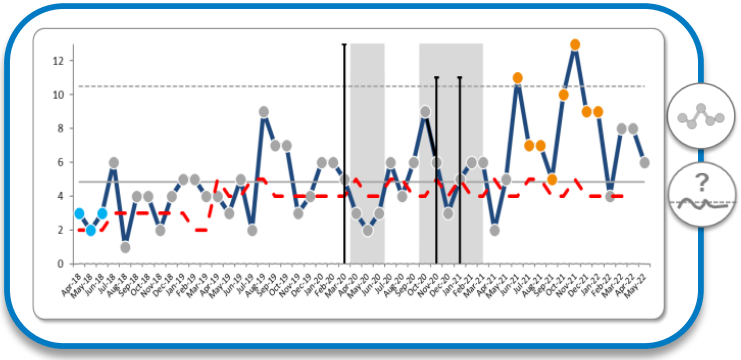
Month 2 [May] | 2022-23 Quality & Safety - Care that is Safe

Responsible Director: Chief Nursing Officer, Chief Medical Officer | Validated for May-22 as 15th June 2022

NHS Worcestershire Acute Hospitals NHS Trust

C-Diff

6



E-Coli

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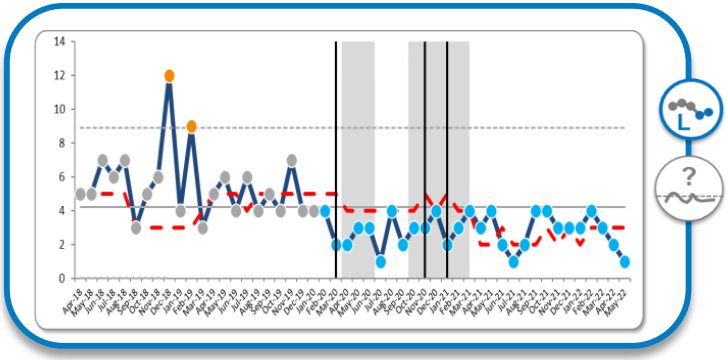

MSSA

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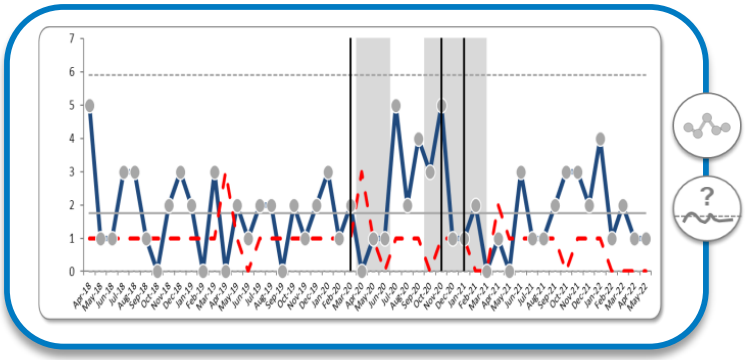

MRSA

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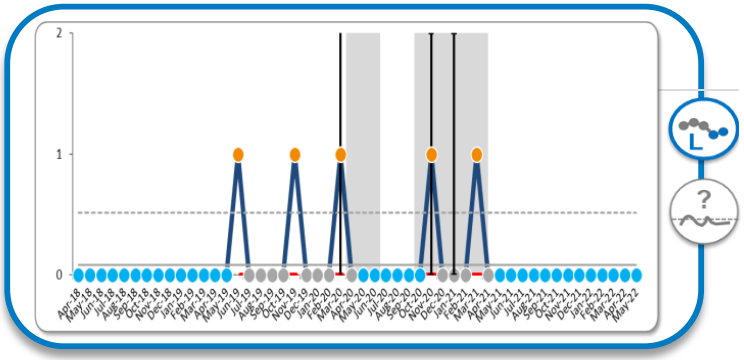


Variation: Special Cause Concern High/Low; Special Cause Note/Investigate High/Low; Common Cause

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

Lockdown Period

COVID Wave

2.1 Care that is Safe – Antimicrobial Stewardship

Overall Compliance (Target 90%)		Antibiotics in line with guidance (Target 90%)		Antibiotics reviewed within 72 hours (Target 90%)	
May-22	Apr-22	May-22	Apr-22	May-22	Apr-22
84.6%	89.6%	85.6%	92.9%	88.0%	93.2%

What does the data tell us?

- A total of 294 audits were submitted in May-22, compared to 227 in Apr-22.
- Antimicrobial Stewardship overall compliance dropped in May-22 and missed the target of 90%.
- Patients on Antibiotics in line with guidance or based on specialist advice dropped in May-22 to 85.6% and failed to achieve the target of 90%.
- Patients on Antibiotics reviewed within 72 hours dropped in May-22 to 88.0% and failed to achieve the target of 90%.

What will we be doing?

- Divisional AMS clinical leads will continue to promote the Start Smart Then Focus monthly audits with their junior doctors
- ASG will continue to monitor the use of carbapenems (current use below pre-COVID baseline)
- Divisions will continue to develop action plans to improve their Quarterly Point Prevalence Survey results
- Significant content review and update of Trust antimicrobial treatment guidelines undertaken and published mid April 2022. Prescribing in line with guidance targets expected to be reduced whilst guideline updates are fully implemented.
- ASG will oversee ongoing review of antimicrobial guidelines and monitoring of antimicrobial consumption with a view to achieving reduction targets specified in standard contract for 'Watch' and 'Reserve' categories.
- AMR CQUIN focussing on improving diagnosis and treatment of UTI in over 16s
- Focusing on accurate completion of allergy documentation to include symptoms of allergic reaction
- Focusing on learning from C diff case reviews where antibiotics may be implicated
- AMS QI project underway across Urgent Care division with a focus on identifying and addressing AMS barriers through behaviour change orientated interventions.

Assurance level – Level 6 – Antimicrobial stewardship level of assurance is 6 as assessed by ASG on 26/05/2022.
Reason: Current performance in relation to C. difficile and MSSA BSI

When expected to move to next level of assurance for non Covid:
This will next be reviewed in Jul-22, when quarter 1 performance can be assessed.

Previous assurance level (Apr 22) – Level 6

SRO: Paula Gardner(CNO)

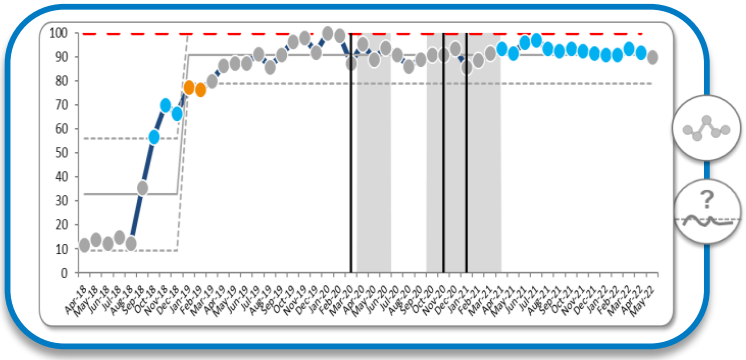
Month 2 [May] | 2022-23 Quality & Safety - Care that is Safe

Responsible Director: Chief Nursing Officer, Chief Medical Officer | Validated for May-22 as 15th June 2022

NHS Worcestershire Acute Hospitals NHS Trust

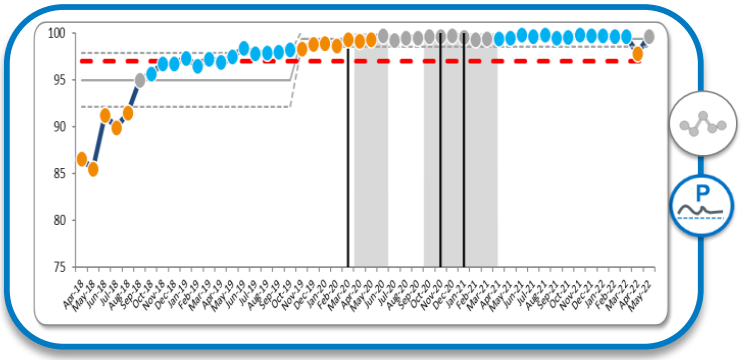
Hand Hygiene Audit Participation (%)

90.1%



Hand Hygiene Compliance (%)

99.7%



Lockdown Period
COVID Wave

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

Sepsis six bundle completed in one hour (Target 90%)	Sepsis screening Compliance Audit (Target 90%)	% Antibiotics provided within one hour (Target 90%)	Urine	Oxygen	IV Fluid Bolus	Lactate	Blood Cultures
76.5%	87.5%	83.3%	91.2%	100%	94.1%	94.1%	91.2%

What does the data tell us?

- Our performance against the sepsis bundle being given within 1 hour has increased in Apr-22 and, although not compliant with the 90% target, has reached it's highest level.
- The Sepsis screening compliance increased for the 4th consecutive month, but is still a little under the target.
- Antibiotics provided within 1 hour fell for the 4th consecutive month and is still below target.
- All five of the other elements of the Sepsis Six bundle were above the 90% target.
- Our Crude in-hospital death rate is 16% (Apr-21 to Mar-22) Nationally, we sit in the lower third of reporting Acute Trusts In the Midlands, we have the 8th lowest rate (of 25). The highest in the Midlands is 24%.
- However, our out-of -hospital death rate is 9.7% (Apr-21 to Mar-22) and nationally we sit in the top 30 highest reporting Acute Trusts. In the Midlands, we have the 9th highest rate (of 25). The highest in the Midlands is 25%.
- Our average LOS for patients with sepsis is 9.1 days (Apr-21 to Mar-22) , this compares to 10.9 days Nationally and 10.3 days in the Midlands.

Actions:

1. Screening of 'Suspected Sepsis' patients and the 'face to face' review on the same form to avoid duplication in the medical/nursing notes by using the new documentation.
2. A retrospective audit will take place to determine the causes of out of hospital deaths and whether there is any cause for concern; it may be that where End of Life Care is being received; patients are discharged home in line with our End of Life Care Strategy.
3. All deaths, including those in community will have mortality review, once additional medical examiners are in post – this will help to identify concerns in real time and ensure learning across divisions.

Current Assurance level – 5 (May-22)	**When expected to move to next level of assurance**: Following deep dive audit.
Previous assurance level – Level 5 (Apr-22)	SRO: Christine Blanshard (CMO)

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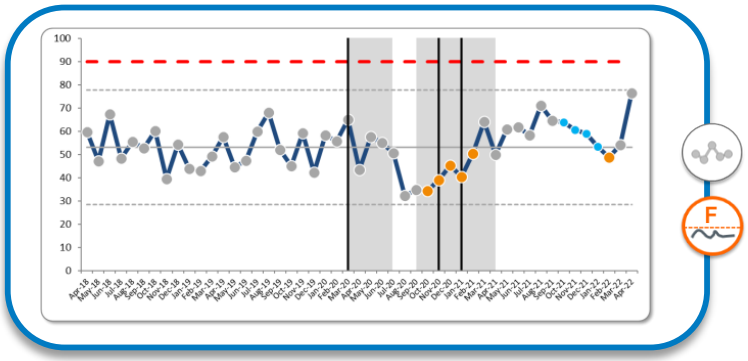
Month 2 [May] | 2022-23 Quality & Safety - Care that is Effective

Responsible Director: Chief Nursing Officer, Chief Medical Officer | Validated for May-22 as 17th June 2022

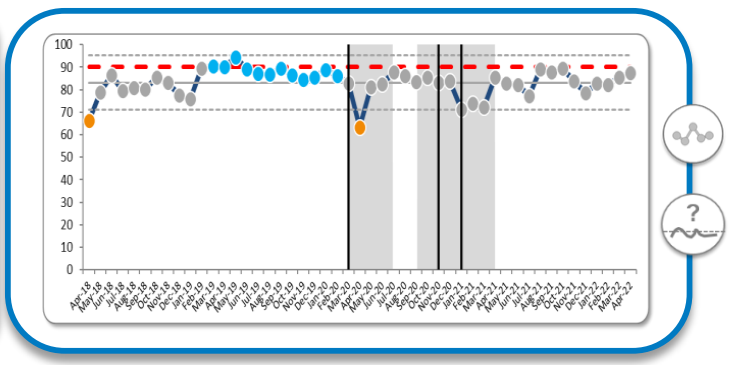
Sepsis 6 Bundle Compliance (audit)

76.5%



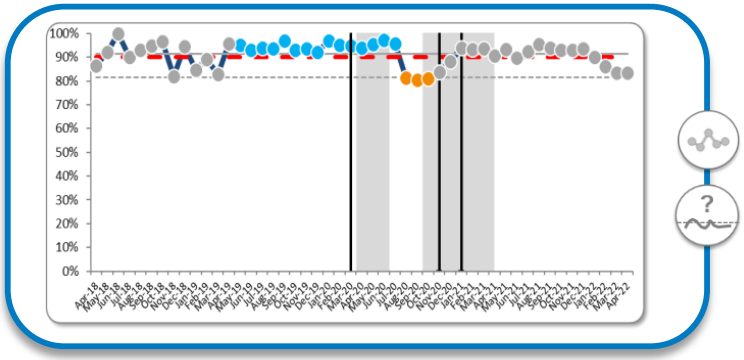
Sepsis Screening Compliance (audit)

87.5%



Sepsis Screening Antibiotics Compliance (audit)

83.3%



2.2 Care that is Effective
VTE assessment and VTE assessments within 24 hours

VTE assessment on admission to hospital	
May-22	Target
93%	95%

What does the data tell us?

- For the third month running, we have been just below the Trust target of 95%. This follows 35 consecutive months being compliant.
- However, W&C are now entering VTE assessments via Badgernet which have not yet been factored into the Trust results. We are aware the exclusion of W&C data is probably having implications on meeting the overall target.
- Conversations continue between the Information Team and W&C to accurately identify the Badgernet VTE dataset in order to pull into our Data Warehouse.
- Excluding W&C, the Surgical Division (90.94%) were the only Division to not achieve the 95% target.

What improvements will we make?

- Trust Thrombosis committee are continuing to monitor actions following the completion of VTE assessments to ensure learning and improved practice
- A new audit tool has been implemented, which focuses on a new approach to what is recorded and lessons learnt. Divisional results will be presented at July's Trust Thrombosis Committee.
- Specialty Medicine Division has undertaken a medical engagement incentive and have recruited some quality care champions in the medical cohort, which has attracted some junior doctors in the area of VTE and Hospital Acquired Thrombosis. Other Divisions are exploring options for quality care champions.
- Junior doctors will be invited to Thrombosis Committee and present any audit data / learning

Current Assurance Level (May-22): 6

Previous Assurance Level (Apr-22): 7

When expected to move to next level of assurance :
Once W&C Data (Badgernet) is included

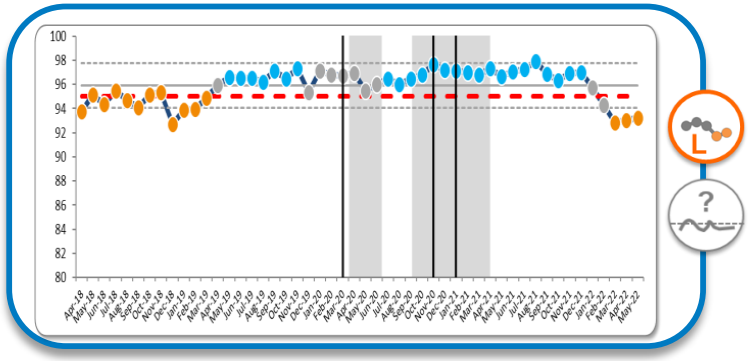
SRO: Christine Blanshard (CMO)

Month 2 [May] | 2022-23 Quality & Safety - Care that is Safe

Responsible Director: Chief Nursing Officer, Chief Medical Officer | Validated for May-22 as 17th June 2022

VTE Assessment Compliance (%)

93%



Please note that % axis does not start at zero.

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

Lockdown Period

COVID Wave

2.2 Care that is effective - ICE Reporting

% Radiology reports viewed - ICE	% Radiology reports filed – ICE	% Pathology reports viewed - ICE	% Pathology reports filed - ICE
88.8% - Apr 2022 (88.9% - Mar 2022)	76.4% (77.3%)	93.7% (93.4%)	77.1% (76.9%)

What does the data tell us?

- The Target of 95% for viewing Radiology Reports on ICE has not been achieved in the past 24 months (range 80.56% to 91.37%). But there has been special cause improvement every month since Aug-21.
- The Target of 95% for viewing Pathology Reports on ICE was missed for the tenth month running in Apr-22 at 93.7% (this follows 12 months consecutive compliance). There has been special cause concern since Sep-21.
- Radiology reports filed on ICE has remained above 70% for eleven consecutive months.
- Pathology reports filed on ICE has increased in Apr-22 to 77.1%.

What will we be doing?

- Filing prompt has gone live to ensure when viewing a result it is then filed appropriately; some amendments need to be made to the system to ensure this does not cause further delays.
- Auto filing of all GP results will be implemented w/c 4th July 2022
- Possibilities for additional auto filing are being explored to reduce the number of reports that require action.

Current Assurance level – 5 (May-22)	**When expected to move to next level of assurance**: Following implementation of the above measures
Previous assurance level: Level 5 (Apr-22)	SRO: Christine Blanshard (CMO)

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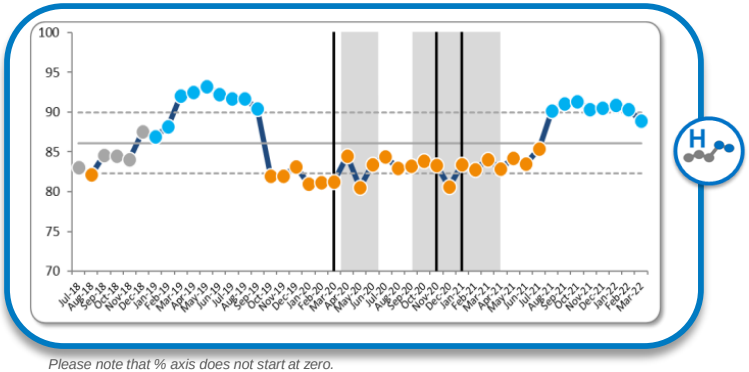
Month 1 [Apr] | 2022-23 Quality & Safety - Care that is Effective

Responsible Director: Chief Nursing Officer, Chief Medical Officer | Validated for Apr-22 as 17th June 2022

ICE reports viewed radiology (%)

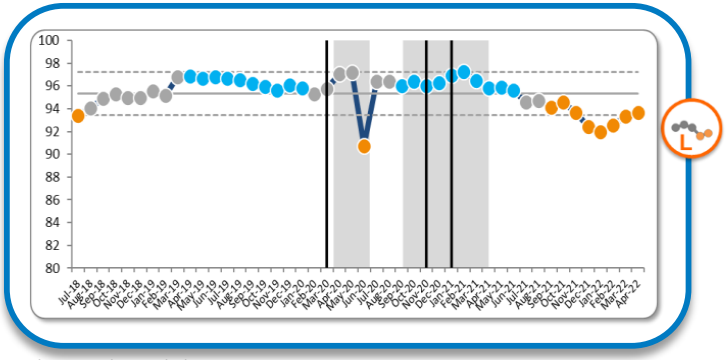
88.8%



Please note that % axis does not start at zero.

ICE reports viewed pathology (%)

93.7%



Please note that % axis does not start at zero.

Lockdown Period

COVID Wave

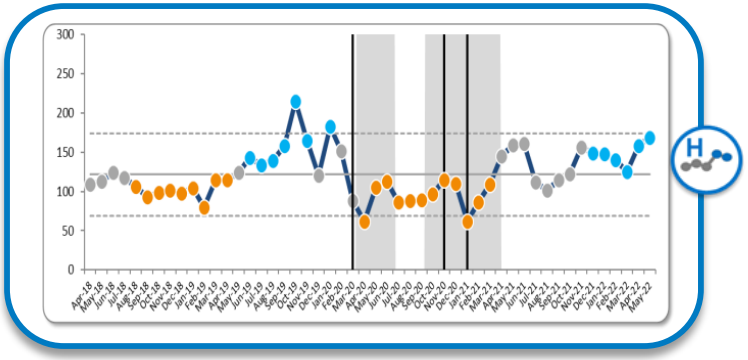
Month 2 [May] | 2022-23 Quality & Safety - Care that is Effective

Responsible Director: Chief Nursing Officer, Chief Medical Officer | Unvalidated for May-22 as 15th June 2022

Worcestershire Acute Hospitals NHS Trust

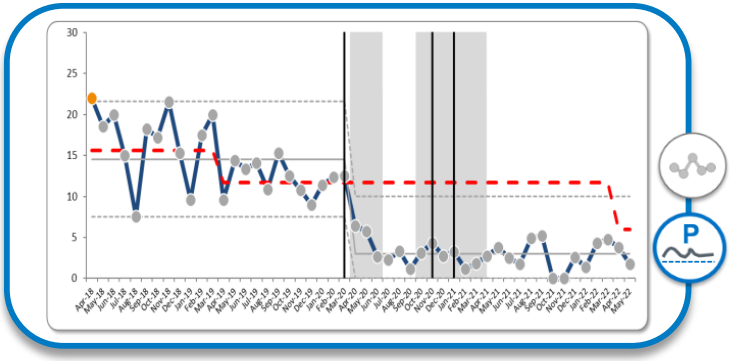
Total Medicine incidents reported

169



Medicine incidents causing harm (%)

1.8%



Lockdown Period

COVID Wave

2.2 Care that is Effective – Fractured Neck of Femur (#NOF)

#NOF – Time to Theatre <= 36 Hours	#NOF – Time to Theatre <= 36 Hours Excluding Unfit Patients
61.1% (May 2022) 60.8% (Apr 2022)	67.7% (May 2022) 75.0% (Apr 2022)

What does the data tell us?
• We are showing normal cause variation for NOF compliance in May-22.
• There were 72 #NOF admissions in May (74 in April).
• The #NOF target of 85% has not been achieved since Mar-20.
• There were a total of 25 breaches in May (down from 29 in April). The primary reasons for delays were
  ◦ 39.3% due to theatre capacity; and
  ◦ 21.4% due to the patient being medically unfit.
• The average time to theatre was 43.7 hours (40.9 in Apr).
• Our In-Hospital Crude Death rate for #NOF is 4.88%, and places us 9th of 30 Trusts in the Midlands (Highest 10.14%)
• Our Overall Crude Death rate for #NOF, including Out of Hospital deaths, is 15.30%, and ranks us 7th of 30 Trusts in the Midlands (Highest 25.56%).
• Our average LOS is 10.1 days (Apr-21 to Mar-22). We have the lowest LOS in the Midlands[1]
[1] *Excluding BWH which only had 6 spells in the year.*
	What will we be doing?
	• We have not had input from orthogeriatricians on a regular basis over the last 12 months. Current we have a retired Care of the Elderly consultant providing some input for these frailty patients (RD). However, a more robust and sustainable plan is required. The Surgical Division are looking at the appointment of an orthogeriatrician to the division to support the input from the Medical Division.
	• The ability to 'pull' hip fracture patients from ED has been limited by the failure to ringfence 1 or 2 assessment beds on the Hazel Trauma ward. When such beds have been available we have been able to pull such patients direct from ambulances when ED has not had capacity to act as intermediary. These assessment beds are essential for a Fast-track Pathway for Fragility Femoral Fracture.
	• Considering the high mortality rate outside of the Trust, it is essential for the whole patient pathway to be considered. When mortality rates were at their lowest there was a ringfenced Hip Fracture rehabilitation unit at Pershore Community Hospital (and previously Evesham CH) which allowed focus of clinical skills for these patients. During COVID pandemic this unit has dispersed and patients are admitted along many community pathways / hospitals. Re-centralisation of the Pershore unit is recommended.
	• As with many frail patients the hospital flow can have a serious effect on patients' outcomes. At any one point T&O have 16 patients waiting Pathways. Hospital acquired functional decline and morbidity impact on outcomes. Continuing work to push for whole pathway solutions is essential.

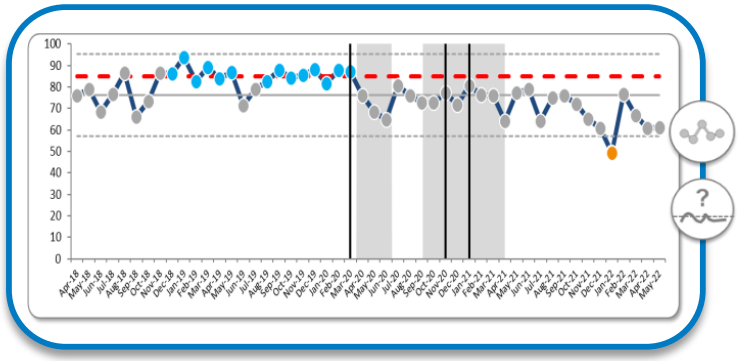
Current assurance level: 5 (May-22)	**When expected to move to next level of assurance**: TBC
Previous assurance level: 5 (Apr-22)	SRO: Christine Blanshard (CMO)

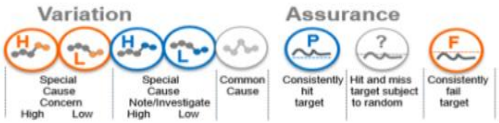
Month 2 [May] | 2022-23 Quality & Safety - Care that is Effective

Responsible Director: Chief Nursing Officer, Chief Medical Officer | Unvalidated for May-22 as 15th Jun 2022

#NOF time to theatre </=36 hours (%)

61.1%





Lockdown Period

COVID Wave

2.3 Care that is a positive experience – Friends and Family

FFT Inpatient Recommended		FFT Outpatient Recommended		FFT AE Recommended		FFT Maternity Recommended	
Apr-22	Target	Apr-22	Target	Apr-22	Target	Apr-22	Target
97.6%	95%	96.0%	95%	88.2%	95%	100%	95%

What does the data tell us?

- The recommended rate for Inpatients has been achieved for 23 of the last 24 months (and it only failed by 0.2% on the remaining month). The response rate dipped just below the 30% target at 29.7%
- The recommended rate for Maternity achieved target at 100%. However although the response rate increased in May, it was only 3.2%.
- The recommended rate for Outpatients rose slightly again in May-22 and achieved it's highest performance to date. We also achieved a response rate of over 11% for the 2nd consecutive month.
- The recommended rate for A&E has improved for the 3rd consecutive month and is at it's highest rate since Jan-21. We did not achieve the 20% response rate target for the 4th month running.

What improvements will we make?

- Divisions report quarterly to the Patient, Carer and Public Engagement steering group – presenting patient experience data and actions from feedback. Divisions also report into Clinical Governance Committee.
- A new Quarterly reporting template and governance process will enhance understanding of what our feedback is telling us and how we are learning/sharing: commencing mid Q2. This report will be generated Divisionally and discussed at the Patient, Carer and Public Engagement steering group and presented at Clinical Governance Committee.
- The Lead Nurse for Patient Experience and Team member from Digital have scheduled a walk around to discuss FFT at ward level while reviewing iPad connectivity – some areas had experienced issues relating to completing FFT digitally.
- Plan to refocus teams on offering and encouraging patients to complete FFT to increase responses.
- Xerox review of FFT cards is ongoing due to the volume of cards registered. Once assurance is gained that we have the most up to date cards, others will be removed from the Xerox register and will be followed by a relaunch following Bronze agreement.
- Lead Nurse for PE will meet with informatics to explore monthly FFT 'league table' report for each area to increase FFT communication and in hope to generate healthy competition to improve responses and move up the table to the Trusts 'Top 10'.

Current Assurance level – 5 (May-22)	**When expected to move to next level of assurance:** To be reviewed at the next CGG
Previous assurance level – Level 5 (Apr-21)	**SRO:** Paula Gardner (CNO)

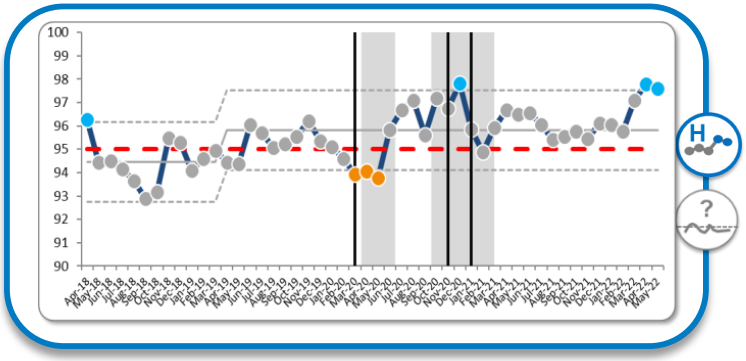
Month 2 [May] | 2022-23 Quality & Safety - Care that is a positive experience for patients/ carers

Responsible Director: Chief Nursing Officer, Chief Medical Officer | Validated for May-22 as 15th Jun 2022

NHS Worcestershire Acute Hospitals NHS Trust

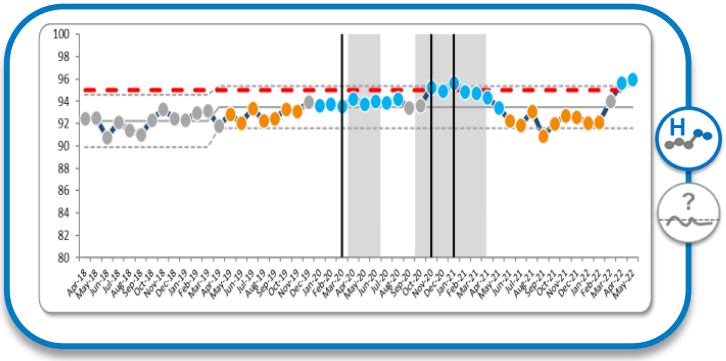
FFT Inpatient Recommended %

97.6%



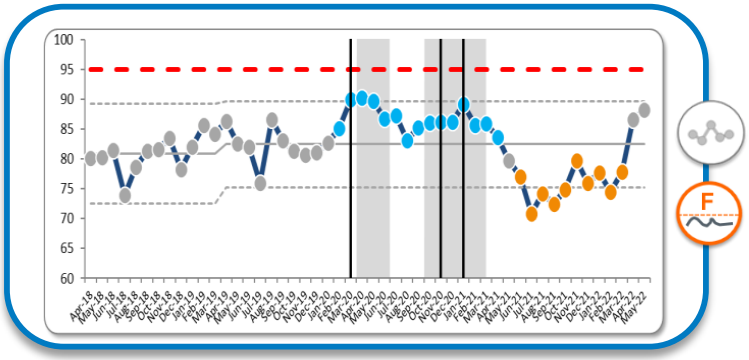
FFT Outpatient Recommended %

96%



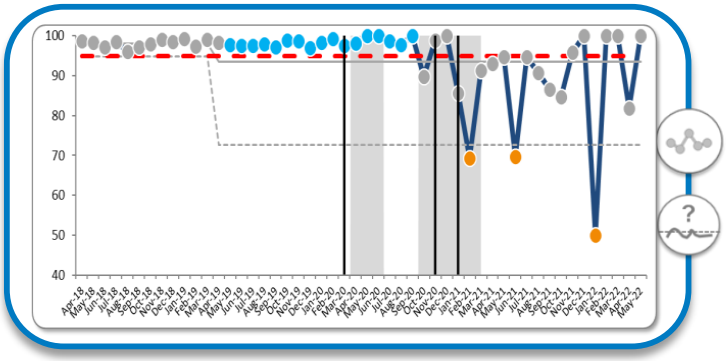
FFT AE Recommended %

88.2%



FFT Maternity Recommended

100%



Lockdown Period

COVID Wave

Note: The y axes have been reduced to show more detail.

2.3 Care that is a positive experience – Complaints

Complaints Responded to Within 25 Days	
May-22	Target
73.44%	80%

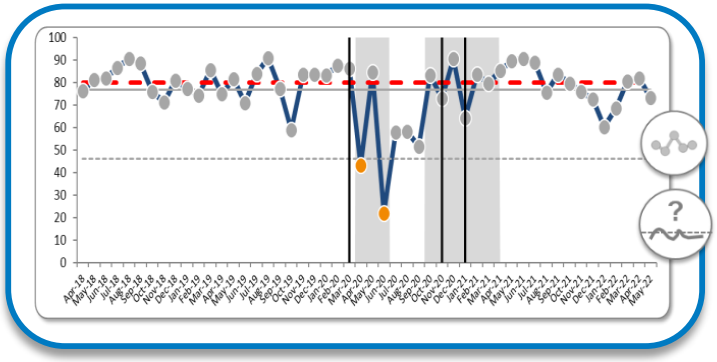
What does the data tell us?	What improvements will we make?
• After 2 consecutive months reaching the target, compliance dropped below 80% in Apr-22. Complaints responded to within 25 working days is currently showing normal variation. • The increased number of cases received in March and April resulted in an increased number of breaches in May. • The total number of new complaints dropped in May for the 2nd consecutive month to 54 after hitting a 12 month high in Mar-22 (71).	• All Corporate cases will be reviewed at the earliest opportunity by the Complaints Manager to aim for early resolution. • The total number of overdue complaints has reduced through May 2022, demonstrating that when a backlog accumulates it is quickly addressed and the impact on performance is negligible. • Continued focus will be devoted to monitoring performance and processing complaint responses ASAP through June.
Current Assurance Level – Level 5	**When expected to move to next level of assurance: N/A**
Previous Assurance Level – Level 5	**SRO:** Paula Gardner (CNO)

Month 2 [May] | 2022-23 Quality & Safety - Care that is Effective

Responsible Director: Chief Nursing Officer, Chief Medical Officer | Validated for May-22 as 15th June 2022

Complaints Responses </= 25 days (%)

73.44%



Lockdown Period

COVID Wave

Maternity

Month 2 [May] 2022-23 Maternity

Admission of full-term babies to neonatal care		Neonatal Deaths (>24+0 weeks gestation)	Stillbirths	Maternal Deaths	Pre-term births		Home births		Booked before 12+6 weeks		Births	Babies
13	2.0%	0	0	0	29	7.7%	9	2.4%	459	75.4%	371	377

What does the data tell us?

- The only metric to show special cause concern is booked before 12^{+6} weeks. It remains below the lower confidence interval, although the data included in the chart is being compared to our previous booking process before BadgerNet was introduced.
- All other metrics show common cause variation.
- There were no neonatal or maternal deaths in the month, and no stillbirths either.

- The new Maternity and Neonates dashboard, created in conjunction with the LMNS, was approved at the Women's Directorate Governance Meeting.
- There is still some work required with the BI team to ensure there is consistency in reporting approach between WAHT and WVT.

What have we been doing?

- Service Improvement Plan remains paused due to pandemic however some activities have continued
- Responding to the Final Ockenden report/NHSE letter re CoC following engagement events with staff
- Completed local LMNS insight visit for Ockenden evidence
- Employed two further posts to support safety agenda.
- Bid submitted to for monies to support employment of a retention midwife
- Advertised PH midwife posts.
- First cohort of MSWs commenced apprenticeship training

- Restart engagement events for MSIP when staffing allows
- Continuing work to achieve compliance for all Ockenden recommendations
- Prepare to recruit further specialist posts to include Digital Midwife, retention midwife and MSW workforce lead
- Commence QI work to improve compliance with decision to delivery intervals for Cat 1 & 2 caesarean sections
- Still await relaunch of year 4 CNST scheme

Current Assurance Level: 5 (May-22)

When expected to move to next level of assurance:

- Completion of work outlined in service improvement plan
- No midwifery vacancies
- No medical staffing vacancies

Previous Assurance Level: 5 (Apr-22)

SRO: Paula Gardner (CNO)

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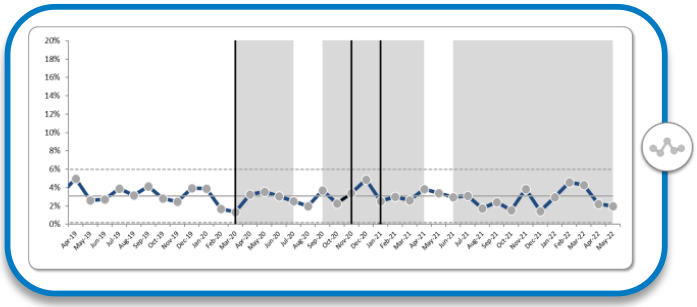
Month 2 [May] | 2022-23 Maternity Summary

Responsible Director: Chief Nursing Officer| Validated for May-22

NHS Worcestershire Acute Hospitals NHS Trust

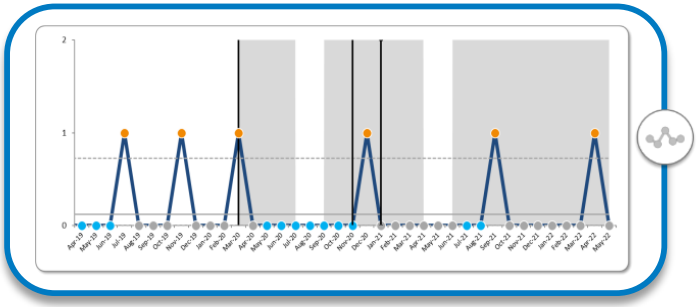
% admission of full-tern babies to neonatal care

2.0%



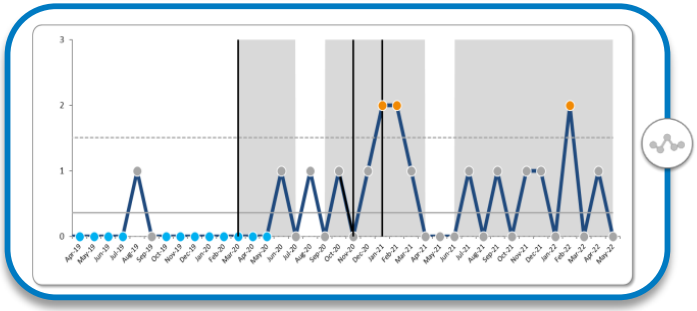
Maternal Deaths

0



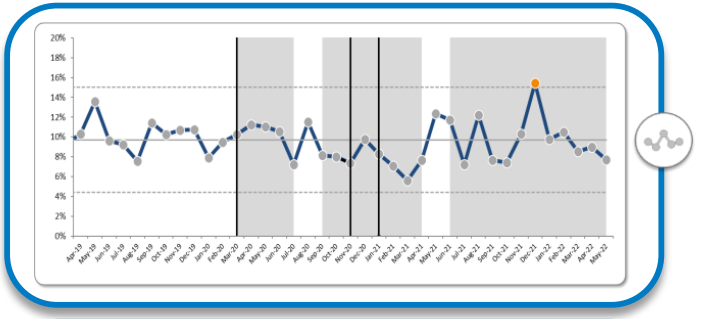
Neonatal Deaths (>24+0 weeks gestation)

0



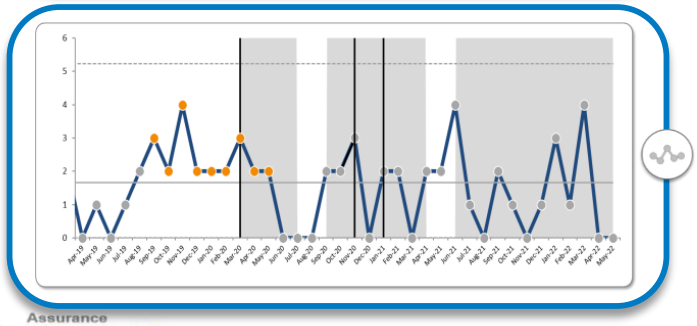
% Pre term births

7.7%



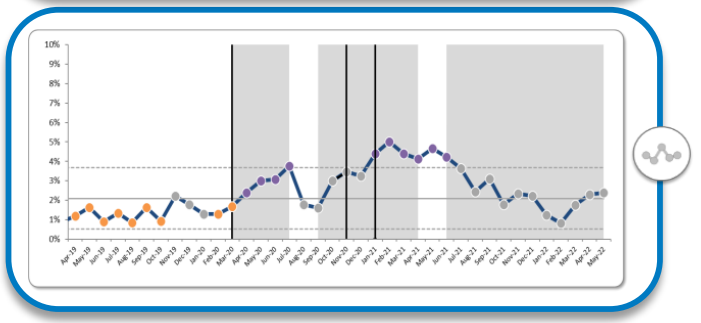
Stillbirths

0



% Home births

2.4%



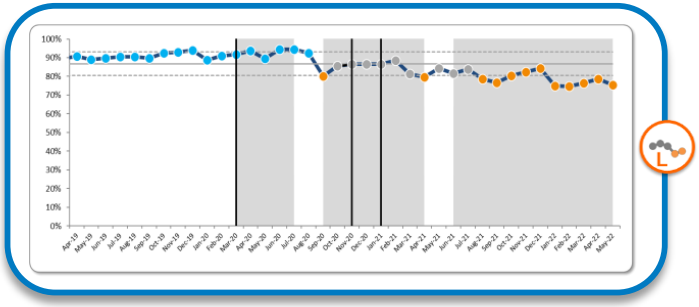
Purple SPC dots represent special cause variation that is neither improvement or concern

Month 2 [May] | 2022-23 Maternity Summary

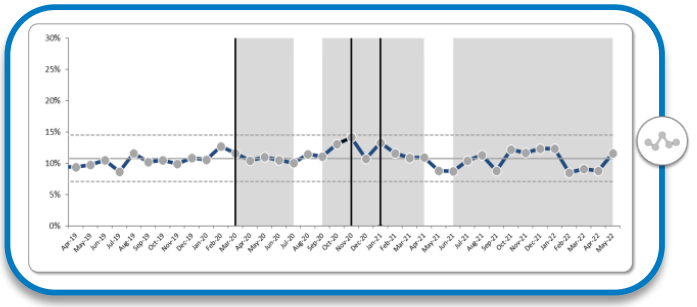
Responsible Director: Chief Nursing Officer| Validated for May-22

NHS Worcestershire Acute Hospitals NHS Trust

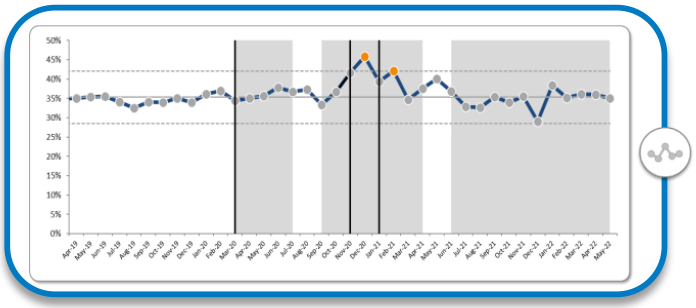
Booked before 12+6 weeks — 75.4%



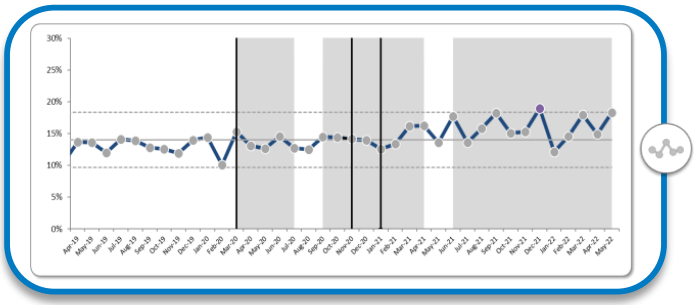
Instrumental Delivery — 11.6%



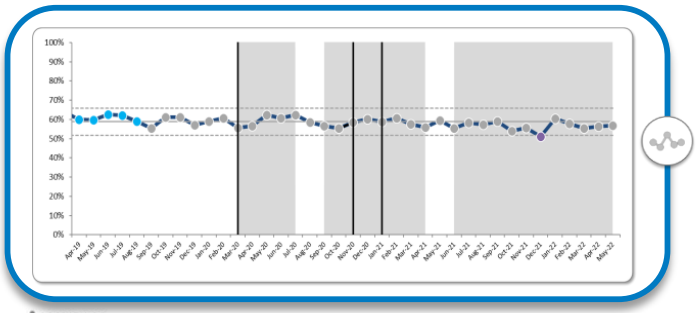
Inductions of labour — 35.0%



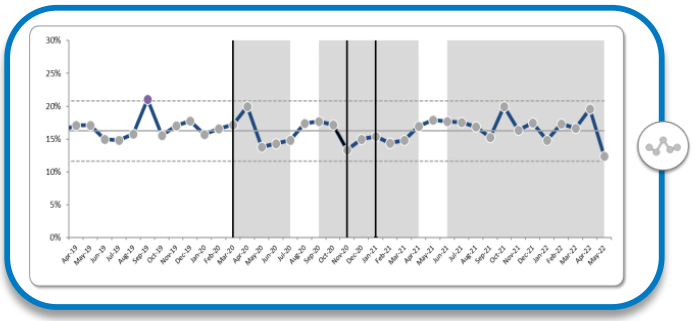
Elective Caesarean — 18.3%



Vaginal Deliveries (non-instrumental) — 56.9%



Emergency Caesarean — 12.4%



Lockdown Period
COVID Wave

● Purple SPC dots represent special cause variation that is neither improvement or concern

Workforce

People and Culture Performance Report Month 2 - Headlines

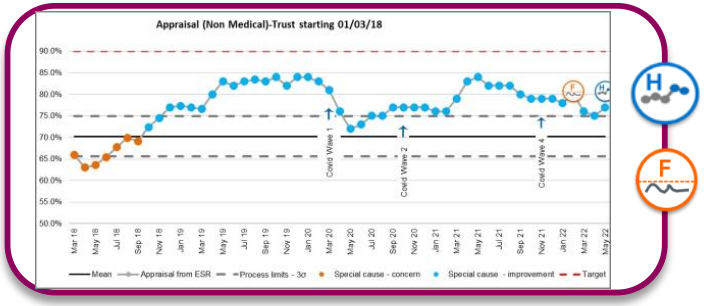
People & Culture	Comments
Getting the Basics Right	• Mandatory training has increased by 1% to 90% this month against a Model Hospital average of 88% and a Trust target of 90%. • Non medical appraisal has increased by 2% to 77% compared with the national average of 78% and Trust target of 90%. • Consultant Job Planning has improved by 9% to 83% month which is 22% better than the same period last year. • Recruitment – we have 23 wte more starters than leavers this month due to sustained recruitment activity.
Performance Against Plan	• Establishment following budget setting has been worked through by Finance and HR to take account of the £12m vacancy factor. • We are currently 73 wte adrift from our workforce plan submitted in June primarily due to 92 leavers in April which is higher than forecast. We have only increased by 26 wte overall in April and May (despite recruiting 182 new staff) against a planned increase of 63 wte.
Drivers of Bank & Agency spend	• Monthly sickness has reduced to 4.93% against a national monthly average of 6.7%. This equates to an average of 289 wte staff absence each day of the month. Our sickness absence target has been adjusted to 5.5% for 2022/23 to take account of covid (previously 4%). • The annual turnover rate is of concern increasing again this month from 13.19% to 13.41% against a target of 11.5%. This is 4.47% worse than the same period last year. The People & Culture annual plan priorities are focused on recruitment and retention. • There are 165 staff on maternity leave, an average of 459 wte staff on annual Leave and 95 wte on other leave each day. • 643 wte were booked to cover vacancies, sickness, additional beds and covid additional staff
Staff Health & Wellbeing	• Cumulative sickness (rolling 12 months) has reduced to 5.15% which is better than target. • Sickness due to S10 (stress and anxiety) improved by 0.04% this month to 1.32%. Surgery continue to be the only division that has a lower level of S10 absence than pre-pandemic levels. Wellbeing Conversations are continuing with training for Managers available on ESR.

Month 2 [May] 2022/23 Workforce "Getting the Basics Right" Summary

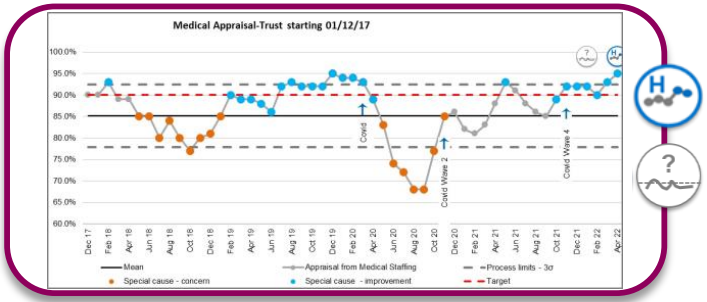
Responsible Director: Director of People and Culture | Validated for May 2022 as 14th June 2022

NHS Worcestershire Acute Hospitals NHS Trust

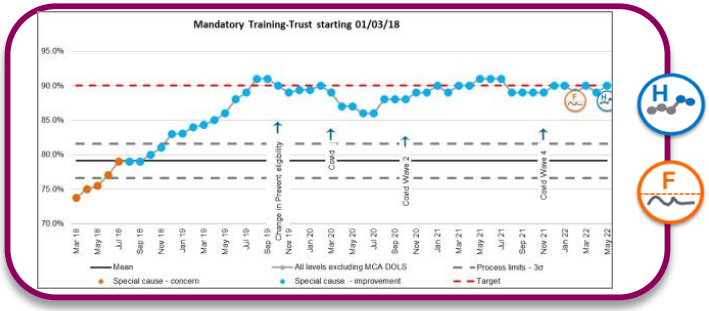
Appraisal (Non-Medical) 77%



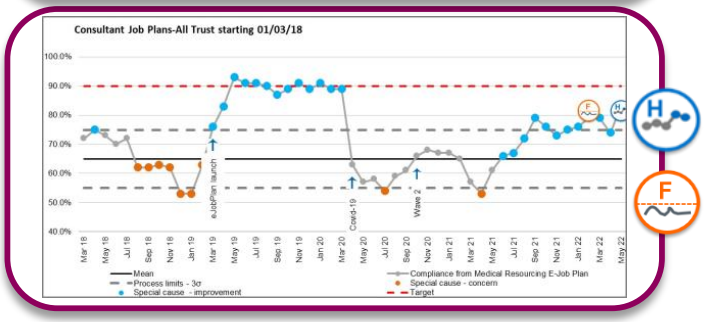
Medical Appraisal 95%



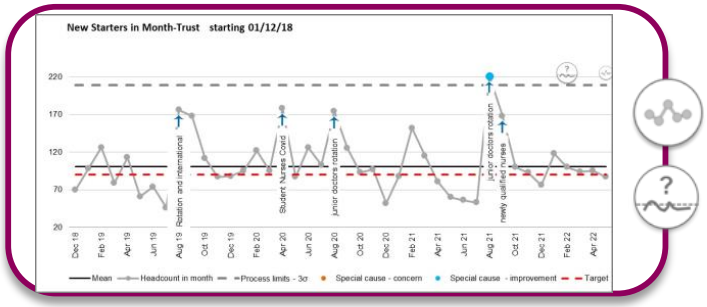
Mandatory Training 90%



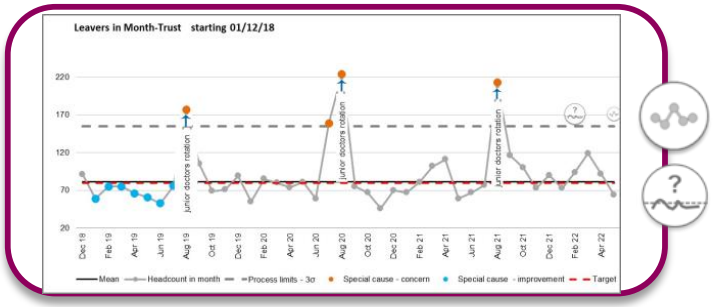
Consultant Job Plans 83%



New Starters in Month 87



Leavers in Month 64



Arrow depicts direction of travel since last month. Green is improved, Red is deteriorated and amber unchanged since last month.

Workforce Compliance Month 1 – (April 22): - Performance Against Plan

Substantive Establishment (ADI)	Contracted Staff in Post (ESR)	Vacancy Rate	Total Hours Worked (ADI)	Bank Spend as a % of Gross Spend (ADI)	Agency Spend as a % of Gross Spend (ADI)
6,512 wte	5,871 wte	9.84%	6,419 wte	7.39%	8.75%

What does the data tell us?

- **Staff in Post** – has increased this month by 20 wte to 5871 wte.
- **Total Hours worked** – has reduced by only 1 wte (an increase of 16 bank and a reduction of 6 wte in agency)
- **Agency Spend as a % of Gross Cost** – Although Agency usage has dropped this month Agency spend as a % of gross cost has increased by 0.51% to 8.75% which indicates that higher Tier spend has been used. Spend has increased in all clinical Divisions and Estates and Facilities. Urgent Care remains an outlier with 24.90%.
- **Bank spend as a % of gross cost -** Bank staff spend as a % of gross spend has reduced by 0.2% to 7.39%.

National Benchmarking (May 2022)
We are Quartile 4 for our use of Temporary Medics staffing with 14.4% of spend compared to National Average of 11.5% (June 2021). We are in the 4th quartile (Worst) for Nursing Agency spend with 10% compared to national average of 5.2% (Feb 2022 rates). We are also in the 4th quartile for Medical Agency spend with 13.2% compared to national average of 6.5%

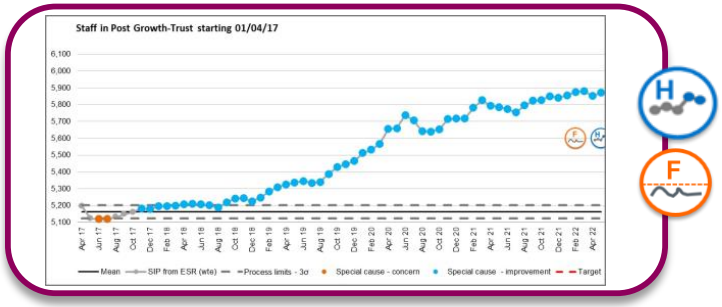
Month 2 [May] 2022-23 Workforce "Performance Against Plan" Summary

Responsible Director: Director of People and Culture | Validated for May -22 as 14th June 2022

Worcestershire Acute Hospitals NHS Trust

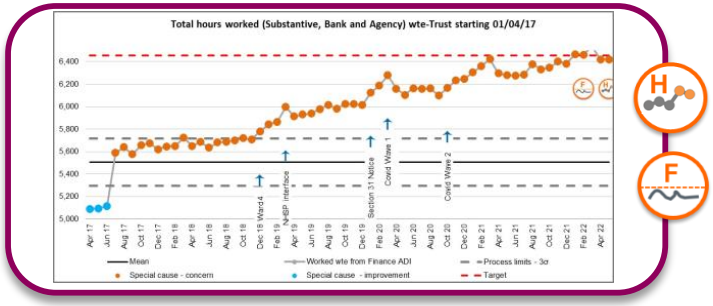
Contracted Staff in Post (ESR)

5871 wte



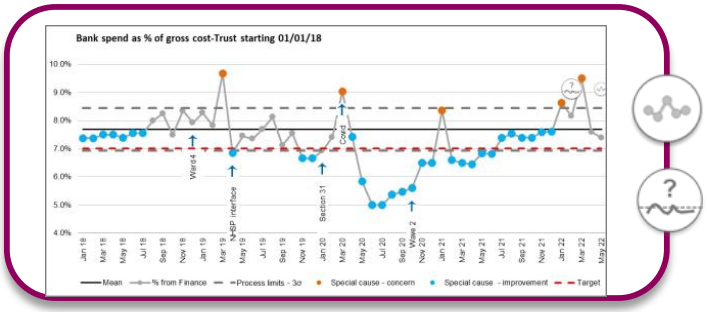
Total Hours Worked (ADI)

6419 wte



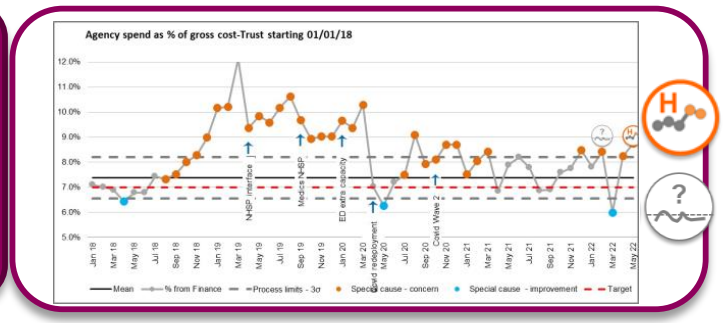
Bank Spend as a % of Gross Cost

7.39%



Agency Spend as a % of Gross Cost

8.75%



Variation Assurance

Arrow depicts direction of travel since last month. Green is improved, Red is deteriorated and amber unchanged since last month.

Workforce Compliance Month 2 – (May 22): - Drivers of Bank and Agency Spend

Staff Turnover	Monthly Sickness Absence	Maternity Leave	Annual Leave	Other Leave	Booking Reasons
13.41%	4.93% 289 wte average per day	165 headcount	459 wte average	95 wte average	Vacancies, Sickness, Additional Beds and Covid

What does the data tell us?

- **Staff Turnover** – Staff annual turnover has deteriorated by 0.22% this month to 13.41% which is 4.47% worse than the same period last year. This is above our 11.5% target which was already adjusted for covid. The people & culture annual plan priorities are focused on recruitment and retention.
- **Monthly Sickness Absence Rate** – Sickness has reduced by 0.77 % to 4.93% which is 0.25% worse than the same period last year. Cumulative sickness for the 12 month period has reduced from 5.57% to 5.15% which is 0.48% higher than the same period last year. Sickness rates are driven by high levels of Long Term Sickness in all divisions except for Digital, with Estates and Facilities and Women and Childrens as hotspot areas. The average number of staff off sick each day has reduced from 333 or 289 wte (including 98 registered nurses and 79 HCAS.)
- **Maternity/Adoption Leave** – The number of staff on maternity and adoption leave has increased by 6 wte to 165 which is 5 more than the same period last year.
- **Annual Leave** – An average of 459 wte staff were on Annual leave each day during May including Whitsun half term. This is a drop of 70 wte from April which included Easter holidays.
- **Other leave** – An average of 95 wte were absent due to Other Leave which will include special leave, study leave, self isolation for Covid etc. This has reduced by 96 wte from last month.
- **Booking Reasons** – 643 wte staff were booked via NHS Professionals to cover gaps compare to 672 wte last month. This included 380 wte staff booked to cover vacancies, 116 wte for sickness (primarily Registered Nursing), 45 wte additional Beds and 19 wte for covid additional staff.

National Benchmarking (May 2022)

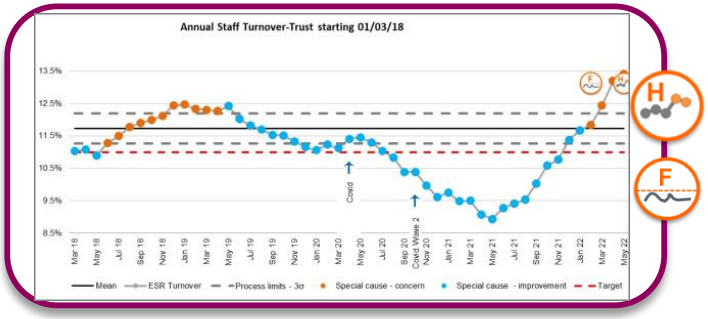
Our Annual Turnover on Model Hospital remains within Quartile 2 for all staff groups apart from Medics and Healthcare Scientists who are of concern at Quartile 3 (Dec 2021 latest data). We have improved to the 2nd Quartile in terms of Sickness on Model Hospital as at February 2022 (latest data) when our sickness was 5.8% against a National median of 5.8%.

Month 2 [May] 2022-23 Workforce "Drivers of Bank & Agency Spend" Summary

Responsible Director: Director of People and Culture | Validated for May -22 as 14th June 2022

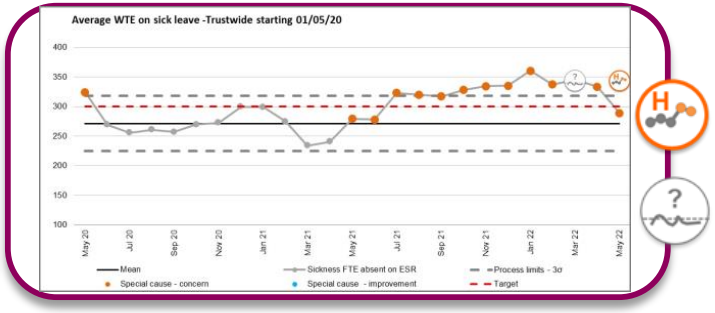
Annual Staff Turnover

13.41%



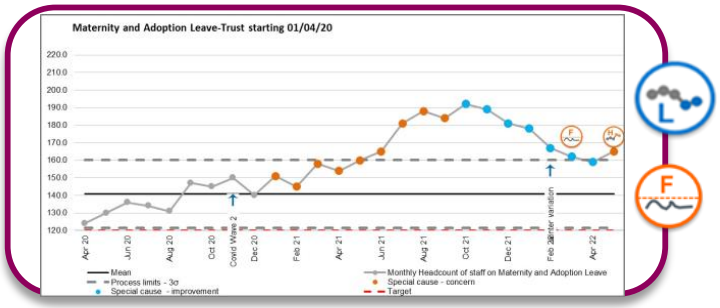
Monthly Average Staff of Sick Per Day

289 wte



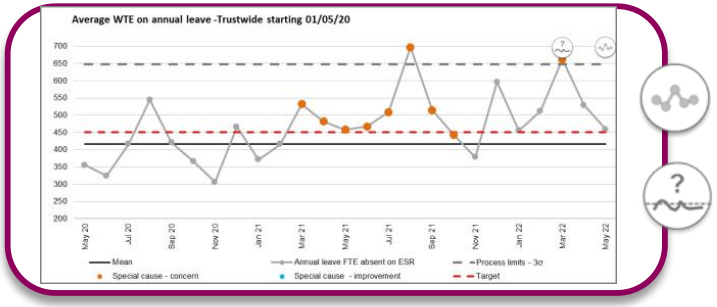
Maternity/ Adoption Leave (Headcount)

165



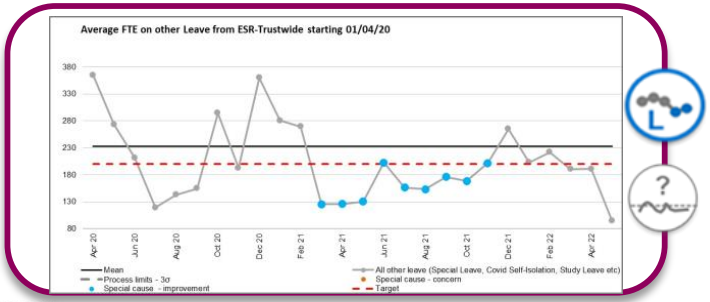
Annual Leave (average staff on leave each dav

459 wte



Any Other Leave (Average FTE per day)

95 wte



Variation Assurance

Arrow depicts direction of travel since last month. Green is improved, Red is deteriorated and amber unchanged since last month.

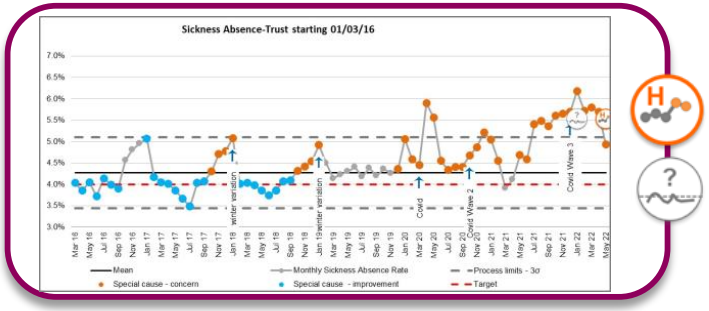
Month 2 [May] 2022-23 Workforce "Health and Wellbeing" Summary

Responsible Director: Director of People and Culture | Validated for May-22 as 14th June 2022

NHS Worcestershire Acute Hospitals NHS Trust

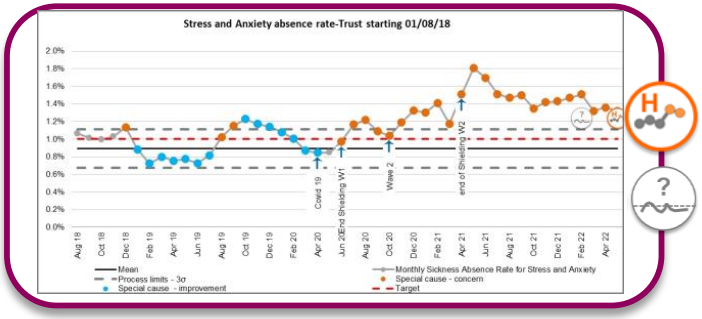
Monthly Staff Sickness Absence Rate

4.93%



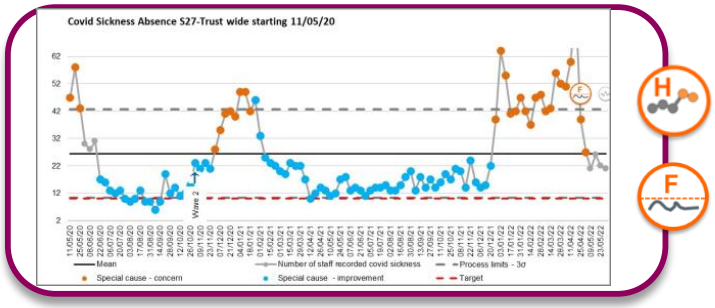
% Staff absent due to Stress and Anxiety (S10)

1.32%



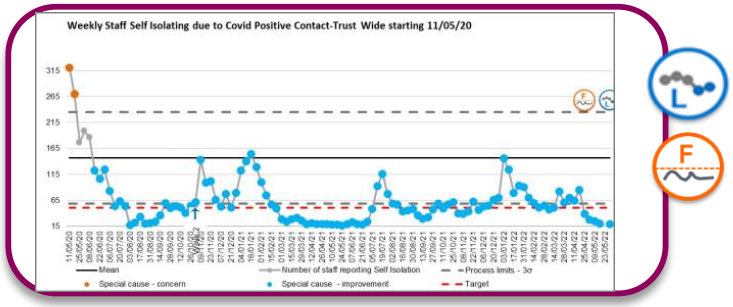
Covid Sickness (S27)

21



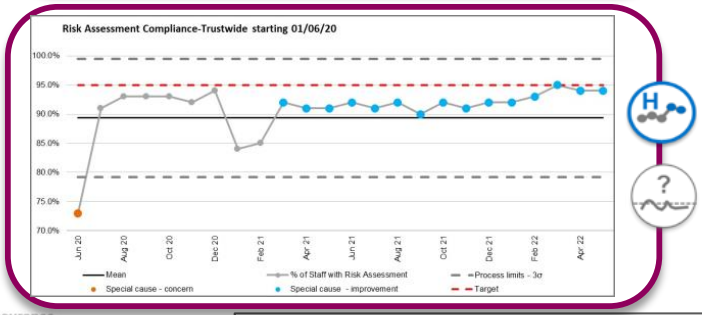
Number Self Isolating

19



Covid Risk Assessment Compliance

94%



Variation | Assurance

Arrow depicts direction of travel since last month. Green is improved, Red is deteriorated and amber unchanged since last month.

Strategic Priorities: Workforce

Strategic Business Priorities			
BP1: Leadership ***An empowered, well led workforce that delivers better outcomes and Performance***	**BP2: Workforce Planning and Transformation** ***The right-sized, cost effective workforce that is organised for success***	**BP3: OD and Staff Experience** ***A just, learning, and innovative culture where colleagues feel respected, valued, included and well at work***	**BP4: Future of HR and OD** *A people function that is organised around the optimum employee journey*

Best People – Our people are recruited, retained and developed so they have the right skills to provide high quality care and work with pride

How have we been doing?

The following areas are where we perform below peer group average:

- Month on month increase in staff turnover

Also of note is the increase in bank and agency usage which is a result of:

- Continued higher levels of sickness absence
- Increased patient acuity
- Use of surge areas

- We have launched the recruitment value stream using our 4ward improvement system
- We continue to address our reliance on the temporary workforce through the Best People Programme
- Sickness Absence rates have improved and have met the Trust target and are lower than Model Hospital average.

What improvements will we make?

- We have developed the people and culture 3 year plan and in year 1 will focus on recruitment and improving the retention of colleagues
- Recruitment is the first value stream under the 4ward improvement system
- We are improving the visibility of establishment and vacancy information by uploading data into ESR and HealthRoster.
- We will continue with the implementation of the Best People Programme to reduce our reliance on the temporary workforce.
- We will continue work to enhance the flexible working offer to staff including Location by Vocation
- We have refreshed our Staff Health and Wellbeing Plan

Overarching Workforce Performance Level – 5 – May 2022 **Previous Assurance Level - 5 – April 2022**	**To work towards improvement to next assurance level**

Finance

Finance Report - Headlines

Finance	Comments
Month 2 May Position	This position is in line with the Annual Plan submitted on 28th April 2022. Note that the plan has since been revised for a further national submission made on 20th June 2022. **Notwithstanding the above the pre-existing M2 monthly position is an actual deficit of £(2.5)m against a plan of £(4.2)m deficit, a positive variance of £1.7m.** Details are on slide 66.
Updated Financial Plan for 2022/23	The delegated Trust Board subgroup agreed to a £22.2m deficit plan where the improved position which was reported was due to £19.9m of additional income (£3m intra system inflation, £0.5m out of system and £16.4m re distribution of CCG surplus). On 20th June, the Chief Executive confirmed with the ICS that alongside other system providers, subject to Trust Board approval, there would be a further £2.6m stretch to the position (with for example additional ERF margin potential). At month 2, we initially had £2.6m favourable variance to plan prior to any re-profiling of the updated plan. Activity / other budgets have since been re-phased as part of the planning resubmission resulting in a revised £1.2m favourable variance at month 2 due to vacancies and (delayed Capital Schemes) depreciation variances to the original plan. Risks remain as follows: c.£8m of high risk PEP / gap, £3m unconfirmed system/nationally funded CAU costs and ERF delivery in full. See updated risks in supporting finance pages. **As a result of the above, the YTD M2 revised position would be a deficit plan of £(2.9)m with actuals of £(2.9)m.**

	£	£
Planned Deficit @ 22nd April Submission		(42,360)
Additional Income		
Inflation 0.7% - Intra System	2,979	
Increase in provider income - out of system	517	
CCG Surplus to Providers	16,361	
		19,857
Additional CDH Income (NHS Other)	2,043	
Additional CDH Costs	(2,043)	
		-
Movement in position		19,857
Revised Deficit		(22,503)

Finance Report - Headlines

Finance	Comments
Productivity and Efficiency	Our Productivity and Efficiency Programme target for 22/23 is £15.7m. Month 2 delivered £0.3m of actuals against the plan in April 2022 of £0.9m. A negative variance of £0.6m. The cumulative position at M2 is therefore £0.6m of actuals against a plan of £1.4m, a negative variance of £0.8m. The 22/23 full year forecast at Month 2 is £10.7m, which is a reduction of £0.3m against the Month 1 position. This is primarily due to the M2 under-delivery. Sessions have been held with CETM to generate ideas of how to close the gap. Work is progressing to evaluate our position against the 2019/20 Lord Carter recommendations for Trust efficiency, and alignment is taking place with the 4ward Improvement System to ensure all waste identified through Waste Walks is quantified and learning is spread across the Trust.
Capital	22/23 Plan **Capital Position** / **22/23 Plan £'000** / **Total YTD Valuation £'000** / **M3 - M12 Spend Forecast £'000** / **22/23 Full Year Forecast £'000** / **Value of Outstanding Orders Placed £'000** Internally Generated capital: 10,233 / 1,909 / 8,324 / 10,233 / 3,151 PDC funding - STP envelope: 13,761 / - / 13,761 / 13,761 / - **Total STP Envelope: 23,994 / 1,909 / 22,085 / 23,994 / 3,151** Externally Funded Schemes: 27,076 / (90) / 27,166 / 27,076 / 10 Lease Additions: 10,785 / / 10,785 / 10,785 / - IFRIC 12 PFI Lifecycle replacement: 326 / 9 / 317 / 326 / - **Total Capital Expenditure: 62,181 / 1,828 / 60,353 / 62,181 / 3,161** Our Capital Position at month 2, being the value of works complete, is £1.8m. This is an increase of £1.2m since month 1.
Cash	**At the end of May 2022 the cash balance was £41.1m against a plan of £49.9m.** The relatively high cash balance is the result of the timing of receipts from the CCG's and NHSE under the continuing COVID era arrangements together with timing of creditor / supplier payments. Requests for PDC in support of revenue funding this year is reviewed based on the amount of cash received in advance under this arrangement. The cash flow forecast main assumptions are: • £40.8m PDC capital funding to be received in phased amounts this financial year, with nil drawn this month. • PDC receipts cover part of the Trust's creditor payments, the balance covered by internally generated working capital cash. Ongoing discussions and reviews are held with Regional NHSI/E colleagues monthly which review the Trusts financial and cash position.

Finance | Key Messages

NHS Worcestershire Acute Hospitals NHS Trust

2022/23 Plan

Our 2022/23 operational financial plan has been developed from a roll forward of the recurrent cost and non patient income actuals from 21/22 adjusting for workforce and activity trajectories, inflationary pressures and the full year effect of any PEP schemes or Business cases which started part way through 21/22. We have then overlaid any new PEP Schemes, new Business Cases and applied a vacancy factor. The Trust's submitted full year plan is a deficit of £(42.4)m – submitted April 2022.

Income & Expenditure Overview

Month 2 – May Position | Against the M2 plan of **£4.2m deficit** we report an actual **deficit of £2.5m,** a positive variance of £1.7m.

Statement of comprehensive income	May-22 Plan £'000	May-22 Actual £'000	May-22 Variance £'000	Year to Date Plan £'000	Year to Date Actual £'000	Year to Date Variance £'000
INCOME & EXPENDITURE						
Operating income from patient care activities	45,675	46,564	889	90,995	92,267	1,272
Other operating income	2,453	2,153	(300)	4,906	4,396	(510)
Employee expenses	(30,281)	(29,575)	706	(60,510)	(59,462)	1,048
Operating expenses excluding employee expenses	(20,156)	(19,804)	352	(40,532)	(39,783)	749
OPERATING SURPLUS / (DEFICIT)	**(2,309)**	**(662)**	**1,647**	**(5,141)**	**(2,582)**	**2,559**
FINANCE COSTS						
Finance income	0	35	35	0	66	66
Finance expense	(1,165)	(1,173)	(8)	(2,330)	(2,311)	19
PDC dividends payable/refundable	(698)	(698)	0	(1,395)	(1,396)	(1)
NET FINANCE COSTS	**(1,863)**	**(1,836)**	**27**	**(3,725)**	**(3,641)**	**84**
Other gains/(losses) including disposal of assets	0	0	0	0	0	0
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**(4,172)**	**(2,498)**	**1,674**	**(8,866)**	**(6,223)**	**2,643**
Add back all I&E impairments/(reversals)	0	0	0	0	0	0
Surplus/(deficit) before impairments and transfers	**(4,172)**	**(2,498)**	**1,674**	**(8,866)**	**(6,223)**	**2,643**
Remove capital donations/grants I&E impact	11	10	(1)	21	20	(1)
Adjusted financial performance surplus/(deficit)	**(4,161)**	**(2,488)**	**1,673**	**(8,845)**	**(6,203)**	**2,642**
Less gains on disposal of assets	0	0	0	0	0	0
Adjusted financial performance surplus/(deficit) for the purposes of system achievement	**(4,161)**	**(2,488)**	**1,673**	**(8,845)**	**(6,203)**	**2,642**

I&E Delivery Assurance Level: Level 3

Reason: £(42.4)m deficit plan submitted for 22/23 with risks to delivery including (but not limited to):

- inability to deliver unidentified PEP
- slippage on any identified transformational PEP
- failure to secure funding for Pathway Discharge Unit
- variance to delivery of planned activity to access ERF 104%,
- pay and non pay inflation above Tariff levels and excess inflation on PFI if RPIX above plan assumption of 8.5%

Combined Income in month variance £0.6m favourable – Combined Income (including Non PbR pass-through Drugs & Devices and Other Operating Income) was £0.6m above the Trust's Operational Plan in May. Community Diagnostic Hub funding £0.3m (offsets costs incurred in expenditure), Pass through Drugs & Devices £0.9m, COVID PCR testing reimbursement (£0.2m) and PDU assumed funding (£0.4m) which is in the Trust's Operational Plan although there remains no formal agreement to funding from the ICS system/commissioners or region. The Trust has reported the full value of the ERF income **(YTD £2.7m)** in the position (agreed by the System).

Employee expenses in month variance £0.7m favourable – Employee expenses were £29.6m in month 2, a favourable variance of £0.7m against the £(30.3)m plan in month and a reduction of £0.3m compared with the April position. Favourable variances against employee expenses in month are due to vacancy (£0.4m) , slippage against business case and central adjustments (£0.8m – key items PDU £0.3m , Surgical reconfiguration and CDH £0.3m) offset by adverse variances including undelivered PEP - mainly for unidentified schemes.

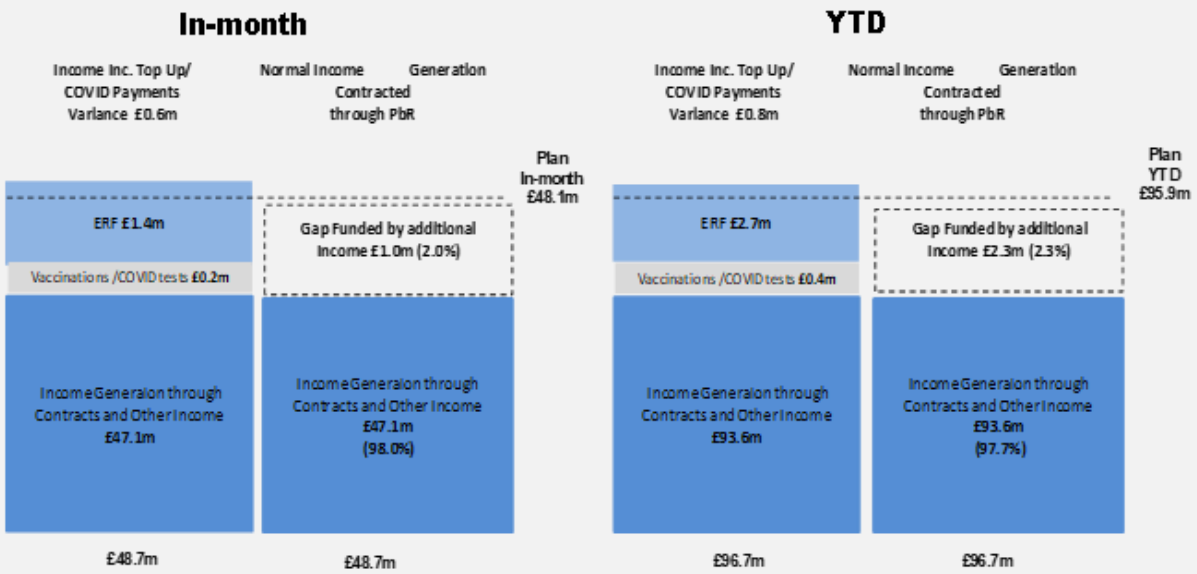
Operating expenses in month variance £0.4m favourable – Favourable variances against operating expenses in month include:A 5 year business rates rebate (£0.4m)

- Business Case slippage – except for CDH (£0.2m), including digital project (£0.1m), PDU (£0.1m)
- Depreciation due to slippage in completion of 21/22 capital projects (£0.2m)
- Maternity Incentive Premium not payable for 22/23 (£0.1m)
- Un spent ERF marginal cost budget (£0.3m)
- Lower supplies and services due to not achieving the activity plan (£0.3m)
- Lower Covid spend due to reduced levels of testing in Pathology (£0.2m)
- Lower usage of outsourcing for 18 week (£0.1m)
- Lower intake of International Nurses (£0.1m)
- Other (£0.2m)

Partially offset by unachieved PEP (£0.5m), overspend on CDH (£0.5m) and Non PbR pass through Drugs (£0.9m).

Finance | Key Messages

Income



The Combined Income (including PbR pass-through drugs & devices and Other Operating Income) was £0.6m above the Trust's Operational Plan in May. In month variance £0.6m: Community Diagnostic Hub funding £0.3m (offsets costs incurred in expenditure), Pass through Drugs & Devices £0.9m, COVID PCR testing reimbursement (£0.2m) and PDU funding (£0.4m) which is in the Trust's Operational Plan but there is no agreed funding from commissioners.

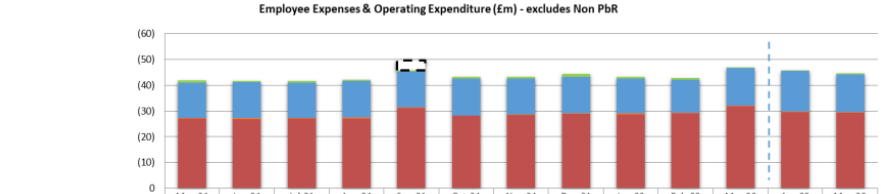
Elective Recovery Fund framework (ERF) - The Trust has been given Elective Recovery Funding (ERF) £16.4m to achieve the required 104% activity target based on 2019/20. There is a clawback of 75% up to a maximum of 75% of the original value if under (25% retained by the Trust), and a 75% additional payment for any overachievement. The scope of the ERF will cover Daycase, Elective, Outpatient Procedures and first attendances. The funding will be also be adjusted if the Trust fails to achieve the follow up target reduction (85% of the 2019/20 activity volumes).

The Trust has reported the full value of the ERF income (YTD £2.7m) in the position (agreed by the System).

Finance | Key Messages

NHS Worcestershire Acute Hospitals NHS Trust

Expenditure



	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Pay Award Impact	0	0	0	0	(3,860)	0	0	0	0	0	0		
COVID-19 Non Pay Costs	(924)	(315)	(541)	(479)	(464)	(561)	(674)	(1,085)	(762)	(653)	(376)	(398)	(301)
Operating Expenditure exc COVID	(13,632)	(13,984)	(13,728)	(14,147)	(13,905)	(14,309)	(13,911)	(14,187)	(13,442)	(12,665)	(14,463)	(15,604)	(14,725)
COVID-19 Pay Costs	(220)	(522)	(212)	(395)	(327)	(171)	(213)	(213)	(435)	(374)	(360)	(235)	(138)
Employee Expenses exc COVID	(27,104)	(26,772)	(27,141)	(27,076)	(31,142)	(28,145)	(28,460)	(28,841)	(28,724)	(29,089)	(31,810)	(29,652)	(29,435)
Total Expenditure	(41,881)	(41,592)	(41,622)	(42,097)	(45,838)	(43,186)	(43,258)	(44,325)	(43,363)	(42,781)	(47,009)	(45,888)	(44,599)

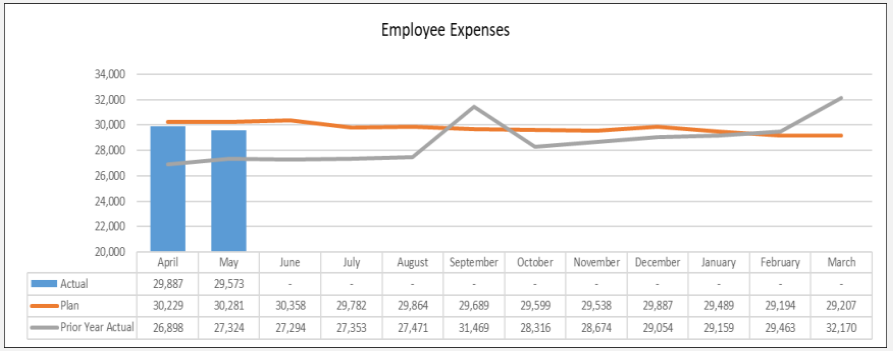
Above chart excludes Non PbR items. Month 12 adjusted to remove key one off items.

Overall employee expenses of £29.6m in month 2 is a reduction of £0.3m compared with the April position. The movement is partly due to only 1 bank holiday in May compared to the 2 in April (£0.2m) as well as a further favourable movement (£0.1m) due to increased vacancies with a reduction in worked WTE of c.8. Of the 8 WTE reduction, c.5 WTE are in Specialty Medicine.

Total temporary staffing spend of £4.8m is largely consistent with last month and was 16.1% of the total pay bill. Bank spend reductions of £0.1m are due to a decrease in Medics spend in month of 5 worked WTE across Surgery and Specialty Medicine. Agency spend has increased in month by £0.1m. Agency medics spend increased by c.9 worked WTE, mainly within Specialty Medicine. There are significant medics retro hits in month with April shifts appearing for the first time on the May report.

Overall operating expenses excluding Non PbR were £15.0m in month 2, a reduction of £1.0m compared with the April position. Expenditure on general supplies and services has reduced in month by £0.5m, partly due to the transfer of £0.2m of capital costs from Digital, as well as a reduction of £0.2m in Estates & Facilities which relates to favourable variations against costs incurred in M1 including disposal and legal fees. There has been a favourable movement on Premises – business rates (£0.4m) due to a 5 year business rates rebate (for 17/18 to date), and a further favourable movement on Clinical negligence (£0.1m) due to late notification that the Maternity Incentive Premium is not payable for 22/23. Non PbR spend has increased by £0.8m in month, mainly on drugs,. Of this £0.4m is activity related and £0.4m phasing for homecare activity.

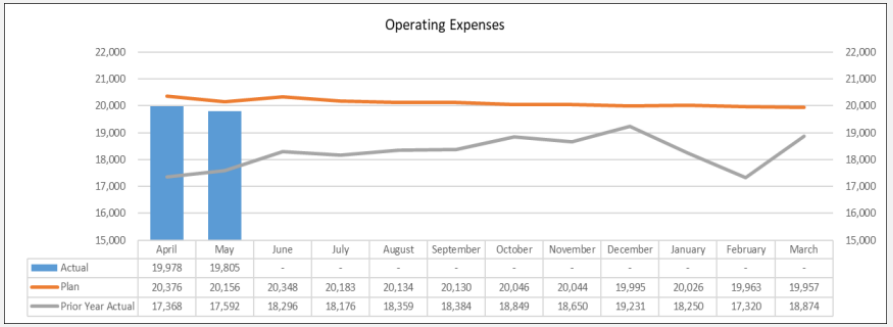
Employee Expenses



	April	May	June	July	August	September	October	November	December	January	February	March
Actual	29,887	29,573	-	-	-	-	-	-	-	-	-	-
Plan	30,229	30,281	30,358	29,782	29,864	29,689	29,599	29,538	29,887	29,489	29,194	29,207
Prior Year Actual	26,898	27,324	27,294	27,353	27,471	31,469	28,316	28,674	29,054	29,159	29,463	32,170

Employee Expenses	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Mvmt	YTD
Agency	(2,159)	(2,238)	(2,131)	(1,888)	(2,172)	(2,149)	(2,226)	(2,462)	(2,279)	(2,480)	(2,700)	(2,462)	(2,588)	(126)	(5,050)
Bank	(1,867)	(1,863)	(2,019)	(2,067)	(2,327)	(2,085)	(2,175)	(2,210)	(2,516)	(2,404)	(4,281)	(2,269)	(2,184)	85	(4,454)
Temporary Total	**(4,026)**	**(4,101)**	**(4,150)**	**(3,955)**	**(4,498)**	**(4,235)**	**(4,400)**	**(4,671)**	**(4,795)**	**(4,883)**	**(6,981)**	**(4,731)**	**(4,772)**	**(41)**	**(9,503)**
WLI	(212)	(293)	(400)	(295)	(316)	(332)	(271)	(328)	(285)	(420)	(611)	(330)	(403)	(73)	(733)
Substantive	(23,086)	(22,900)	(22,804)	(23,221)	(26,655)	(23,750)	(24,002)	(24,055)	(24,078)	(24,160)	(24,578)	(24,826)	(24,398)	428	(49,224)
Substantive Total	**(23,298)**	**(23,193)**	**(23,204)**	**(23,516)**	**(26,970)**	**(24,082)**	**(24,273)**	**(24,382)**	**(24,364)**	**(24,580)**	**(25,189)**	**(25,156)**	**(24,801)**	**355**	**(49,957)**
Employee Expenses Total	**(27,324)**	**(27,294)**	**(27,353)**	**(27,471)**	**(31,469)**	**(28,316)**	**(28,674)**	**(29,054)**	**(29,159)**	**(29,463)**	**(32,170)**	**(29,887)**	**(29,573)**	**314**	**(59,460)**
Agency %	7.9%	8.2%	7.8%	6.9%	6.9%	7.6%	7.8%	8.5%	7.8%	8.4%	8.4%	8.2%	8.8%	0.5%	17.0%
Bank %	6.8%	6.8%	7.4%	7.5%	7.4%	7.4%	7.6%	7.6%	8.6%	8.2%	13.3%	7.6%	7.4%	-0.2%	15.0%
Bank & Agency %	14.7%	15.0%	15.2%	14.4%	14.3%	15.0%	15.3%	16.1%	16.4%	16.6%	21.7%	15.8%	16.1%	0.3%	32.0%

Operating Expenses



	April	May	June	July	August	September	October	November	December	January	February	March
Actual	19,978	19,805	-	-	-	-	-	-	-	-	-	-
Plan	20,376	20,156	20,348	20,183	20,134	20,130	20,046	20,044	19,995	20,026	19,963	19,957
Prior Year Actual	17,368	17,592	18,296	18,176	18,359	18,384	18,849	18,650	19,231	18,250	17,320	18,874

Finance | Key Messages

NHS Worcestershire Acute Hospitals NHS Trust

Capital

The Capital Plan for 2022/23 is a total of £62.2m, as per the latest plan submission in June 2022. This plan has not changed from the original submission earlier in the year. Our Capital Position at month 2, being the value of works complete, is £1.8m. This is an increase of £1.2m since month 1.

Capital Assurance Level: Level 4

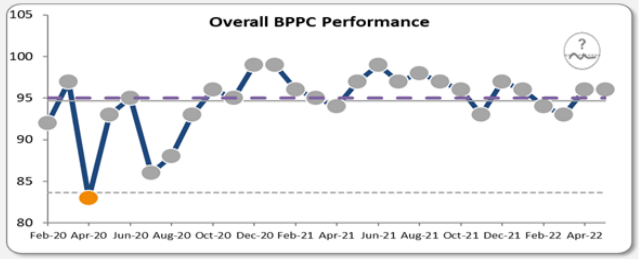
Reason: Major capital schemes continue into 2022/23 requiring significant programme management. Commitment monitoring and prioritisation of schemes completed. Risk remains in medium term. **The Trust has insufficient funding to manage its backlog maintenance and urgent schemes and therefore has had to assume slippage on schemes until further sources of funding can be identified.**

Cash Balance

At the end of May 2022 the cash balance was £41.1m. The high cash balance is the result of the timing of receipts from the CCG's and NHSE under the COVID arrangement as well as the timing of supplier invoices. Requests for PDC in support of revenue funding this year is reviewed based on the amount of cash received in advance under this arrangement.

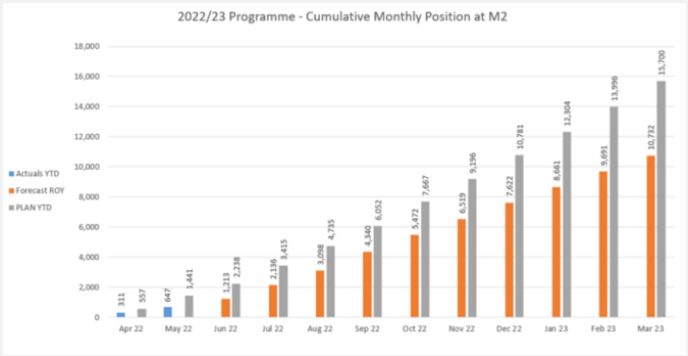
Cash Assurance Level: Level 6

Reason: Good cash balances, rolling CF forecasting well established, achieving BPPC target, positive SPC trends on aged debtors and cash. Risks remain around sustainability given (£42.4m) deficit 22/23 submitted plan.



Productivity & Efficiency

The P&E Programme has delivered £0.33m of actuals at Month 2 against a plan of £0.88m.

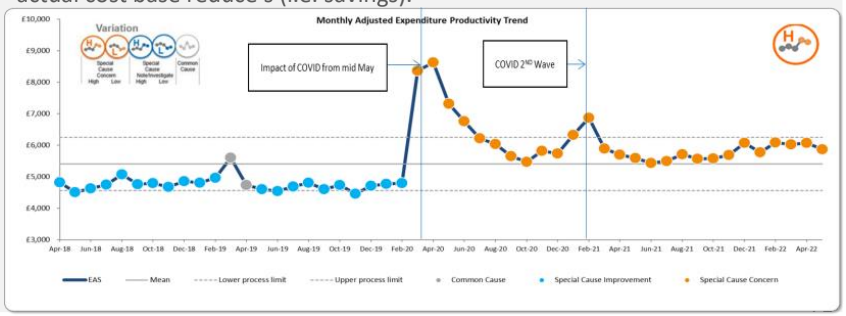


	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Nov 22	Dec 22	Jan 23	Feb 23	Mar 23
Actuals YTD	311	647										
Forecast ROY			1,213	2,136	3,098	4,340	5,472	6,519	7,622	8,661	9,691	10,732
PLAN YTD	557	1,441	2,238	3,415	4,735	6,052	7,667	9,196	10,781	12,304	13,996	15,700

Adjusted Expenditure Productivity Trend

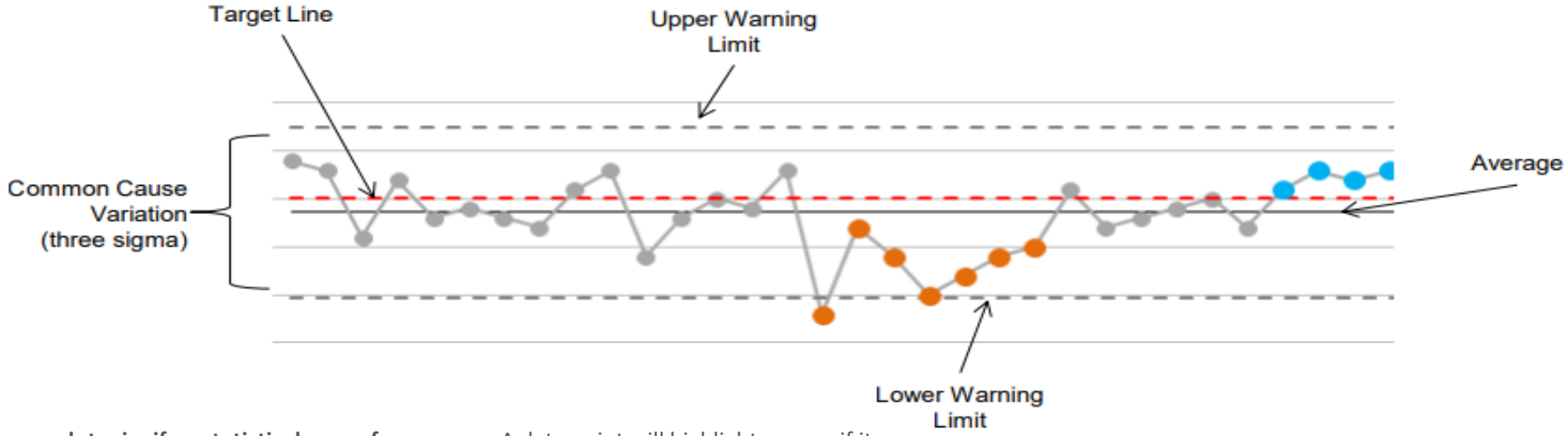
COVID significantly impacts our spend against weighted activity. This local metric allows us to follow productivity changes through COVID recovery and to track against forecasted activity going forward.

May Cost per WAU has reduced from April due to increased activity volumes in both Elective and Emergency. With costs predominantly fixed from month to month, the WAU is only affected by activity volumes changes each month. The cost base has been normalised to remove any non-recurrent (one off costs) to make it comparable from one month to another. WAU will only improve if additional activity is delivered for the same cost base or if the actual cost base reduce s (i.e. savings).



Appendices

Statistical Process Charts (SPC) Guidance



Orange dots signify a statistical cause for concern. A data point will highlight orange if it:
A) Breaches the lower warning limit (special cause variation) when low reflects underperformance or breaches the upper control limit when high reflects underperformance.
B) Runs for 7 consecutive points below the average when low reflects underperformance or runs for 7 consecutive points above the average when high reflects underperformance.
C) Runs in a descending or ascending pattern for 7 consecutive points depending on what direction reflects a deteriorating trend.

Blue dots signify a statistical improvement. A data point will highlight blue if it:
A) Breaches the upper warning limit (special cause variation) when high reflects good performance or breaches the lower warning limit when low reflects good performance.
B) Runs for 7 consecutive points above the average when high reflects good performance or runs for 7 consecutive points below the average when low reflects good performance.
C) Runs in an ascending or descending pattern for 7 consecutive points depending on what direction reflects an improving trend.

Special cause variation is unlikely to have happened by chance and is usually the result of a process change. If a process change has happened, after a period, warning limits can be recalculated and a step change will be observed. A process change can be identified by a consistent and consecutive pattern of orange or blue dots.

Levels of Assurance

RAG Rating	ACTIONS	OUTCOMES
Level 7	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/ reasons for performance variation.	Evidence of delivery of the majority or all the agreed actions, with clear evidence of the achievement of desired outcomes over defined period of time i.e. 3 months.
Level 6	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/ reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement of the desired outcomes.
Level 5	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/ reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with little or no evidence of the achievement of the desired outcomes.
Level 4	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/ reasons for performance variation.	Evidence of a number of agreed actions being delivered, with little or no evidence of the achievement of the desired outcomes.
Level 3	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/ reasons for performance variation.	Some measurable impact evident from actions initially taken AND an emerging clarity of outcomes sought to determine sustainability, agreed measures to evidence improvement.
Level 2	Comprehensive actions identified and agreed upon to address specific performance concerns.	Some measurable impact evident from actions initially taken.
Level 1	Initial actions agreed upon, these focused upon directly addressing specific performance concerns.	Outcomes sought being defined. No improvements yet evident.
Level 0	Emerging actions not yet agreed with all relevant parties.	No improvements evident.

MAY 2022 IN NUMBERS

Worcestershire Acute Hospitals NHS Trust

8,504
Walk-in patients (A&E)

4,305
Patients arriving by ambulance

12,120
Inpatients

38,767
Face to Face outpatients

10,373
Telephone consultations

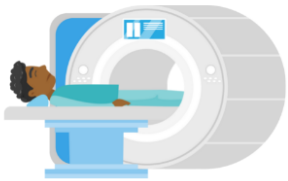
377
Babies

1320
Elective operations

195
Trauma Operations

195
Emergency Operations

6.1
Average length of stay



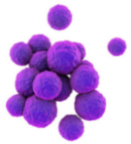
17,602
Diagnostics

Putting Patients First 4ward

QUALITY AND SAFETY IN NUMBERS

May 2022

NHS Worcestershire Acute Hospitals NHS Trust

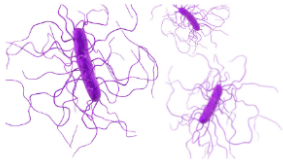


MRSA

0

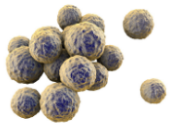
ECOLI

1



CDIFF

6



MSSA

1

Hand Hygiene

Participation	**90.10**
Compliance	**99.70**

Sepsis

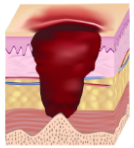
Screening Compliance	**87.50**
Sepsis 6 bundle compliance	**76.47**

ICE reports viewed

Radiology	**88.8**
Pathology	**93.70**

Falls per 1,000 bed days causing harm

0.00



Pressure Ulcers

All hospital acquired pressure ulcers	**25**
Serious incident pressure ulcers	**0**

Response Rate

A&E	**14.21**
Inpatients	**29.70**
Maternity	**3.20**
Outpatients	**11.91**

Recommended Rate

A&E	**88.24**
Inpatients	**97.60**
Maternity	**100**
Outpatients	**96.00**

HSMR 12 months rolling (March 22) **102.44**

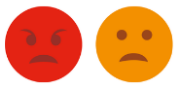
Mortality Reviews completed </=30 days (Nov-20) **35.50**

Risks overdue review **239**

Risks with overdue actions **288**

Discharged before midday

14.12



Complaints Responses </=25 days

73.44

Total Medicine incidents reported **169**

Medicine incidents causing harm (%) **1.78**

Putting Patients First 4ward

WORKFORCE COMPOSITION IN NUMBERS

NHS Worcestershire Acute Hospitals NHS Trust

May 2022

Employees

6,796

BAME employees

20%

Part-time workers

45%

Female

82%

Registered nurses

1,985 (29%)

Registered midwives

253 (4%)

HCAs, helpers and assistants

1,313 (19%)

Doctors

733(11%)

Other clinical and scientific staff

826 (12%)

>55

Over age 55

19%

≤30

30 years and under

20%

Staff with less than 2 years service

27%

Staff with 20 years service or over

10%

Committee Assurance Reports

Trust Board

14th July 2022

Finance & Performance Committee Assurance Report: 29 June 2022

Accountable Non-Executive Director	Presented By	Author
Richard Oosterom – Associate Non-Executive Director	Richard Oosterom – Associate Non-Executive Director	Jo Wells, Deputy Company Secretary

Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y	**BAF number(s)**	2, 3, 4, 7, 8 ,9, 10, 11, 13, 14, 15, 16, 17, 18, 19, 20

Executive Summary

The Committee met virtually on 29 June and the following key points were raised : Escalations to Board:

Item	Rationale for escalation	Action required by Trust Board
Annual Plan Resubmission	Trust Board for noting	For noting

The following levels of assurance were approved:

Item	Level of Assurance	Change	BAF Risk
2022/23 Annual Plan Resubmission	Level 4	N/A	7, 8, 9, 11, 14, 18, 19
Integrated Performance Report	Level 4	Maintained	2, 3, 4, 7, 8 ,9, 10, 11, 13, 14, 15, 16, 17, 18, 19, 20
Finance Report: Income and Expenditure	Level 3	Maintained	7 and 8
Finance Report: Capital	Level 4	Maintained	7 and 8
Finance Report: Cash	Level 6	Maintained	7 and 8
Value for Money: Workforce	Level 5	N/A	9
Value for Money: Estates & Facilities	Level 3	N/A	7 and 8
Robot Assisted Surgery (RAS) Implementation Update	Level 4	N/A	7 and 8
Ambulance Handover Delays: Health Overview & Scrutiny Report	Not Reported	N/A	N/A
Contract Award: Allscripts Change Control Notice for programme acceleration	Not Reported	N/A	N/A
Contract Award: Linen Contract	Not Reported	N/A	N/A

Finance and Performance Committee Assurance Report

Executive Summary

The Committee met virtually on 29 June and the following key points were raised :

Item	Discussion
2022/23 Annual Plan Resubmission	Committee reviewed the plan and addendum. Key profile changes were noted. The AMU/PDU funding was still outstanding and highlighted as a risk. Trust Board would note the updates.
Integrated Performance Report	Executive summary headlines were noted. The key operational performance issues were highlighted relating to activity, elective and ongoing UEC pressures. Discussion took place regarding outpatient cancellations, risk of harm for patients who are waiting and cancer performance. Pressures were noted in relation to the increase in the number of COVID-19 positive inpatients and the workforce risks to the plan. Divisional attendance at the Committee from 27th July was welcomed. **Assurance level 4 overall was agreed**
Finance Report – Month 2	Committee noted the challenges of a M2 report. M2 position was actual deficit of £(5.5)m against a plan of £(4.2)m deficit, a positive variance of £1.7m. PEP risks were discussed in detail in relation to gaps, vacancies, theatres, capital and maintenance backlog. **Assurance levels were maintained at levels 3 I&E, 4 capital and 6 cash**
Value for Money	Reports for Workforce and Estates & Facilities were presented for information. These areas are owned by individual directors and further improvement would be driven by benchmarking aligned with the 4ward Improvement system.
Robot Finance Update	The Committee reviewed the key assumptions made and the comparison to the latest expectations and developments. Challenges were noted with recruitment and income.
Ambulance Handover Delays: Health Overview & Scrutiny Report	Committee reviewed and noted the Health Overview & Scrutiny Committee patient flow and progress update on ambulance handover delays. Questions would be put to the Chief Operating Officer and fed back to the next meeting.
Contract Award – Allscripts Change Control Notice	The Committee were informed that the change control notice related to acceleration support notice was undergoing comprehensive quality review including clarity of roles and responsibilities for internal and external resources all prior to updating the business case.
Contract Awards – Supply Chain	The Committee were informed that the a number of major rust supplier had reported a rise in costs of delivering services (energy cost rises etc.) and which posed potential supply chain risk of failure. A management team group would review the options with Estates and others.

Quality Governance Committee Assurance Report – 30 June 2022

Accountable Non-Executive Director	Presented By	Author
Dr Sue Sinclair – Associate Non-Executive Director	Dr Sue Sinclair – Associate Non-Executive Director	Rebecca O'Connor, Company Secretary

Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y	**BAF number(s)**	2, 3, 4, 7, 8 ,9, 10, 11, 13, 14, 15, 16, 17, 18, 19, 20

Executive Summary

The Committee met virtually on 30 June 2022 and the following were agreed as escalations to Board:

Item	Rationale for escalation	Action required by Trust Board
Safeguarding Annual Report	Trust Board approval required	Recommended for approval
Infection Prevention & Control Annual Report	Trust Board approval required	Recommended for approval
Continuity of Carer	For discussion as to the future approach	Recommended for approval
Undertakings	Trust Board approval required	Recommended for approval

The following levels of assurance were approved:

Item	Level of Assurance	Change	BAF Risk
Integrated Performance Report	Level 4	Maintained	2, 3, 4, 7, 8 ,9, 10, 11, 13, 14, 15, 16, 17, 18, 19, 20
Harm Review Report	Level 6	Maintained	4
Safeguarding Annual Report	Level 6	Maintained	7, 8, 9, 11, 14, 18, 19
Infection Prevention & Control Annual Report	Level 6	Maintained	2, 3, 4, 11, 17, 18, 19, 20
Maternity Services Safety Report	Level 5	Maintained	2, 4, 9, 10
Continuity of Carer	Level 5	N/A	3
Enforcement Undertakings	Not reported	N/A	4, 11

Quality Governance Committee Assurance Report – 30 June 2022

Executive Summary

The Committee met virtually on 30 June 2022 and the following key points were raised:

Item	Discussion
CNO/CMO escalations	Covid fifth wave is being seen. Increase in inpatients now at 98 with a mix of primary and incidental. There are multiple Covid outbreaks and increased staff sickness. Mask wearing is now in place in all clinical areas. High acuity and attendances have presented in ED leading to the opening of the ITU corridor to enable 3 WMAS crews to be released. This has now been closed, however the ongoing significant clinical risk is being held by WAHT and WMAS. The Trust has pushed for boarding in the H&CT and for support from the CCG regarding discharge to nursing homes. The position is easier today but the Trust continues to work to level 4 actions. Thanks were expressed to the staff for their support. A never event had been reported and will be investigated, but no harm has occurred. The Trust has pleased to have been granted Veterans Aware status and is working towards silver status in the Armed Forces Covenant.
Harm Review Report	Paper has been shared with the ICB for assurance to the system. Waiting lists have been reviewed, patients contact and harm identified which was debated in detail. There is a balance between using clinicians to identify harm v clinicians to treat patients and prevent harm and the alternative means of doing this was discussed. Process will be reviewed to focus on higher risk groups such as 104 day cancer, as opposed to 12 hour trolley waits. Level of assurance was debated as being related to the process not the level of harm.
Safeguarding Annual Report	Highlighted focus on PREVENT, noting the Trust has met its obligations and noted PREVENT concerns have increased since lockdown has eased. One case has been shared with CHANNEL. Level 6 assurance on MHA assessments is linked to national issues around demand on tier 4 placements. Safeguarding alerts (CPIS) have been rolled out and risk closed. The areas below level 7 assurance were discussed in turn and plans are in place for each. Committee commended the progress made to Debbie Narburgh and her team.
Infection Prevention & Control Annual Report	4 out of 5 targets were achieved. Bed cleaning was discussed and plans are in place for both WRH and ALX to restore this service. The approach to managing the logistics of the unusual 955 ribotype was noted. The key issues from the report had been debated in detail by Committees over many months and the report was welcomed.
Maternity Services Safety Report	Slipped to previous levels of booking at 12+6. Perinatal mortality is within normal rates. Neonatal death was noted as being unbooked and the investigation is ongoing. 3 HSIB reports waiting to be received. One has been received and an action plan agreed. Training compliance is improving or sustained but this is taking time. CNST skills and drills training is now extended to 18 months not 12. No training was cancelled in May. Turnover reduced in May with several leavers and retirements in March. Some have returned but not all. Vacant consultant post remains. Kennedy report will follow next month. Insight visit from NHSEI has taken place factual inaccuracies are being addressed and any gaps in evidence will be submitted.
Continuity of Carer	Paper required to confirm national ambition of COC being the default model by March 2024. Predominant issue is safe staffing. Expect to be at full establishment by March 2023, with 20 teams to met the requirement. Plan to roll out over a 14 month period with predicated conditions. This will be subject to a full management of change process, which will start in September. This is an ambitious plan, neighbouring trusts are moving more slowly and there is a risk of attrition, but the health outcomes of the COC model were endorsed. A business case will be required across the ICS. Staff views, ways of working, pace of change, engagement and the impact of the same were discussed in detail.

Quality Governance Committee Assurance Report – 30 June 2022

Executive Summary

The Committee met virtually on 30 June 2022 and the following key points were raised:

Item	Discussion
AMU/PDU/Whitespace	MAU as now adjacent to the ED, will move into the whitespace and become the AMU from Tuesday. The old MAU will be cleaned in readiness for the pathway discharge unit (PDU) to open on 11 July. Discharge cell SOP will be revised from next week to support the PDU and the staffing model is being reviewed. Modelling of ambulance handovers will be monitored, but no major difference expected until the following week when the PDU is in place. Report to the next meeting.
Integrated Performance Report	Overall assurance level of 4. High number of cancer referrals and significant ED pressures are ongoing. Numbers of surgery and outpatients DNAs were noted; surgical are often Covid related. Outpatient DNAs are being surveyed to understand the issue. Short notice patients are on standby in some specialities. Kidderminster theatre utilisation was discussed. Fractured NOF pathway LOS was discussed, but some downstream capacity issues were noted at times. TIA achievement of 97% was welcomed.
Enforcement Undertakings	The draft undertakings were discussed and noted
CGG and RMG	The Committee reports were noted.

NHS
Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	14 July 2022
Paper number	Enc G

Infection Prevention Annual Report 2021-22

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

Accountable Director	Paula Gardner, CNO		
Presented by	Tracey Cooper, DIPC	**Author /s**	Tracey Cooper, DIPC

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

Report previously reviewed by		
Committee/Group	Date	Outcome
Clinical Governance Group	7th June 2022	Approved
Trust Management Executive	22nd June 2022 (cancelled due to operational pressures)	Progressed under Executive review
Quality Governance Committee	30th June 2022	Approved

Recommendations	Trust Board is requested to: • Approve the annual infection prevention report for 2021-22, including the statement of compliance with the Hygiene Code and the COVID Board Assurance Framework and the summary annual programme for 2022-23, endorsing a Level 6 assurance overall. • Endorse publication of the report on our public internet site.

Executive summary	• This annual report follows the format of the Code of Practice 2015 (known as the *Hygiene Code*), as required by the Health & Social Care Act (2008)[1], and demonstrates our compliance with the requirements of the Hygiene Code, including our annual statement of compliance. • The report also reflects the COVID-19 Board Assurance Framework[2] which was first issued by NHS England/Improvement the previous year. It is set out using the Hygiene Code framework, and this annual report also provides assurance of compliance with this framework. • Our improvement in standards and achievement of a GREEN rating from NHSEI following their visit on 09-03-22 is also reflected in the report.

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	14 July 2022
Paper number	Enc G

- The report also sets out our priorities and plans to achieve further improvement and reductions in infection in our summary infection prevention improvement plan during 2022-23.
- There is a requirement for Trust Board approval of the annual report, and for it to be made publically available.

References

1. The Health & Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (2015). https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/449049/Code_of_practice_280715_acc.pdf

2. Infection Prevention & Control Board Assurance Framework 2021:COVID-19-19. https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/ipc-board-assurance-framework-v1.5-feb-2021.pdf

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	*BAF Risk 3*

Assurance Level (x)	0	1	2	3	4	5	6	X	7	N/A
Financial Risk	Managing each case of healthcare-associated infection (HCAI) uses resources which could be used more effectively to treat other patients. Increased levels of HCAI will result in increased treatment costs to WAHT, whereas reducing infection will help ensure best use of resources in line with trust strategy.									

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	**End June 22: review of progress with key issues and Q1 performance**					

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	14 July 2022
Paper number	Enc G

Introduction/Background

The Annual Infection Prevention Report 2021-22 accompanies this cover paper.

Issues and options

Recommendations

Trust Board is requested to:

- Approve the annual infection prevention report for 2021-22, including the statement of compliance with the Hygiene Code and the COVID Board Assurance Framework and the summary annual programme for 2022-23, endorsing a Level 6 assurance overall.

- Endorse publication of the report on our public internet site.

Appendix 1: 7 Levels of Assurance Framework

Reference: *Hooper G (May 2019) The NHS has suffered a critical loss of authentic internal challenge. Health Service Journal.*

Seven Levels of Assurance Framework

This paper is presented using the *7 Levels of Assurance* model, as published by Hooper G (May 2019).

7 levels of assurance

Aims:

To ensure desired outcomes are clearly described in all SMART improvement plans such that they include actions to BOTH address specific concerns AND the underlying systemic reasons for this variation.

To mitigate risks of familiarity and self – review by ensuring responsibility for formally evaluating the delivery of an improvement plan and presenting assurance on delivery is NOT given to an individual also responsible for the development and delivery of the improvement/action plan.

To ensure evaluations of delivery include both actions and outcomes of operational and systemic issues, using the seven levels of assurance detailed.

The seven levels of assurance offer trust boards a clear progression from:

levels 0 – 2 rated RED, reflecting actions directed towards specific concerns, with evidence only available regarding delivery of specific actions;

levels 3 – 5 rated AMBER, reflecting actions in the process of being delivered to address both specific and underlying causes for variance;

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a single GREEN rated level 6, representing actions to address both specific and underlying causes for variance being in an advanced stage of delivery, with emerging evidence of the achievement of desired outcomes; and

a final level 7 rated BLUE representing achievement of a sustained improvement, with evidence of delivery of the majority or all of the agreed actions and clear evidence of the achievement of desired outcomes over a defined period of time i.e. three months.

RAG rating	ACTIONS	OUTCOMES
Level 7	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes over a defined period of time ie 3 months.
Level 6	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with clear evidence of the achievement of desired outcomes.
Level 5	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of delivery of the majority or all of the agreed actions, with little or no evidence of the achievement of desired outcomes.
Level 4	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Evidence of a number of agreed actions being delivered, with little or no evidence of the achievement of desired outcomes.
Level 3	Comprehensive actions identified and agreed upon to address specific performance concerns AND recognition of systemic causes/reasons for performance variation.	Some measurable impact evident from actions initially taken AND an emerging clarity of outcomes sought to determine sustainability, with agreed measures to evidence improvement.
Level 2	Comprehensive actions identified and agreed upon to address specific performance concerns.	Some measurable impact evident from actions initially taken.
Level 1	Initial actions agreed upon, these focused upon directly addressing specific performance concerns.	Outcomes sought being defined. No improvements yet evident.
Level 0	Emerging actions not yet agreed with all relevant parties.	No improvements evident.

Worcestershire Acute Hospitals NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

INFECTION PREVENTION & CONTROL

ANNUAL REPORT 2021-2022

Authors:

Paula Gardner, Chief Nursing Officer

Tracey Cooper, Director of Infection Prevention & Control

Dr Emma Yates, Consultant Microbiologist and Co-Infection Control Doctor

Dr Eftihia Yiannakis, Consultant Microbiologist and Co-Infection Control Doctor

Zeshan Riaz, Antimicrobial Pharmacist

PULL TOGETHER TO PREVENT INFECTION

Index

Foreword

I am pleased to introduce our annual infection prevention and control report for 2021-22. The continuing pandemic this year has reinforced the importance of good infection prevention practices as part of everything we do across the NHS.

Like 2020-21, the year has been dominated by the COVID-19 pandemic and our annual report reflects this. Our focus on cleanliness, antimicrobial prescribing and other hygiene measures has continued during the year to ensure that people are receiving safe and effective care from us.

We are delighted that NHS England/Improvement have awarded us a GREEN rating for infection prevention and control following their visit in March 2022, confirming assurance of embedded good practice.

We remain committed to ensuring that we achieve very high standards of infection prevention practice. The Trust Board views this as a priority for our patients as part of our commitment to *Putting Patients First.* The Quality Governance Committee continued to scrutinise our infection prevention progress quarterly on behalf of the Board throughout 2021-22.

Paula Gardner, Chief Nursing Officer

This annual report follows the format of the Code of Practice 2015 (known as the *Hygiene Code*), as required by the Health & Social Care Act (2008)[1], and demonstrates our compliance with the requirements of the Hygiene Code.

The report also reflects the COVID-19 Board Assurance Framework[2] which was first issued by NHS England/Improvement the previous year. It is set out using the Hygiene Code framework, and this annual report also provides assurance of compliance with this framework.

Many of the control measures required to prevent the spread of COVID-19 build upon existing infection prevention practices. Therefore, the measures we have taken during 2021-22 to prevent spread of COVID-19 have also been improvements which help us to prevent the spread of other infections.

The report also sets out our priorities and plans to achieve further improvement and reductions in infection during 2022-23 as we move beyond the challenge of the COVID-19 pandemic.

Tracey Cooper, Director of Infection Prevention & Control (DIPC)

Executive Summary

Criterion 1: Systems to manage and monitor the prevention and control of infection.

- Leadership and governance arrangements are in place in line with Hygiene Code requirements.
- Our organisational incident command and control arrangements remained in place throughout 2021-22 and continued to co-ordinate our response to the pandemic.
- A multi-disciplinary Infection Prevention & Control Team is in place, including nursing, administration and data support, microbiology, and an antimicrobial pharmacist.
- We met 4 of our 5 national infection reduction targets: E coli bacteraemia, MRSA bacteraemia, *Pseudomonas aeruginosa* bacteraemia, and *Klebsiella species* bacteraemia. We did not meet our national target for *Clostridioides difficile* reduction, or our internal reduction target for MSSA bacteraemia.
- A range of actions were taken during the year to identify and implement key improvements needed so that we can achieve the infection reductions needed.
- Our *Key Standards to Prevent Infection* are a core part of our programme.
- Following review by NHSEI in March 2022 we have achieved a GREEN rating for infection prevention and control.

Criterion 2: Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

- Our deep cleaning teams remain an embedded part of our cleaning programme.
- We have continued monitoring our cleaning standards using the national Credits4Cleaning system and ensured results are available for all staff on the trust electronic quality reporting system.
- All our sites achieve over 95% compliance to the cleaning standards, and our clinical areas consistently meet the required national cleaning standards for their category of risk.
- We have implemented the new National Standards of Cleanliness (2021), and display our Star Ratings outside our clinical areas.
- We have scrutiny processes in place where concerns about cleanliness are identified.

Criterion 3: Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.

- We have made significant progress in antimicrobial stewardship in 2021-22.
- All Divisions have Divisional Board approved action plans to improve AMS and have improved their assurance levels during 2021-22 with four Divisions at level 6 and one at level 5.
- We are seeing increasing ward and medical participation and engagement with antimicrobial stewardship reviews through our *Start Smart Then Focus* (SSTF) monthly audits.
- An extensive review and update of the Trust Antimicrobial Treatment Guidelines has been published.
- Following review and update of the Trust neutropenic sepsis guidelines, we have seen a significant decrease in carbapenem antibiotic usage with data demonstrating continuing reductions. We are no longer a high outlier for carbapenem use.

Criterion 4: Provide suitable accurate information on infections to service users, their visitors and person concerned with providing further support or nursing/medical care in a timely fashion.

- Information on our *Key Standards to Prevent Infection* are displayed across the Trust. This includes wards displaying their achievement of the standards required.
- Our internet contains key information for our patients and visitors, and we have used social media to share key messages to the public, especially during the pandemic.
- As an additional support we have continued to ensure our public entrances are staffed during 2021-22, so that patients and visitors can be guided in use of facemasks and hand gel to reduce risk of infection spread, and they can also be directed to the department they need to visit.
- As well as virtual visiting we have gradually re-opened to visiting during 2021-22, in line with evolving national guidance. Visitors are now able to book their visiting slot via an internet app, to ensure we can support visitors whilst minimising the risk of COVID-19 spreading in our wards.
- Part of our pandemic response continues to include sharing of a daily report with other care providers clearly setting out any areas where we had COVID-19 outbreaks or concerns, to support decision-making about patient transfers to other organisations.

Criterion 5: Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.

- Assessment tools for infection risks are in use for patients on admission and throughout the in-patient stay. This includes diarrhoea and vomiting as well as COVID-19 infection.
- Our Infection Prevention & Control Team provide a service to advise and support clinical staff on all infection-related queries. During the year the service has provided a 10-hours per day nurse service in addition to the consultant microbiologist on-call service out-of-hours.
- We have point-of-care testing for patients arriving in our Emergency Departments and other admission areas, to rapidly detect anyone positive for COVID-19. This is in addition to routine swabbing of patients, with our laboratory testing the samples and providing results usually within 24 hours.
- A range of non-COVID-19 outbreaks and infection-related incidents have been effectively dealt with in 2021-22. These are listed in Appendix 1.

Criterion 6: Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infections.

- Highly visible senior nursing leadership has been maintained during the pandemic through leadership visits by divisional teams, the DIPC and the Chief Nursing Officer.
- Statutory and mandatory training and Trust induction continue to include infection prevention & control as core requirements.
- At the end of 2021-22 mandatory level 1 training (non-clinical staff) achieved 95% compliance meeting the Trust requirement. Level 2 training (clinical staff) was at 85% compliance.
- A very significant amount of ward-based training, electronic resources and posters have been put into place to support staff knowledge and awareness as the pandemic continued to evolve and guidance changed during 2021-22.
- We have taken action on the learning from our review process for cases of *Clostridioides difficile* infection and MSSA bacteraemia. As a result of our reviews we a good understanding of the causes of these infections, and have quality improvement measures focussed on reducing these infections.

Criterion 7: Provide or secure adequate isolation facilities.

- The Trust has over 130 single rooms available to support isolation requirements.
- Trust policy includes use of cohort facilities to nurse patients with the same infections when numbers exceed the number of single rooms.
- This cohort model has been used extensively during the pandemic, with wards for COVID-19 patients being flexed up and down depending upon the number of patients infected.
- Throughout the year we have amended our processes in response to the changing national guidance for the management of COVID-19 infection.

Criterion 8: Secure adequate access to laboratory support.

- We have an onsite microbiology laboratory which is accredited by UKAS, confirming it operates an effective and quality controlled service.
- The laboratory links with regional and national laboratory networks as required to provide a full range of microbiology testing.
- In 2021-22 the laboratory provided sufficient capacity for on-site testing of all COVID-19 swabs for our patients and staff displaying symptoms.
- In 2022-23 the laboratory will implement molecular based testing for enteric pathogens including a wider range of viruses to assist in the control of infection.

Criterion 9: Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.

- Our *Key Standards to Prevent Infection* has been the cornerstone of good clinical practice during 2021-22.
- Use of national High Impact Intervention audit tools to monitor compliance with our Key Standards monthly. Results are available for all staff to view on our electronic quality reporting system, helping support improvement.
- Our policy review programme has been progressed, with the few outstanding policies in the process of being reviewed.
- Throughout the year we have implemented a wide range of policies and procedures to manage COVID-19, in line with national guidance.
- Participation in hand hygiene audit is 94.6% and hand hygiene practice compliance has remained high and has met our target of 99%.

Criterion 10: Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

- Our Occupational Health Service along with Human Resources Team (Health, Wellbeing and Flexible working) supports the health and wellbeing of our staff, as well as the staff of our PFI partners.
- A health monitoring and vaccination programme is in place
- In 2021-22 we did not meet our staff influenza vaccination target, achieving 64%.
- During the pandemic the Occupational Health Service and our Human Resources Team have provided a significant amount of support to staff, including counselling and psychological support. There continues to be a focus on staff health and wellbeing.

The COVID-19 Pandemic

The pandemic continued through the whole of 2021-22, and has been unprecedented in scale and impact on the whole of the NHS. We put in place a co-ordinated and effective incident command structure which continued to operate through the year. We have performed several self-assessments of our compliance with the requirements in the COVID-19 Board Assurance Framework during 2021-22 most recently version 1.8 (December 2021), and have confirmed we comply with the requirements set out in this document.

This section of the report focuses on a summary of the actions we have taken to protect staff and patients from infection, as well as reporting information on hospital-acquired infection and outbreaks.

Healthcare Associated Infection

COVID-19 is reported to have an incubation period (the time between catching the infection and showing symptoms) between 1-11 days. This means someone can be admitted to hospital with no symptoms and test negative for COVID-19, despite having already caught the infection. National guidance sets out the following definitions for categorising COVID-19 infections which are detected during admission to hospital:

Community acquired	Onset day 0-2
Hospital onset – indeterminate acquisition	Onset Day 3-7
Hospital onset – probable hospital acquired	Onset day 8-14
Hospital onset – definite hospital acquired	Onset day 15 onwards

*The day of admission is Day Zero.

Throughout 2021-22 we have continued to care for large numbers of patients with COVID-19 infection. We have monitored healthcare-associated infection closely, declaring and managing outbreaks of infection in line with national guidance.

For the year 21-22, we cared for 1785 patients with COVID-19 infection. Of these, 190 were determined to be probably or definitely acquired in hospital. This is 10.6% of all COVID-19 patients. Detail is set out in the table below:

Category	Category description	Total
1. Community-Onset	Positive specimen date <=2 days after admission to Trust	1379
2. Hospital-Onset Indeterminate Healthcare-Associated	Positive specimen date 3-7 days after admission to Trust	216
3. Hospital-Onset Probable Healthcare-Associated	Positive specimen date 8-14 days after admission to Trust	113
4. Hospital-Onset Definite Healthcare-Associated	Positive specimen date 15 or more days after admission to Trust	77
Total		**1785**