Worcestershire Acute Hospitals NHS Trust

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

Sir David Nicholson
Chairman

Agenda			Enclosure
1	**Welcome and apologies for absence:**		
2	**Patient Story**		
3	**Items of Any Other Business** *To declare any business to be taken under this agenda item.*		
4	**Declarations of Interest** *To declare any interest members may have in connection with the agenda and any further interest(s) acquired since the previous meeting.* Sir David Nicholson has been appointed Chairman of Sandwell and West Birmingham NHS Trust. Rebecca O'Connor, newly appointed Company Secretary, has submitted a nil return.		
5	**Minutes of the previous meeting** *To approve the Minutes of the meeting held on **11 February 2021** as a true and accurate record of discussions.*	*For approval*	**Enc A** **Page 3**
6	**Action Log**	*For noting*	**Enc B** **Page 12**
7	**Chairman's Report**	*Verbal*	
8	**Chief Executive's Report**	*For noting*	**Enc C** **Page 14**
9	**Strategy**		
9.1	**COVID -19 Update** Chief Operating Officer	*For assurance*	**Enc D1** **Page 16**
9.2	**Update on ICS and Trust Action Plan** Director of Strategy and Planning	*For noting*	**Enc D2** **Page 32**
9.3	**Annual Planning Restoration and Medium Term Financial Strategy** Director of Strategy and Planning/Chief Operating	*For noting*	**Enc D3** **Page 38**

Officer/Chief Finance Officer

10	**Performance**		
10.1	**Integrated Performance Report**	*For assurance*	**Enc E**
10.1.1	**Executive Summary/SPC Charts/Infographic** Chief Executive/Executive Directors		**Page 45**
10.2.2	**Committee Assurance Reports** Committee Chairs		**Appendix 3** **Page 113**
11	**Governance**		
11.1	**Nursing and Midwifery staffing report – December 2020 and January 2021** Chief Nursing Officer	*For assurance*	**Enc F1** **Page 118**
11.2	**CQC Inspection Report - Maternity December 2020** Chief Nursing Officer	*For assurance*	**Enc F2** **Page 138**
11.2	**Going Concern** Chief Finance Officer	*For approval*	**Enc F3** **Page 201**
11.3	**Trust Management Executive** Chief Executive	*For assurance*	**Enc F4** **Page 208**

Any Other Business *as previously notified*

Date of Next Meeting
The next public Trust Board meeting will be held on 22 April 2021, virtually.

PRIVATE TRUST BOARD

Currently no items for a private Trust Board meeting

Enc A

Worcestershire Acute Hospitals NHS Trust

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

Present:		
Chairman:	Sir David Nicholson	
Board members: (voting)	Waqar Azmi	Non-Executive Director
	Paul Brennan	Deputy Chief Executive/Chief Operating Officer
	Anita Day	Non-Executive Director
	Mike Hallissey	Chief Medical Officer
	Matthew Hopkins	Chief Executive
	Dame Julie Moore	Non-Executive Director
	Vicky Morris	Chief Nursing Officer
	Robert Toole	Chief Finance Officer
	Bill Tunnicliffe	Non-Executive Director
	Mark Yates	Non-Executive Director
Board members: (non-voting)	Richard Haynes	Director of Communications and Engagement
	Colin Horwath	Associate Non-Executive Director
	Jo Newton	Director of Strategy and Planning
	Tina Ricketts	Director of People and Culture
	Sharon Thompson	Associate Non-Executive Director
In attendance	Simon Adams	HealthWatch
	Siobhan Gordon	Head of Quality Hub & Healthcare Standards Patient *item 140 /20 only*
	Justine Jeffery	Divisional Director of Midwifery and Gynaecology Nursing *items 149/21/1 and 2 only*
	Rebecca Brown	Deputy Chief Digital Officer
	Rebecca O'Connor	Company Secretary Designate
	Martin Wood	Deputy Company Secretary
Public	10	Via YouTube
Apologies	Vikki Lewis	Chief Digital Officer
	Richard Oosterom	Associate Non-Executive Director

139/20 **WELCOME**

Sir David welcomed everyone to the meeting, including those viewing via YouTube. He particularly welcomed Loraine Mahachi who is undertaking a reverse mentoring arrangement with Mrs Morris and is shadowing Mrs Morris at this meeting.

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

Sir David referred to the sadness at the recent death of Peter Pinfield, Chair of Healthwatch. He had known Peter for many years. Peter represented the views of

patients and public and at national events was often seen on the front row providing challenge. Peter will be greatly missed by his family, those who knew him and by the NHS.

140/20 **PATIENT STORY**

Sir David explained that each Board meeting starts with a patient story. He was pleased to welcome Siobhan Gordon who was a patient and is also our Head of Quality Hub and Healthcare Standards.

Siobhan gave her story of when she required urgent treatment due to a sudden onset of symptoms for a gastroenterology problem. Coming into hospital when you experience a sudden deterioration in your health can be a frightening and bewildering experience. Having to be admitted during the COVOD-19 pandemic brings further fears and anxieties. Siobhan provided her account of her experience through the Emergency Department, Surgical Assessment Unit and Beech B (surgical ward) at Worcestershire Royal Hospital in November 2020.

Having completed the NHS 111 APP form the guidance was that she should present at her local emergency department. On arrival at the emergency department she was informed that she had not followed the correct process and should not be there. However, the nurse let her in. Whilst in hospital the expectations were laid out to Siobhan about her role in keeping herself safe such as staying in her bay, wearing a mask, hand washing and using the call bell rather than wandering into other areas looking for a nurse. This was by far the best experience she had ever had as a patient in a safe clinical environment. Siobhan was able to rest because her family did not feel the need to all turn up every day meaning she could rest and sleep. She was able to contact home or family on her terms. She felt dignified to be able to move back and forth to the rest room without a room full of people she did not know. Staff on Beech B were particularly helpful.

Siobhan found the aftercare process confusing. On discharge she was told she would need a further test in about six weeks' time. However, the week following discharge an appointment was received for the test at Kidderminster Treatment Centre but two days after the appointment notification it was agreed that this was too early and cancelled. Another appointment has been held but no indication when the next appointment will be other than that it would be at a different venue.

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

- Ms Day commented that 111 had not worked as intended giving a poor experience on first interaction with our Emergency Department. Siobhan said that she was aware of the change to contact 111 and our Trust were not as well versed with that process as in other Trusts. Siobhan felt in the way. However, the rest of the experience was positive.
- In response to Mr Yates, Siobhan said that although she was a member of staff she was not known on wards and in all areas she was treated with the same level of care and compassion.
- In response to Dr Tunnicliffe, Siobhan said that whilst the Family Liaison Service was not yet in place during her stay she was able to easily contact her family. The wi-fi was excellent.
- Mr Horwath asked how we would maintain the calmness in wards when services are restored. In response, Mrs Morris said that there is a balance in providing the care patients need with increasing activity.
- Sir David thanked Siobhan for articulating her experience following her visit to our Trust. He invited the Executive Team to reflect on ensuring that the right

publicity is in place for 111 to help people understand the process for attending the Emergency Department. There is now an opportunity as we begin to restart services to look at how we can introduce visiting in a different way. Engagement will be necessary with patients and public how we do this. We need to understand what created the issues following discharge which undermined the positive experience.

141/20 **ANY OTHER BUSINESS**
There were no items of any other business.

142/20 **DECLARATIONS OF INTERESTS**
The Board noted that the full list of declarations of interest were on the website.

143/20 **MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON 14 JANUARY 2021**
RESOLVED THAT the Minutes of the public meeting held on 14 January 2021 be confirmed as a correct record and signed by the Chairman.

144/20 **MATTERS ARISING/ACTION SCHEDULE**
Mr Wood reported that five actions had bed deferred due to COVOD-19, two were for a future meeting and three had been completed.

145/20 **CHAIRMAN'S REPORT**
Sir David had nothing further to report.

146/20 **CHIEF EXECUTIVE'S REPORT**
In presenting his report, Mr Hopkins paid tribute to Peter Pinfield, Chair of Healthwatch, who had sadly passed away at the end of January 2021. He had worked with Peter over the last two years. His emotional intelligence had always shone through. Peter represented the publi's concerns and often raised then informally. Peter provided challenge and support and his approach will be greatly missed.

Staff continue to rise to the challenges of COVID and had successfully staffed the vaccination hub on the Alex site. We need to redouble our efforts to support front line staff and protect them from verbal abuse being experienced by our staff from some relatives, patients and members of the public, who are unwilling to comply with Government guidance on our premises. He referenced the letter of appreciation received from the West Midlands Ambulance Service.

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

- Ms Thompson acknowledged the good levels of communication and asked if there is any collective communication with our partners to get the message across jointly about COVID, vaccination and preventing staff abuse. In response, Mr Hopkins said that a variety of communication routes are used with stakeholders including MPs and Councillors. He acknowledged that there is always more which could be done. Mr Haynes added that he works closely with colleagues in the CCG and Health and Care Trust and the Local Authority around COVID and the vaccination programme. There will be engagement with partners so that one message is delivered about restoration of services. He acknowledged that we need to reach all audiences.
- Mr Azmi referenced the huge impact COVID is having on our staff and asked for information on our support to staff particularly as we plan to restart services. In response, Mr Hopkins said that we have increased our staff offer of support and have a comprehensive package in place. Currently there is no restoration plan in place and discussions are ongoing as to what that plan might look like when we exit wave 2. Ms Ricketts added that an infographic of the support available is

being widely publicised as staff may not realise the support available to them. There are three areas being prioritised, recognising what staff have encountered, how to retain staff with extended breaks and to maintain staff wellness. Dr Tunnicliffe congratulated Ms Ricketts and the Executive Team for the good support offer. He expressed concern that nationally we do not have the right level of support and there should be a push for proper recognition.

- Sir David recognised that we continue to learn to improve communication messages. It is right that there is proper recognition for staff who we need to continue to support as we develop our restoration plans which must be at a pace to enable us to provide that support.

RESOLVED THAT: The report be noted.

147/20 **STRATEGY**

147/20/1 **COVID- 19 Longer View Update**

Mr Brennan presented the report providing a broad and long view of the current wave of Covid-19 and its impact on our Trust. Specifically around inpatient numbers and trends, a comparison of deaths and treated patients. The report provided a comparison between the first and second waves of the pandemic. There is some reduction in the number of cases although they continue to be above those in wave 1. In wave 1 there were 760 COVID patients with a mortality rate of 32%. In wave 2 there were 1,500 COVID patients with a mortality rate of 24%. The maximum number of patients in wave 1 was 142 with the peak in wave 2 of 260. The current number is 175 which remains above wave 1. There are 740 general and acute beds with the peak in wave 2 occupying 46% of those beds. Today this is 36%. There is a higher rolling seven day average in wave 2 of 35 patients which today has reduced to 16. The number of positive patients reduced sharply in wave 1 which is not being seen to that extent in wave 2. We continue to operate at alert level 5 with ITU surge capacity over 200%.

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

- Mr Horwath asked when we expect the decline in patient numbers to increase, the impact of the vaccination programme and whether this will change the age profile of patients. In response, Mr Brennan said that the current view is that it will not be until the first week of March 2012 that number will be around the peak of wave when we will be able to increase activity. Cancer activity has increased on the Worcester site during the last two weeks.
- Ms Day asked whether there are any indications on the number of long patients between the two waves. In response, Mr Hallissey said that the CCG are undertaking a project to understand the impact of long COVID patients in the community and the impact between the two waves is not yet known. Mr Brennan added that we have not seen any long COVID patients in our hospitals.
- In response to Mr Azmi, Mr Brennan said that the age, gender and ethnicity of COVID patients will be included in the next report.
- Sir David said that it is too early to assess the impact of the vaccine. He stressed the importance to adhere to the national guidance of wearing face masks, maintaining social distancing and hand washing. He again expressed on behalf of the Board the remarkable work of staff which he found humbling.

RESOLVED THAT The Trust Board received the report for assurance.

147/20/2 **Update on ICS and Trust Action Plan**

Mrs Newton presented the report saying that implementation of the ICS action plan continues whilst awaiting the outcome of the designation process. Unless further

national guidance is provided it is assumed that the target date for full implementation remains April 2022. Following a board development session in December 2020, the Executive Team have reviewed the outputs to produce an eight point action plan aligned to our latest understanding of ICS development and timings. We have been invited to become involved in developing themes reflecting the Region's view of our level of maturity.

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

- Ms Day recognised the good progress being made but said we need to work differently to be effective in the system. She referenced the collaboration taking place with the Chairs of the respective Audit and Assurance Committees. Mrs Newton commented that Dave Mehaffey, the new ICS programme Director, is leading a piece of work to develop a blended approach to better understand how our partners work.
- Mr Yates reported that the ICS Executive Forum has accepted a report which will act as a catalyst for partners to work more closely. We have made improvements in the last four years on collaboration and he congratulated the Executive Team on those improvements. We need to continue with those improvements.
- Mr Horwath in recognising the importance of the digital programme questioned whether the digital plan is too ambitious. In response, Mrs Newton explained that as a system we need to catch up on data to create the platform to develop PLACE.
- Mr Azmi referenced the eight point action plan asking where engagement formed part of that plan. In response, Mrs Newton said engagement is part of our behaviours and fits with objectives 1 and 2. There will be internal communications and engagement.
- Mr Haynes said that the STP communications plan was prepared in 2018 and the update has paused due to COVID. He will share that version for comment.

ACTION – **Mr Haynes** to share for comment the current STP Communication Plan.

- Mr Hopkins said that the Executive Team is providing leadership on the development of the ICS. In particular, Ms Ricketts is the Executive Lead for people and culture, Mr Brennan is leading with Mr Hallissey and GP leaders on developing elective planned care building on the work during COVID and Mr Toole is developing financial action plans.
- In summary, Sir David said that progress is being made; however, we need to work through and confront the issues as they arise.

RESOLVED THAT:-

- **The update on ICS development be noted.**
- **The Trust internal action plan be endorsed.**

147/20/3 **Update on Annual Planning 2021/22**

Mrs Newton presented the report describing the implications for our Trust and our proposed response to the announcement by NHSE/I on 13 January 2021 that a planning and contracting round would not be initiated before the end of March 2021 because of COVID pressures and that the current financial arrangements will be rolled over to quarter 1. We will work with our system partners to support the development of the Herefordshire and Worcestershire STP/ICS plans and operating framework.

Mr Toole added that background work is taking place to prepare a budget for quarter 1 whilst we awaiting details of the financial framework.

Sir David commented that it is deeply unsatisfactory for our Trust not to known its next year's financial position. It is important that a proper budget is issued as soon as possible to enable financial performance to be measured. We need to continue to reduce our cost base.

RESOLVED THAT:-

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

148/20 **PERFORMANCE**

148/20/1 **Integrated Performance Report**

148/20/1/1 **Executive Summary**

In introducing the report, Sir David said that the Integrated Performance Report has been scrutinised by the Board Committees.

Mr Hopkins presented the report for month 9, December 2020 saying that the focus has been on the BAF risks. The areas of challenge identified were the impact of COVID-19, long waiters, infection prevention and control, the Ockenden Report and people and culture issues.

Mrs Morris drew attention to the pathway changes which were now for COVID and Non-COVID patients. There had been 26 hospital acquired infections (HCIAs) with a review how they are being managed.

Ms Ricketts said that there has been an improvement in appraisal, job planning, vacancy and turnover performance. Mandatory training performance has remained constant. The 90% flu vaccination target has been achieved. As at 7 February 2021 the COVID vaccination take up rate was 78% for all staff and 64% for BAME staff. We are working to improve rates with a webinar being held for all staff with an emphasis on BAME staff on the evening of the Board meeting. The completion rates for occupational health risk assessments is 94% for all staff and 89"% for BAME staff which is showing improved performance.

Mr Yates emphasised the improvement in job planning performance where Emergency Department performance is 100% demonstrating that metrics are showing improvements.

Dr Tunnicliffe expressed his appreciation to Mrs Cooper for her work on infection, prevention and control noting that MSSA performance in month was within target although the year end target has already been exceeded.

RESOLVED THAT: The report be received for assurance.

148/20/1/2 **Committee Assurance Reports**

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

149/20 **GOVERNANCE**

149/20/1 **Nursing and Midwifery Staffing Report – October – November 2020 with a**

situation report 13/01/2020 0f the response for the COVID – 19 third wave
Mrs Morris presented the report providing an overview of the staffing safeguards for Nursing and Midwifery during October and November 2020. She highlighted Appendix 1 to the report which provided an account of staffing measures and actions taken through December 2020 to 13 January 2021 following the expediential rise of COVID 19 patients requiring care from 1st January 2021. From that date a step by step redeployment of nursing/allied health care/health scientists has taken place. A blended team model of care has been provided in ITU. Medical staffing has been used for nursing input. 165 whole time equivalent staff have been required for ITU with 119 staff being redeployed. Mrs Morris thanks all staff for their valuable input.

Mrs Jeffery explained the background to midwifery staffing saying that activity had increased with the unavailability of team due to COVID and staff vacancies. Mitigating actions had been put in place to provide safe care. Care was not to the level we would wish to provide but it was safe. There has been a good response to the staff advertisement. The position has improved since December 2020.

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

- Dr Tunnicliffe observed that the Friends and Family response rate had dipped and there is learning for the test to be carried out. He questioned whether Wye Valley staffing should be brought to our Trust rather than sending patients to Wye Valley. Recruitment has taken place to 10 additional nursing posts and he asked whether our staffing in October 2020 was too lean. In response, Mrs Jeffery said that there are opportunities to recruit twice a year. The impact of COVID on staff travelling and shielding could not have been anticipated. Following a change in the rules, staff returning to work were not able to provide face to face care. The new IT system was also being implemented. These factors created a “perfect storm”. Mrs Jeffery said that patients were given the opportunity on a care by care basis whether they wished to go the Wye Valley Trust.
- Mrs Jeffery explained that staff raised concerns over the staffing situation in September 2020. In October 2020 six open staff meetings took place to hear concerns on the impact of changes on their ways of working with the main concern that they were not able to provide the level of care expected. An action plan has been developed and staff meetings continue. Mr Yates added that the People and Culture Committee had looked at staffing across the Trust and in particular during COVID and in the maternity service. They looked at blended care and gained an understanding of safest care. The Committee were assured that safe staffing had been provided but on occasions it was sub optimal but at no stage was it unsafe.
- Mr Hopkins said that we need to promote a culture where staff feel safe to raise concerns and are supported. Freedom to Speak Up Champions are available for staff to raise concerns.

RESOLVED THAT
Trust Board are requested to note:

- **Staffing of the wards to provide the ‘safest’ staffing levels for needs of patients being cared for throughout October and November have been achieved through mitigations in real time having been taken for challenged areas identified – Maternity department and Alexandra site.**
- **Workforce plans have been instigated to redeploy staff to support patient care needs in adult wards and critical care units following the surge in Covid 19 infections**
- **A vaccination hub commenced at the Alexandra in December requiring**

staffing to support staff and patients to received Covid 19 vaccination.

149/20/2 **Ockenden Report – Review Gap Analysis**

In introducing the report Sir David said that he had visited the maternity unit on the Worcester site earlier in the week and his observations from that visit were that communication is important and cannot be under estimated to convey the most simplest of messages. Also, there have been dramatic changes in the way the service is delivered particularly around the introduction of the continuity of carer requirement. Change is difficult to implement. The view of staff is that this is the right approach for the benefit of mothers and their babies. He thanked Mrs Jeffery for the excellent work in challenging circumstances.

Mrs Morris said that the Ockenden report was published in December 2020 following an investigation into the safety of the maternity services at Shrewsbury and Telford NHS Trust. Following the publication of that report Trusts were asked to provide assurance against eight categories outlining 14 immediate safety actions. A gap analysis was completed and the Division were able to demonstrate compliance with seven of the 14 immediate actions. In a further six areas a gap had been noted and actions identified to meet the standard were outlined in the report.

Mrs Jeffery presented a slide summarising since report preparation the actions taken and the next steps.

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

- Mr Hopkins said the he and Mrs Morris had conducted a challenge session on the gap analysis to test that the right actions are being undertaken and this was confirmed. As lead for the LMNS, Mr Hopkins said that two of the Ockenden Report recommendations impact on the wider system. Firstly, the recommendation for the chair of the LMNS to have a clinical background impact on our LMNS where the chair is currently a Non-Executive Director from the Wye Valley Trust with Mr Hopkins as the SIRO. This arrangement works well. Secondly, the recommendation that the chair of the Maternity Voices Partnership must not be a clinician does not necessarily address our issue in that the current chair is a retired professor of midwifery and is highly challenging of service users in the County.

RESOLVED THAT The gap analysis; the actions identified and support the Division to demonstrate compliance be noted.

149/20/3 **Maternity Serious Incident Report Quarter 3 (September – December 2020)**

Sir David introduced the report for assurance.

RESOLVED THAT The Serious Incidents reported in Maternity in Q3 – October – December 2020 contained within the report and the Ockenden recommendations for the reporting and scrutiny of all serious incidents be noted.

149/20/4 **Audit and Assurance Committee Report**

Sir David invited Ms Day to present her first report as Chair of the Committee. Ms Day drew attention to the three internal audit reports and the improvements made in the assurance levels where the BAF was level A and Health and Safety Follow Up and Governance Arrangements Divisions Review where significant assurance was provided. The external auditors' commencement of the audit of the annual accounts was delayed due to COVID and this is currently not seen as a risk although information will be required to be provided from teams within a shorter timeframe.

RESOLVED THAT the report be noted for assurance.

150/20 **DATE OF NEXT MEETING**

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

The meeting closed at 12.04 pm.

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

Enc C

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

PUBLIC TRUST BOARD ACTION SCHEDULE – MARCH 2021

RAG Rating Key:

Completion Status	
	Overdue
	Scheduled for this meeting
	Scheduled beyond date of this meeting
	Action completed

Meeting Date	Agenda Item	Minute Number (Ref)	Action Point	Owner	Agreed Due Date	Revised Due Date	Comments/Update	RAG rating
12-11-20	Patient story	82/20	Review training for staff on iPads	VL	Jan 2020	March 2021	IPAD refresher training has been offered to the maternity team. Action closed.	
12-11-20	Patient story	82/20	Consider the use of volunteers for breast feeding support	VM	Mar 2020		Each year prior to the Covid-19 pandemic about 20 volunteers were recruited to undertake breastfeeding training to enable them to help new mothers and breastfeeding. Our volunteers tend to be with us for about 6 months, then move on, but we have had a few who have stayed a lot longer. In 2020 we had to defer this programme but hope that as soon as we are able, we will resume volunteers for breast feeding support. Action closed.	

11-02-21	Update on ICS and Trust Action Plan	147/20/1	Share for comment the current STP Communication Plan.	RH	Mar 2021		Plan circulated for comment. Action closed.	

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	11 March 2021
Paper number	Enc C

Chief Executive Officer's Report

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

Accountable Director	Mathew Hopkins Chief Executive Officer		
Presented by	Mathew Hopkins Chief Executive Officer	**Author /s**	Martin Wood Deputy Company Secretary

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

Report previously reviewed by		
Committee/Group	Date	Outcome

Recommendations	The Trust Board is requested to • Note this report

Executive summary	This report is to brief the board on various local and national issues. Items within this report are as follows: • CQC Maternity Services Inspection Report • Health and Wellbeing Conversations • Letter from Regional Director of NHS Midlands on the success of COVID vaccination programme in our area • BAME network webinar on Covid-19, the vaccine and PPE

Risk			
Which key red risks does this report address?	N/A	**What BAF risk does this report address?**	N/A
Assurance Level (x)	0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | N/A		X
Financial Risk	N/A		

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

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

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	11 March 2021
Paper number	Enc C

Issues and options

CQC Maternity Services Inspection Report: The Care Quality Commission's report into Maternity Services following the unannounced inspection in December 2020 was published on Friday 19 February 2021**.** It is disappointing that the rating for our Maternity Services has been reduced to "Requires Improvement" although three of the five domains remain rated as "Good". The Women and Children Division and Executive Team continue to implement the improvement plan in response to the report. The full report appears as a separate agenda item on the Trust Board papers.

Health and Wellbeing Conversations: In order to put patients first, we all need to look after ourselves and our colleagues. We want to create a culture where staff wellbeing and wellness form part of the day to day interactions between leaders, line managers and their teams. Three tools have been developed to support these conversations - a personal wellbeing action plan, wellbeing conversation crib sheet and a health and wellbeing pinwheel. The aim of these tools is to help line managers to reflect with their teams on factors both at work and at home that might adversely impact on health and wellbeing, to identify actions to prevent and reduce these issues and to signpost individuals to support and advice where they would benefit from further help, including mental health support.

Letter from Regional Director of NHS Midlands on the success of COVID vaccination programme in our area: I have received a letter from Dale Bywater, Regional Director of NHS Midlands, recording his gratitude to our team for the excellent progress to date with the design and delivery of the COVID-19 vaccination programme in our system. It is pleasing to receive this recognition for all the hard work undertaken in delivering the vaccination programme. I have shared the letter with key members of our vaccination team who have played such a vital part in this huge and complex programme..

BAME network webinar on Covid-19, the vaccine and PPE: On the evening of our last Trust Board meeting we held a special webinar arranged by the Black, Asian and Minority Ethnic (BAME) Network discussing the BAME uptake of the COVID-19 vaccination and safe use of Personal Protective Equipment. This webinar was chaired by Sir David Nicholson with guest speakers including our Non-Executive and Executive Directors and Professor Wei Shen Lim, Member of the Joint Committee on Vaccination and Immunisation and Consultant Respiratory Physician at Nottingham University Hospitals.. As reported elsewhere in the papers, the uptake of the vaccine by BAME staff remains below the uptake for the trust staff in general.

Conclusion

Recommendations

The Trust Board is requested to

- Note this report

Appendices - None

NHS
Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

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

Covid-19 Update

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

Accountable Director	Paul Brennan, Deputy Chief Executive & Chief Operating Officer		
Presented by	Paul Brennan, Deputy Chief Executive & Chief Operating Officer	**Author /s**	John Reading, Information Manager

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

Report previously reviewed by		
Committee/Group	Date	Outcome

Recommendations	Trust Board is invited to note this report for assurance.
Executive summary	The downward trend in the number of patients with Covid-19 admitted to the Trust is continuing with the last week of February 2021 showing: ▪ If admissions and discharges continue at the same rate as the last 7 days, the total Trust COVID inpatient cohort should drop below 100 in the next 7 days. ▪ Despite continuing to operate at over 150% normal capacity, ITU has seen reductions in patient numbers. ▪ Although continuing to see a downward trend in COVID inpatient numbers, the discharge numbers are beginning to reduce. To date this has been offset by the reduction in new diagnoses. ▪ Crude mortality, has worsened since the beginning of 2021, but has improved when comparing January and February 2021. ▪ The admission pathway change in January (COVID/Non-COVID) has produced a reduction in Probable and Definite HCAI numbers on both sites. ▪ The temporary pattern of higher Non Symptomatic admissions has been reversed. This is not to understate some of the current challenges faced: ▪ Any reduction in patient numbers relies on sustaining the current level of patient discharges. ▪ At this point in time we meet two (out of six) of the criteria set for de-escalation and the STP remains at level 5 despite the national level being reduced to 4. ▪ The slowing down of discharges will make meeting the Rolling 7 Day Average COVID Discharges 4 Higher than New Diagnoses criteria more difficult to attain.

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

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

Risk																			
Which key red risks does this report address?				**What BAF risk does this report address?**															
Assurance Level (x)	0		1		2		3		4		**5**	X	6		7		N/A		
Financial Risk																			
Action																			
Is there an action plan in place to deliver the desired improvement outcomes?	**Y**				N				N/A										
Are the actions identified starting to or are delivering the desired outcomes?	**Y**				N														
If no has the action plan been revised/ enhanced	Y				N														
Timescales to achieve next level of assurance	Dependent on community-prevalence																		

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

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

Introduction/Background

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

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

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

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

Issues and options

Current situation, Inpatient numbers and Trends

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

Combined (Since 23 March 2020)

Site	Total No. inpatients	Combined LOS	Discharged (treated)	Died (in hospital)	Combined discharges	Crude mortality rate	Avg LOS (treated)	Avg LOS (died)
ALX	1275	14908	851	377	1228	30.7%	11.1	12.2
WRH	1363	15391	1038	291	1329	21.9%	10.9	12.0
Trust	**2638**	**30299**	**1889**	**668**	**2557**	**26.1%**	**11.0**	**12.1**

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

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

Wave 1 (23 March - 22 September 2020)

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

Wave 2 (23 September 2020 to 26 February 2021)

Site	Total No. inpatients	Combined LOS	Discharged (treated)	Died (in hospital)	Combined discharges	Crude mortality rate	Avg LOS (treated)	Avg LOS (died)
ALX	874	10277	593	234	827	28.3%	10.8	12.9
WRH	1003	11387	778	191	969	19.7%	10.7	12.6
Trust	**1877**	**21664**	**1371**	**425**	**1796**	**23.7%**	**10.7**	**12.8**

Observations:

- The crude mortality rate for Wave 2 has worsened since the beginning of 2021, increasing from 21.2% to 23.7%.
- However, there is no indication that the crude mortality rate will rise further, with the January 2021 rate of 27.72% reducing to 17.76% in February 2021(as at 26th).
- The crude mortality rate for patients admitted during wave 2 continues to show much improvement over those admitted during the earlier part of the pandemic and the net result is an improved combined mortality rate for the life of the pandemic thus far.
- The average LOS (ALOS) for those treated during Wave 2 (10.7) is below the ALOS for Wave 1 (11.6), with very little difference across Trust sites.
- The average LOS (ALOS) for deceased patients during Wave 2 (12.8) is higher than the ALOS for Wave 1 (10.9), with only a small difference across Trust sites.

At the time of writing we have reported 106 inpatients across the Trust who have tested positive for Covid-19 (was 138 last week). There are a further 17 patients who have not yet had a positive PCR sample but are symptomatic and hence being treated as positive.

In the 37 days since reaching the Wave 2 peak of 269 inpatients, there has been a reduction of 60.59% in inpatient numbers. This compares favourably with a 57.45% reduction over the same time frame after the Wave 1 peak of 143.

Over the last week the inpatient cohort has reduced by an average 3.6 patients per day. This has been facilitated by a rolling 7 day average of 7.1 new diagnoses and 1.7 readmissions (where Detected swab taken <=14 days before readmission), accompanied by 9.6 discharges and 2.9 deaths.

On this basis it is probable that the inpatient numbers will drop below 100 in early March 2021.

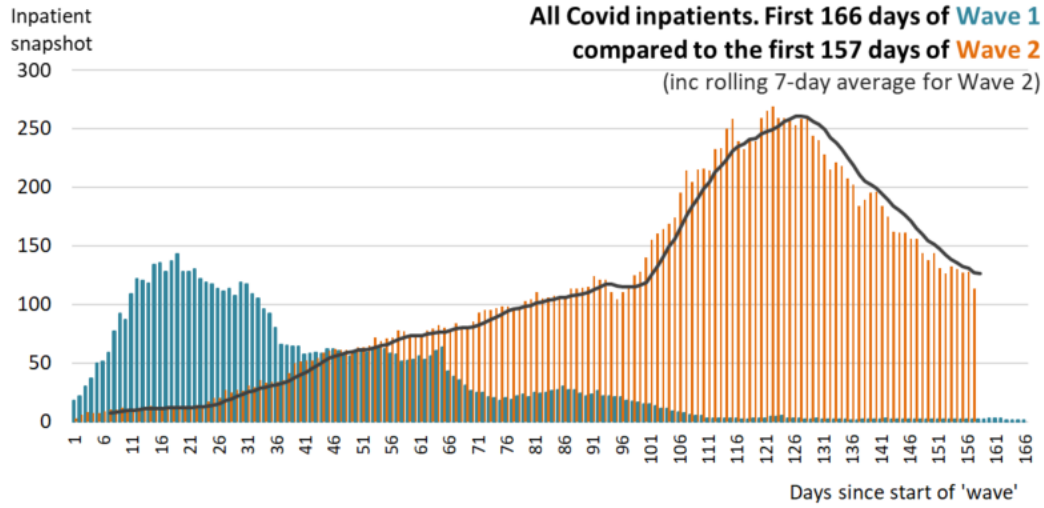
The previous of report indicated that the Trust had reached a position comparable to 30-31 December, and this improving position has continued, with the current inpatient figures being comparable with the Trust position on 12-13 December.

The impact on the number of beds required for COVID patients can be seen on the following chart. This shows the inpatient 'snapshot' as reported on a daily basis. It compares **wave 2** (up to 26 February) with the first 166 days of **wave 1**. It also includes a **rolling 7-day average** for wave 2.

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

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

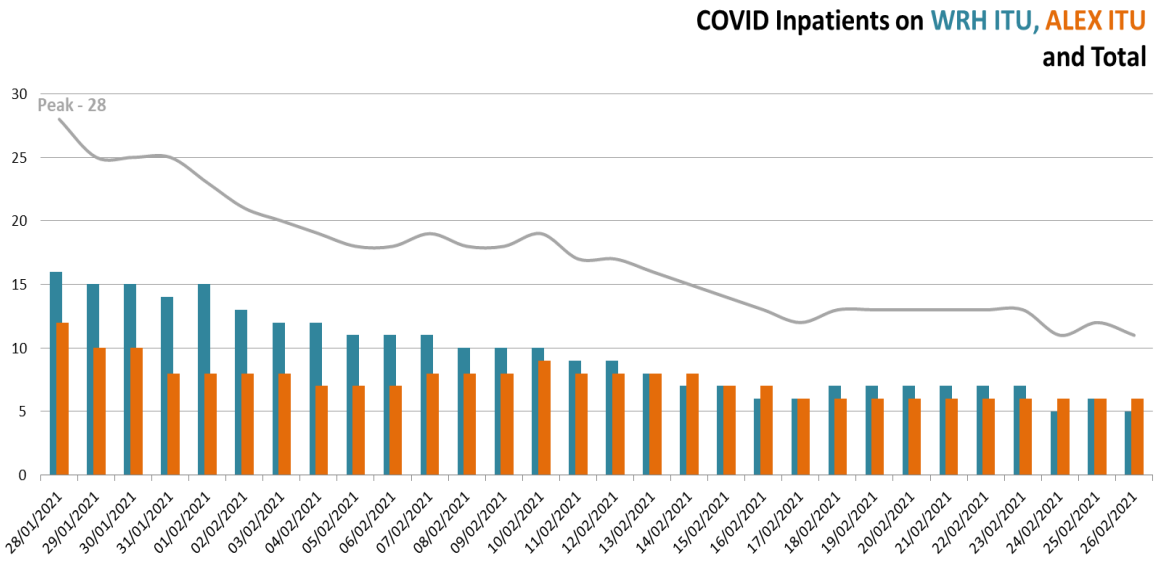


Information provenance: This data is taken directly from our daily snapshot returns, it is what is outlined in the bronze meeting each day. It is just a longer view.

Observations:

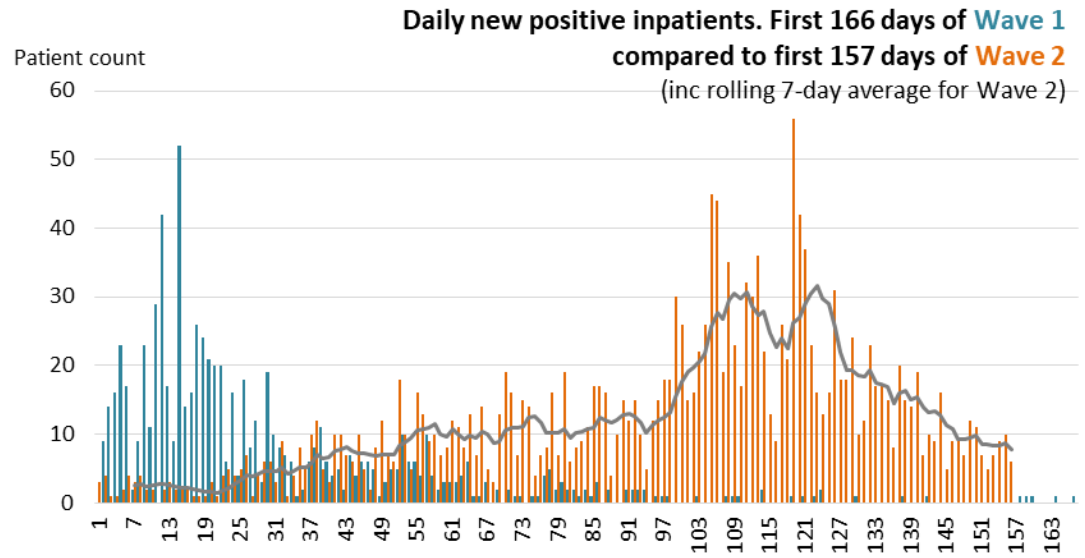
- The reduction in the number of COVID inpatients has continued and is now well below the Wave 1 peak.
- This shows both the improved position over the last four weeks and the scale of the challenge (and likely timescales) if we are to get our inpatient numbers below 100, 50 etc.
- It is reasonable to expect a deceleration in the rate of decrease of COVID inpatients over the coming weeks.

The affect that this overall reduction in COVID inpatients has had on ITU occupancy (including Surge ITU's) is illustrated by the chart below.



The following chart shows the *daily* new positive inpatients. As before, this compares **wave 2** (up to 26 February) with the first 166 days of **wave 1**. It also includes a **rolling 7-day average** for wave 2.

Please note: This excludes readmissions.



Observations:

- We are continuing to see a reduction in new positive cases (inpatients) across the Trust which reflects the reductions in community cases at local and national levels.
- The trend in readmissions and hospital acquired cases (see next sections) will dampen any subsequent rate of reduction.

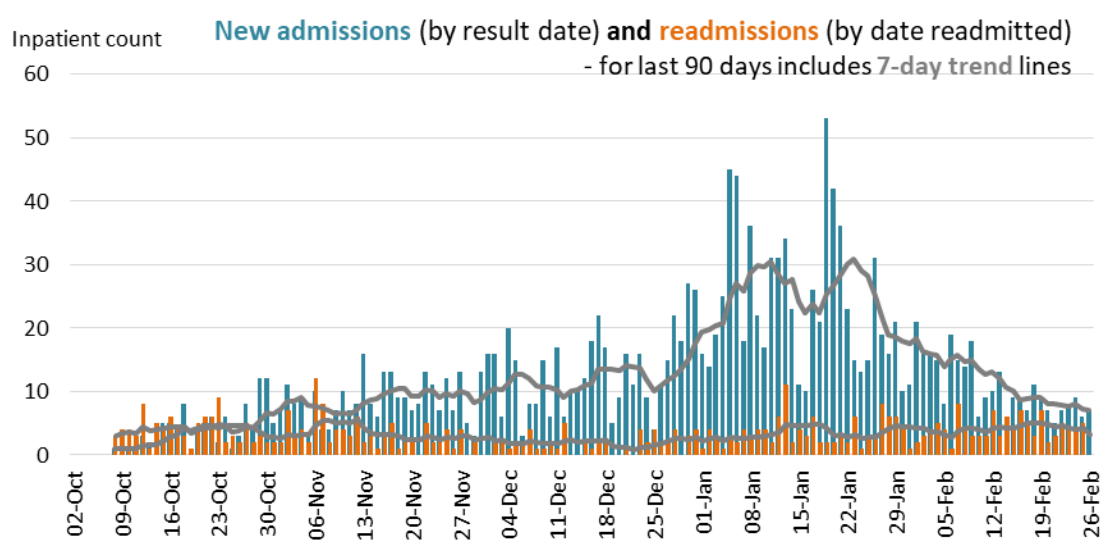
Readmissions

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

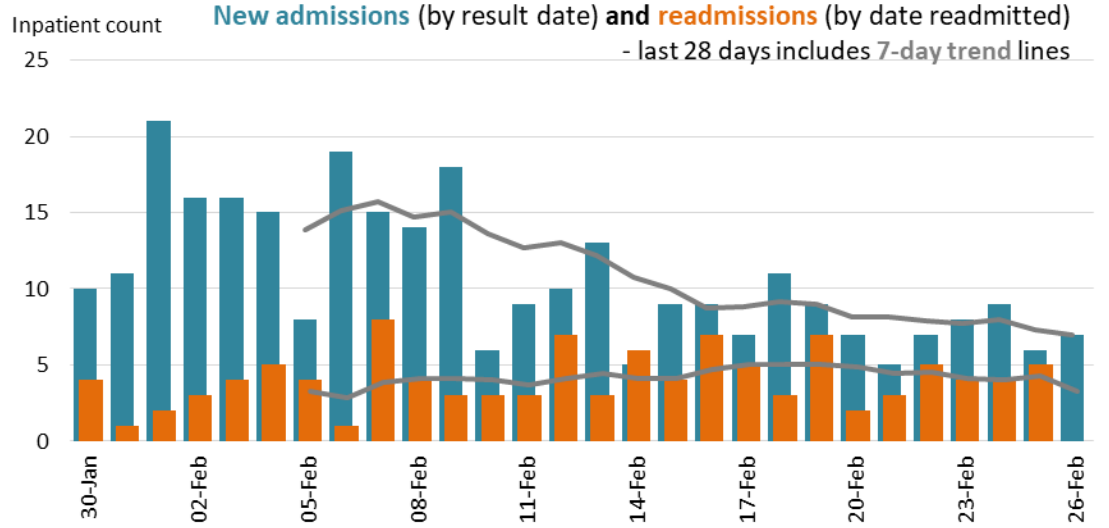
Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

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



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



Observations:

- New admissions have continued to fall whereas readmissions remain relatively stable (if not slightly elevated).
- The net result is that a greater proportion of our most recent COVID patients are likely to be readmissions or hospital acquired cases.
- A further examination of Wave 2 readmissions can be found later in this report.

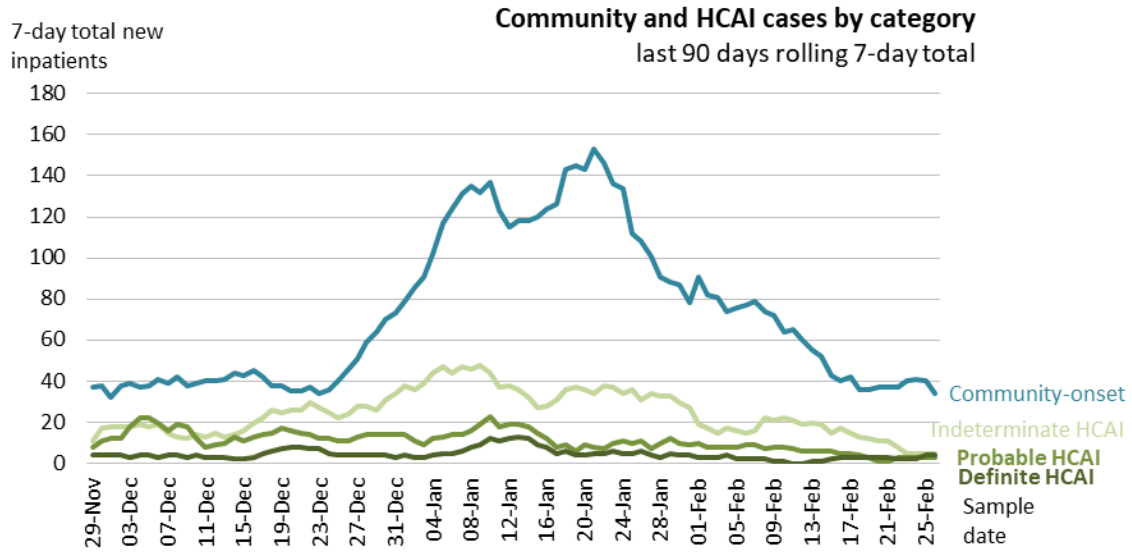
Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

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

Healthcare Associated Infections (HCAI)

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



Observations:

- Community-onset cases remain the main factor behind our inpatient cohort

On the 08/01/2021, the Trust moved to a COVID / Non COVID admission pathway ;

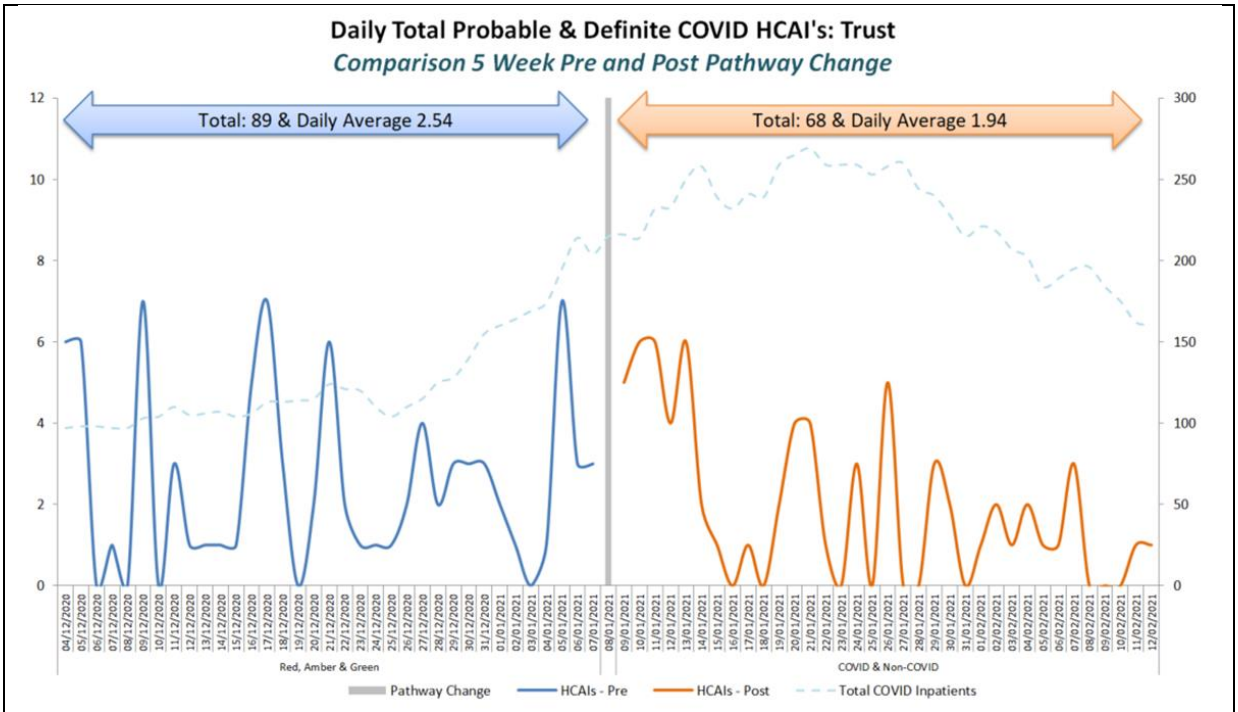
- COVID Wards: COVID-19 Detected and Suspected patients.
- Non-COVID Wards: Patients Not Detected and Not Suspected of having COVID-19.
- Purple Wards : Super Clean Wards: Elective Surgery Non-COVID Patients

This chart illustrates the HCAI prevalence for Probable (specimen date 8-14 days after admission) and Definite (15+ days after admission) HCAI's for the 5 week periods pre and post the pathway change.

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

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



Observations:

- The introduction of the new COVID/NON-COVID admission pathway has been accompanied by a fall in both the total, and the average daily number of Probable and Definite COVID HCAI's in the Trust when comparing the 5 weeks pre and post pathway change (see chart below).
- Despite an initial rise in Probable and Definite COVID HCAI's on the Worcestershire Royal Hospital site, over the first 10 days post the pathway change, the numbers have now dropped when reviewing a 5 week period.
- There has also been a reduction on the Alexandra Hospital site.
- This reduction has occurred at the same time that the Trust has experienced a significant rise in the number of COVID Detected patients being admitted, including the second wave peak on 21/01/2021.

Worcestershire Acute Hospitals NHS Trust

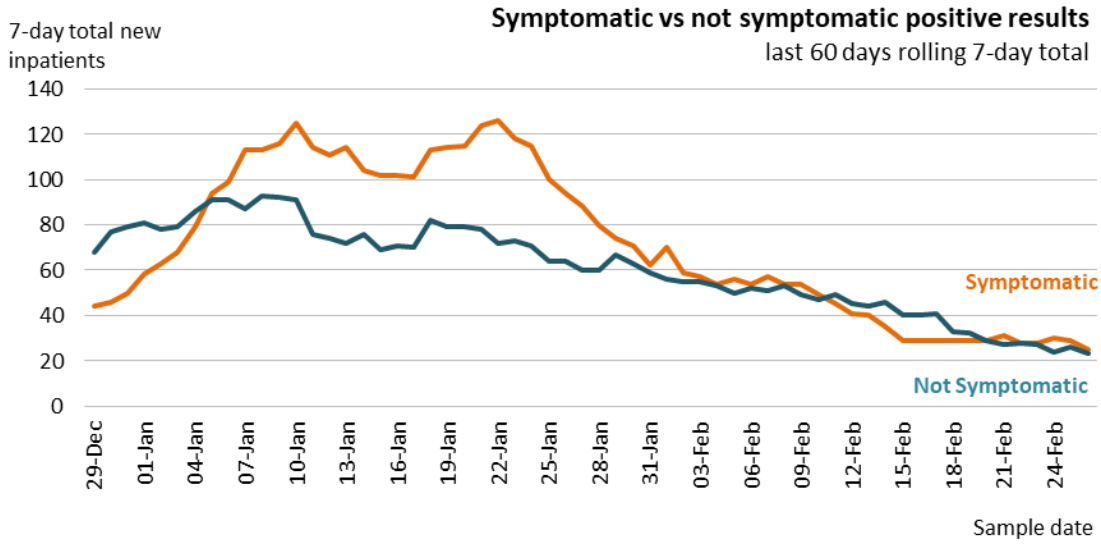
Assurance levels Nov 2020

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

Prevalence of Symptomatic patients

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

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



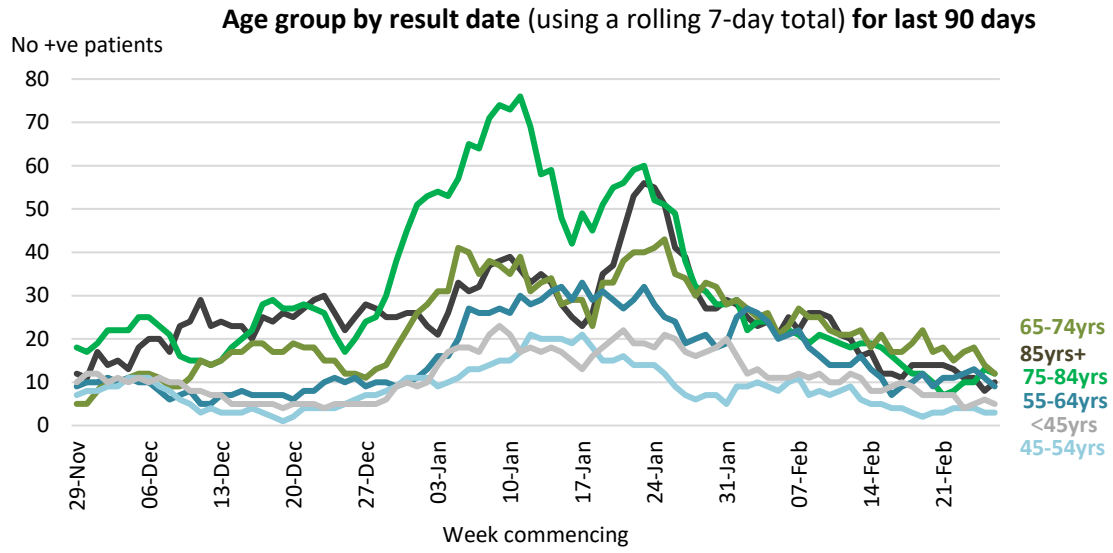
- Following a 9 day period (11th Feb – 19th Feb) when Non Symptomatic cases exceeded Symptomatic cases, the reverse has been the case since 21st February.

Age Groups

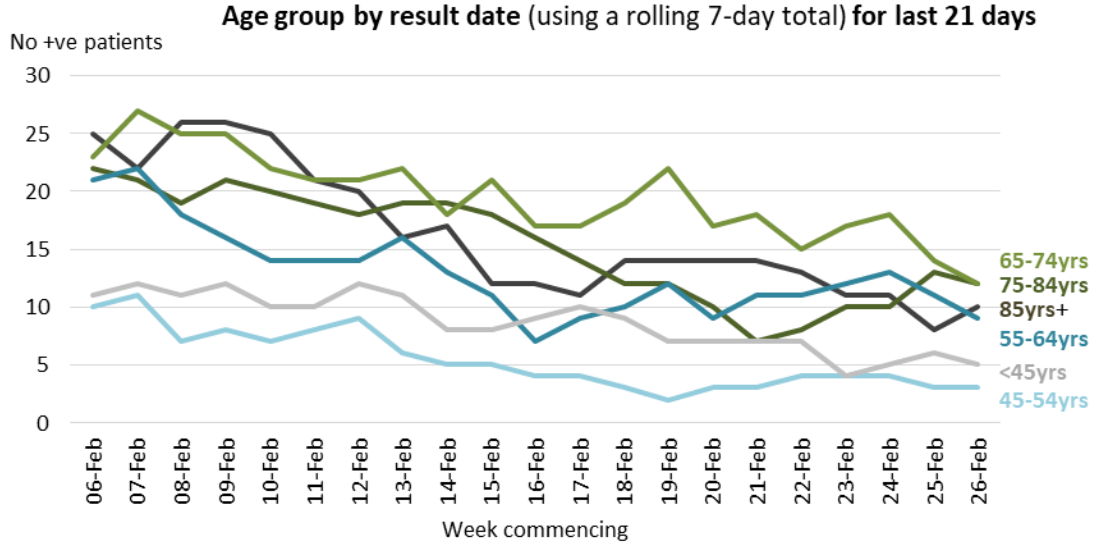
We continue to see shifts in the influence of age on new COVID inpatients. The following two charts show the rolling 7-day total new inpatients (based on result date) by a broad age grouping.

Assurance levels Nov 2020

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



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



Observations:

- Over the last 90 days the age groups with the largest 7 day rolling average admissions were the '75-84 years' and '85+ years' age groups (31.69 and 25.22 respectively).
- However, over the last 21 days the '75-84 years' and '85+ years' age groups have seen significant drops in those rolling averages to 15.23 and 16.28 respectively.
- The same level of reduction has not been seen in the 7 day rolling average admissions for the '65-74 years' age group, which has only reduced from 22.64 to 19.57. And this group had had the largest 7 day rolling average admissions over the last 21 days.

Worcestershire Acute Hospitals NHS Trust

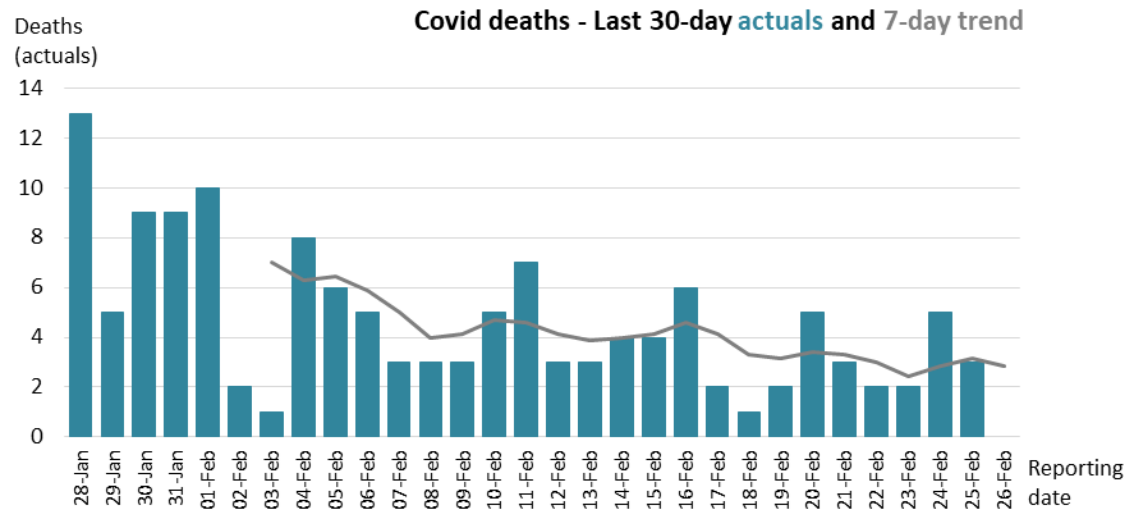
Assurance levels Nov 2020

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

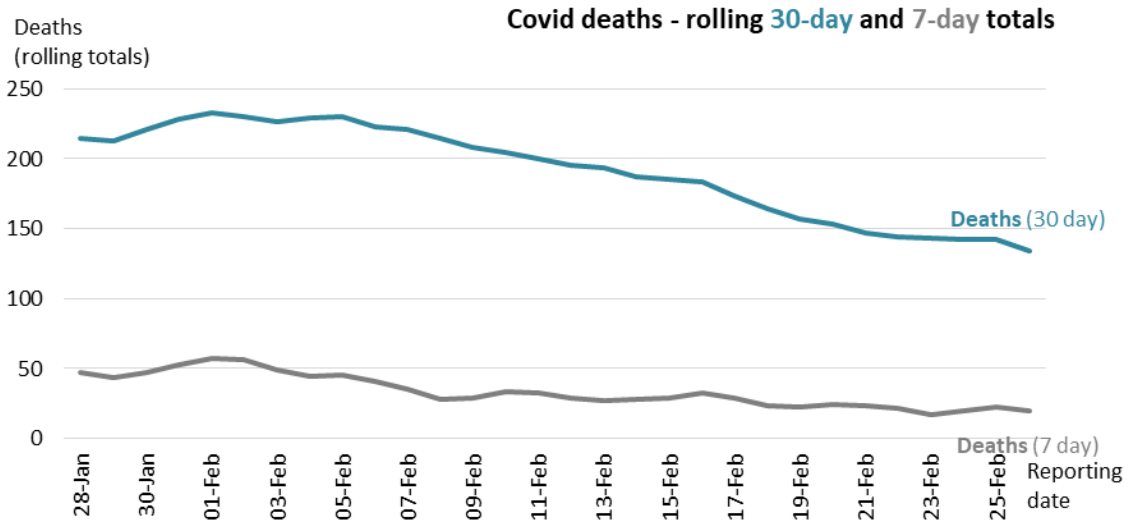
Mortality

As of the 26th February, the rolling 7 day average number of COVID inpatient deaths is 2.9. This is significantly reduced from the peak, which occurred on the week ending 21/01/

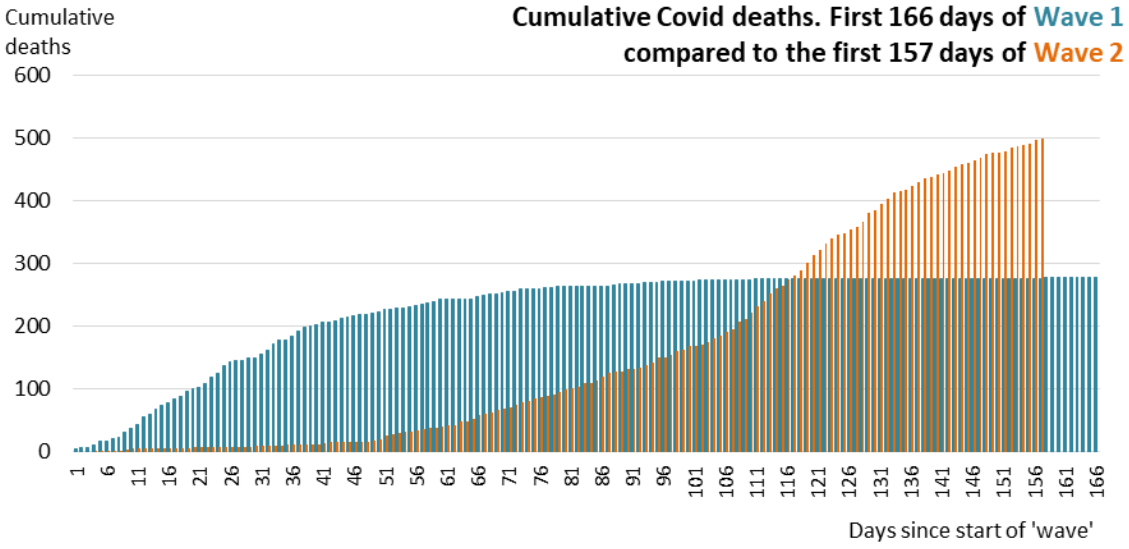
The following chart shows the actual numbers of daily Covid deaths for the last 30 days. Along with a 7-day average.



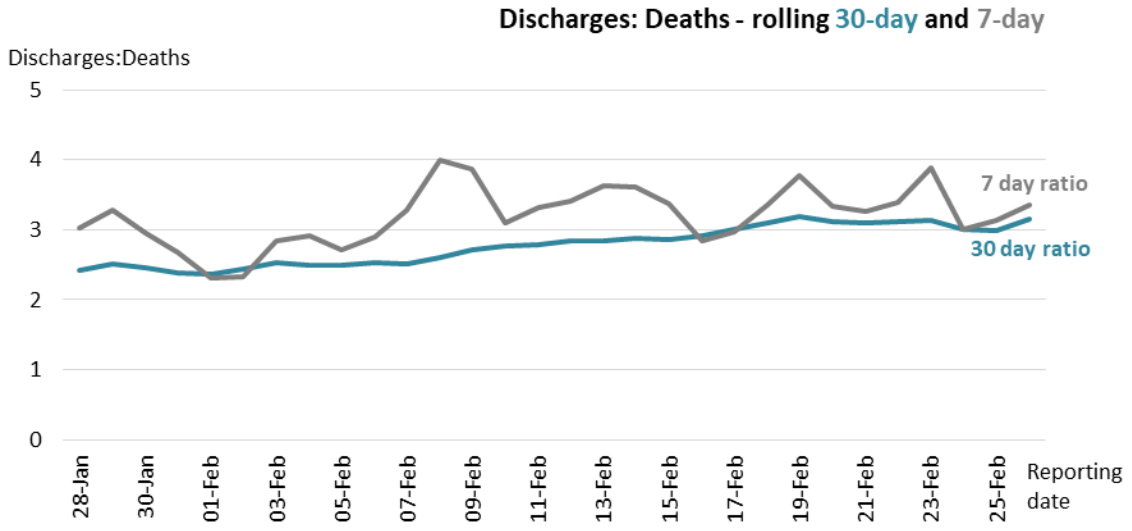
This can be viewed in light of the next chart which shows the longer, 30-day trend against the shorter, 7-trend.



The following chart shows the cumulative deaths for the first 166 days of **wave 1** against the first 157 days of **wave 2**.



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



Observations:

- Our mortality rate is beginning to improve as is the daily number of reported deaths.
- Over the last seven days the number of daily reported deaths has ranged from zero to five (the previous week was two to seven).
- We are continuing to see an improvement in the ratio of treated to deceased patients.

Worcestershire Acute Hospitals NHS Trust

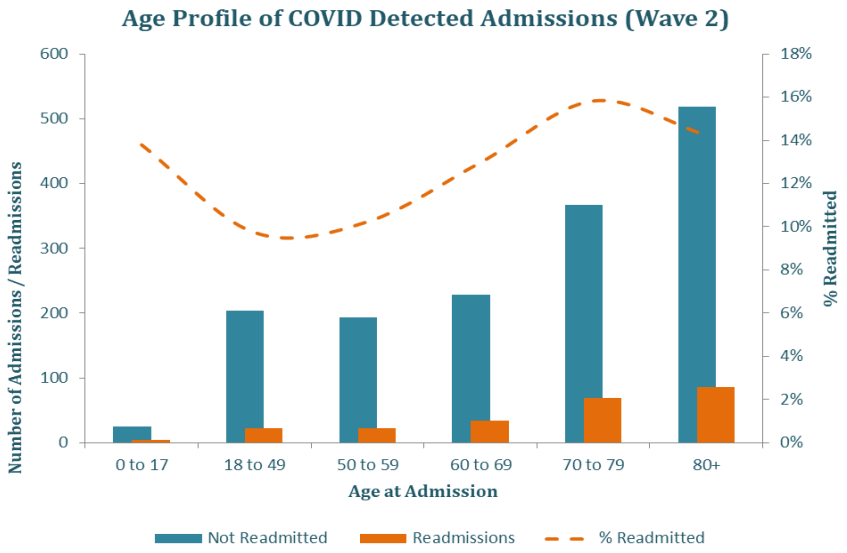
Assurance levels Nov 2020

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

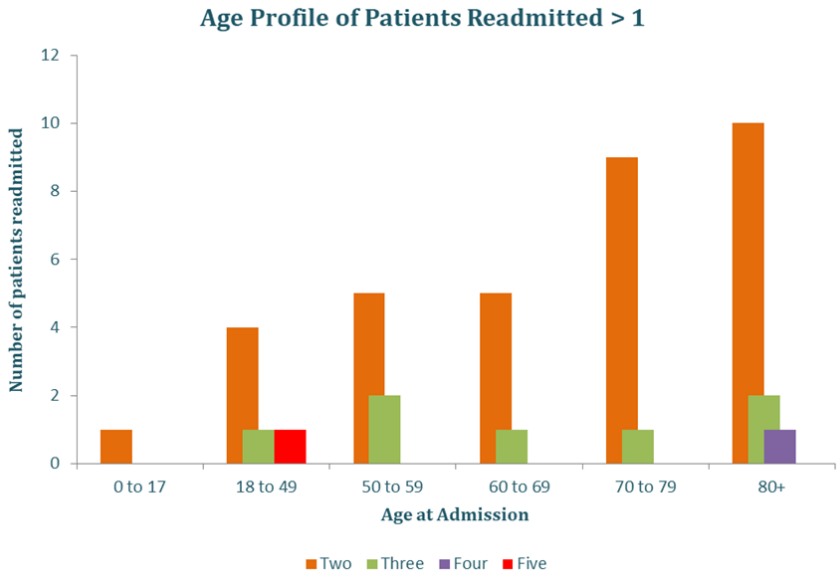
Readmissions – Wave 2 (23rd September 2020 to 22nd February 2021)

Numbers

Since the commencement of the 2nd Wave of the COVID Pandemic, there have been 1,772 distinct patients admitted to the Trust, who during their hospital spell had a Detected COVID PCR result, of which a total of 237 (13.37%) were readmitted at least once.

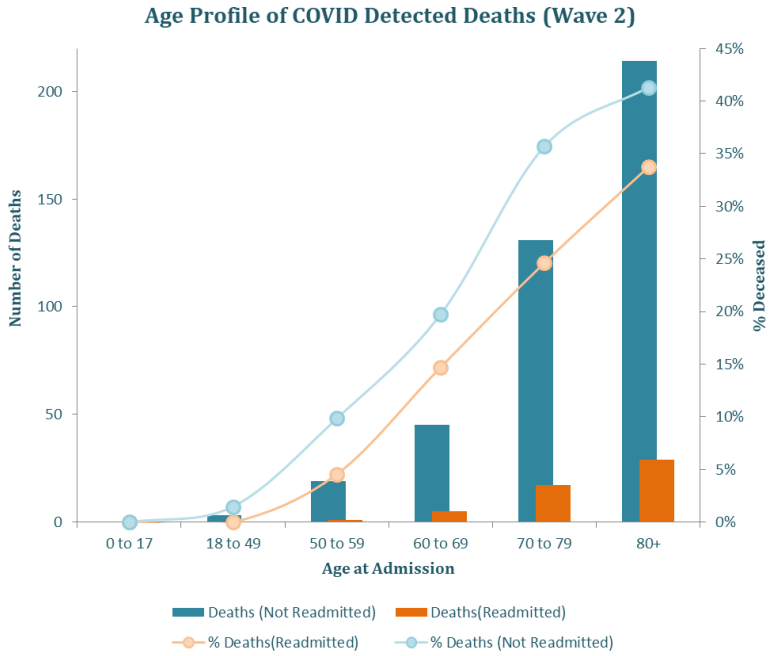


18.14% (43) of those 237 have been readmitted on more than one occasion since their Detected inpatient hospital spell.



Deaths

Of the 1,535 (86.63%) patients not readmitted during wave 2, a total of 412 (26.84%) have died.
Of the 1,772 admissions there have been 237 (13.37%) patients readmitted, of which 52 (21.94%) have died.



Intensive Care

Of the 1,535 COVID Detected patients admitted during wave 2,who did not have a readmission, 146 (9.51%) had an episode in an Intensive Care Unit (Includes surge ITU's), of which 57 (39.04%) died.

Of the 237 COVID Detected patients who were readmitted, 32 (13.5%) had an episode in an Intensive Care Unit (Includes surge ITU's), of which 7 (21.88%) died.

Of the 32 readmissions;

- 21 had their ITU episode during their first admission spell
- 10 had their ITU episodes on readmission (6 died)
- 1 was admitted to ITU on both their first admission spell and their readmission (1 died)

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

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

Conclusion
The data in this report supports the following actions (underway): ▪ Continuation of the migration of COVID beds to non-COVID beds (eg. Trauma Side B) ▪ A consolidation of those units used to deliver 'super surge' ITU, and a review regarding what the future demand for ITU will be, so that we can ensure that it is sustainable for recovery and any future increase in COVID patients
Recommendations
Trust Board is invited to note this report for assurance.
Appendices

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

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

Update on ICS and Trust Action Plan

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

Accountable Director	Jo Newton, Director of Strategy & Planning		
Presented by	Jo Newton	**Author /s**	Jo Newton David Meheffey ICS Programme Director

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

Report previously reviewed by		
Committee/Group	Date	Outcome

Recommendations	The Board are asked to: • Note the details of the ICS White Paper • Endorse the approach outlined by the ICS Executive forum

Executive summary	The proposed legislation regarding the future development of Integrated Care Systems was published in the form of a White Paper in February 2021. This paper seeks to provide a summary of the key changes proposed and the priority areas for focus agreed by the ICS Executive forum.

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

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

Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y	x	N		N/A	
Are the actions identified starting to or are delivering the desired outcomes?	Y	x	N			
If no has the action plan been revised/ enhanced	Y		N			
Timescales to achieve next level of assurance	**March 2021**					

Introduction/Background

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

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

The proposed legislation regarding the future development of Integrated Care Systems was published in the form of a White Paper in February 2021. A full copy of the document is available at:

https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-html-version

The legislation is frequently described as “enabling” and “permissive” – potentially giving a lot of scope for local determination in terms of how to respond. A stocktake of current arrangements in light of the new direction of travel is underway and system partners will be looking to develop specific proposals for review and approval over the coming weeks and months.

This paper focuses on summarising the key features of the White Paper.

Issues and options

What will the Integrated Care System (ICS) look like?

All areas of England will be designated as an ICS from April 2021. There will be a year of shadow running and transition before the new legislation for ICSs takes effect in April 2022. ICS areas will be constituted of two component bodies:

1. An NHS ICS Body
2. An ICS Health and Care Partnership

The NHS ICS Body

The NHS Body will effectively have day to day responsibility for running the ICS and will be specifically responsible for:

- Developing a plan to meet the health needs of the population within their defined geography.
- Developing a capital plan for the NHS providers in their health geography.
- Securing the provision of health services to meet the needs of the system population.

It will subsume most of the CCG’s functions - commissioning, strategic, allocative, oversight and scrutiny roles; alongside new responsibilities that will be delegated from NHSE regional teams.

It must have a “Unitary Board”, which is responsible for performance and spend associated with NHS resources in the ICS area. The membership must include:

- A chair
- A chief executive (who will be the Accounting Officer for the NHS spend)
- Representatives from NHS Trusts
- Representatives from Primary Care
- Representatives from Local Authorities

For local determination, the board could also include:

- Community health services
- Mental Health Trusts
- Non-executives

The legislation does not describe how Clinical Leadership is expected to be enacted beyond stating "ICSs will also need to ensure they have appropriate clinical advice when making decisions". Work has already started with System and Place-based clinical leaders to explore how this can be taken forward.

The NHS ICS body will be set specific system-wide financial targets and will be held to account for managing to those targets.

NHS Trusts will retain all of their existing organisational obligations around finance, quality and performance, but must have "regard to" the system financial target in making their organisational decisions.

All NHS bodies in the ICS will have a "duty to collaborate" to achieve better outcomes for people and there is provision in the legislation that could lead to the NHS ICS body being subject to CQC review of system working.

The NHS ICS body will not have any powers to direct NHS Trusts and NHS Trust relationships with the CQC will be unaffected.

The NHS ICS body will have powers to delegate functions to Place-based alliances or to Provider Collaboratives, including the ability to "double-delegate" functions that have been devolved from region.

The NHS ICS Body will be able to form joint committees with a wide range of partners to make decisions on the provision of local services, which will be particularly important element of creating effective Place-based approaches that span both planning and provision of local healthcare services.

Membership for the ICS Board will be fundamental to achieving the objective of having "all partners mutually invested" in its success.

The ICS Health and Care Partnership

The ICS Health and Care Partnership (HCP) will include:

- NHS bodies.
- Local Authorities.
- Wider partners such as Healthwatch, Voluntary Sector and wider public-realm bodies such as housing providers, social care providers.

The ICS HCP will be responsible for:

- Bringing together health, social care, public health and member of the wider "public space" (such as social care providers, housing providers).
- Developing a plan that addresses the wider health, public health and social care needs of the system.

The ICS HCP will need to interact closely with the Health and Wellbeing Boards and have

due regard to the Joint Strategic Needs Assessment and Health and Wellbeing Strategies.

It will clearly be important to explore how the ICS HCP and the two HWBBs coordinate their activities as much as possible.

Competition and the purchaser/provider split

Whilst legislative proposals emphasise that there remains a clear "distinction" between strategic planning and providing services, the requirement for competition has been significantly changed. There is no longer a legal requirement to competitively procure services where there is no obvious benefit from competition. Instead, the decision on whether to use a formal procurement route or not is for local determination.

The NHS tariff will remain and will primarily be used for maintaining financial rigour and benchmarking, but it is unclear how it will be used as a currency for contracting.

Patient Choice will remain an important tenet of local provision and the NHS ICS Body will have a duty to Protect, Promote and Facilitate Patient Choice in respect of services and treatments offered.

The Secretary of State will have more powers to create new NHS Trusts where that would be helpful to ensuring alignment of provision within the integrated system.

Social Care Changes

Whist the majority of changes affect NHS bodies, there are some significant implications for social care as well:

A common framework will be developed for the collection and reporting of social care provision, regardless of whether that is local authority funded or privately funded. This will include the levels and costs of provision to provide a more complete picture of social care demand.

There are proposals to introduce a new assurance model for local authority social care functions.

There will be a number of technical changes to how the Better Care Fund is managed, but these will not affect the operational arrangements.

The Secretary of State will have powers to make direct payments to social care providers to prevent financial instability in care provision to vulnerable people.

There will be new legislation to support discharge to assess pathways, including the removal of previous "Delayed Transfers of Care" elements such as discharge notices and fining arrangement for DTOCs between Trusts and Local Authorities.

Data sharing

Under the legislation a new Data Strategy for Health and Care will be produced to address structural, cultural/behavioural and legislative barriers to effective data sharing. This will:

- Require organisations to routinely share anonymised data where there is a benefit to the health and care system.
- Ensure that NHS Digital shares data with health and social care system that it holds in exercising its functions.
- Enable the Secretary of State to mandate standards for how data is collected and stored so that it can flow through the system in a useable way and be accessed and provided in a standard form.

Other changes
There are a number of other changes to be brought about by the legislation, some of which will not have a such a direct local impact:

NHSE and NHSI will formally merge into one body, to be called NHSE.

Alongside this legislation there will be parallel proposals to create a National Institute for Public Health to replace Public Health England.

Whilst the ICS is being established to have more responsibility for local decisions, equally the Secretary of State is gathering up more powers to intervene in how local services are run. For example, this includes:

- The power to intervene in reconfigurations without referral from a local authority.
- The power to transfer functions between Arms-length bodies.
- The power to instruct NHSE to take on functions provides by other bodies.
- The power to intervene in the management and delivery of social care functions where they are deemed to be failing.

There will also be changes to quality and safety regimes, such as:

- The formation of the Health Service Safety Investigation Body (HSSIB) as a separate entity to conduct confidential safety investigations in NHS and Independent sector care.
- Changes to the medical examiner regime to scrutinise deaths that are not referred to the coroner.
- Changes to the Medicines and Healthcare Products Regulatory Authority powers to collect data to inform evidence based clinical reviews.
- Changes to the Mental Health Act to enable people to have more control over their own treatment and to ensure they are treated with dignity and respect.
- Changes to Learning Disability and Autism legislation to promote less reliance on inpatient facilities.
- Changes to the regulatory landscape for healthcare professionals, including the future option to bring NHS Senior Managers, Leaders and other staff groups into a suitable regulator regime.

The ICS Executive Forum has agreed to focus on the following areas:

The permissive nature of the legislation provides the opportunity to determine the best model for our system, to be developed with the proposed priority topics:

1. Developing the right clinical leadership model (April/May)

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

2. Determining the constitution for the NHS ICS Board, membership and appointing to roles
3. How to practically ensure we achieve a mutual commitment to system performance and financial outcomes alongside existing organisational responsibilities through the duty to collaborate.
4. The operational and governance model required to enable devolving responsibilities from System to Place, including performance, finance and quality, as well as service design and delivery.
5. Achieving practical application of the "subsidiarity" principle by ensuring that we get the right balance between what we do at each "layer" in the system.
6. The potential future relationship between the ICS HCP and our two HWBBs, particularly in regard to avoiding unnecessary duplication in areas where there is clear overlap.

Our WAHT response

The board approved an eight point ICS action plan in February 2021 to support the development work towards an ICS

The board are asked to note the report

Conclusion

The permissive nature of the legislation allows us with system partners to develop an ICS that meets the needs of our communities in line with previously communicated ICS development plans. Whilst providing further clarity to inform decision making, the pace of development remains a challenge given current operational pressures. Continued close partnership working will be needed to support the safe transition required.

Recommendations

The Board are asked to:

- Note the details of the ICS White Paper
- Endorse the approach outlined by the ICS Executive forum.

Appendices

NHS
Worcestershire Acute Hospitals NHS Trust

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

Annual Planning, Recovery and Medium Term Financial Plan update

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

Accountable Director	Executive Team		
Presented by	Jo Newton, Director of Strategy & Planning	**Author /s**	Jo Newton, DSP Paul Brennan, Deputy CEO Annual Planning Steering group members

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

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

Recommendations	It is recommended that Trust Board: • Note the changes to the timescale and approach for annual planning 2021/22 following Wave 2 COVID and recent national announcements • Acknowledge the complexity of annual planning given the need for restoration and recovery of services and alignment with the emergent ICS • Endorse the direction of travel and approach proposed

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

Risk															
Which key red risks does this report address?			**What BAF risk does this report address?**	*BAF 1, 7, 8*											
Assurance Level (x)	0		1		2		3 x		4		5		6		7		N/A	
Financial Risk	*N/A*																	

Worcestershire Acute Hospitals NHS Trust

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

Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y	x	N		N/A	
Are the actions identified starting to or are delivering the desired outcomes?	Y	x	N			
If no has the action plan been revised/ enhanced	Y		N			
Timescales to achieve next level of assurance	**April 2021, following publication of national guidance**					

Introduction/Background

Our proposed approach to annual planning for 2021/22 was discussed at Finance and Performance Committee on 25th November 2020 and endorsed by the December board. It set out the context for the 2021/22 annual and financial planning process, and also proposed an approach and timeline for the development of plans. On 13th January 2021, NHSE/I announced a pause to the planning and contracting round due to COVID pressures and that the current financial arrangements will be rolled over to quarter 1.

Since this announcement the trust escalated the operational position to level 5 in response to a surge in COVID. As discussed in a separate paper it is anticipated that the trust will propose de-escalation to level 4 in the next week and is engaged with the STP to determine an agreed systemwide Recovery plan. This paper describes the implications of this for the Trust and outlines our proposed response.

Issues and options

National planning approach

NHSE/I announced deferment of the 2021/22 annual planning process in January, indicating a revised national approach to planning:

- To minimise the planning burden during quarter 4 2020/21 with the requirement for national returns minimised.
- To rollover the current financial framework into quarter 1 2021/22, although the national total available quantum is still under negotiation at a national level.
- To defer the planning round to quarter 1 2021/22 with a focus on planning for quarters 2 to 4.

Quarter one 2021/22

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

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

Quarters 2 - 4 2021/22
Following quarter 1, our current understanding is that the financial framework in quarters 2-4 will be based on:

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

Once planning guidance is published for the period Q2 onwards we will be able to assess the implications.

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

Our approach to date

Work to date
Work to develop the Trust's annual plan commenced in November 2020 but was paused in January. Internally a light touch approach has been continued with weekly meetings of the steering group corporate members.

- Discussions have taken place with those divisions which completed their draft strategic objective templates, lists of PEPs and lists of business cases. Divisions are continuing to develop and refine these informed by Model hospital and other data sources.
- First cut activity data is being reviewed by divisions and the informatics and contracting teams
- Budget discussions have continued where practical. Divisions have a good understanding of their underlying exit run rate from 2020/21 and how this aligns back

to the agreed 2020/21 planned deficit. Executive led sessions have been scheduled in March to review this output.

- Further work is required to triangulate with workforce and demand activity
- The assumptions on which the 2021/22 plans will be based have been drafted, although these assumptions will need to be revised following publication of national and ICS assumptions.
- The 2021/22 Budget Setting Policy has been updated following feedback from Trust Management Executive. Defined the Business case prioritisation process.

Next phase approach

A. Recovery of services

STP Recovery plan

In advance of regional guidance, system partners are devising a recovery plan based on the following principles:

- Focus on reducing clinical risk to prioritise patients not yet seen or diagnosed
- Clinical review and stratification of the waiting list prior to enable targeted approach to reducing the backlog which has increased by 30% versus pre COVID levels
- Restart NHS Long-term Plan ambition, updated by Covid experience
- Agree pathway priorities, supported by the Planned Care ICS theme group
- Implement Phase 3 recovery plan emphasis on health care inequalities and digital strategy

Trust Restoration of Services

By the end of April 2021 the aim is to restore elective inpatient / day case activity to 90% of pre-COVID levels, supported by scanning operating close to 90%.

Plans are underway to reconfigure the first floor of the Alexandra site for elective activity to commence w/c 15th March, subject to minor refurbishment. Theatre utilisation at the Kidderminster Treatment Centre is being stepped up with the aim of being fully functional by the end of March. The next phase will be to reconfigure the Worcester site to enable more elective work to take place at the Alex.

More challenging will be restoration of screening (a national issue) and outpatient activity due to the impact of social distancing on face to face appointments. Acceleration of the Attend Anywhere high impact change will enable more virtual appointments. A new advice and guidance policy co-designed with PCN clinical leads has reduced referrals since implementation in October 2020. Priority is therefore being given to patients referred between March-October 2020 who have been triaged but not yet received their first appointment to minimise risk to these patients.

B. Restarting of planning process

Activity is now being reinstated with a stocktake of progress to date with Divisions including business case prioritisation and a review of PEP schemes which will be reported to Finance & Performance committee for discussion.

Executive Led Divisional finance review meetings scheduled in March will support setting an initial start point budget. It is recognised that roll over creates uncertainty in terms of planning and work will continue with Divisions to manage through the next quarter.

In its simplest term, the financial plan will represent a cost base built on our 2020/21 financial plan adjusted for agreed business cases and inflationary increases. Further work is required to provide assurance on the level of activities that can be delivered within this resource envelope in 2021/22 acknowledging external influences and the ongoing impact of COVID.

The annual planning steering group will now step up work particularly around activity and workforce. As part of the work it is anticipated that roles and responsibilities in delivery will be emphasised aswell as wider consideration of the outputs from the system wide use of resources workstream.

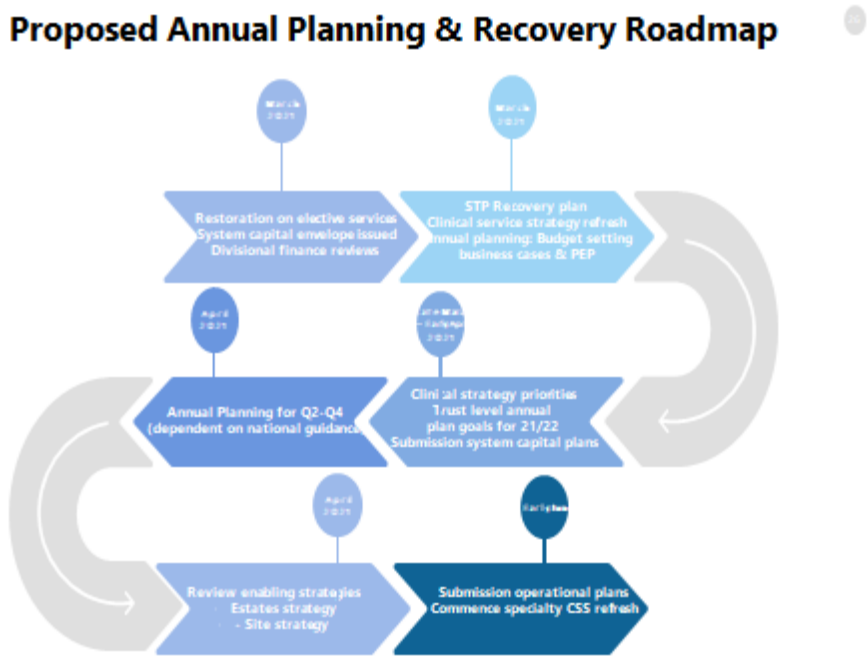
Taking into account the above we have refined our approach as outlined below:

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

Timescales and next steps

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

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



Clinical Services Strategy
A desk top exercise to review the priorities emerging from the Clinical Services strategy for year 2 has been undertaken and dialogue with the Divisions has restarted to test versus the bottom up approach. This aligns with the work at system level and further work through the Spring will provide the framework for prioritisation as part of the Annual planning priorities.

Medium Term Outlook
The Board last formally considered the Medium Term Financial outlook in January 2020, prior to the impact of COVID-19 and the change in financial architecture. At this point, elements of the underpinning enabling strategies that would drive step change were not sufficiently developed to be reflected within the modelling. As a result of the impact of COVID-19 and the changed financial architecture, further work on the enabling strategies and refresh of the Medium term outlook was put into abeyance. Notwithstanding the pause in development work, subsequent considerations of the medium term financial landscape have taken place through Board Workshop / Finance and Performance Committee. We have maintained good financial governance measures throughout COVID-19, ensuring expenditure controls remain in place, but recognise that we need to increasingly focus on changes in our ways of working to improve productivity.

Through the 2021/22 planning cycle as described above, focus will return to the underpinning enabling strategies improvement opportunities supporting determination of a Medium Term Financial outlook. This will facilitate a refresh to the Medium Term Financial baseline position, and more critically the ability to reflect the financial implications of the changed architecture, enabling strategies; Clinical Services Strategy; Estates Strategy including major Capital Projects (UEC/ASR Alex Theatres) and Digital Strategy (PAS/DCR);

Worcestershire Acute Hospitals NHS Trust

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

and Workforce; alongside productivity and pathway schemes and programmes both within the Trust and more broadly with those in the H&W System.

Conclusion

The 2021/22 annual planning process will be challenging given the environment in which we are setting our plans. The paper presents our revised approach, which is subject to further change in light of national guidance when it is published. We will work with our system partners to support the development of the Herefordshire and Worcestershire STP/ICS recovery plans within known financial constraints.

Recommendations

It is recommended that Trust Board:

- Note the changes to the timescale and approach for annual planning 2021/22 following Wave 2 COVID and recent national announcements
- Acknowledge the complexity of annual planning given the need for restoration and recovery of services and alignment with the emergent ICS
- Endorse the direction of travel and approach proposed

Appendices

NHS
Worcestershire Acute Hospitals
NHS Trust

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

Integrated Performance Report – Month 10 2020/21

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

Accountable Director	Paul Brennan – Chief Operating Officer, Vicky Morris – Chief Nursing Officer, Mike Hallissey – Chief Medical Officer, Tina Ricketts – Director of People & Culture, Robert Toole – Chief Finance Officer		
Presented by	Vikki Lewis – Chief Digital Officer	**Author /s**	Steven Price – Senior Performance Manager

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

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

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

Executive summary

The Impact of COVID-19

January 2021 was the Trust's most pressured month to respond to in relation to the COVID-19 pandemic; a month when on average there were 230 positive patients in a bed and at our peak, 269 on the 21st January. This unprecedented pressure resulted in numerous surge and super surge responses to be enacted with staff redeployed to expand our ICU capacity to six units across the two sites and nearly all elective and ambulatory activity on the WRH and ALX sites ceased.

A Star Chamber was subsequently established to review patients on a case by case basis to determine if surgery could take place on the Worcestershire Royal site and whether certain ambulatory services could be restarted. The Trust continued to undertake activity in the Independent Sector but at much lower volumes than previously due to the changes in the national IS contract. Services at KTC were maintained and gradually increased throughout January.

Reduced capacity for routine surgical treatments and diagnostic testing led to appointments being cancelled and patients being added back to the waiting lists. However, the Trust was able to sustain theatre capacity for non-elective inpatients and undertook 101 elective theatre procedures for cancer patients; in context, routine theatre procedures reduced from 861 in Dec-20 to 185 in Jan-21 (125 of which were at KTC).

The reduction in capacity and cessation of activity described above meant that at the end of January, the following numbers of patients were waiting:

- 255 patients on a 62 day cancer pathway waiting over 62 days, and of those, 100 have been waiting over 104 days.
- 4,467 patients waiting over 52 weeks for their RTT related treatment, and of those, 683 have been waiting over 70 weeks.
- 8,459 patients waiting 6+ weeks for their diagnostic test and of those, 1,533 have been waiting 13+ weeks.

Although there was a reduction in people attending A&E during the month, the Trust saw its highest conversion rate to date with an average of 37%. This put pressure on our capacity and prevented patient flow working to the levels achieved in previous months of 20/21. Discharging COVID-19 patients was an important component of managing the increased demands and the Trust averaged 18 COVID-19 discharges a day in Jan-21.

Quality and Safety

Infection Prevention and Control

Current work on the prevention of infection continues to be focussed primarily on the management of COVID- 19 infection. Although the continued focus on both antimicrobial stewardship and MSSA bacteraemia has been impacted by the need to focus on the surge in cases in the second wave of the pandemic, there have only been single cases in both Dec-21 and Jan-21 and the impact of the quality improvement work appears to be on-track to deliver clear improvement by Mar-21. The CMO plans to focus on antimicrobial stewardship with Divisional Directors as soon as the significant surge of the second wave of the COVID pandemic has receded. Managing outbreaks continues to be challenging both clinically and operationally. To date during the pandemic second wave surge we have detected and managed 26 outbreaks; 15 of these are being actively managed, and the other 11 have been closed.

People & Culture

There are signs that the COVID-19 pandemic is starting to impact on our colleagues with an increase in non-COVID-19 related absence and above normal levels of absence relating to stress and depression. We have a comprehensive staff health and wellbeing offer but the immediate focus will be on staff wellness that supports individuals to take small actions each day to maintain both their physical and mental wellbeing. In addition, supporting colleagues with flexible working solutions to allow time out or a change of environment will be critical if we are to continue with the improvement in staff turnover rates.

Our “getting the basics right” has been impacted by level 5 escalation and we have seen a further reduction in appraisal compliance and low levels of job planning compliance - the exception being the Urgent Care division who have achieved 100% completion of job plans. However, mandatory training compliance has maintained consistently good levels throughout

the pandemic with the 90% target now being achieved.

Our Financial Position

Internal Plan
Against the internal £(78.9)m operational deficit plan (Budget), the month 10 (January 2021) actual surplus was £0.8m vs Plan £(6.4)m, a £7.2m positive variance. This is against a very different activity, income and resource plan.

The combined pay and non-pay expenditure variance against our internal budget is £(1.3)m adverse. This position includes £1.8m of incremental COVID-19 costs.

The combined income position was £8.1m (Top-up £9.1m) favourable to budget in month recognising the interim funding regime. This revised payment mechanism has been extended into Q1 2020/21.

Note Year to date Income top-up of £73.6m including £14.5m Covid Related.

NHSI Financial Framework 20/21
NHSI Financial Framework submission - The Trusts Income & Expenditure position was £2.2m monetarily better than the Financial Framework plan assumptions.

As we responded to COVID In January, Elective and Outpatient activity reduced compared to December, and Emergency admissions increased.

Income was £0.35m above plan due to NHS England pass through Drugs.

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

- Forecast assumed that all beds would be open in December 2020 and that we would incur significant additional temporary staffing costs for heightened levels of sickness / absenteeism. Ward 10 remains closed and absenteeism levels have been lower than forecast. As a result temporary staffing and associated premium costs did not increase to the levels anticipated (£0.4m).
- Fill rates for temporary staff to perform patient temperature checks in Outpatients and Radiology and Theatres roles such as runners for RED theatres are low. In the main, these tasks have been completed by utilising the goodwill of our substantive workforce, stretching existing staff. Workforce colleagues have been working closely with Directorate leads. (£0.1m)
- Slippage in recruitment – in many cases this is deemed to be a timing difference with recruitment moving into 2021/22. (c. £0.1m)

Worcestershire Acute Hospitals NHS Trust

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

	Non-Pay costs were £0.8m (5%) lower than the NHSI financial framework plan. The key items driving this position include: • Lower than anticipated patient activity delivered in the private sector, this is offset by lower income (£0.2m) • Incremental variable costs driven by bed capacity and activity lower than anticipated (£0.3m) • Release of accrual for COVID related Supplier Support Payments following notification that these would not be claimed for the period August-December (£0.3m) Financing costs are £0.2m favourable to plan following a reforecast in the PDC dividend at M9 due to the agreement to defer elements of the capital programme into 2021/22 (£0.2m). Our Forecast Out Turn remained as at end of Q3 at a £(2.5)m deficit position. This would result in a remaining positive year end variance of £4.8m against the revised phase 3 Financial Framework Plan submission of £(7.3)m deficit. A revised Trust and STP review of the Forecast will take place in M11 (February) and is likely to lead to a finance position comparable with the separately allocated system funding allowance although with reduced activity and productivity outputs given the wave 2 Covid impact. This system allocation was set independently of the phase 3 Trust Return.

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

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

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

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

Worcestershire Acute Hospitals NHS Trust

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

- Trust Board Integrated Performance Report (Jan-21 data)
- WAHT January 2021 in Numbers Infographic
- Committee Assurance Statements

Integrated Performance Report

NHS Worcestershire Acute Hospitals NHS Trust

Trust Board

11th March 2021

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

Operational Performance

Operational Performance Report - Headlines

Operational Performance	Comments
Urgent care and patient flow including Home First Worcestershire	• 4 hour EAS and 12 hour breaches continues to show special cause concern for Jan-21; however ambulance handover breaches returned to normal variation. There continues to be a direct correlation to these measures and the pressure on both hospital sites to manage bed capacity, patient flow and COVID-19 positive patients requiring a bed during the second spike. • Although there was pressure at the front door, the other SPC graphs for this section of operational performance returned to normal variation apart from the LOS in AMU. • Even more beds have had to be allocated to COVID-19 pathways over the course of the month so elective procedures were cancelled. Redeployment was actioned as part of our surge and super surge response plan but this did not offset the increase in staff absence related to COVID-19 or the recommended ratio of patients to staff required for intensive care treatment.
Cancer	• Cancer two week waiting times have not changed significantly in the last three months. This process is currently unlikely to achieve the 93% target whilst Breast Services continues not to be able to see the majority of their patients within two weeks. Overall performance may be expected to vary between 73% and 98%. Workforce adjustments have been made so improvements should be observed in February and March. • Cancer two week waits for Breast Symptomatic remains a concern with the majority of patients still not being seen within 14 days. Although the target of 93% can be, and has been met, it is unlikely to be achieved with variance between 22% and 100%. • Cancer 62 day waits have not changed significantly since Aug-19. This process will not achieve the 85% target but may be expected to vary between 60% and 80%. • **Long Waits:** The backlog of patients waiting over 62 days has increased to 255 and is above the phase 3 trajectory as treatments and diagnostics pathways were impacted by the latest surge in COVID-19 positive patients. Of this cohort those waiting over 104 days has also increased significantly; our internal target of zero patients cannot be met until more services and pathways are restored.
RTT	• RTT remains a cause for concern; a direct result of the impact of COVID-19 on elective treatment and surgery. The waiting list has grown for 7 of the last 8 months, and there are almost as many patients waiting 52+ weeks as between 40 and 52 weeks. With the cancellation of elective surgery and outpatient appointments, it is to be expected that the profile of the waiting list will show an increase in breaches; although phase 3 analysis does show little change in the inpatient waiting list as patients were not having outpatient appointments. • **Long Waits:** 4,290 patients (10% of the RTT waiting list) are now waiting over 52 weeks for their treatment, with General Surgery, Urology, T&O and OMF having over 500 patients each. 693 of those patients waiting 52+ weeks have been waiting over 70 weeks and approximately 80% remained undated. As previously reported, 40% of those very long waiters are for orthodontic treatment or oral surgery. Our worst case scenario for 52+ weeks, based on no clock stops, would result in 10,000 patients waiting at the end of Mar-21. Currently we are tracking on a forecast of 6,500.
Outpatients	• Jan-21 saw the cancellation of outpatient activity at WRH and ALX, with as much activity being relocated to KTC as possible. This reduced January activity to 16,615 appointments, 6,716 below the Phase 3 forecast for the month. As expected given the cause of cancellations, the lost activity in Jan-21 was primarily face to face appointments. Non-face to face first appointments exceeded the Phase 3 forecast by 751 appointments,; this is consistent with previous months. Non-face to face follow-up appointments were 1,515 below plan, but this is also consistent with previous months.
Theatres	• Although non-elective and cancer surgery theatre procedures were maintained through Jan-21, many routine day case and elective surgery procedures were cancelled, particularly on the WRH and ALX sites. The Independent Sector did undertake some day case and elective activity, but not at the levels of previous months.
Diagnostics	• Diagnostic testing remains a cause for concern; the process is currently not capable of achieving the 1% target. Prioritising category 1/1A requests, moving restored activity to peripheral sites and cancelling routine tests have contributed to a reduction in activity and increase in the number of patients waiting 6+ weeks. • **Long Waits:** 4,430 patients are waiting over 6 weeks for their diagnostic test and of the total number of breaches, 1,533 have been waiting over 13 weeks.

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

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

12 Hour Breaches	Ambulance Handover Delays (Home First Programme metric)			Average Occupancy			
	15-30 mins	30-60 mins	60+ mins				
29	968	279	192	WRH	88.86%	ALX	60.93%

What does the data tell us?

- **EAS** - The overall Trust EAS performance which includes KTC and HACW MIUs was 75.35% in Jan-21, compared to 76.18% in Dec-20. The EAS performance at WRH increased by 1.89 percentage points with 565 **fewer** ED attendances and 318 **fewer** 4 hour breaches than Dec-20 (Jan-21 breaches were 5,111). The ALX EAS decreased by 2.16 percentage points, with 492 **fewer** attendances and 16 **fewer** 4 hour breaches (Jan-21 breaches were 768). Total Type 1 attendances across ALX and WRH was 8,723; a 10.8% **decrease** on the previous month and a 17% **decrease** on Jan-20.
- **EAS Type 1:** Our performance across the two sites, from Apr-19 to Jan-20, was 63.85% with 41,299 patients breaching 4 hours. Our performance for Apr-20 to Jan-21 is 80.62% with 18,974 patients breaching; this is a 54% reduction in patients breaching 4 hours. We have had 16,330 fewer patients attend ED in the ten months of 20/21.
- **Ambulance Handovers** - There were 192 x 60 minute ambulance handover delays; with breaches at both sites.
- **12 hour trolley breaches –** There were 29 validated 12 hour trolley breaches in Jan-21; we have reported 67 12 hour trolley breaches in 20/21 compared to 847 by the end of January 19/20.
- **Specialty Review times** – Specialty Review times remain within normal variation; however this is under the target that has been set.
- **Discharges** – Both sites continue to have variation in performance with the percentage of non-COVID discharges compared to admissions at the WRH between 71% and 135% and between 44% and 135% at the ALX. Before 12pm discharges (on non-COVID wards) is showing no significant change however, the process will not achieve the target of 33%. The number of patients with a length of stay in excess of 21 days increased from 50 (at 31st December) to 57 with 11 being MFFD.
- **Total Time in A&E:** The 95th percentile for patients total time in the Emergency departments has decreased from 855 minutes in Dec-20 to 742 in Jan-21. This metric has returned to normal variation and the process is unlikely to consistently achieve our target of 380 minutes but may be expected to vary between 315 and 749 minutes.

What have we been doing?

Acute Patient Flow

- Coaching on Board Round standards continued until January , however resource now depleted and unable to sustain presence on Board Rounds
- Multiple bed moves and ward reconfiguration due to COVID has impacted on early discharges due to multiple specialist on individual wards.
- Seven day review continued at the ALX for all patients with a stay over 7 days.

Acute Front Door

- ANP role has been extended to include direct patient care, therefore using senior skills.
- Paediatric streaming pathway in place for medical presentations, flexible use allowing resource and area to be utilised for COVID-19 positive patients in the event of surge
- Fortnightly meetings working through rotas', job plans and activity based requirements are taking place.
- Middle grade appointment offers made at last round of interviews, now awaiting acceptance and references. 5 offers made for 6 vacancies at WRH
- 2 ED Consultants appointed – 12/14 cross site in post, an Acute Medical Lead appointed at WRH and ATR approved for 5 Redditch vacancies and advert now live.
- Clinical Director actively following up and reviewing weekend cover, where trends in performance or quality outcomes appear.
- The SDEC push model continues to function at the ALX and has been expanded to include Urology. The Ambulance service are now engaged with the direct access to SDEC offer.

Frailty

- Geriatric Emergency Service (GEMS) team being established that will operate primarily at the WRH site focused on patients presenting to the Urgent Care footprint and those already within the hospital
- Participation in H&W Integrated Care System Frailty /Quality Review Service - Quality Standards for Care of Older People.

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

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

Total time in A&E – 95th percentile (Target – 360 mins)	Overnight Bed Capacity Gap (Target – 0)	30 day re-admission rate (Dec-20)	Aggregated patient delay (APD) (Target – 0)	Discharges as a % of admissions – (Target >100%)			
742	19 Beds	3.10%	494	WRH	102.3%	ALX	99.3%

What does the data tell us?

- **Bed Capacity** - Our G&A bed base is 761; with closed wards and unused beds during January our average number of G&A beds occupied per day was 550, down from 598 the month before; the average occupancy was 72.27%.
- **The 30 day re-admission rate** shows no significant change since Jun-20; the process limits have widened and this indicates a change during COVID-19 that we have not yet got control of.
- **Aggregated patient delay (total time in department for admitted patients only per 100 patients – above 6 hours) –** this indicator has returned to normal variation for Jan-21 and the process indicates we cannot achieve the target of zero.
- **Conversion rates** – 3,144 Type 1 patients were admitted in Jan-21; a Trust conversion rate of 36.99%. The conversion rate at WRH was 38.15% and the ALX was 35.41%. The conversion rate at WRH in Jan-21 compared to Jan-20 is 6.1% percentage points higher continuing the trend of higher acuity for patients attending the Emergency Department; on ten days in the month the conversion rate was greater than 40% at WRH, and includes one day at 50% and seven days at ALX.
- **15 minute time to triage –** The Trust performance is 89.41%, showing no significant change; the process will not achieve the target of 95% consistently but may be expected to vary between 88% and 97%. It is the same at site level, no significant change for WRH or ALX.

What are we doing next?

Acute Patient Flow

- Re-instate Golden discharges with an aim to improve pre-midday discharges
- Continue LLOS reviews across both sites weekly and escalate and chase outstanding actions

Acute Front Door

- Scope engagement work for a system wide strategy group for development of new pathways for Primary Care presentations.
- Work with stakeholders, including patients, to design system wide primary care pathways that avoid attendance through the WAHT front door

Frailty

- Further system analysis of the impact of the UCR to review impact and gaps in pathways. Consideration of enhanced model with immediate paramedic to senior nurse/GP discussion
- Matron/Ward Manager Quality Audit questions have been finalised for upload to GAP

Current Assurance Level: 5 (Jan-21	**When expected to move to next level of assurance:** This is dependent on the on-going management of COVID-19 second wave and achieving operational standards.
Previous assurance level: 5 (Nov-20)	**SRO: Paul Brennan**

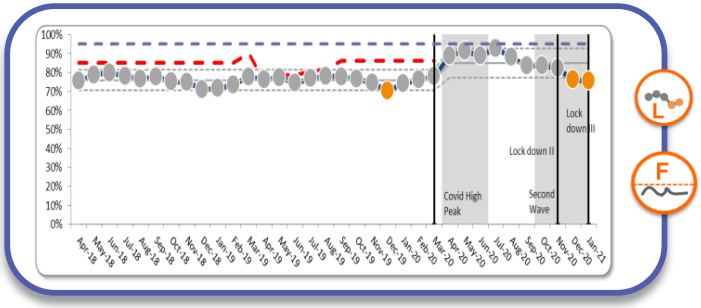
Month 10 [January] 2020-21 | Operational Performance: Urgent Care & Patient Flow

Responsible Director: Chief Operating Officer | Validated for Jan-21 as 3rd February 2021

NHS Worcestershire Acute Hospitals NHS Trust

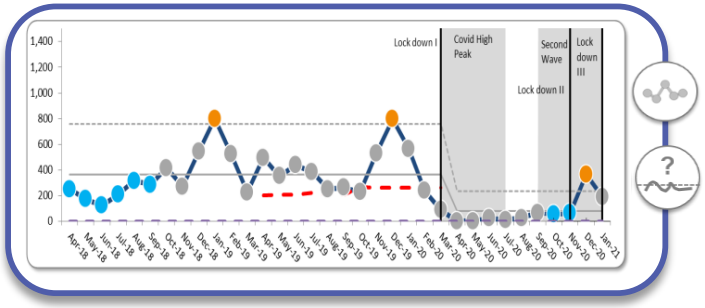
4 Hour EAS (all)

75.35%



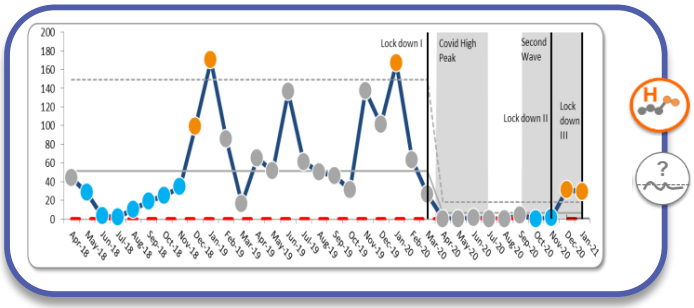
60 minute Ambulance Handover Delays

192



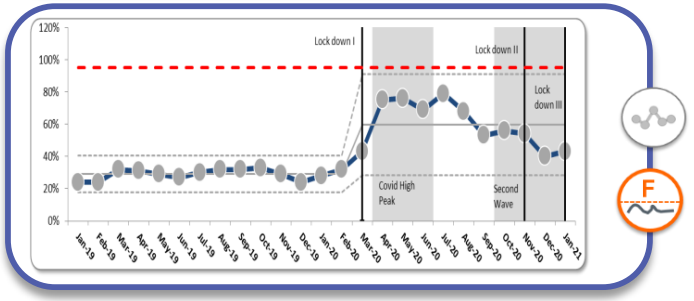
12 Hour Trolley Breaches

29



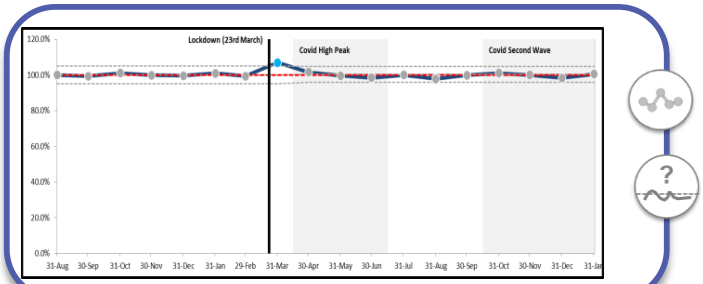
Specialty Review within 1 hour

43%



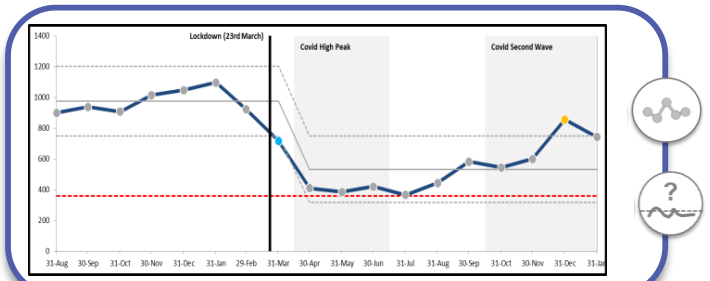
Discharge as a percentage of admissions

100%



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

742



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

Key

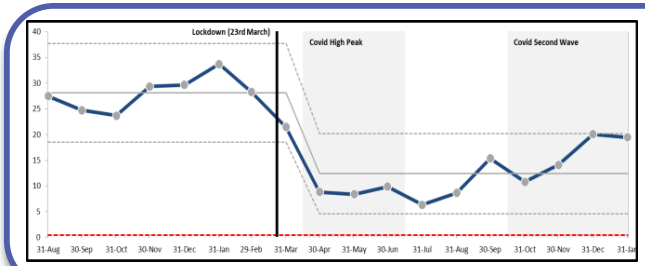
- Internal target
- Operational standard

Month 10 [January] 2020-21 | Operational Performance: Urgent Care & Patient Flow

Responsible Director: Chief Operating Officer | Validated for Jan-21 as 3rd February 2021

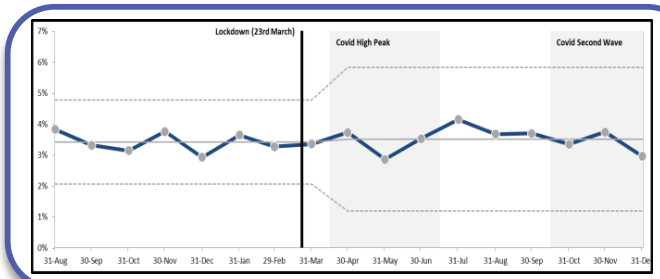
Capacity Gap (Daily avg. excl. EL)

19



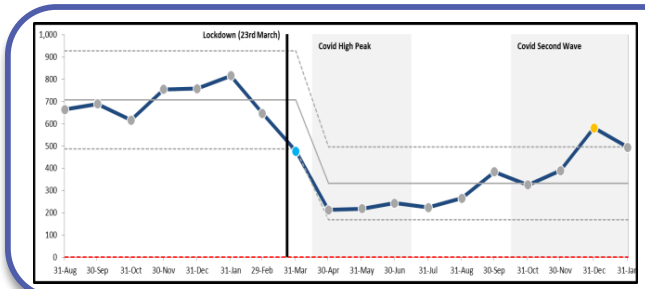
30 day readmission rate for same clinical condition (Oct-20)

2.96%



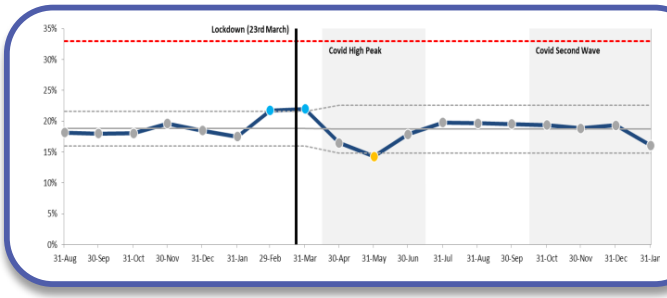
Aggregated Patient Delay (APD)

494



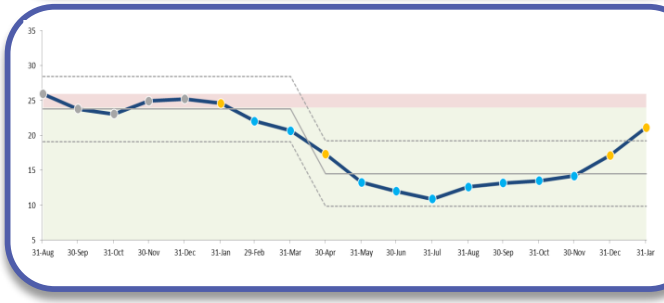
Discharges before midday (Non COVID-19 wards)

350



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

21.1



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

Key

- Internal target
- Operational standard

Operational Performance: Urgent Care Benchmarking

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

National Benchmarking (January 2021)

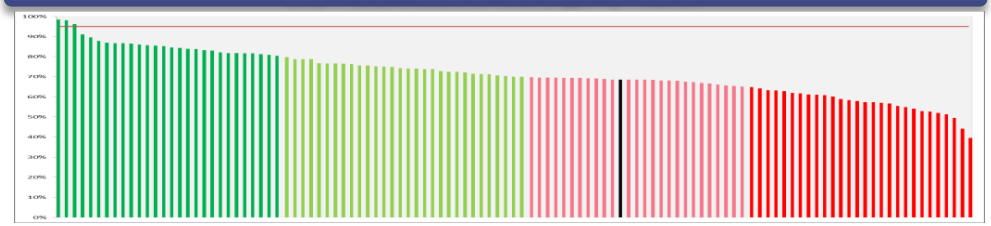
EAS (All) - The Trust was one of 11 of 13 West Midlands Trusts which saw a decline in performance between December and January. This Trust was ranked 6th of 13; where we were 8th previous month. The peer group performance ranged from 59.26% to 82.66% with a peer group average of 70.34%; decreasing from 73.95% the previous month. The England average for January was 78.50%, a 1.8 percentage point decrease from 80.30%, in December.

EAS (Type 1) - The Trust was one of 3 of 13 West Midlands Trusts which saw an improvement in performance between December and January. This Trust was ranked 4th of 13; where we were 7th previous month. The peer group performance ranged from 54.85% to 80.85% with a peer group average of 61.98%; decreasing from 64.99% the previous month. The England average for January was 71.10%, a 1.0 percentage point decrease from 72.10%, in December.

In Jan-21, there were 3,809 patients recorded as spending >12 hours from decision to admit to admission. 29 of these patients were from WAHT; 0.76% of the total.

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

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



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

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

WAHT — Operational Standard 95%

8

Operational Performance: Cancer

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

Cancer Referrals	Patients seen within 14 days (2WW) (All Cancers)	Patients seen within 14 days (2WW) Breast Symptomatic	Patients treated within 31 days	Patients treated within 62 days	Backlog of patients waiting 63 days or more	Of which, patients waiting 104 days or more
1,839	73.53% (1,806 total seen)	9.90% (101 total seen)	88.94% (235 total treated)	72.09% (150.5 total treated)	255	100

What does the data tells us?

- **Referrals**: there has been no significant change in referrals since Jun-20, although the we have dropped below the mean, There are no significant changes in referrals at specialty level; although Lower GI, Upper GI and Urology have had the biggest decrease in referral this month.
- **2WW:** The Trust saw 90 fewer patients in Jan- 21 than Dec -20 and 73.55% were within 14 days. The Breast service saw 349 patients but only 13.18% were within 14 days. Of the 478 breaches, 178 (63%) were attributable to Breast Services. Across all tumour sites, only 53 2WW breaches were due to patient choice.
- **2WW Breast Symptomatic:** The Trust saw no significant change in patients referred for breast symptoms but the waiting time performance is 9.90%. The waits have increased significantly in the last two months and the process is very unlikely to achieve the 93% target.
- **31 Day:** Of the 235 patients treated in Jan-21, 208 waited less than 31 days for their first definitive treatment from receiving their diagnosis. This showing significant variation and the process is still likely to achieve the target but not consistently.
- **62 Day:** There have been 150.5 recorded first treatments in Jan-21 to date and 72.58% within 62 days. This does continue the trend of no significant change in variation since Aug-19 and, currently, the 85% target is not achievable.
- **Backlog:** The number of patients waiting 62+ days for their diagnosis and, if necessary, treatment has increased from 195 in Dec-20 to 255 in Jan-21; this is still tracking under our December phase 3 forecast of 224. Of that cohort, the number of patients waiting 104 days or more is 100, 39 diagnosed and 61 suspected; this metric cannot currently meet the target of zero.
- **Conversion rates:** In 2019 the Trust's conversion rate from referral to positive diagnosis was 9.43% across all specialties. In 2020, to Nov-20, our conversion rate is 10.71%, however this is in the context of fewer total referrals and, fewer positive cases.

What have we been doing?

- Additional capacity for Breast and Urology via workforce reorganisation and WLI's should ensure achievement of 2ww target going forwards (Breast from March and Urology from February).
- Use of the independent sector (IS) has been established to provide some operating capacity (though significantly less than during the first wave) and establishment of Star Chamber, a panel that meets 3 times a week to assess the risk / benefit of bringing specific cancer patients onto the WRH or ARH sites for their cancer operation.
- Establishment of a process working collaboratively with the PCN that sees all cancer patients offered a Covid-19 vaccination ahead of starting their cancer treatment to protect against increased mortality risks.
- Sought mutual aid from Gloucester to treat some Urology prostatectomy patients.
- Increase of ring-fenced bed to treat cancer treatments with further plans to increase as and when reductions of Covid-19 patients in our overall bed base are realised.

What are we doing next?

- Continued liaison with the IS for additional capacity as and when their staffing / priorities allows.
- Ongoing monitoring of the bed base position to further ring-fence beds for cancer patient surgery.
- Ongoing weekly monitoring of the cancer PTL's to ensure cancer patients continue to be prioritised after priority 1 patients.

Current Assurance Levels (first time split by cancer waiting times standard)

- **2WW - Level 5**
- **31 Day Treatment - Level 5**
- **62 Day Referral to Treatment - Level 4**

When expected to move to next levels of assurance: when we are consistently meeting the operational standards of cancer waiting times and the backlog of patients waiting starts to decrease

SRO: Paul Brennan

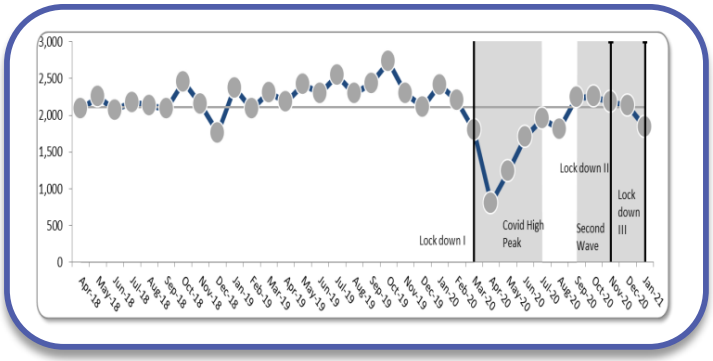
Month 10 [January] 2020-21 | Operational Performance: Cancer

Responsible Director: Chief Operating Officer | Unvalidated for Jan-21 as 3rd February 2021

NHS Worcestershire Acute Hospitals NHS Trust

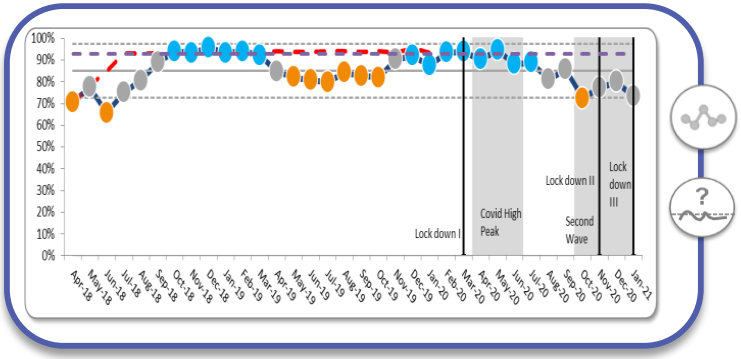
2WW Referrals

1,839



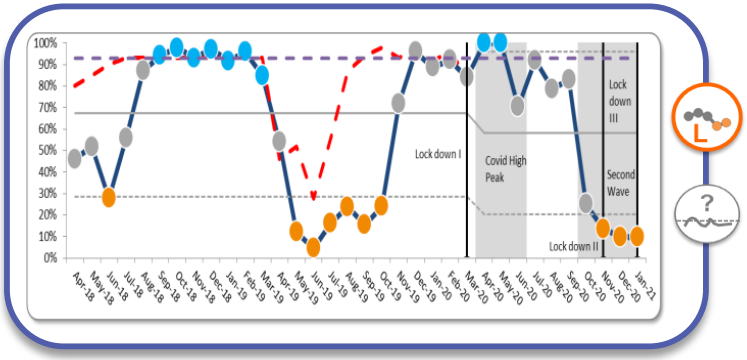
Cancer 2WW All

73.53%



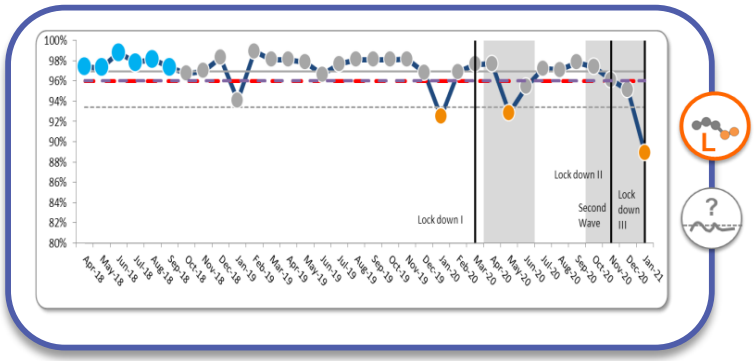
Cancer 2WW Breast Symptomatic

9.90%



Cancer 31 Day All

88.94%



Key

- Internal target
- Operational standard

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

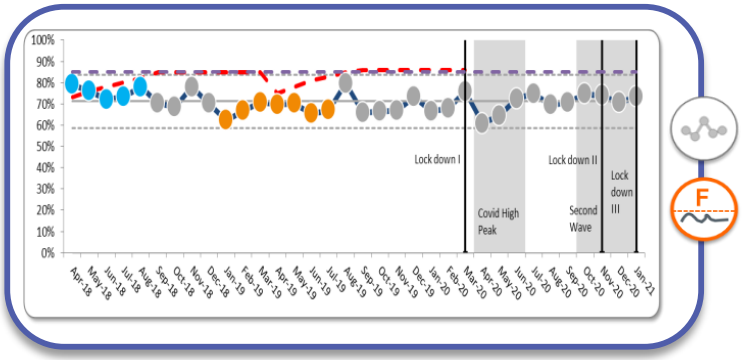
Month 10 [January] 2020-21 | Operational Performance: Cancer

Responsible Director: Chief Operating Officer | Unvalidated for Jan-21 as 3rd February 2021

NHS Worcestershire Acute Hospitals NHS Trust

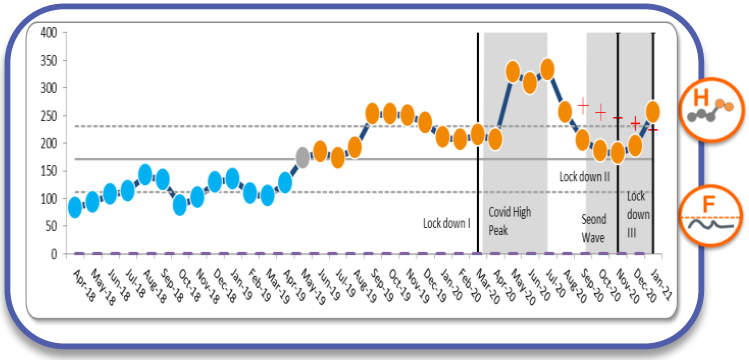
Cancer 62 Day All

72.09%



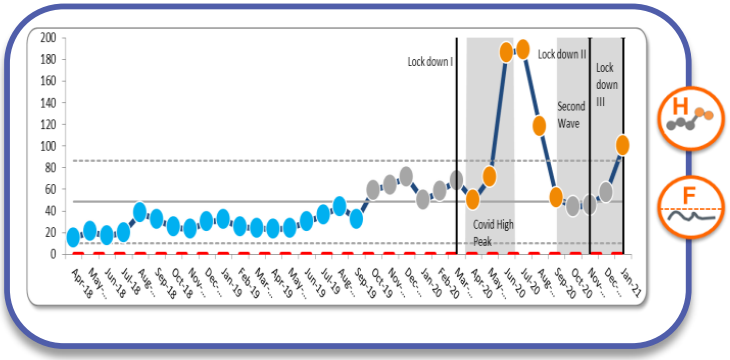
Backlog Patients waiting 63 days or more

255

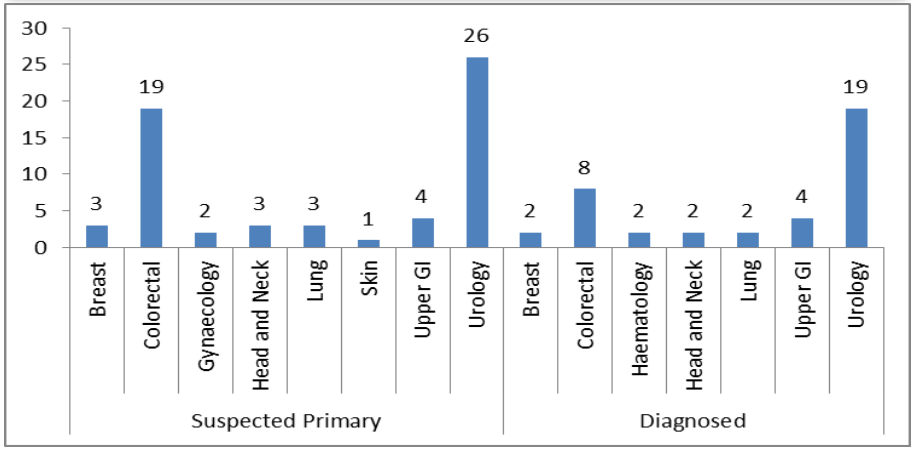


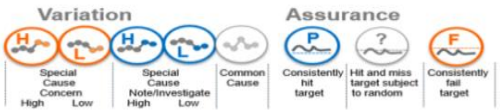
Backlog Patients waiting 104 day or more

100



104+ Day Backlog profile by specialty





Key

\+ phase 3 target

\- Internal target

\- Operational standard

Operational Performance: Cancer Benchmarking

National Benchmarking (December 2020)

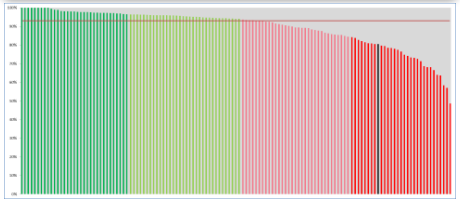
2WW: The Trust was 7 of the 13 West Midlands Trusts which saw an improvement in performance between November and December. This Trust ranking is 9 out of 13. The peer group performance ranged from 44.25% to 98.01% with a peer group average of 81.97%; increasing from 80.73% the previous month. The England average for December 2020 was 87.54%, a 1.46 percentage point decrease from 87% in November.

2WW BS: The Trust was one of 11 of the 13 West Midlands Trusts who saw a decline in performance between November and December. This Trust was ranked 9 of 13. The peer group performance ranged from 1.92% to 98.67% with a peer group average of 46.68%; increasing from 44.96% the previous month. The England average for December 2020 was 67.05%, a 0.78 percentage point decrease from 67.83%, in November.

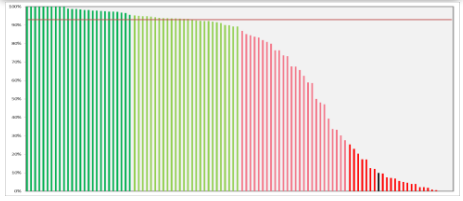
31 days: The Trust was one of 4 of the 13 West Midlands Trusts who saw a decline in performance between November and December. This Trust was ranked 7 of 13. The peer group performance ranged from 86.60% to 100% with a peer group average of 94.16%; increasing from 92.21% the previous month. The England average for December 2020 was 96%, a 0.79 percentage point increase from 95.21%, in November.

62 Days: The Trust was one of 7 of the 13 in the West Midlands Trusts who saw an improvement in performance between November and December. This Trust its position is 6 of 13. The peer group performance ranged from 38.90% to 82.35% with a peer group average of 64.68%; increasing from 66.50%; the previous month. The England average for December 2020 was 75.17%, 0.38 percentage point decrease from 75.55% in November.

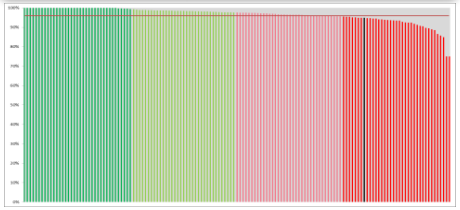
2WW (All cancers) | Dec-20



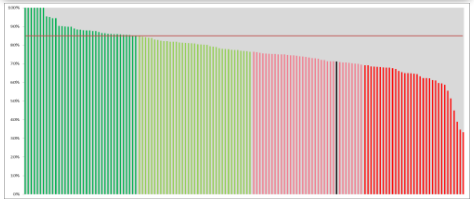
2WW Breast Symptomatic | Dec-20



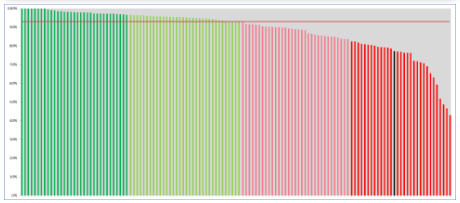
Cancer 31 Day (All cancers) | Dec-20



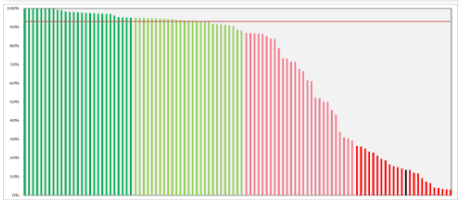
Cancer 62 day (All cancers) | Dec-20



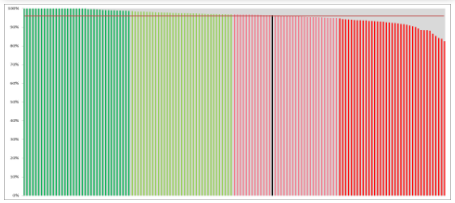
2WW (All cancers) | Nov-20



2WW Breast Symptomatic | Nov-20



Cancer 31 Day (All cancers) | Nov-20



Cancer 62 day (All cancers) | Nov-20

WAHT — Operational Standard 93%

WAHT — Operational Standard 93%

WAHT — Operational Standard 96%

WAHT — Operational Standard 85%

Operational Performance: RTT

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

Total Waiting List	Number of patients waiting over 18 weeks	Percentage of patients on a consultant led pathway waiting less than 18 weeks for their first definitive treatment	Number of patients waiting 40 to 52 weeks or more for their first definitive treatment	52+ weeks	Of which, waiting 70+ weeks	RTT Referrals (Routine and Urgent) received
42,169	18,900	55.18%	4,420	4,290	683	3,527

What does the data tells us?

- The Trust has seen a 4.13% increase in the overall wait list size in Jan-21 compared to Dec-20; from 41,572 to 42,169. This is currently +1,189 more patients on our waiting list than the phase 3 forecast.
- The number of patients over 18 weeks who were unable to be seen or treated has increased to 18,900. This is 891 more patients than Dec-20's snapshot. RTT performance is validated at 55.18% compared to 56.68% in Dec-20. This remains sustained, significant cause for concern from Apr-20 and the 92% waiting times standard cannot be achieved.
- The number of patients waiting between 40-52 weeks for treatment is 4,420, and those patients waiting over 52 weeks which is now 4,290; this is currently +2,260 more patients waiting 52+ weeks than on our phase 3 forecast. There has been a subtle shift in the number of patients waiting to be almost as many 52+ weeks as 40-52 weeks, partly due the reduction in referrals during wave 1 finally coming through in to the 40-45 week cohort.
- Of the 4,290 patients waiting over 52 weeks, 683 have been waiting over 70 weeks with 278 patients requiring oral surgery / orthodontics treatment.
- Eight specialties have over 1,000 patients waiting over 18 weeks; this is 78% of all our 18 week breaches. Three of those specialties now have over 2,000 patients breaching. Those 8 specialties contribute 84% of all patients waiting over 52 weeks.
- **Referral Assessment Services (RAS)**: In Jan-21, 3,347 referrals were received through this service to be triaged, 3,130 (3.5%) of all Jan-21 referrals have been outcomed, and 58% of those were outcomed within 14 working days. 2,715 appointments have been booked, 94 referrals were cancelled but there remains 433 referrals awaiting action.

Current Assurance level: 4 (Jan-21)	**When expected to move to next level of assurance:** This is dependent on the on-going management of COVID-19 second wave, the restoration of elective activity and reduction of long waiters
Previous Assurance Level: 4 (Nov-20)	**SRO: Paul Brennan**

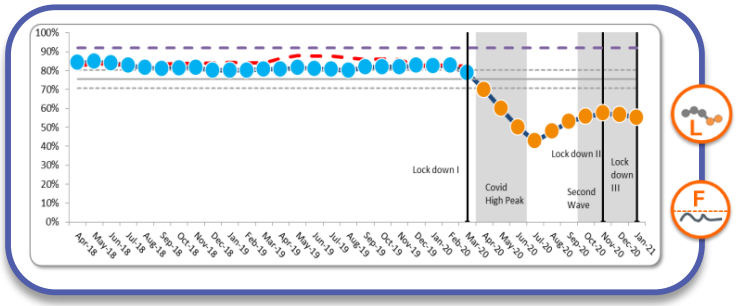
Month 10 [January] 2020-21 | Operational Performance: RTT

Responsible Director: Chief Operating Officer | Validated for Jan-21 as 19th February 2021

NHS Worcestershire Acute Hospitals NHS Trust

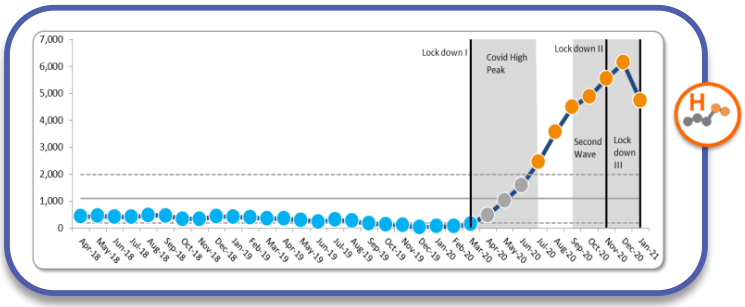
RTT % within 18 weeks

55.18%



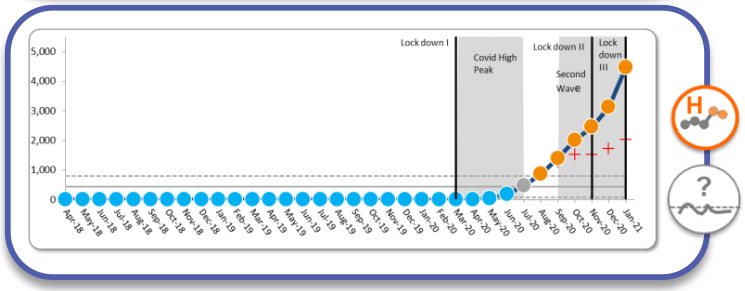
40-52 week waits

4,420



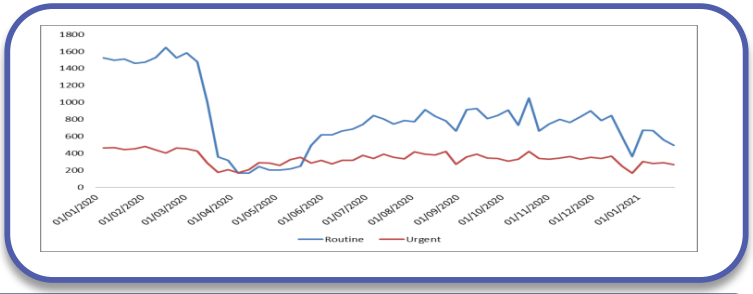
52+ week waits

4,290

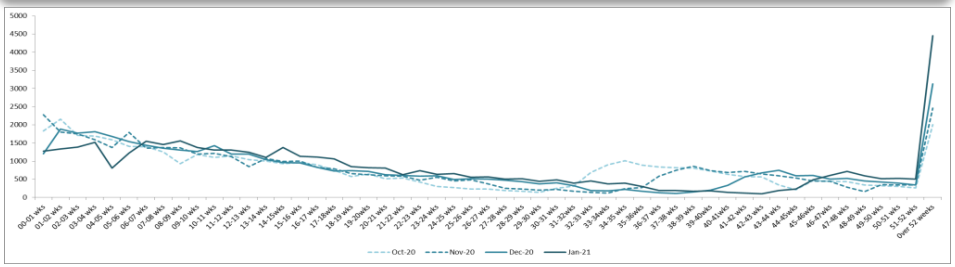


RTT Referrals Profile

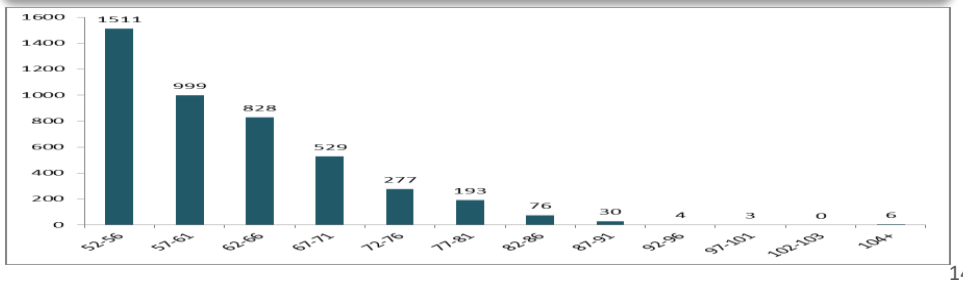
3,527



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



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



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

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

Key

+ phase 3 target
- Internal target
- Operational standard

Operational Performance: RTT Benchmarking

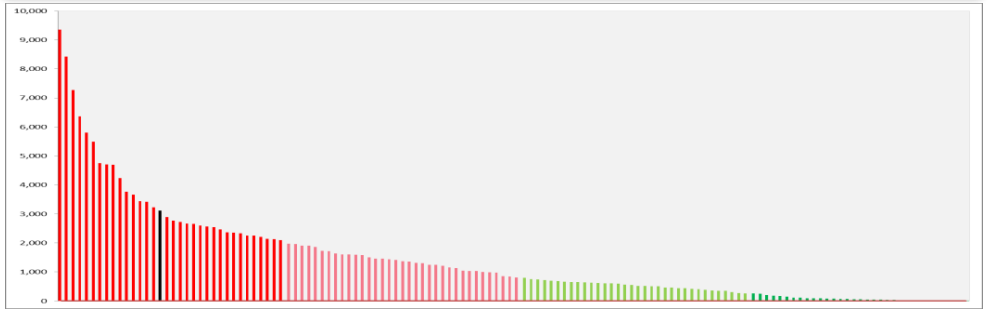
2.4 - Maintain access to all emergency surgery (inc trauma) and triage elective waiting list to prioritise access for those at greatest risk of harm from delay

National Benchmarking (December 2020) | The Trust was one of 10 of the 13 West Midlands Trusts who saw an improvement in performance between November and December. This Trust is now ranked at 13 of 13.The peer group performance ranged from 56.71% to 83.12% with a peer group average of 66.29%; increasing from 63.07% the previous month. The England average December 2020 was 67.8%, a 0.4 percentage point decrease from 68.20%, in November.

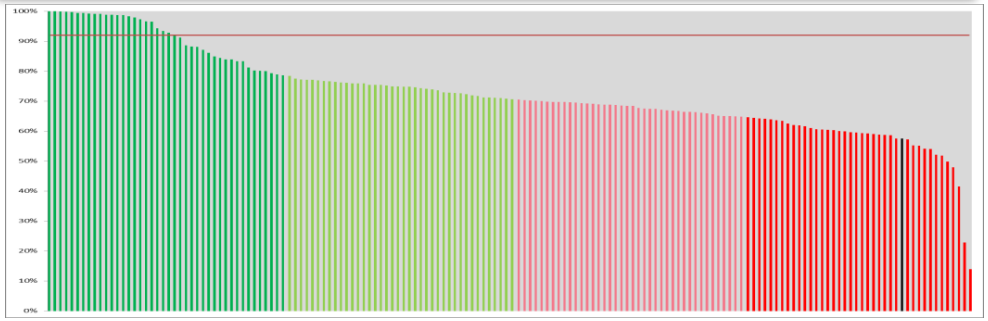
Nationally, there were 224,205 patients waiting 52+ weeks, 3,119 (1.39%) of that cohort were our patients.

RTT - % patients within 18 weeks | Dec-20

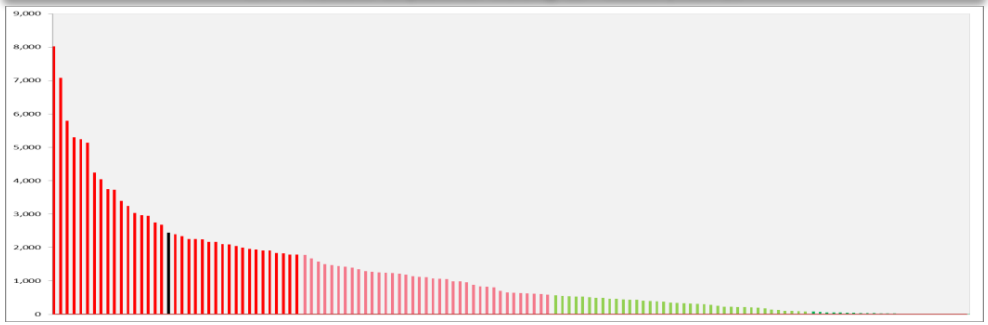
RTT – number of patients waiting 52+ weeks | Dec -20



RTT - % patients within 18 weeks | Nov-20



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



WAHT — Operational Standard 92%

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

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

News Face to Face (excl OP+ – all other activity)	News Non Face to Face (excl OP+ – all other activity)	News % Non Face to Face	Follow ups Face to Face (excl OP+ – all other activity)	Follow ups Non Face to Face (excl OP+ – all other activity)	Follow ups % Non Face to Face	Total % Non Face to Face
9,516	2,432	24.87%	16,064	11,026	41.75%	35.71%

Outpatients - what does the data tell us?

- The Trust undertook 32,717 outpatient appointments in Jan-21. This is 17,060 fewer appointments than Jan-20 (66% of Jan-20 activity), and 6,556 less than Dec-20. When looking specifically at consultant led activity, in line with phase 3 restoration monitoring expectations, we achieved 61% of our submitted plan activity.
- In Jan-20, 2,209 non-face-to-face appointments took place which increased to 13,892 in Jan-21. Of all appointments in the month, 35.71 (both new and follow-up) were non-face-to-face.
- As at 13th February the outpatient backlog for **new** outpatients was 45,634 with 18,669 on an RTT pathway and 26,965 on a non-RTT pathway. 6,105 patients had been dated which leave 39,529 not yet dated. 37,011 patients of the total new outpatient waiting list are deemed to be routine.
- Looking specifically at our phase 3 plan (slide 19), we undertook 16,808 appointments against a target of 23,331. Our area of success continues to be Consultant-led first outpatient attendances (telephone/video) where we were +771 to plan.

Planned Admissions - what does the data tell us?

- On the day cancellations shows no significant change since Jun-20.
- After theatre utilisation achieved an upwards trend of 7 consecutive months, this could not be continued in to Jan-21 with the cancellation of most non-emergency surgery (slide 17) and the number of day case and elective theatres shows special cause variation for this same reason.
- From our inpatient elective monitoring, day case spells were -917 below and ordinary spells were -119 below our phase 3 forecasts.
- Routine theatre procedures decreased from 861 in Dec-20 to 185 in Jan-21; however we maintained a similar number of non-elective (514) and cancer (101) in Jan-21 when compared to Dec-20.
- The Independent Sector undertook 75 day cases and 15 electives; however this was a 70% reduction in activity compared to Dec-20.

Current Assurance Level: 4 (Jan-21)	**When expected to move to next level of assurance:** This is dependent on the on-going management of COVID-19 second wave allowing for the restoration of outpatient appointments and planned admissions for surgery
Previous Assurance Level: 4 (Nov-20)	**SRO: Paul Brennan**

Month 10 [January] 2020-21 | Operational Performance: Theatre Utilisation & Outpatients

Responsible Director: Chief Operating Officer | Unvalidated for Jan-21 as 3rd February 2021

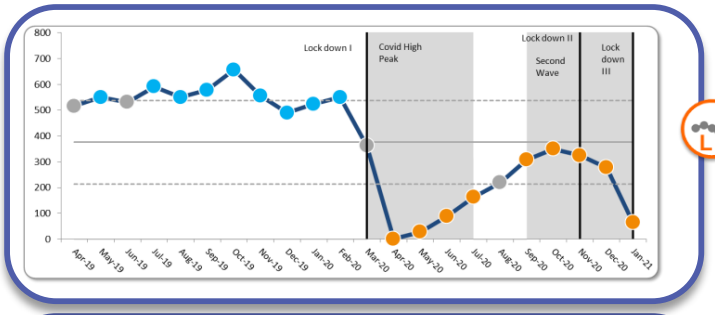
NHS Worcestershire Acute Hospitals NHS Trust

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

7.90%

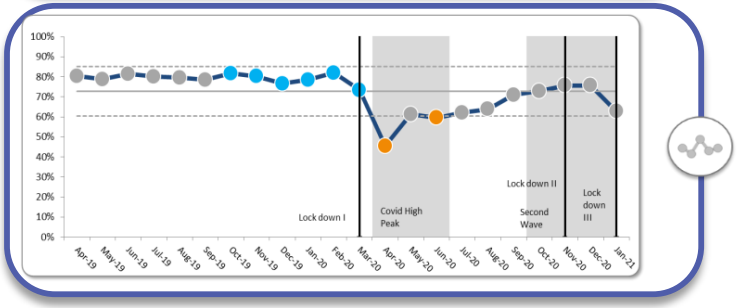
Electives on elective theatre sessions (n)

64



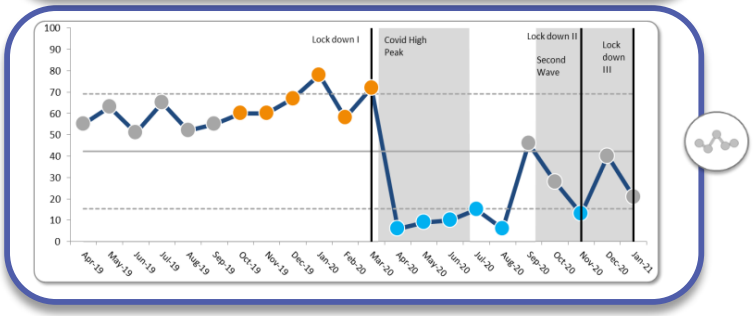
Actual Theatre session utilisation (%)

62.70%



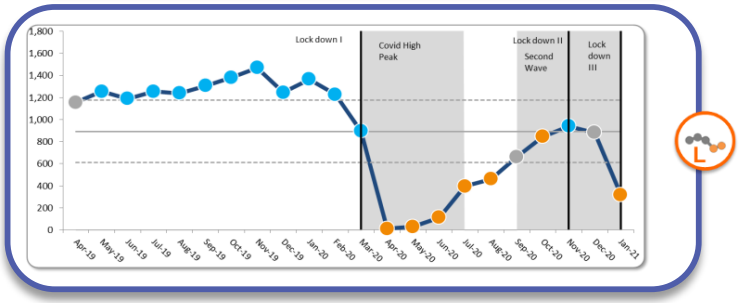
Non-electives & emergencies on elective theatre sessions (n)

21

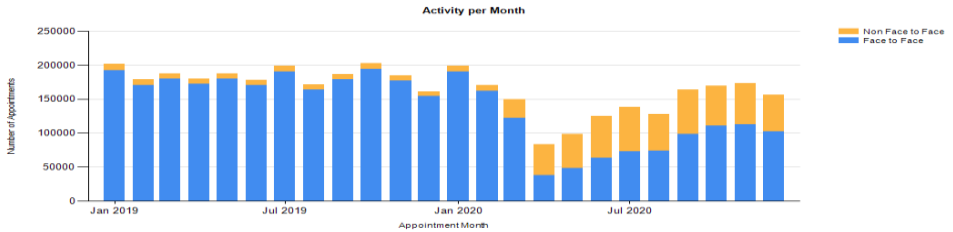


Day cases on elective theatre sessions (n)

319



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



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

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

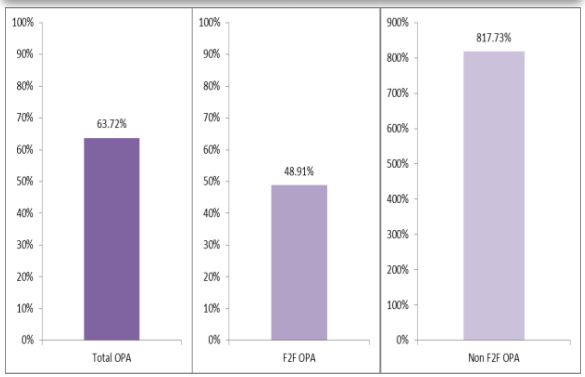
Month 10 [January] 2020-21 | Operational Performance: Outpatients

Responsible Director: Chief Operating Officer | Validated for Jan-21 as 19th February 2021

NHS Worcestershire Acute Hospitals NHS Trust

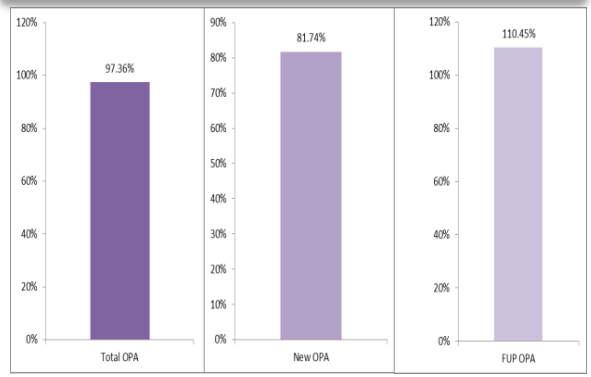
Outpatients Activity | Jan-20 activity as a percentage of Jan-19 activity (all activity apart from excluding OP+)[1]

New

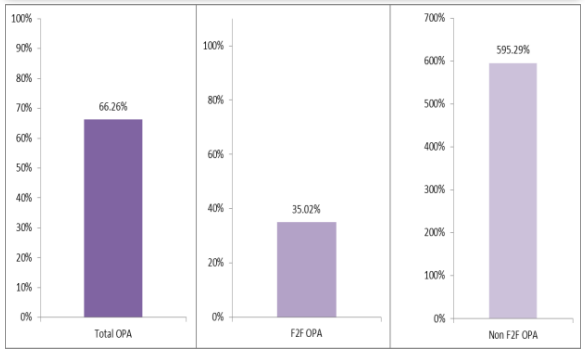


Emergency

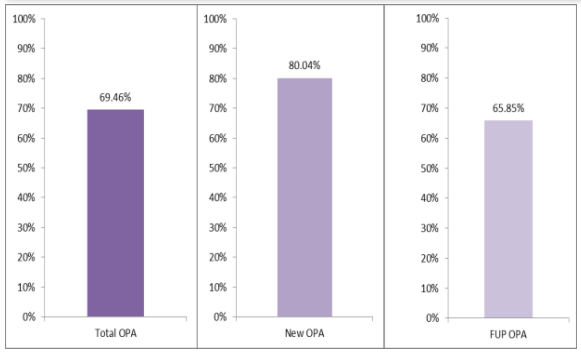
Cancer



Follow up



Urgent



Routine

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

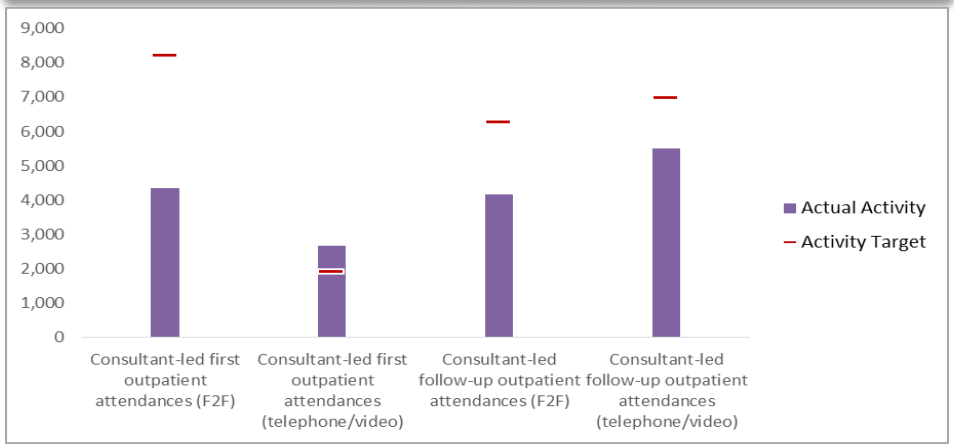
Month 10 [January] 2020-21 | Operational Performance: Outpatients

Responsible Director: Chief Operating Officer | Validated for Jan-21 as 19th February 2021

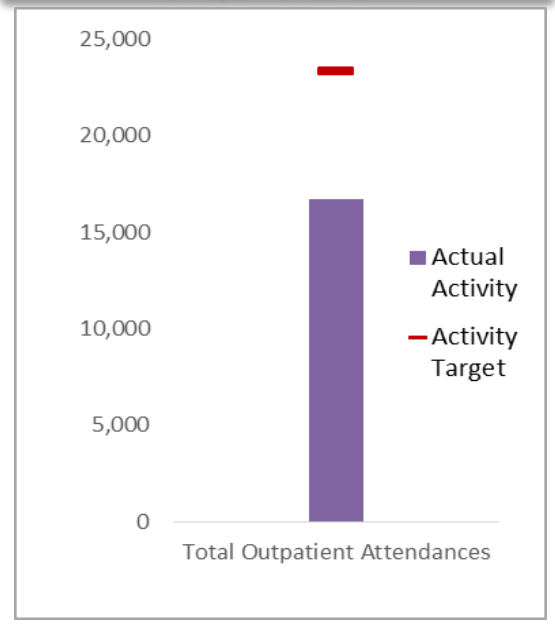
NHS Worcestershire Acute Hospitals NHS Trust

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

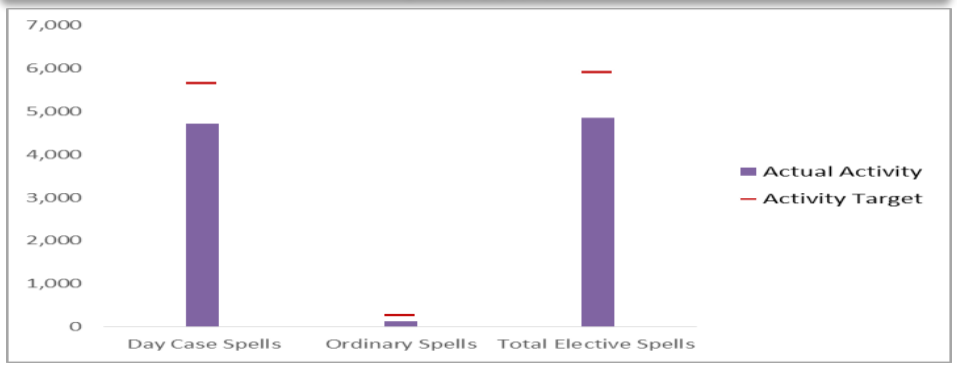
Consultant-led outpatients attendances



Total outpatients attendances



Inpatient Electives



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

Operational Performance: DM01 Diagnostics

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

NHS Worcestershire Acute Hospitals NHS Trust

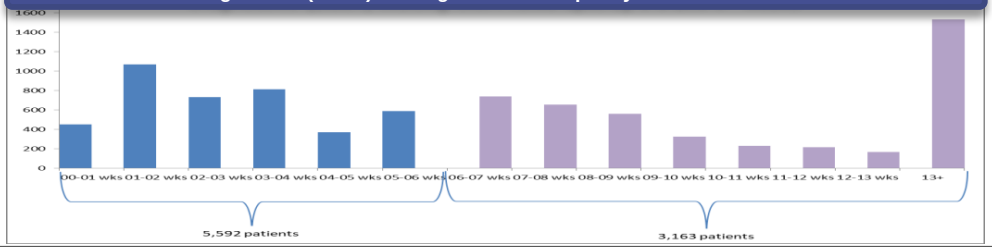
The total waiting list, the number of patients waiting more than 6 weeks for a diagnostic test, and % of patients waiting less than 6 weeks

Trust Total			Radiology			Physiology			Endoscopy		
8,459	4,430	47.63%	4,699	2,139	54.50%	2,091	1,314	37.20%	1,669	977	41.50%

What does the data tell us?

- The DM01 performance is unvalidated at 47.63% of patients waiting less than 6 weeks for their diagnostic test, no significant change from the previous month and consistent with the sustained underperformance since the cessation of elective diagnostic tests due to COVID-19 created a backlog of patients.
- The diagnostic waiting list has decreased with the total waiting list currently at 8,459 patients, an decrease of 296 patients from the previous month.
- The total number of patients waiting 6+ weeks has increased by 1,267 patients (3,163 in Dec) and there are now 1,533 patients waiting over 13 weeks (1,438 in Dec-20).
- Radiology has the largest number of patients waiting at 4,699 and has the largest number of patient waiting over 6 weeks at 2139; an increase of 921 in Jan 21 compared to Dec-20.
- 10,882 diagnostics tests were undertaken in Jan-20, 22.96% less than Dec-20 and 33.99% lower than Jan-19.
- Radiology undertook 1,928 fewer tests in Jan-20 compared to Dec-20. Comparing to our phase 3 activity target, CT and MRI were above the forecast and MRI non-obstetric ultrasound was below it.
- Endoscopy completed 779 fewer tests in Jan-20 than Dec-20. Comparing to our phase 3 activity target all were below target.
- Physiology undertook 537 few test in Jan-20 compared to Dec-20.

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



What have we been doing?

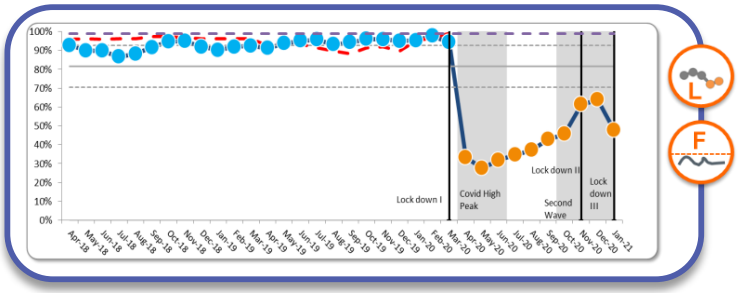
- Activity that wasn't Cat 1/1a as per level 5 response resulted in routine patients being cancelled and put back on the waiting list for all modalities.
- Radiology was subsequently allowed to recommence CT/MRI/US at peripheral sites on the 2nd week of January but this reduced capacity levels. It took a few days to mobilise and book patients onto lists and some lists were reduced due to COVID-19 related issues i.e. sickness/CEV but there was no effect on activity due to redeployment.
- A significant amount of endoscopy staff were redeployed, were shielding and been affected by COVID-19 related issues. This has had some impact on our ability to staff sessions however, staffing is discussed at the weekly endoscopy Forward Look meeting where any short full in staffing is discussed in order to minimise impact where possible.
- Staff are routinely working across all site in order to maximise activity.

What are we doing next?

- Radiology: activity in February will be similar to January but February half term will impact on the uptake of WLIs.
- Endoscopy: there was agreement from Star chamber to recommence routine activity on the peripheral sites from 1st February

DM01 Diagnostics % patients waiting <6 weeks

47.63%



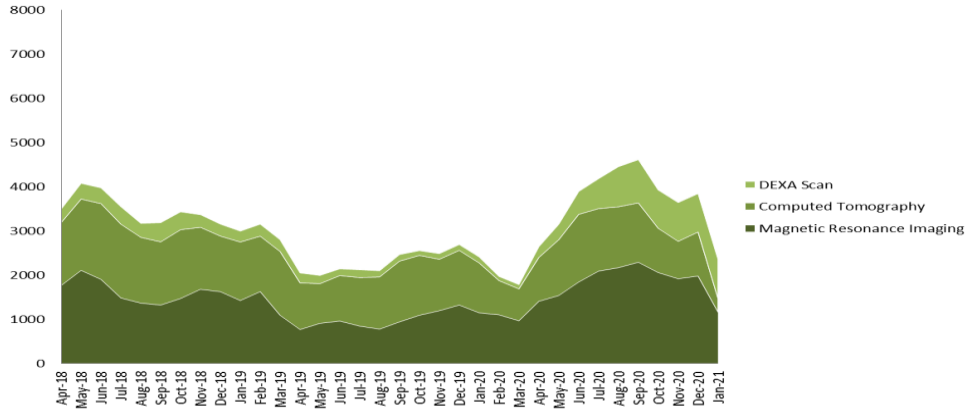
Current Assurance Level: 4 (Jan-21)	**When expected to move to next level of assurance:** This is dependent on the on-going management of COVID-19 increasing our capacity for routine activity
Previous assurance level: 5 (Nov-20)	**SRO: Paul Brennan**

20

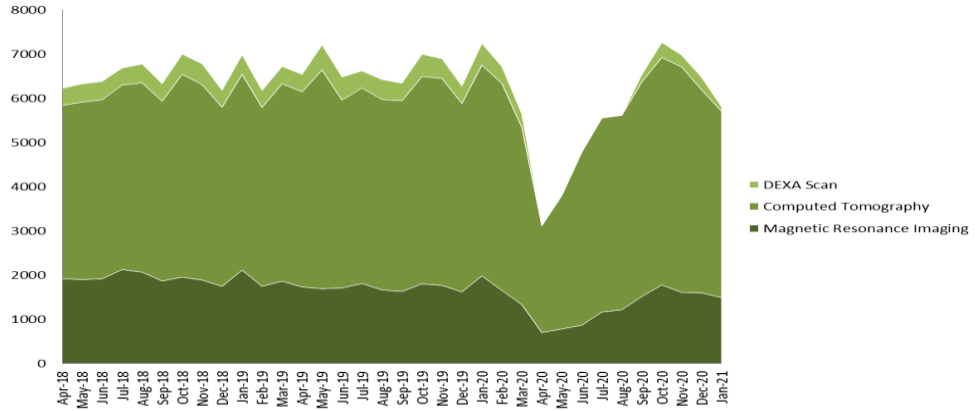
Month 10 [January] 2020-21 | Operational Performance: DM01 Diagnostics

Responsible Director: Chief Operating Officer | Validated for Jan-21 as 19th February 2021

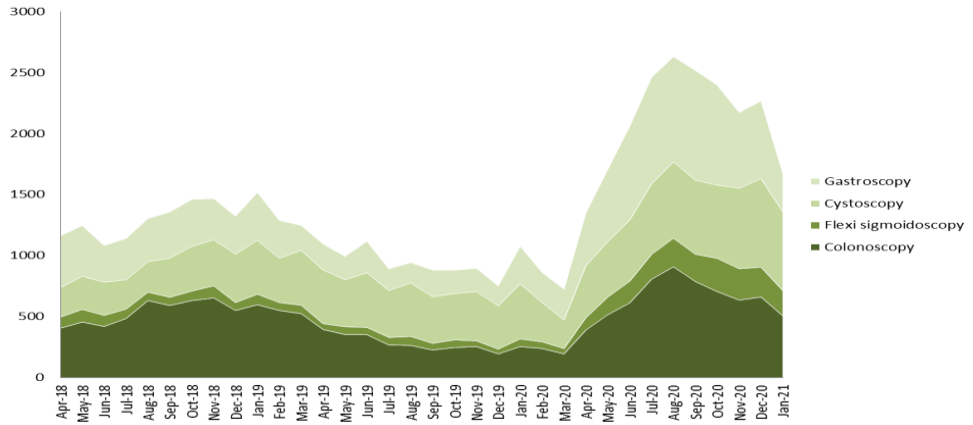
Radiology DM01 waiting list size - Monthly snapshot



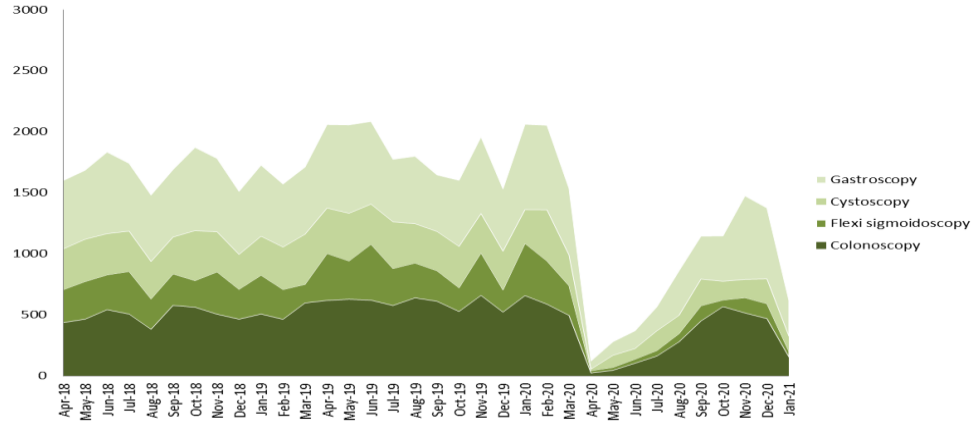
Radiology DM01 Activity - Monthly snapshot



Endoscopy DM01 waiting list size - Monthly snapshot



Endoscopy DM01 Activity - Monthly snapshot



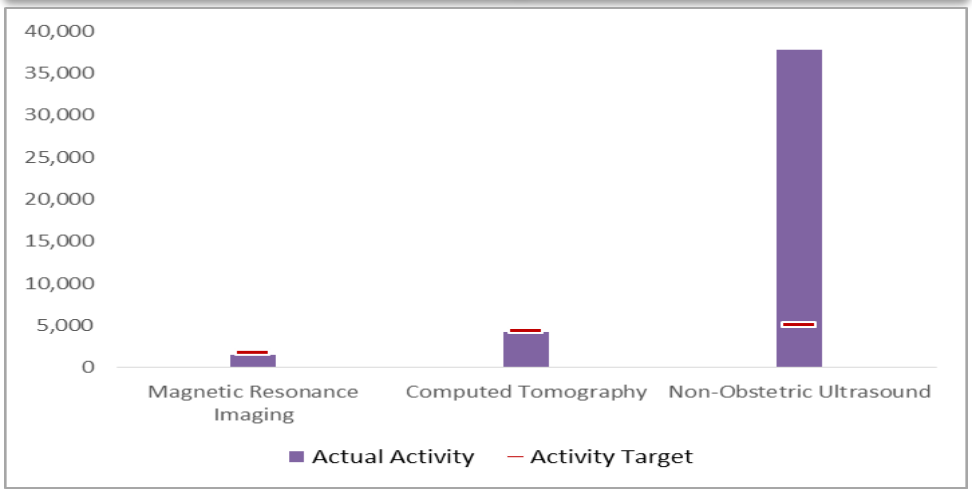
Note the different scaled axis on the graphs when comparing them

Month 10 [January] 2020-21 | Operational Performance: DM01 Diagnostics

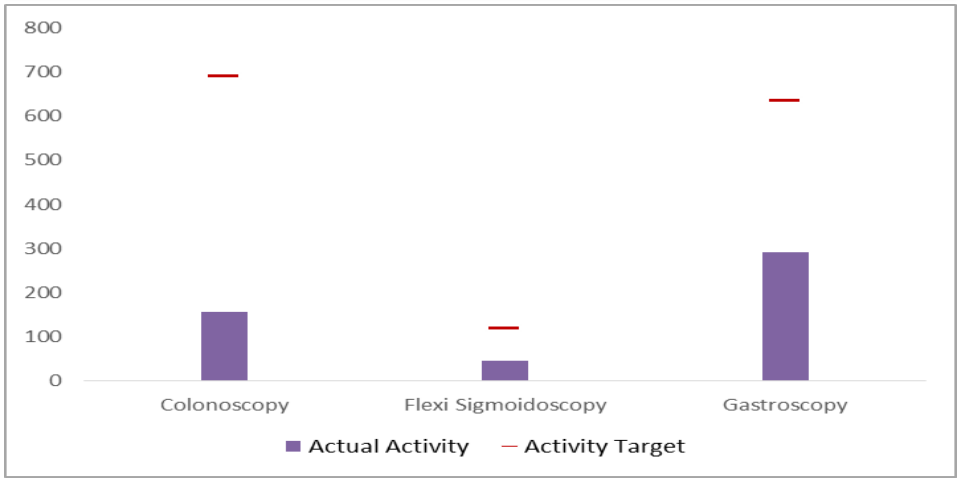
Responsible Director: Chief Operating Officer | Validated for Jan-21 as 19th February 2021

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

Radiology



Endoscopy



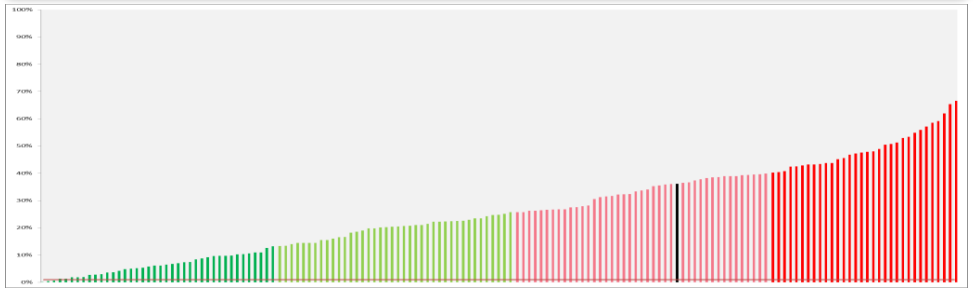
These graphs represent phase 3 restoration only, as submitted in the plan. All physiology tests, DEXA and cystoscopy were not included in the request from NHSEI

Operational Performance: Diagnostics (DM01) Benchmarking

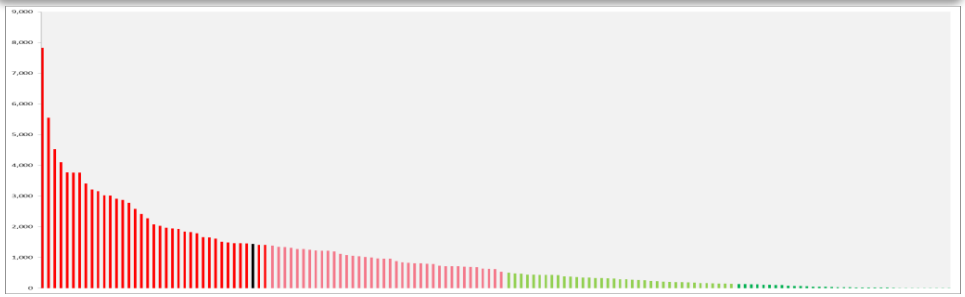
National Benchmarking (December 2020) | The Trust was one of 5 of the 13 West Midlands Trusts which saw a reduction in patients waiting over 6 weeks. This Trust was ranked 9 of 13 in December 2020. The peer group performance ranged from 2.79% to 46.77% with a peer group average of 28.06%; increasing from 25.51% the previous month.

The England average for December 2020 was 29.2%, a 1.7 percentage point increase from 27.5% in November.
In December, there were 151,795 patients recorded as waiting 13+ weeks for their diagnostic test; 1,438 (0.94%) of these patients were from WAHT.

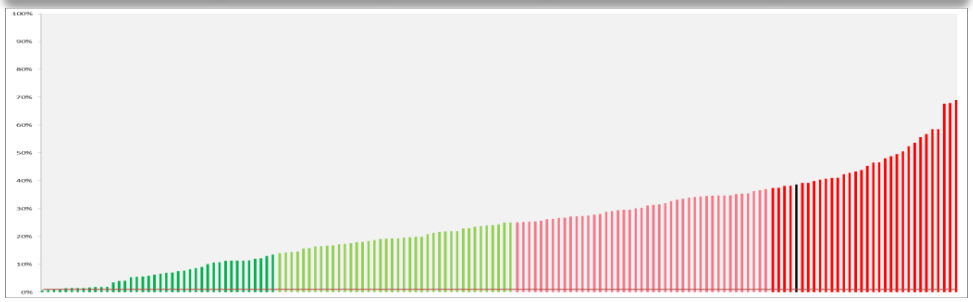
DM01 Diagnostics - % of patients waiting more than 6 weeks | Dec -20



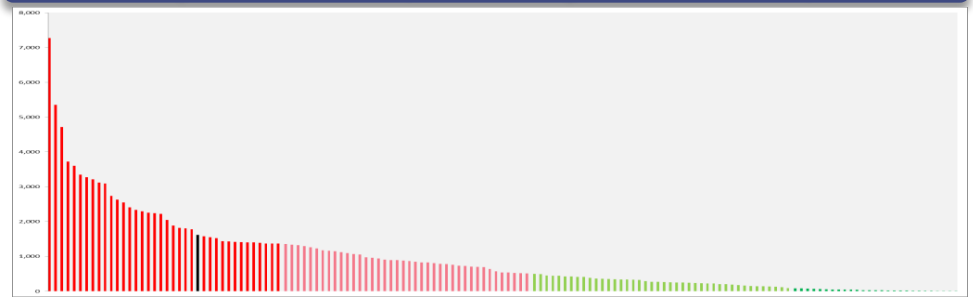
DM01 Diagnostics - number of patients waiting more than 13 weeks | Dec -20



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



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



Operational Performance: Stroke

% of patients spending 90% of time on a Stroke Ward	% of patients who had Direct Admission (via A&E) to a Stroke Ward	% patients seen in TIA clinic within 24 hours	% of patients who had a CT within 60 minutes of arrival	SSNAP Q2 Jul-20 to Sep-20			
70.69%	20.69%	100%	27.59%	Score	76.0	Grade	B

What does the data tell us?

- All four main stroke metrics show performance that is within common cause variation.
- Patients spending 90% of their time on a stroke ward shows no significant change in performance since Apr-18. The process is unlikely to achieve the target of 80% consistently but may be expected to vary between 60% and 90%.
- Patients who had Direct Admission (via A&E) to a stroke ward shows no significant change in performance since Oct-19. The process will not achieve the target of 90% but may be expected to vary between 16% and 57%.
- Patients seen in TIA clinic within 24 hours showed a step change in Mar-20. The process will currently consistently achieve the target of 70%.
- Patients who had a CT scan within 60 minutes of arrival shows no change since Sept-18. The process will not achieve the target of 80% but may be expected to vary between 33% and 70%.

- Stroke consultant recruited on a permanent basis in December and is scheduled to start beginning of April. This will enable the team to provide a sustainable 7 day service within core hours and potentially return to weekday consultant cover (9-8pm)
- A meeting has been held with Hereford stroke team to discuss their Stroke service provision and their concern regarding limiting consultant resources. The discussion was mainly focused on establishing what consultant support Worcester can provide to help with urgent and planned consultant leave when their permanent consultant leaves in March and these discussions are ongoing
- New admission assessment packs are in the process of being approved which will support timely assessment and decision making

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

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

Current Assurance Level: 5 (Jan-21)	**When expected to move to next level of assurance:** This is dependent on the on-going management of COVID-19 allowing for the ring-fencing of (non-COVID-19) stroke beds and increased availability of MRI scanning.
Previous assurance level: 6 (Nov-20)	**SRO: Paul Brennan**