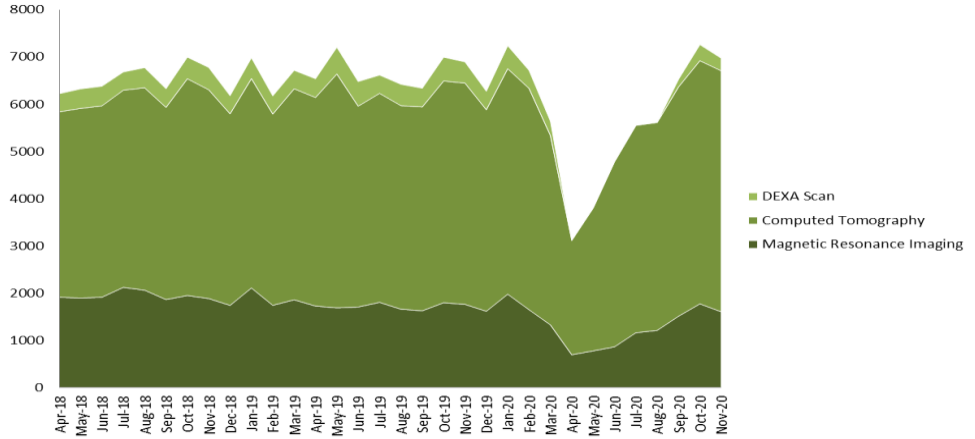
Month 8 [November] 2020-21 | Operational Performance: DM01 Diagnostics

Responsible Director: Chief Operating Officer | Validated for Nov-20 as 4th January 2021

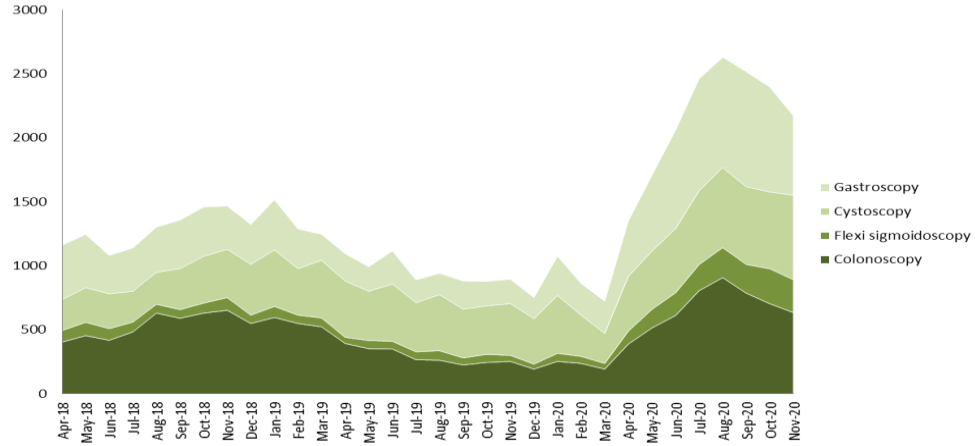
Radiology DM01 waiting list size - Monthly snapshot



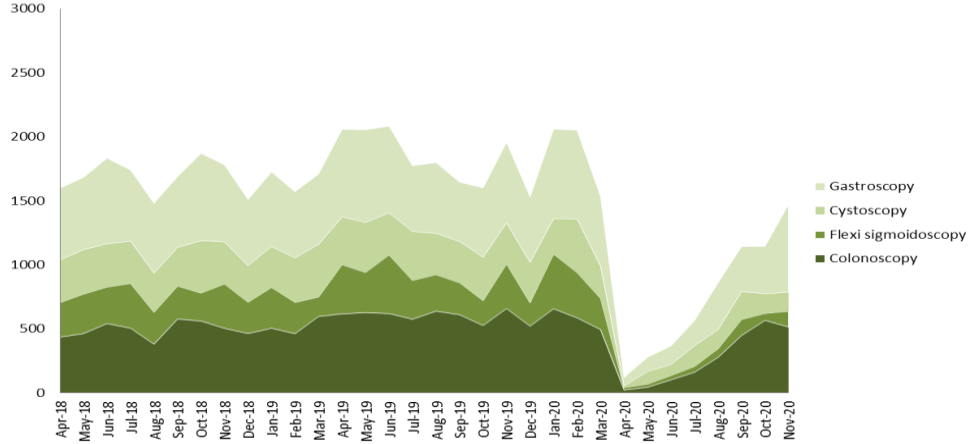
Radiology DM01 Activity - Monthly snapshot



Endoscopy DM01 waiting list size - Monthly snapshot



Endoscopy DM01 Activity - Monthly snapshot



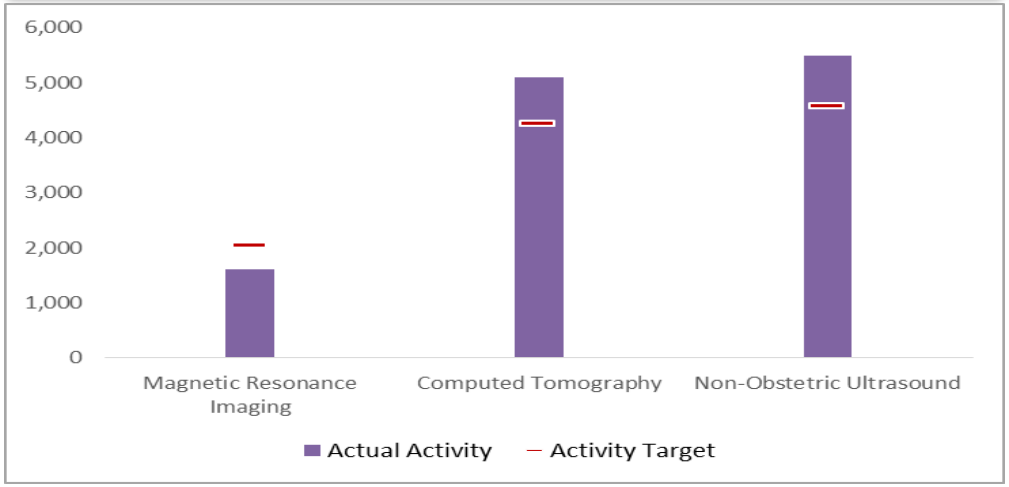
Note the different scaled axis on the graphs when comparing them

Month 8 [November] 2020-21 | Operational Performance: DM01 Diagnostics

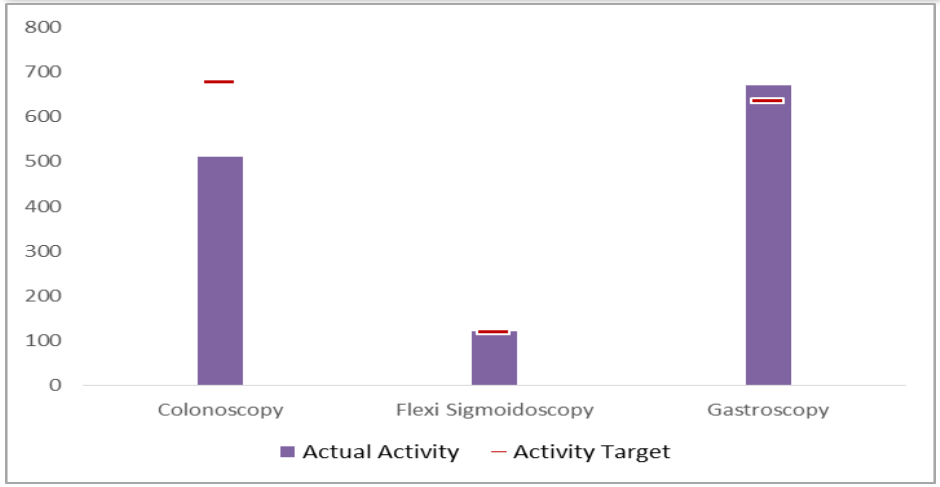
Responsible Director: Chief Operating Officer | Validated for Nov-20 as 4th January 2021

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

Radiology



Endoscopy



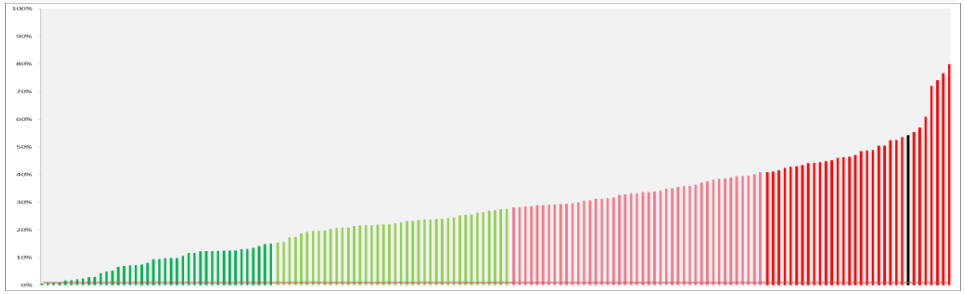
These graphs represent phase 3 restoration only, as submitted in the plan. All physiology tests, DEXA and cystoscopy were not included in the request from NHSEI

Operational Performance: Diagnostics (DM01) Benchmarking

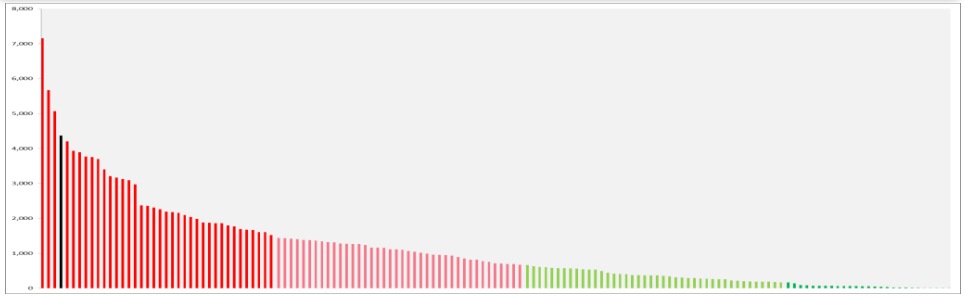
National Benchmarking (October 2020) | The Trust was one of 12 of the 13 West Midlands Trusts which saw a reduction in patients waiting over 6 weeks. This Trust was ranked 13 of 13 in October 2020. The peer group performance ranged from 2.16% to 54.30% with a peer group average of 26.89%; decreasing from 31.83% the previous month.

The England average for October 2020 was 29.2%, a 3.8 percentage point reduction from 33% in September.

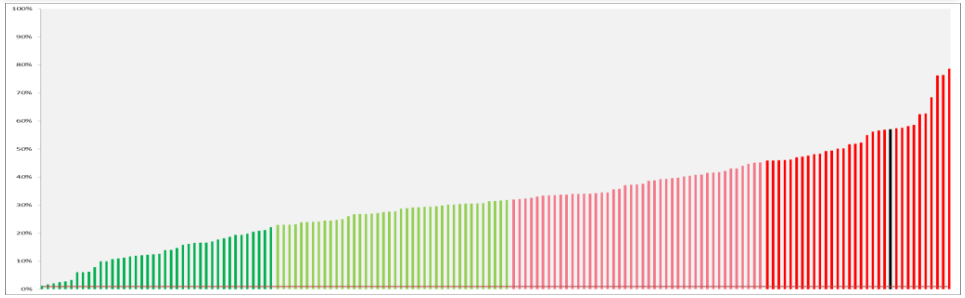
DM01 Diagnostics - % of patients waiting more than 6 weeks | Oct-20



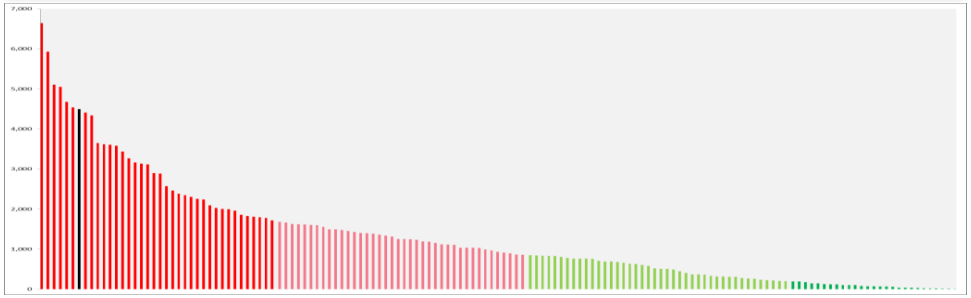
DM01 Diagnostics - number of patients waiting more than 13 weeks | Oct-20



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



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



WAHT — Operational Standard 1%

24

Operational Performance: Stroke

% of patients spending 90% of time on a Stroke Ward	% of patients who had Direct Admission (via A&E) to a Stroke Ward	% patients seen in TIA clinic within 24 hours	% of patients who had a CT within 60 minutes of arrival	SSNAP Q2 Jul-20 to Sep-20			
50.77%	44.62%	72.09%	67.69%	Score	76.0	Grade	B

What does the data tell us?

- The increase in TIA referrals and insufficient capacity to see them all in clinic within 24 hours has resulted in special cause concern for this metric in October; however it did remain above the target.
- The other three main stroke metrics show that all performance is within common cause variation.
- **SSNAP Q2** – The score has been maintained at level B for the second quarter although it has been a testing period due to Covid-19. The team remained focussed on sustaining or improving on previous performance, which is very encouraging to see.

The key differences between Q1 & Q2 are:

Improvements

- Domain 3 – Thrombolysis from a E to D

Reduction

- Domain 2 – Stroke unit from a C to a D
- Domain 9 – Standards by Discharge From A to B
- Domain 10 – Discharge process from a C to a D

What have we been doing and what are we doing next?

The consultant recruited in September is yet to receive his GMC membership and has booked PLAB 2 test for 21st of January as an alternative. This is likely to delay anticipated start date of January 2021. The advert for the permanent consultant post closed on Friday 4th December 2020 and interviews are arranged for January 12th 2021.

CNS Post – Currently advertising for a Band 6 CNS to the existing vacancy and also in the process of raising an ATR to appoint on a 12 month contract to cover long term sickness.

The number of TIA clinic slots on weekdays has increased from 5 to 7 to match increasing referrals and have agreed to reintroduce weekend TIA clinic. This would ensure the team is fully compliant in achieving the 24hr target. More recently, the number of follow up clinic slots has also increased to reflect the slight increase in backlog and one additional clinic for the next 3 weeks has been planned to reduce the backlog.

Stroke Pathway - The plan is to review the current Stroke pathway for stroke patients presenting at Alexandra Hospital. The SOP was updated to reflect current changes in service provision and the pathway needs to be aligned to establish a clear pathway. This was discussed in the November directorate meeting, however needs to be represented in the next directorate meeting to seek final approval.

Assurance Level: 6 (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: Level 6 (Oct-20)	**SRO: Paul Brennan**

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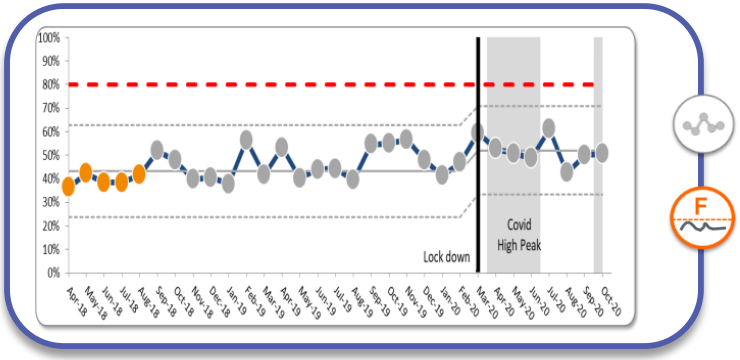
Month 7 [October] 2020-21 | Operational Performance: Stroke

Responsible Director: Chief Operating Officer | Validated for Oct-20 as 9th December 2020

Worcestershire Acute Hospitals NHS Trust

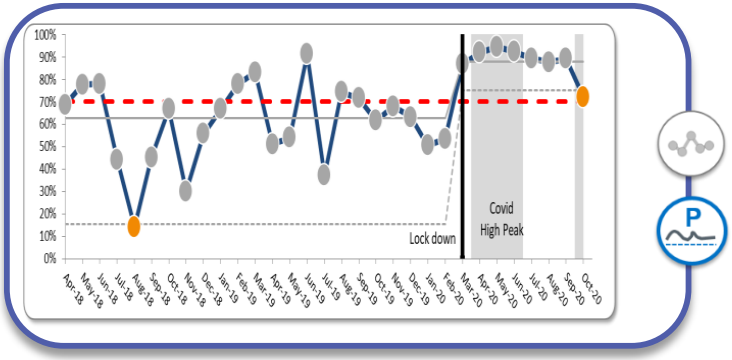
Stroke : % CT scan within 60 minutes

50.77%



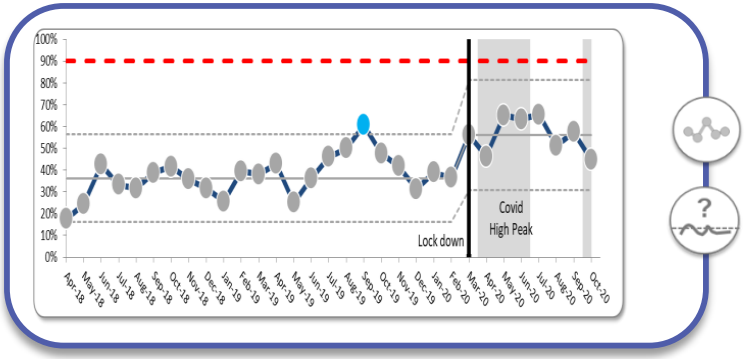
Stroke: % seen in TIA clinic within 24 hours

72.09%



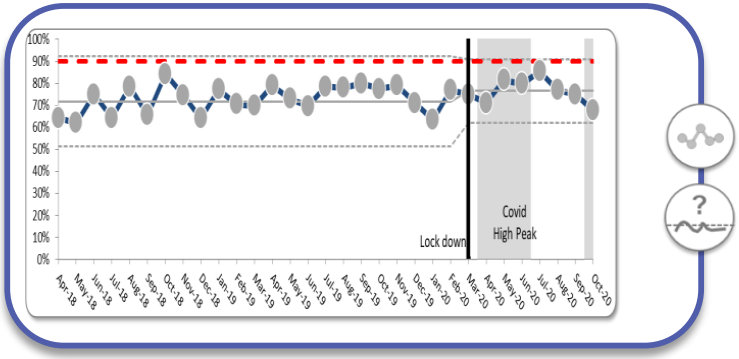
Stroke : % Direct Admission to Stroke ward

44.62%



Stroke: % patients spending 90% of time on stroke unit

67.69%



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.

Quality and Safety

Integrated Quality Performance Report - Headlines

Quality Performance	Comments
Infection Control	• E-Coli infections remain below trajectory for year to date. • C difficile infections were above trajectory for November, and are now above trajectory for year to date. • MSSA infections were above trajectory in November 2020, and have already exceeded the year end target. • First MRSA infection reported in November. • Hand hygiene compliance continues to remain on target
SEPSIS 6	• Performance for completing the SEPSIS 6 bundle within one hour rose in November to 34.31%, but is still significantly below the target of 90%. • Measures within the divisions are in place to raise awareness, and training compliance
ICE Reporting	• The Target of 95% for viewing Radiology Reports on ICE has not been achieved in the past 12 months. • Auto filing of reports is currently only available for specific categories, and work is ongoing to resolve this issue.

2.1 Care that is Safe - Infection Prevention and Control

Embed our current infection prevention and control policies and practices | Full compliance with our Key Standards to Prevent Infection, specifically Hand Hygiene above 97%, Cleanliness in line with national standards, ongoing care of invasive devices

C-Diff		E-Coli		MSSA		MRSA	
November: Month / Monthly target	Year to date: Actual / Year to date target	November: Month / Monthly target	Year to date: Actual / Year to date target	November: Month / Monthly target	Year to date: Actual / Year to date target	November: Month / Monthly target	Year to date: Actual / Year to date target
6 / 5	**40/ 36 (EOY target – 53)**	**3/5**	**21 / 33 (EOY target – 50)**	**5 / 1**	**21/8 (EOY target – 10)**	**1 / 0**	**1 / 0 (EOY target – 0)**

What does the data tell us?

- C *difficile* infections were above trajectory for October, and are now 4 above trajectory for year to date.
- E-Coli BSI was better than target for November, and remains better then trajectory for year to date,
- A new MRSA BSI was detected in November, and has exceeded the year end target of 0.
- MSSA infections were above trajectory in November 2020, and have already exceeded the year end target. The Specialty Medicine Division have reported 50% of the cases to date.
- The Hand Hygiene audit participation rate dropped in November to 90.18% (last month 91.89%)
- Hand Hygiene Practice Compliance rate was relatively unchanged at 99.64% (last month 99.66%) , meeting the 98% target.

How have we been doing?

- The first MRSA BSI of 2020/21 was identified in November, in a blood culture which also grew MSSA. This has been externally reported, and is being investigated.
- Concerns about increasing trend in Carbapenem antibiotic consumption, with the Trust having the highest rate of use regionally.
- Typing from two recent *C.difficile* periods of increased incidence on wards confirmed no cross infection. Therefore antimicrobial prescribing the most likely causative factor.
- Major focus remains on COVID prevention and management: 8 ward outbreaks declared and being actively managed in November 2020.

What improvements will we make?

***Staphylococcus aureus* BSI (MRSA and MSSA)**

• MSSA Quality Improvement Project underway, with first meeting in Nov 2020, building on actions already in place by Divisions. Review of progress Jan 2021.
• Learning identified shared cross divisionally.

***C difficile* Infections**

• Cases reviewed by divisional teams., and scrutinised TIPCC S&L under current process for quarterly overview of Trust attributable cases. *Note currently stood down due to pandemic.
• Actions as agreed via TIPCC are being managed at divisional level.

Antimicrobial Stewardship

• Divisions will ensure full compliance with AMS audit data collection by 31/12/2020.
• Review and relaunch Trust antimicrobial prescribing policy – target date being confirmed.
• Continue review antimicrobial prescribing guidelines – time bound programme to be set.
• Divisional SMART action plans for improved performance to be shared to support learning.

Carbapenem consumption

• Review Carbapenem consumption pattern for last 12 months and agree actions at ASSG meeting 14/12/2020.
• Explore development of WREN dashboard for Carbapenem consumption based on ward usage by 31/12/2020.

COVID Outbreaks

- Being actively managed 7-days per week by divisions and Infection Prevention Team.
- Escalated to Level 2 outbreak meetings due to number of wards affected.

Assurance level – Non-COVID Level 3: COVID BAF Level 6
Reason: - Assurance level for non-COVID falls to Level 3 due to the increase in MSSA BSI.
Level 6 for COVID BAF based upon the detailed COVID BAF self-assessment work previously reported.

When expected to move to next level of assurance for non Covid:
Non-COVID – Level 4 by end of Q4, dependant on sustained AMS improvement, and MSSA situation being controlled.

Previous assurance level (Sep 2020) –Level 6 COVID-19 / Level 4 for Non-Covid

SRO: Vicky Morris (CNO)

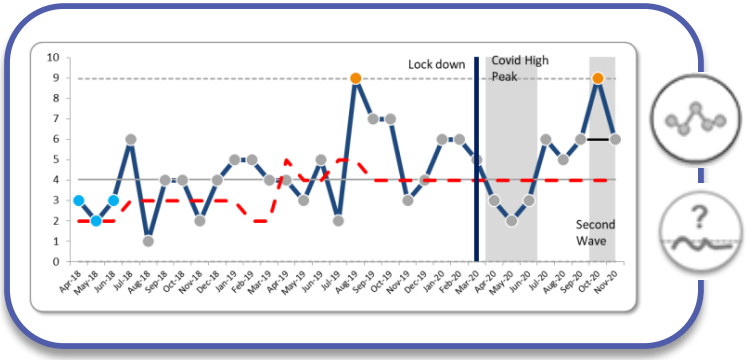
Month 8 [November] | 2020-21 Quality & Safety - Care that is Safe

Responsible Director: Chief Nursing Officer, Chief Medical Officer | Validated November 20 as at 11th December 2020

NHS Worcestershire Acute Hospitals NHS Trust

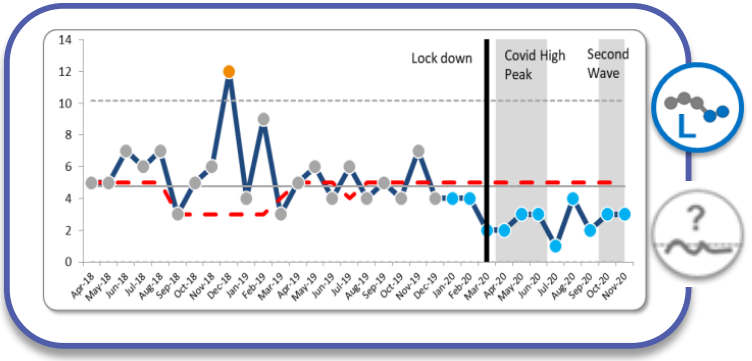
C-Diff

6



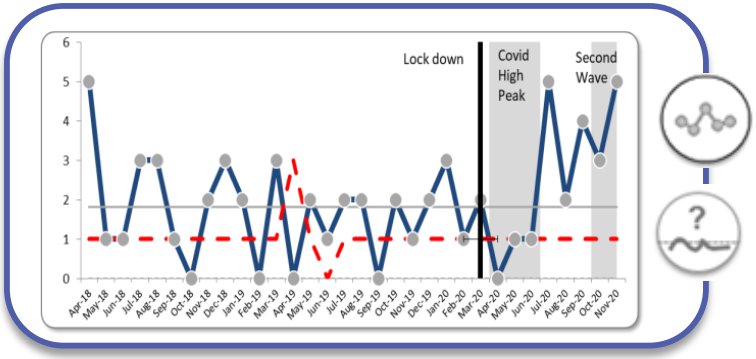
E-Coli

3



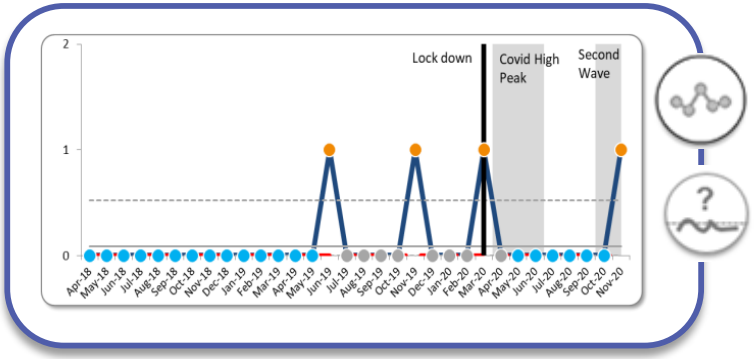
MSSA

5



MRSA

0



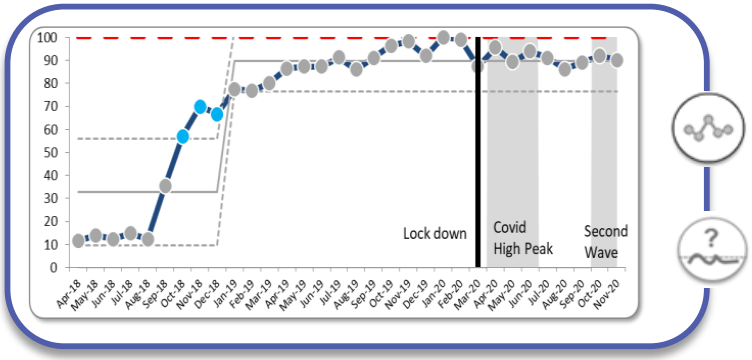
Month 8 [November] | 2020-21 Quality & Safety - Care that is Safe

Responsible Director: Chief Nursing Officer, Chief Medical Officer | Validated November 20 as at 11th December 2020

Worcestershire Acute Hospitals NHS Trust

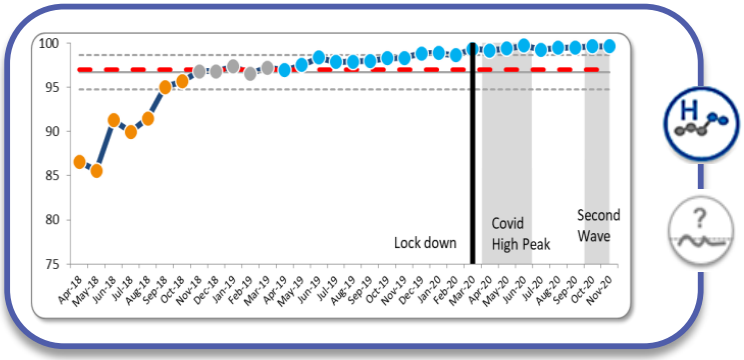
Hand Hygiene Audit Participatio

90.18



Hand Hygiene Compliance (%)

99.64



2.2 Care that is Effective – Improve Delivery in Respect of the SEPIS Six Bundle

Sepsis six bundle completed in one hour (Target 90%)	% Antibiotics provided within one hour	Urine	Oxygen	IV Fluid Bolus	Lactate	Blood Cultures
34.31% - Oct 2020 (34.26% - Sept)	81.02% (80.56%)	64.23% (55.56%)	81.75% (76.85%)	78.10% (64.81%)	63.50% (62.96%)	65.69% (65.74%)

What does the data tell us?

- Performance for Sepsis Screening completed rose to 85.54% in October (82.93% - Sep). However Urgent Care and SCSD both exceeded 93%, which is above the 90% target.
- Performance for completing the Sepsis 6 bundle within one hour increased to 34.31% in October, but is still significantly below the target of 90%.
- Performance for providing antibiotics within one hour rose slightly in October 2020 but is below the 90% target. However SCSD performed better than the target at 100%.
- Performance for the Urine, Oxygen, IV Fluid Bolus and Lactate components of the Sepsis 6 bundle rose in October 2020.
- Performance Blood Culture component of the Sepsis 6 bundle fell slightly in October 2020.

How have we been doing?

- The new e-learning module has been launched
- The Sepsis audit tool was re-launched on the 17th November
- The Specialty Medicine Division held its first virtual forum with the sepsis link nurses from each ward in November.
- SCSD have noted good performance with 'Door to Needle time' with neutropenic sepsis, so paradoxical poor performance with other aspects of care bundle. SCSD have concerns regarding what is being measured.
- Surgery identified information collection as an issue after undertaking a deep dive into Sepsis recording. This found significant issues with accuracy of completion.

What improvements will we make?

- Further work is underway in Divisions to raise the issue of completion including a senior nurse being seconded to provide a physical presence on the wards in order to educate, prompt good practice and aid audit compliance (Spec Med)
- Real time audit of form completion continues.
- Review feedback following the launch of the audit tool.
- Following some concern about the validity of what is being measured, the Quality and Service Improvement Team have offered support to the Sepsis team to understand what exactly is being audited, and what associated data is being collected.
- The Women & Children's division are continuing to work with the Trust Sepsis lead to align with the rest of the organisation, and will be carrying out a number of retrospective audits.
- Work is being undertaken with the Chief Registrar on the method of recording and considering using a modified form as a sole method of documentation of management.

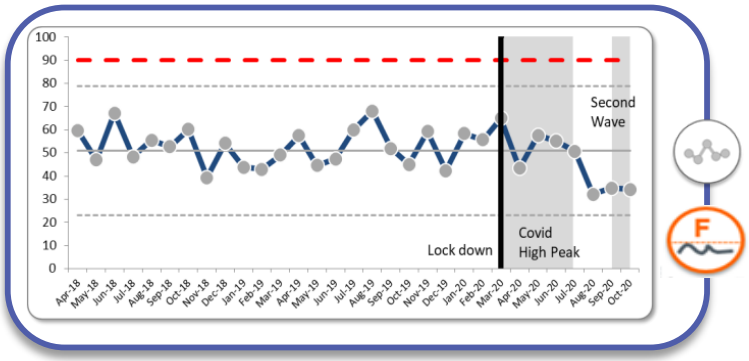
Month 8 [November] | 2020-21 Quality & Safety - Care that is Effective

Responsible Director: Chief Nursing Officer, Chief Medical Officer | Validated November 20 as at 11th December 2020

Worcestershire Acute Hospitals NHS Trust

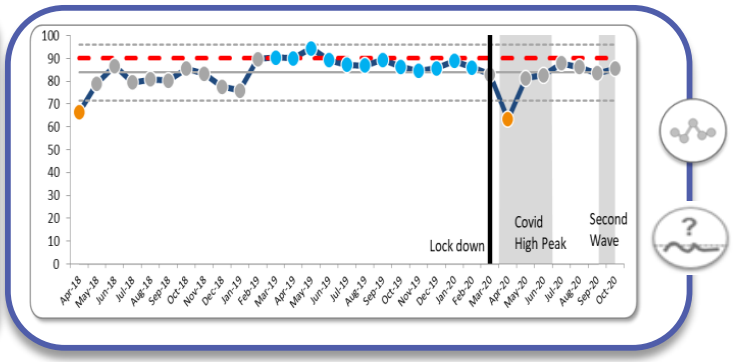
Sepsis 6 Bundle Compliance (audit) (%)

34.31



Sepsis Screening Compliance (audit)

85.54



2.2 Care that is effective - ICE Reporting

% Radiology reports viewed - ICE	% Radiology reports filed - ICE	% Pathology reports viewed - ICE	% Pathology reports filed - ICE
80.05% - Nov 2020 (84.21% - Oct 2020)	55.11% (56.85%)	95.31% (96.44%)	68.95% (72.63%)

What does the data tell us?

- The Target of 95% for viewing Radiology Reports on ICE has not been achieved in the past 12 months (range 80.05% to 85.58%).
- The Target of 95% for viewing Pathology Reports on ICE has been achieved in 11 of the past 12 months (only Jun 2020 below at 91.72%).

What have we been doing?

- The data reported on WREN is now included within the governance reports to each directorate meeting.

What will we be doing?

- Auto filing of reports is currently available for specific categories.
  Areas of development:
  - Identify and auto-file self reported images
  - Define the criteria for auto filing in-patient results
  - Auto file MRSA screening swabs which are negative

Assurance level – Level 4

When expected to move to next level of assurance:
When review of criteria for inclusion is complete – February 2021.

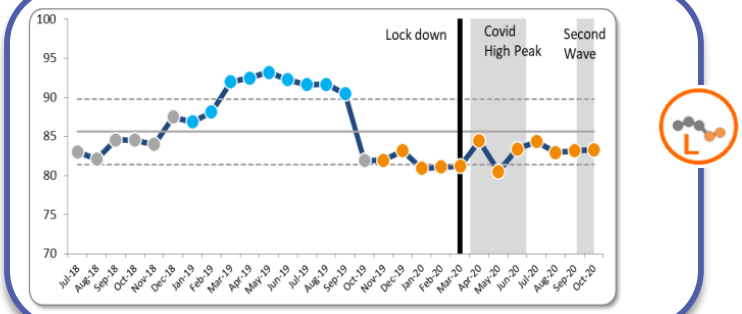
Previous assurance level: Level 4 (Nov 2020)

Month 8 [November] | 2020-21 Quality & Safety - Care that is Effective

Responsible Director: Chief Nursing Officer, Chief Medical Officer | Validated November 20 as at 11th December 2020

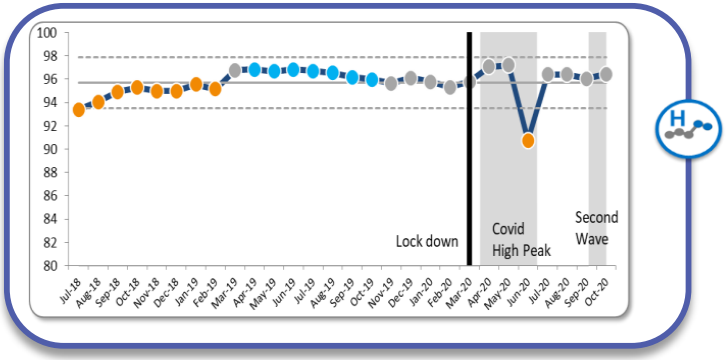
ICE reports viewed radiology (%)

83.35



ICE reports viewed pathology (%)

96.05



Also discussed at Clinical Governance Group

Subject	Summary	Assurance Level
Safety Alerts Report – Quarter 2 2020/21	• For Quarter 2, 2020-21, the Trust was notified of 36 safety alerts, all of which were acknowledged within the two working day deadline. • Of the 7 safety alerts due for completion in Quarter 2, 2020-21, one alert did not require action. The remaining 6 have been completed and closed; 83% (5) were closed on time and one was closed 1 working day late.	Level 5
Nutrition and Hydration Documentation Update	Following a review of serious incidents at the Nutrition and Hydration Steering Group and audits of current practice; there is poor compliance throughout the Trust for completion of fluid balance and food charts and escalation where appropriate. In response to these SI's the Nutrition and Hydration Steering Group have therefore redesigned these charts to include clear escalation and plan to relaunch this documentation in mid-December to improve patient care and outcomes.	N/A

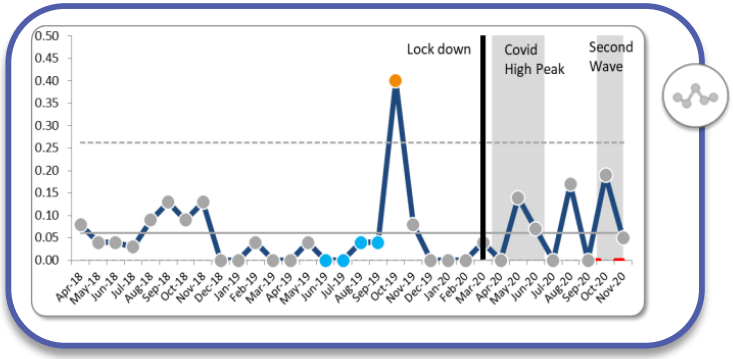
Month 8 [November] | 2020-21 Quality & Safety - Care that is Safe

Responsible Director: Chief Nursing Officer, Chief Medical Officer | Validated November 20 as at 11th December 2020

Worcestershire Acute Hospitals NHS Trust

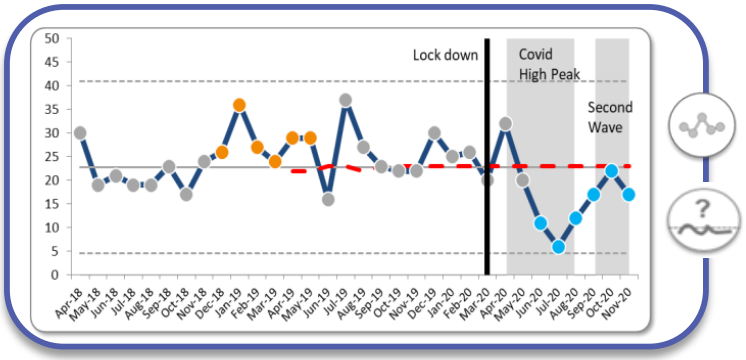
Falls per 1,000 bed days causing harm

0.05



All Hospital Acquired Pressure Ulcers

17



Serious Incident Pressure Ulcers

0