Trust Board
There will be a meeting of the Trust Board on **Thursday 12 May 2022** at 10:00am. It will be held virtually and live streamed on You Tube.

Sir David Nicholson
Chair

Item		Assurance	Action	Enc	Time
020/22	**Welcome and apologies for absence:**				**10:00**
021/22	**Patient Story**				**10:05**
022/22	**Items of Any Other Business** To declare any business to be taken under this agenda item				**10.30**
023/22	**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.				
024/22	**Minutes of the previous meeting** *To approve the Minutes of the meeting held on 7 April 2022*		*For approval*	**Enc A** **Page 3**	**10:30**
025/22	**Action Log**		*For noting*	**Enc B** **Page 14**	**10:35**
026/22	**Chair's Report**		*For noting*	**Verbal**	**10:40**
027/22	**Chief Executive's Report**		*For noting*	**Enc C** **Page 16**	**10:45**
	Best Services for Local People				
028/22	**2022/23 Annual Plan** Director of Strategy and Planning/ Chief Finance Officer	Level 4	*For noting*	**Enc D** **Page 19**	**10:50**
	Best Experience of Care and Outcomes for our Patients				
029/22	**Integrated Performance Report** Executive Directors	Level 4	*For assurance*	**Enc E1** **Page 26**	**11:15**
030/22	**Committee Assurance Reports** Committee Chairs			**Enc E2** **Page 109**	
031/22	**Ockenden Final Report April 2022** Director of Midwifery		*For noting*	**Enc F** **Page 115**	**11:40**
	Best Use of Resources				

032/22	**Chief Finance Officer's Report Month 12** Chief Finance Officer	Level 4	*For assurance*	**Enc G** **Page 119**	**11:50**
	Best People				
033/22	**Safest Staffing Report** Chief Nursing Officer/Director of Midwifery **a) Adult/Nursing** **b) Midwifery**	 Level 5 Level 4	*For assurance*	**Enc H** **Page 156** **Page 162**	**12:05**
	Governance				
034/22	**Review of Conditions FT4 and G6** Company Secretary	Level 5	*For assurance*	**Enc I** **Page 170**	**12:15**
035/22	**Terms of Reference:** **a) Finance & Performance** **b) Quality Governance** Company Secretary	Level 6	*For approval*	**Enc J** **Page 183** **Page 188**	**12:20**
036/22	**Any Other Business** *as previously notified*				**12:30**
	Close				

Reading Room:

- Enc C – ICB nomination documentation
- Enc D – Slide deck
- Enc F – Risk assessment and supporting paper from QGC

MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON THURSDAY 7 APRIL 2022 AT 10:00 AM HELD VIRTUALLY

Present:		
Chair:	Sir David Nicholson	
Board members: (voting)	Waqar Azmi	Non-Executive Director
	Christine Blanshard	Chief Medical Officer
	Paul Brennan	Chief Operating Officer
	Anita Day	Vice Chair, Non-Executive Director
	Matthew Hopkins	Chief Executive
	Colin Horwath	Non-Executive Director
	Paula Gardner	Chief Nursing Officer
	Dame Julie Moore	Non-Executive Director
	Simon Murphy	Non-Executive Director
	Robert Toole	Chief Finance Officer
Board members: (non-voting)	Richard Haynes	Director of Communications and Engagement
	Vikki Lewis	Chief Digital Information Officer
	Jo Newton	Director of Strategy and Planning
	Richard Oosterom	Associate Non-Executive Director
	Rebecca O'Connor	Company Secretary
	Tina Ricketts	Director of People and Culture
	Sue Sinclair	Associate Non-Executive Director
	Sharon Thomson	Associate Non-Executive Director
In attendance	Justine Jeffery	Director of Midwifery
	Simon Adams	Healthwatch
	Jo Wells	Deputy Company Secretary
	Anna Sterckx	Head of Patient, Carer & Public Engagement (for item 002/22)
	David Ryan	Chaplain (for item 002/22)
	Melanie Stinton	Freedom to Speak Up Guardian (for item 009/22)
	David Wilson	Consultant Cardiologist (for item 010/22)
Public		Via YouTube
Apologies	There were no apologies	

001/22 **WELCOME**

Sir David welcomed everyone to the meeting, including the public viewing via YouTube observers and staff members who had joined.

002/22 **PATIENT STORY**

Sir David welcomed Mr Ryan and gave thanks for the work he and the chaplaincy team do to support patients.

Mrs Gardner echoed Sir David's comments about the chaplain service and the approach they had taken with the challenges faced throughout the COVID-19 pandemic.

Mr Ryan shared two stories in relation to recent schemes that had been introduced:

Sanjida Khan, a member of staff in Theatres at the Alexandra Hospital with the support of the Chaplaincy team, led the fundraising for and distribution of 250 Quran Cubes. Quran Cubes are small, portable devices that play recitations and prayers from the Quran, the Muslim holy book, enabling patients on wards to listen personally to the sacred Scripture of Islam. They have been introduced and distributed across all wards in our hospitals and are providing welcomed emotional support, comfort and spiritual healing for our Muslim patients.

Art in a Hurting Place had been displayed in corridors at the Alexandra Hospital and has been an encouragement to staff. Local schools have assisted with the creation of the art work.

The team are planning a volunteer day to bring experienced volunteers back together to reignite interest and maintain skills. The majority of Chaplaincy volunteers withdrew at the start of the COVID-19 Pandemic and there have been ongoing challenges with recruitment due to fear of coming on site and/or health/age related concerns. There have also been restrictions throughout the pandemic relating to volunteer numbers and activity

Ms Day commended the introduction of the Quran Cubes and asked whether there were any plans to expand the content of the Cubes for other faith styles. Mr Ryan replied that the team were looking into options. Other speakers were available that can be used for music for reminiscence which helps dementia patients. Wards have been really receptive and supportive of the Cubes.

Ms Newton advised that the artwork has been used to good effect and weaving mental wellbeing into the physical setting. Ms Newton encouraged broadening the scheme across other sites.

Sir David gave thanks to the team for creating a better environment for staff and patients and encouraged the team to continue to pursue such ideas.

Mr Ryan and Ms Sterckx *left the meeting*.

003/22 **ANY OTHER BUSINESS**
There were no items of any other business.

004/22 **DECLARATIONS OF INTERESTS**
There were no additional declarations pertinent to the agenda. The full list of declarations of interest is on the Trust's website.

005/22 **MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON 10 MARCH 2022**
There being no amendments noted, the minutes were approved.

RESOLVED THAT subject to the above the Minutes of the public meeting held on 10 March 2022 confirmed as a correct record and signed by the Chair.

006/22 **ACTION SCHEDULE**
Ms O'Connor presented the action log noting the updates as set out in the paper. All other actions were either closed as per the log, or not due for update at this meeting. Significant operational pressures have impacted the ability to chase and follow up some actions.

007/22 **CHAIR'S REPORT**
Sir David highlighted that the Healthcare system was under constant pressure, particularly in relation to urgent and emergency care, noting the Emergency Department (ED) staff are doing an incredible amount of work. The new building would assist with capacity, however

focus needed to be on enhancing attempts to manage front end demand and improve flow.COVID-19 had not ended and remains a significant challenge in the hospital. Fortunately, the severity is much lower and only a very low numbers were in intensive care. Sir David thanked the teams for the incredible work staff are doing.

The second Ockenden report had been published and was included on the agenda for later discussion. The Board will discuss the most recent report in some detail in due course. It is an appalling catalogue of stories, outlining a number of staff did not listen to patients. In response to the report, Sir David asked that thought was given to the way in which we engage and listen to patients and staff.

RESOLVED THAT: the Chair's update be noted

008/22 **CHIEF EXECUTIVE'S REPORT**

Mr Hopkins presented his report which was taken as read. The following key points were highlighted:

- The Trust was experiencing significant operational pressures.
- Drive to reduce waiting lists as quickly as possible.
- The number of COVID-19 patients continues to rise. There were currently 174 positive inpatients across both sites which was a 36% increase.
- On 26th and 27th March there was a major flood in the PFI part of the building at Worcester as a consequence of a boiler failure. Teams were working with facilities management partners to complete an investigation. It is the second issue within 12 months relating to the building. There was a significant impact on patients, staff and the building. Mr Hopkins extended his thanks to colleagues for their response. This was a significant concern on top of the current pressures.
- A successful upgrade of the patient administration system (PAS) to Allscripts had taken place and was well executed. Thanks were given to Ms Lewis and colleagues who led the upgrade.
- Work has progressed following the results from the Staff Survey which would inform the key priorities of the People and Culture Plan. The full report will be reviewed by the Board following a review at the sub-committees.
- Thanks were given to Graham James, Deputy Chief Medical Officer who was retiring from the Trust. Jules Walton was welcomed as the new Deputy Chief Medical Officer. John Hughes was welcomed as the Chief Clinical Information Officer.
- Following the Ockenden publication, the leadership of Women's and Children's division would consider the recommendations, immediate actions and letter received regarding the implementation of the new model of midwifery delivery. Some good progress had been made as a consequence of the letter and Ockenden to ensure that the service is run in the safest way.

Dame Julie queried if there were any penalty clauses relating to the PFI failures. Mr Hopkins advising that there did not appear to be an unavailability clause in order to issue a fine on the basis of availability of the building and services. Options were being reviewed to obtain recompense. The contract in place was an early one and not as robust with financial consequences as later PFI contracts. Sir David encouraged hard perusal of the options as there was potential that other issues may arise in the future.

Dr Murphy would welcome an early review of the staff survey, as by their nature, the results were already out of date.

Mr Oosterom complimented the teams on the PAS upgrade and the handling of the major incident. Mr Oosterom encouraged going further than a typical root cause analysis, focussing on single points of failure around critical assets.

Mr Azmi asked if there was an impact assessment of the Major Incident. Mr Azmi also stated that a staff survey comparison would be helpful to review any improvements and asked whether any learning could be taken from other Trusts with high completion rates. Mrs Ricketts advised that a summary had been submitted to the People & Culture Committee the previous week along with a draft strategy for discussion and would be presented to the Board in June. A Senior Leaders Briefing had been held with divisions followed by the creation of action plans. There is benchmarking against certain questions allowing comparison and showing improvement. The team do reach out through HRD networks to share best practice and will reach out to other Trusts. It was acknowledged that more needed to be done to improve how staff feel and that they are recognised, rewarded and had opportunity for learning and development. Improvements had been made with inclusivity and compassion.

Sir David reflected the need to understand the overall analysis. There were some organisations who have had a good response and we need to learn from them.

Ms Day recommended triangulating data from different sources such as Freedom to Speak Up, Networks and Guardians for Safe Working. Ms Ricketts replied that the tangibles, why, when and how would be monitored and focused upon at the next People & Culture Committee.

Mr Hopkins gave thanks to the handling of the Major Incident, and in particular to Mr Toole as Incident Commander.

Sir David reflected that analysis of the Major Incident needed to be at a high level and with external assurance provided. The efforts of the Executive Team were recognised and that of all the staff who dealt with the incident. Sir David would write to the Chairs of a number of other organisations assisted and all played their part of mitigation.

The Board noted positive feedback had been received following the announcement of the approval of Robotic assisted surgery business case.

RESOLVED THAT: the report be noted

009/22 **Freedom to Speak Up Report**

Mrs Stinton joined the meeting to present the report and highlighted the following key points:

- There had been an increase in the number of concerns raised since the portal had been developed. 142 concerns had now been logged. A link to the portal has been included on the staff app.
- Main themes related to poor attitude and bullying and harassment. These themes were recognised nationally.
- There had been no increase in protected characteristics concerns.
- The team had been shortlisted for the HSJ award for organisation of the year.

Mr Azmi queried how many of the FTSU Guardians and champions were from a BAME background. Mrs Stinton replied that she had met with all champions and was in the process of a deep cleanse to ensure all wanted to continue to be a champion, were trained and recognised the standards. This work needed to be completed in order to give a true

representation. Sir David asked for focus on recruiting more champions, particularly from a BAME background.

Mr Murphy asked if there could be assumption that there were champions for other networks. Mrs Stinton replied that there was not at the moment. Work was underway to review and recruit representatives in other areas.

Dr Murphy asked what changes had come following investigations. Mrs Stinton replied that one case had resulted in dismissal. Dr Murphy suggested that outcomes were reported in some way to show that we are making a difference and that it is visible for staff. Mrs Stinton advised that she had met with Dr Sally Millett and was reviewing the outcomes in order to share with staff and outcomes would be included within future reports.

Mr Horwath queried if there was a feedback loop back through to the individual who raised the concern. Mr Horwath referenced the Clinical Assessment Unit (CAU) and asked whether lessons had been learnt. Mrs Stinton responded that the CAU concerns were dealt with quickly with senior staff taking action. Feedback on the action taken was provided to those raising concerns, by way of a feedback loop to ensure that those raising the concerns are satisfied with the feedback and resolution.

Mr Oosterom asked if the Trust was an outlier from other organisations. Mrs Stinton confirmed that it was not. Bullying and harassment concerns were amongst the highest reported nationally. Psychological safety work was ongoing to make people feel safe to bring low level concerns forward. Lower level behaviours were the most commonly reported themes.

Ms Day acknowledged the huge progress made. The staff app link would be beneficial and made it easier for staff to raise concerns and with an anonymity option. There were network champions and a large group of people all involved with culture from different perspectives. The review would look at ways of bringing all of these advocates together. Mr Haynes commended reenergising staff engagement networks.
Sir David supported the working being done and ongoing communications.

Mrs Stinton added that follow up training was about to launch and invited the Board to participate. Sir David advised that the training could be incorporated into a Board Development session.

ACTION: FTSU training to be included within a Board Development session.

RESOLUTION: The report was received for assurance.

Mrs Stinton left the meeting

Best Services for Local People

010/22 **RESEARCH & INNOVATION STRATEGY**

Dr Blanshard, supported by Dr Wilson presented the strategy with a view to increasing articulation in research and the opportunity to recruit patients:

- Research is key to and underpins clinical intervention.
- 1000 participants had been recruited per annum.
- The Trust was the fifth highest recruiter within the Midlands.

The aspirations were:

- To increase participation in clinical research.
- Increase income efficiency.
- Embed culture.
- Enhance reputation.

The Strategy is cost neutral, though there was potential for future investment proposals.

Sir David queried whether the work related to that of the innovation hub. Dr Blanshard advised that the innovation hub related largely to IT and digital strategies not clinical innovation.

Mr Azmi asked how it would enhance patient experience. Dr Blanshard stated that there would be improved mortality outcomes, better clinical outcomes and reduced length of stay. Mr Wilson added that there would be better liaison between clinicians.

Mr Horwath welcomed the strategy and how it would be demonstrated within incentive and recruitment. Dr Blanshard replied that it would will be an activity sighted in strategy and teams were reviewing recruitment in order to highlight it.

Sir David recognised the need for investment and encouraged the increase in infrastructure for funding.

Ms Day queried the sense of enthusiasm and the mitigations to weaknesses. Dr Blanshard informed that there was much enthusiasm. Progress would be reported with the implementation of the strategy. The Trust was connected to the Hereford Research Consortium.

Mr Hopkins encouraged the inclusion of nursing research. Thanks were passed to Dr Wilson and Ms Masters in the creation of the strategy.

RESOLVED THAT: the Research & Innovation Strategy was approved.

Dr Wilson left the meeting.

Best Experience of Care and Outcomes for Patients

011/22 **INTEGRATED PERFORMANCE REPORT**

Mrs Lewis presented the report for month 11, which had an overall assurance level of 4 and highlighted the following key points:

- Impact of COVID-19 - Demand did not ease in February, with an average of 87 patients per day and 98 inpatients at its peak.
- Urgent and emergency care pressures – Impact of the number of COVID-19 patients, challenged system flow, sustained number of medically fit patients awaiting discharge and non-elective demand has placed continued pressure on capacity and has led to operational challenges.
- Cancer – Referrals increased between January and February by 7%. The backlog of patients waiting 62+ days has decreased to 330 and those waiting 104+ days has decreased to 113.

Mr Hopkins informed that a key recommendation from a recent system meeting was that all Acute Trusts had a visibility of cat 1 and 2 of the local ambulance service. Performance could be viewed via multi-agency app which showed the system response allowing real time

monitoring of performance. The data would be included within the IPR on a regular basis, as instructed from the national team to ensure of system wide understanding of the pressure and risk in community of delays in ambulance responses. There was a clear message that the risks experienced by patients is shared across the system.

Sir David observed that there was no benchmarking data. Mr Brennan advised that he Trust did not have the highest number of delays in the region, but were running highest at the number of hours lost spent on the back of an ambulance.

Mr Brennan referred to elective activity long waits forecasted to exit at 356 over 104 weeks. The actual exit was 328 with 271 being orthodontics. Regarding the 57 in other specialities, of those, 20 patients were COVID-19 positive and could not be treated, or refused an admission date in March. The Trust was on track to achieve the 104 target by end of June.

In the last 10 days, the Trust had seen a 48% increase in the number of positive COVID-19 patients, which currently stood at 174 which is higher than any point in wave 1. If the increase continued, the Trust would surpass the high of 269 in January 2021. Community rates are having no relevance in predicting hospitalisation. Discussion had taken place with Public Health and they agreed community prevalence is no longer indicative of hospitalisation. Sir David queried how many recent patients were admitted due to COVID-19. Mr Brennan advised that 79% were incidental, 29% were due to COVID-19.

Ms Day observed that the independent sector were not assisting with elective and asked whether going forward they would only assist with diagnostics. Mr Brennan replied that there are contracts with the independent sector and CCG. The Trust direct use had predominantly been diagnostic capacity whilst awaiting for Kidderminster CDC to come on board.

Dr Murphy observed that the Alexandra was performing well and asked if learning was being taken from those teams. Mr Brennan advised that length of stay was one of the best within the region. Inpatient elective had been moved to the Alexandra, with head, neck, Paediatric and Vascular remaining at Worcester. Beds and theatres needed to be fully utilised and were looking at how to ensure any patients suitable to be operated on at Kidderminster are, rather that Worcester or the Alexandra.

Mr Toole clarified the year end position as £1.9m deficit. It was adverse to plan YTD but forecasts moved positively. There were some one off benefits but there are ongoing staffing costs due to COVID-19 absence and extra capacity in Critical Care. Focus was on the run rate for next year.

There was a level of work to do in month 12 relating to capital, which was mitigated and cash remained in a good position.

Mr Oosterom queried the cause of the monthly staff turnover and noted that the flu vaccination rate was low and asked what was being done to improve. Ms Ricketts informed that turnover had been impacted by unregistered workforce, changes in the employment market and job availability in other sectors. Staff offers were being focused on those groups. Changes to pensions had also impacted upon the number of retirements and work was underway to look at retaining some staff through retire and return. Flu dates of availability were not yet available but the vaccination programme plan would be presented at Trust Management Executive and the People & Culture Committee. The levels reported were reflective of last year's campaign.

RESOLVED THAT: the report be noted for assurance.

012/22 **COMMITTEE ASSURANCE REPORTS**

The following points were highlighted by Committee Chairs:

- F&P: Mr Oosterom updated that the main focus of the committee had been 22/23 Planning. The run rate was the biggest concern. There was much to do in terms of building Productivity and Efficiency Plans for next year.
- QGC: Dame Moore reported that the committee had reviewed IPC, maternity and picker reports.
- P&C: Dame Moore further reported that the People & Culture draft outline Strategy was reviewed along with the FTSU report. Committee noted the international nurses staff story and this would feature at a future Board meeting. A workforce plan will be reviewed in future months.

RESOLVED THAT: The Committee reports be noted for assurance.

013/22 **SAFEST STAFFING REPORT**

a) Adult/Nursing and Quality Impact Assessment (QIA)
b) Midwifery

Adult/Nursing

Mrs Gardner reported an assurance level of 5.

- The priority from February reports was health and wellbeing, the effects of winter and the major incident.
- Work was continuing with support from occupational health.
- Check in meetings with band 7s had been reduced to once weekly where issues could be raised.
- Professional Nurse Advocacy Training Programme was now in place.
- Recruitment for international nurses has commenced with arrivals planned from April to December.

Midwifery

Mrs Jeffrey reported an assurance level of 4.

- Acuity had been maintained.
- Sickness had reduced slightly and the vacancy rate was 12%, which has been halved in the last 6 weeks.
- There was a reduced number of COVID-19 absence during February, however there was a rice in March.
- There had been an increase in full rates, assisted by the incentives in place.
- 1 red flag concern relating to supernumerary status of shift leader.
- No harm was reported but there were delays in the labour pathway.
- The service remained safe, however significant mitigations were put in place in order to achieve this. There was deployment of staff to achieve acuity.

Sir David queried the peak in labour induction cause. Ms Jeffrey replied that it was difficult to pinpoint the cause.

Ms Day asked how the sense of morale was and whether recent media was having an impact. Ms Jeffrey stated that a drop in session was held last week with staff when the Ockenden report was issued. There had been a lot of media negativity around maternity services which was aimed at midwives had caused an issue. The team were subdued but

many saw it as an opportunity for improvement to move forward. The teams would continue to be supported. There had not been any additional concerns raised through PALS or via midwives.

RESOLVED THAT: The Trust Board received the report for assurance

014/22 **Ockenden Compliance Report**

Ms Jeffrey advised the Board that following the publication of the first Ockenden report, the Trust were required to provide feedback on the immediate actions. The first submission of evidence was in the summer of 2021 and contained within the report.

Further assurance was requested in February this year and resubmissions on the full recommendations were due by the end of next week.

An assurance level of 6 was reported with compliance of Ockenden at 96% and 81% of other recommendations.

Guideline process and recruitment stages of new midwives was underway to support the work undertaken. There had been an update to the training programme for band 6s and rotation of staff but there were challenges with availability of staff.

Investment was required to create leadership posts. Funding had been secured to enhance the website detailing pathways of care.

A visit by the Local Maternity and Neonatal System was planned on 3rd May and a visit by NHSI/E planned for 31st May to be attended LMNS to look at evidence and to give further guidance.

Mr Horwath asked if more needed to be done with recruitment and retention. Ms Jeffrey advised that a plan did need to be formalised and that there was an ongoing recruitment process.

RESOLVED THAT: The Trust Board received the report for assurance

Best Use of Resources

015/22 **Net Zero Carbon Strategy and Green Development Management Plan 2022-5**

Ms Newton presented the strategy which has been reviewed at the Finance & Performance Committee. The strategy was in the interest of both public and staff.
There had been some slippage with the creation of the plan and the Trust was an outlier in terms of progress made. Two appendices were included with the strategy – a detailed plan and draft action tracker.

The strategy was presented to note the requirements and seeking Board approval of the approach and principle being taken.It was recognised that the some of the Green Plan elements were covered under other plans. It was in the preparation stages and aligned with other Trust strategies.

The challenges and achievements to date were outlined.

Page 7 outlined plans to achieve without exhausting resources, embedding sustainability and helping to inspire staff and the Trust role as an anchor institution. The action plan would be reviewed by the Finance & Performance Committee in June.

Dr Murphy asked what expertise we had and how the Trust compared with others. Mrs Newton replied that the Trust was part of the ICS Green Plan Group. Wye Valley have progressed well teams were having active discussions with them. The new Director of Estates and Facilities would review the strategy. There was a Sustainability lead within Estates who has been leading on the plan to date.

Ms Day expressed the need to be able to apply for funding for new projects. The Trust had a number of capital works which were ongoing. Ms Newton replied that there was a minimal issue with new capital schemes as they needed to comply with green statements. Trust suppliers also have that requirement. Capacity is one of the challenges faced. The team needed to identity projects coming up and how to access them. The Trust was linking in with the Health & Care Trust.

Dr Sinclair encouraged the engagement of staff and asked if there was any progression with the network of champions. Ms Newton agreed that there was an opportunity and staff had started to come forward following a request made at the Senior Leaders Group.

Sir David asked if there was any progression with solar panels and electric parking. Ms Newton advised that these had not progressed.

Mr Hopkins gave thanks to Ms Newton for her involvement to date with the strategy and plan but clarity was required on who would lead it going forward. The new Director of Estates was due to start in May.

RESOLVED THAT: the Net Zero Carbon Strategy and Green Development Management Plan approach was supported

016/22 **TERMS OF REFERENCE**

Ms O'Connor presented the updated terms of reference, noting the changes as highlighted within the appendices. The updates related to recent strategy development and publications of the Enhanced Board Oversight document.

Audit & Assurance:
Approved

People & Culture
Approved

RESOLVED THAT: the Terms of Reference for the Audit & Assurance Committee and the People & Culture Committee were approved.

017/22 **AUDIT & ASSURANCE COMMITTEE REPORT**
Ms Day presented the report which was taken as read.

The report highlighted the work with external audit and value for money. There were some recommendations and ability to demonstrate the progress made.

Sir David queried the confidence level with the actions in place around value for money. Mr Toole responded that there were a number of key areas; workforce strategy, better people performance, Estates Strategy, a review of benchmarking by external consultants, data quality and GIRFT. Progress can be demonstrated.

RESOLVED THAT: the report be noted for assurance.

018/22 **TRUST MANAGEMENT EXECUTIVE REPORT**
Mr Hopkins introduced the report which was taken as read.

019/22 **ANY OTHER BUSINESS**
There was no further business raised.

DATE OF NEXT MEETING
The next Public Trust Board meeting will be held virtually on Thursday 12 May 2022 at 10:00am.

The meeting closed.

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

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

PUBLIC TRUST BOARD ACTION SCHEDULE

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
10.03.22	CEO Report	186/21	Ms Gardner to obtain more information regarding the distribution of the quality of life survey and feed back to the next meeting.	PG	April 2022		Information is being sourced.	
10.03.22	Communications & Engagement Report	187/21	Mrs Ricketts to circulate an update regarding the Behaviour Charter.	TR	April 2022		Update scheduled to the next People & Culture Committee in May (included in Integrated P&C report).	
13.01.22	Charter	158/21	Mrs Rickets to circulate to Board Members information on the work of the IDEA Committee and the EDI agenda within the Trust.	TR	March 2022	TBC	To be scheduled for a board development session. Board development plan under review.	
13.01.22	Charter	158/21	Mrs Ricketts and Mr Hopkins to continue the conversation regarding meaningful action and outcome measures and report back to Board in two months	MH/TR	March 2022	May 2022 (P&C)	Task and Finish Group established to oversee implementation of charter. Outcome measures being developed through this group. Update to be provided to People & Culture Committee 31st May 2022	

10.03.22	CEO Report	186/21	LGBTQ+ relaunch to be presented to Trust Board	TR	TBC		Date to be agreed for network to present. ROC to follow up.	
10.3.22	Action Schedule	184/21	Decisions regarding increases of staff to be documented including source of funding, whether this is recurrent/non recurrent and reported to Finance and Performance Committee	TR/RT/JN	May 2022	June 2022	Action plan considered by CETM in April. Update to be provided to People & Culture Committee 31st May 2022	
9.12.21	Board Assurance Framework	141/21	Ms O'Connor to share the Board analysis and bring a paper to Board following the next quarter's review	ROC	Feb 2022	June 2022	Annual review prepared and meeting with Chair to review scheduled. Paper to follow to Board in June 2022	
13.01.22	Minutes	154/21	Communications Report to reflect upon how could they engage better with communities and diversify our approach.	RH	May 2022	June 2022	Report due to Trust Board in June 2022	
14.10.21	Matters Arising	100/21	An update with regards to HIC would be received at the next Finance and Performance Committee and Trust Board.	JN	Dec 2021		This action was considered as part of the three year planning process and the HIC are split across the annual priorities of the 22/23 plan. Action closed.	
10.03.22	Board Assurance Framework	188/21	Ms Lewis to circulate an update on additional funding for cyber security.	VL	April 2022		A briefing was circulated to NEDs in light of developments in Ukraine and a watching brief held. There is no further update. Action closed.	
07.04.22	Freedom To Speak Up Report	009/22	FTSU training to be included within a Board Development session.	ROC	TBC		This is being progressed via staff story at People & Culture Committee. Action closed.	

NHS
Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	7 April 2022
Paper number	Enc C

Chief Executive Officer's Report

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

Accountable Director	Matthew Hopkins Chief Executive Officer		
Presented by	Matthew Hopkins Chief Executive Officer	**Author /s**	Rebecca O'Connor Company Secretary

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

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

Recommendations	The Trust Board is requested to • Note this report.

HS	This report is to brief the Board on various local and national issues. Items within this report are as follows: • ICS Update • Joint Board Meeting • Opening of Peony Room • International Day of the Midwife/International Nurses Day • NHS National Leadership Event

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

Assurance Level (x)	0		1		2		3		4		5		6		7		N/A	X
Financial Risk	None directly arising as a result of this report.																	

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

Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	7 April 2022
Paper number	Enc C

Introduction/Background

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

Issues and options

ICS

The Health & Care Act has received Royal Assent which means that the ICB will formally take on statutory form from July 1st 2022. The ICB will have a unitary board, which means that all board members, including partner members, are collectively and corporately accountable for meeting statutory duties and delivery of organisational outcomes. The core duties of the ICS will be to:

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience and access
- Enhance productivity and value for money, and
- Help the NHS to support broader social and economic development.

The ICS executive forum have overseen designate appointments to Integrated Care Board roles and are now able to seek nominations for the wider membership from partner organisations. The partner members on the main board of the ICB are appointed to bring the perspective of their sector to the discussions and decisions made by the ICB. They are not appointed as representatives of the interests of any particular organisation, sector or geography.

There are 3 places for NHS trusts on the ICB to be drawn from the 4 providers (WAHT, WVT, WMAS & HWHCT). Each trust can make up to 2 nominations, but one representative needs to be able to bring knowledge and experience of mental health. Further details are imminent with the closing date for nominations on the 13th May. Confirmation of the operating model for the elements of the ICS will now follow with the intention that an ICS 2 year plan be agreed in the Autumn.

HW Health & Care Trust Board to Board

Worcestershire has developed strong partnership working over the last few years and this month we were able to hold our first face to face board to board with the Health & Care trust since the pandemic. This is an important milestone in our collaboration to both celebrate areas where we are working well, and accelerate areas of future benefit to improving patient outcomes. Following the event the executive teams will confirm areas for further joint working and quick wins to bring back to their respective boards.

Opening of the Peony Room

Last week (2-6 May) was Dying Matters Week, an annual event which encourages people to come together and talk about death, dying and bereavement. It also provided a timely opportunity for the opening at WRH of the Peony Room, a new facility which provides an oasis of calm where relatives and loved-ones of patients who are nearing the end of their lives can take a break away from the busy ward environment to rest, reflect and have some refreshments.

Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	7 April 2022
Paper number	Enc C

The Peony Room development, is part of a wider initiative launched by our Palliative and End of Life Care team, the SUPPORT initiative, which Board members will recall was the subject of the patient story at our January Board meeting.

The creation of the Peony Room was a response to feedback from relatives who highlighted a lack of space where they could spend a little time by themselves during a very distressing time. Congratulations to Avril Adams, our Lead Nurse Specialist for Palliative and End of Life Care and her team for making this happen and also thank you to Worcestershire Acute Hospitals Charity for helping to furnish the room and provide refreshments for the families using it. Work is now under way to develop a similar facility at the Alexandra Hospital.

International Day of the Midwife/International Nurses Day

The day of our Board meeting (Thursday 12 May) coincides with International Nurses Day, which provides us with a timely opportunity to thank all our nursing colleagues for their continuing hard work and dedication to putting our patients first. We hope to allow time during the day for those Board members who are on site to visit some of our teams to repeat those thanks in person.

At the time of writing this report we had also just marked International Day of the Midwife (5 May) which gave us a chance to say a huge 'thank you' to all our maternity staff for the compassionate care they provide for our women, birthing people and their families.

As colleagues will be aware, maternity services nationally have been in the media spotlight recently for the wrong reasons, and we have discussed on several occasions the Ockenden Report and its impact, so it was important that we also took some time to celebrate the many positive and joyful aspects of maternity care and our dedicated teams who remain passionately committed to delivering that care and bringing new lives safely into the world.

National NHS Leadership Conference

At the end of April I joined Trust and System Chief Executives from across England for an NHS National Leadership event hosted by NHS Chief Executive Amanda Pritchard. This was a welcome chance to meet with many of my fellow leaders in person for the first time since the pandemic and talk through our immediate operational and strategic objectives as well as looking ahead to an update of the NHS Long Term Plan.

Areas for focus will come as no surprise to Board members given that they reflect the opportunities and challenges that we discuss on a regular basis, and included quality and safety; access (especially around urgent and emergency care and elective recovery); tackling inequalities; workforce and productivity/finance.

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	12 May 2022
Paper number	Enc D

2022/23 annual plan

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

Accountable Director	Jo Newton, Director of Strategy, Improvement and Planning		
Presented by	Jo Newton, Director of Strategy, Improvement and Planning Robert D. Toole, Chief Finance Officer	**Author/s**	Lisa Peaty, Deputy Director of Strategy and Planning Jo Kirwan, Deputy Director of Finance Nikki O'Brien, Associate Director of Business Intelligence, Performance and Digital Zoe Scott-Lewis, Head of Transformation and PMO Bianca Edwards, HR Business Partner Christian Stevens, Head of Income and Contracts

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
Finance & Performance	23rd February 2022 17th March 2022 19th & 27th April 2022	Further iterations of the plan
Trust Board	17th March 2022 7th & 27th April 2022	Further iterations of the plan Plan approval 27th April 2022

Recommendations	It is recommended that Trust Board note: • Approval of the 22/23 annual operational plan • The priorities identified to deliver the plan • The risks and opportunities to be addressed

NHS
Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	12 May 2022
Paper number	Enc D

Executive summary	This paper confirms that the 22/23 operational plan considered and approved at private board on 27th April was submitted to NHSE/I as part of the ICS system plan for Herefordshire and Worcestershire. The paper further outlines the key priorities for 22/23 and the risks and mitigations to delivery of the plan.

Risk																		
Which key red risks does this report address?		**What BAF risk does this report address?**	*7, 8, 9, 11, 14, 18, 19*															
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	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						

Introduction/Background

Our plan has been developed in conjunction with system partners as part of the required ICS plan. Feedback from NHSE/I on our draft submission was incorporated into our final plan.

Dialogue and challenge has continued along with further discussion at regional and national level, including exceptional cost pressures and the need for system support for the PDU. As we move into 22/23 and formal ICB arrangements, the shared risks and responsibilities to deliver the plan through collaboration will evolve.

Issues and options

The board acknowledges that the plan is ambitious and will need tight management to deliver the performance and objectives. A sensitivity analysis is also being undertaken to monitor impact of performance. A detailed action plan to mitigate outstanding risks will be overseen by TME with regular reporting to Finance & performance committee and board.

The 22/23 plan forms the first year of our emergent 3 year plan and focuses on the key priorities of quality, improving access, and supporting healthier lives for our communities and staff, underpinned by financial stability. Investment in our 4ward improvement system to challenge and change our approach plays an underpinning role as part of our strategic pyramid to deliver the change required.

Key headlines from the Trust 22/23 operational plan include:

Activity

- National activity and performance targets are met, (subject to the new outpatient/follow up conversion rule being removed from the baseline by NHSE/I).
- Achievement of 104 week waits excluding 88 patients for orthodontics

Workforce

- The workforce position for 2022/23 is an investment in staff of 144.73 wte (198.76wte from May to Dec) in establishment composed of:
- 32.89 wte externally funded
- 111.84wte linked to business cases
- temporary growth of 54.03wte from May to December to staff the MAU and PDU clinical areas
- Other posts are in the existing run rate and are being covered by a range of agency, bank and temporary workforce solutions.
- Overall bank and agency reduction is 43.7wte by March 2023.

Finance

- The submitted financial position for 2022/23 for the trust reports a £42m deficit which includes a high risk element of full PEP delivery and ERF. The income and expenditure financial gap is driven mainly by:
- Non recurrent income reduction of £36.5m including COVID and other adjustments from 21/22
- Pay and non-pay inflation including a significant increase in energy prices and PFI charges
- Revenue impact of significant business cases including the Urgent & Emergency Care Centre

This also requires delivery of a PEP target of £15.7m (c3%) and full recovery of the £15.7m Elective Recovery Fund associated with 104% delivery of 2019/20 activity in the context of limited investment of c. £2.1m non pay marginal cost of activity and £1m of pay (surgery and theatres) in the baseline alongside full year investment in surgical reconfiguration included in the plan and broader ICS dependency.

It should be noted that no costs have been included for the Pathway Decision Unit (PDU) which is assumed to be fully funded nationally or covered by the Herefordshire and Worcestershire ICS.

The PEP and ERF recovery are clearly significant challenges that will need to be managed through effective performance of detailed plans at and below speciality level where appropriate to ensure delivery.

The Herefordshire and Worcestershire ICS submitted a plan reporting a deficit of £(52.6)m.

2 Delivering the plan

Our Priorities

Consistent with the Long-term plan and national policy our priorities for 2022/23 reflect current strategic transformation programmes and key strategic risks outlined in the board assurance framework. As expected, they support the delivery of the operational plan submitted to NHSE/I by the ICS on 28th April 2022, particularly the requirements to reduce the backlog of patients which arose as a result of COVID-19 and to meet operational performance standards. Deliverability of the actions and measures will depend on progress with addressing the backlog of patients as a consequence of COVID-19; pressures related to the demand for emergency and urgent care; the future trajectory of the COVID-19 pandemic and success of our Targeted Investment Fund bid.

Quality

As we progress towards our aspiration of outstanding as rated by CQC, we will implement our 4ward Improvement system to improve quality by:

- **Care that is safe**: a refreshed Quality & Safety Strategy, including a focus on maternity improvement, infection prevention & control
- **Investing and delivering improved infrastructure** in estates, including opening a new Urgent and Emergency centre, delivering the Acute Services Review and further investments in diagnostics; and digital infrastructure (Electronic patient record and cybersecurity)
- **Focus on getting the basics right** as a platform for future development; reducing waste to release more time to care and reinvestment of cashable and non-cashable benefits

Improving access

- **Elective recovery and reset**: focus on reducing the time patients have to wait for procedures and working with system partners to deliver transformational change including outpatient's transformation and embedding delivery of elective hubs for inpatients at the Alexandra hospital and day case (Kidderminster)
- **Flow and discharge**: improve flow by working in partnership with all system partners at place through the Homefirst programme
- **Work with partners** to deliver high quality seamless care: service sustainability, lead provider voice at place, demonstrate corporate social responsibility as an anchor institution.

Healthier lives

To improve wellbeing of our staff and our communities

- **An empowered, well led workforce** that delivers better outcomes and performance: workforce development infrastructure.
- The **right sized, cost-effective workforce** that is organized for success: substitute bank & agency for permanent staff.
- **Adjust, learning and innovative culture** built on respect for our people: develop organisational culture using the 4ward Improvement system.
- A people function that is organised around the optimum employee journey: **workforce resilience and wellbeing.**
- **Addressing health inequalities** by supporting population health management to prevent ill health: optimising health of those on our waiting lists, supporting smoking cessation
- **Promoting long-term health** by implementing the Trust's Green plan: substitution anaesthetic gases; reducing energy use; location by vocation

Performance against these priorities will be monitored via the Trust's internal and ICS governance processes.

3 Plan governance

Progress on delivery of the plan will be reported through monthly divisional PRMs, although performance management of activity delivery will take place on a fortnightly basis. Annual Planning Steering Group will focus on the ongoing development of the PEP programme and delivery of PEPs identified to date, with theatres and outpatients cross cutting themes overseen at TME and F&P. The Transformation Guiding Board will be responsible for oversight of the implementation of the 4Ward Improvement System and progress of the flow and recruitment value streams, although tools and approaches will be adopted for all cross cutting themes. Ongoing progress of the ICS operational plan will take place monthly with escalations as appropriate.

4 Key risks

Risk	Mitigation
Future COVID surges and other operational pressures limit capacity of operational and clinical colleagues to deliver activity	Monitor plans through PRMS Agree and implement revised accountability framework Continue to monitor any significant shifts in delivery of activity and develop and deliver rectification plans Complete surgical reconfiguration programme
Non achievement of ERF / ERF alignment incentive*	Rigorous monitoring of plans throughout the year through PRMs with clear rectification actions in place Identification of additional PEP schemes
Number of orthodontics 104 week waiters means that target to eradicate 104 week waits cannot be delivered	Further development and implementation of system plans to reduce orthodontics 104 week waits;
Workforce availability (e.g. sickness, staffing levels) impacts delivery of plans)	Delivery of Best People Programme work streams Implementation of staff wellbeing initiatives
Ongoing COVID operational guidance and community infection rates impact outpatient and elective care cancellation rates, and activity	Adherence to cancellation policy, overbooking of clinics
Inability to identify and deliver PEPs to value of plan plus slippage in delivery mean financial plan is not achieved	Continued focus on PEP identification, develop and delivery throughout year Rigorous monitoring of PEP delivery through PRMs (divisional), TME and F&P (divisional & cross cutting)

*There are four elements to this risk:

- WAHT fail to deliver activity to levels required for ERF payment. Our approach to delivery is described above and our track record of over delivery of activity compared to plan in H2 provides a good basis for achievement in 22/23
- Wye Valley Trust fail to deliver their agreed activity levels. Whilst this is not within our control, system oversight and quarterly review meetings with NHSE/I should challenge and support non delivery
- Changes to guidance and requirements made nationally. We have experienced these in that last few weeks and it is currently unknown whether further changes will be made and any potential impact on our ability to reach any revised activity or performance targets.
- The financial plan only included £2.1m to support the delivery of the £15.7m ERF included in the financial plan.

5. Next steps

The system-level planning return was submitted to NHSE/I on 28th April 2022. The targets laid down in the 2022/23 operating plan are extremely challenging and accountability will be enhanced as described above.

- Elective delivery plans will need to be issued at specialty level (it is accompanied by reports which are updated daily). Formal monitoring will occur fortnightly and performance will be reported monthly via the Finance and Performance Committee.

- Targets will be identified at a directorate to ensure delivery of the Elective Recovery Fund
- Cash releasing savings targets to achieve the 3% will be fully aligned to budgets
- Business case will be tracked to ensure delivery of benefits associated with Board approval
- Sensitivity analysis on elements of the plan will also be further refined
- Communication of the plan in a simple accessible way as part of our wider narrative will be shared

As we progress development of our 3 Year Plan, it is important to note that the national intention is to publish revenue allocations for 2023/24 and 2024/25 in the summer, and systems will need to be able to demonstrate how they plan to step back down spend (convergence) in line with the NHS Long Term Plan settlement. This is consistent with the develop of an ICS/place plan by March 23. The interim financial architecture through COVID has made it more challenging to assess whether financial performance is positive or not as the previously used benchmarks have become less meaningful. Taking a more medium term view of financial performance and sustainability should facilitate better decision making and a focus on continuous financial improvement.

Conclusion

Our 22/23 plan is ambitious to meet the extremely challenging targets set by NHSE/I. Significant work has been undertaken to triangulate activity, workforce and finance at trust and then system level to make the plans as robust as possible. Delivery of activity will be closely monitored through PRMs (supported by an accountability framework), TME and TGB (supported by a revised accountability framework), as well as the ICS Reset and Recovery Group.

Despite the challenges we continue to invest in our workforce and infrastructure, underpinned by the 4ward improvement system, to deliver our strategic objectives and vision to put patients first.

Recommendations

It is recommended that Trust Board note:

- Approval of the 22/23 annual operational plan
- The priorities identified to deliver the plan
- The risks and opportunities to be addressed

Appendices

NHS
Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	12 May 2022
Paper number	Enc E

Integrated Performance Report – Month 12 2021/22

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

Accountable Directors	Paul Brennan – Chief Operating Officer, Paula Gardner – Chief Nursing Officer, Christine Blanshard - Chief Medical Officer, Tina Rickets – Director of People & Culture, Robert Toole – Chief Finance Officer		
Presented by	Vikki Lewis – Chief Digital Information 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	20th April 2022	Approved
Finance and Performance	27th April 2022	Assured
Quality Governance	28th April 2022	Assured

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

Key Issues	**Covid as a presenting condition** A change in the bed allocation model for Covid patients was established in April, which has been fully risk assessed through the Covid command structure. Patients admitted with a primary presentation of Covid will continue to be placed on a Covid ward. Patients admitted with an incidental presentation of Covid will be placed on the correct ward for their presenting condition. **Good News Stories** **1. Workforce** We have consistently performed above peer group and national average for our sickness absence rates throughout the COVID pandemic. With latest figures on model hospital (Jan 2022) showing 6.2% cumulative sickness absence rate (including COVID related absence) for the Trust against a national rate of 6.7%, a medical and dental absence rate of 2.2% compared to a national average of 2.8% and a nursing absence rate of 7.3% against an average of 7.6%. The main factors driving this good performance has been our approach to individual occupational health risk assessments, our staff health and wellbeing offer, staff flu and covid vaccination programmes and rapid access to COVID testing.

NHS
Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	12 May 2022
Paper number	Enc E

2. Recovery and Restoration (performance against H1/H2 plan)

Metric	Mar-22 (2nd SUS)	2021/22
New Outpatients (Consultant led)	1,061 above plan	10,119 above plan
Follow Up Outpatients (Consultant led)	1,283 above plan	9,412 above plan
Day Cases	438 above plan	1,886 above plan
Inpatients	177 below plan	1,544 below plan
Total Electives Inpatients	261 above plan	342 above plan
Diagnostics Imaging	1,130 above plan	9,663 above plan
Diagnostics Endoscopy	663 below plan	5,641 below plan
Diagnostics Echocardiography	486 above plan	1,511 above plan
RTT 52+ weeks waiting	356 below plan	-
RTT 104+ weeks waiting	60 below plan	-
Total RTT Incomplete WL	81 below plan	-

Table 1 - Combined H1/H2 position as at Mar-22

Although still unvalidated for Mar-22, we have achieved the majority of our restoration targets set out in the H1/H2 plan. Achieving the plans to reduce our long wait patients and increase overall activity in-line with national planning guidance will be a key area of focus in 22/23.

3. Finance Year End Position

Against our final submitted position of a £(1.9)m deficit out-turn for 21/22 we have achieved a position of £(1.4)m a £0.562m favourable out-turn. Key changes to the previous adjusted forecast of £(3.4)m deficit with a favourable in month impact of £2m includes some significant year end stock movements c.£1.2m increase alongside some additional income and a number of movements in respect of balance sheet provisions and liabilities.

Overall our pre Audited adjusted financial performance position is thus a deficit of £1.4m.

Areas for Improvement

1. Urgent and Emergency Care

Our services continue to operate under sustained pressure. Covid-19 demand continued throughout Mar-22 with an average of 104 patients per day and 128 inpatients at its peak.

Our 21/22 type 1 front door demand was 11% higher than 19/20 and 26% higher than 20/21 and emergency admissions via ED were 5% higher in 21/22 than 19/20 and 13% higher than 20/21.

Non-elective pressures continue to result in crowding in our Emergency Department (ED) which in turn impacts our ambulance handover performance which has been above 700 a month since Jul-21 and above 1,000 in Mar-22 for the first time on record. Over the course of the month, there were 25 days where a divert was in place to the Alexandra Hospital.

Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	12 May 2022
Paper number	Enc E

Unfortunately, the flow challenges have again resulted in a high number of 12-hour trolley waits and time spent in department.

2. Cancer

Cancer referrals hit an all-time high in Mar-22. Improvements in the timeliness of patients being seen within two weeks by Breast Services were offset by significant demand on Lower GI and Skin in excess of available capacity. We are not yet achieving the 28-day faster diagnosis standard and this remains at risk whilst we continue to have delays at the start of patient cancer pathways. These delays also impact the 62-day pathway; however, we do continue to start over 90% of first treatments within one month of the decision to treat.

Our backlog of cancer patients waiting 63+ days remains significant at 335 and of those, 144 have been waiting 104+ days.

3. Infection Prevention and Control

In 2021-22 we achieved 4 of our 5 national infection reduction targets.

We did not achieve our C.difficile target. Analysis of cases highlights that we need to make improvements in the following areas: cleanliness (especially related to the estate and nursing cleanliness), antimicrobial prescribing, mandatory training compliance and ensuring we detect and manage patients with diarrhoea appropriately.

Additional actions are being implemented, targeted initially on wards in the Aconbury building and T&O Ward as these areas accounted for 39% of cases in 2021-22.

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	2, 3, 4, 5, 7, 8 ,9, 10, 11, 13, 14, 15, 16, 17, 18, 19, 20

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

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

Recommendations
The Board is asked to ▪ note this report for assurance
Appendices
▪ Trust Board Integrated Performance Report (up to Mar-22 data) ▪ WAHT March 2022 in Numbers Infographic ▪ WAHT Maternity and Neonatal Dashboard (up to Mar-22) ▪ Committee Assurance Statements (Apr-22 meetings)

Integrated Performance Report

Trust Board

12th May 2022

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

Topic		Page
Operational Performance	Summary Performance Table and Headlines	3 – 4
	Urgent and Emergency Care	5 – 8
	Patient Flow and Capacity	9 – 10
	Cancer	11 – 15
	Planned Care	16 – 21
	Diagnostics	22 -25
	Stroke	26 – 27
Quality & Safety	Summary Performance Table and Headlines	29 – 31
	Infection Prevention and Control | Antimicrobial Stewardship	32 – 36
	Falls	37 – 38
	Sepsis Six Bundle	39 - 40
	VTE	41 - 42
	EDS Completion	43 – 44
	ICE Reporting	45 – 46
	Fractured Neck of Femur	47 – 48
	Friends and Family Test	49 – 50
	Complaints	51 – 52
	Maternity	54 - 57
People & Culture	Getting The Basics Right	58 – 59
	Performance Against Plan	60 – 61
	Drivers of Bank and Agency Spend	62 – 63
	Health and Well-being	64 – 65
	Strategic Objectives	66
Finance	Headlines	68 – 71
Appendices	Statistical Process Charts (SPC) Guide	93
	Levels of Assurance	74

Operational Performance

Summary Performance Table | Month 12 [March] 2021-22

Performance Metrics		Latest Month	Measure	Target	Performance	Assurance	Mean	Lower process limit	Upper process Limit
EAS	Percentage of Ambulance handover within 15 minutes	Mar-22	41%	-		-	61%	47%	75%
	Time to Initial Assessment - % within 15 minutes	Mar-22	62%	-		-	82%	75%	90%
	Average time in Dept for Non Admitted Patients	Mar-22	285	-		-	211	184	238
	Average time in Dept for Admitted Patients	Mar-22	739	-		-	471	364	579
	% Patients spending more than 12 hours in A&E	Mar-22	12%	-		-	6.25%	2.64%	9.85%
	Number of Patient spending more than 12 hours in A&E	Mar-22	1494	-		-	715	335	1096
RTT	Incomplete (<18 wks)	Mar-22	47%	92%			69%	64%	73%
	52+ weeks waiting	Mar-22	5,849	0			2207	1,609	2,806
	104+ weeks waiting	Mar-22	331	0			71	27	115
CANCER	2WW All	Mar-22	58%	93%			80%	66%	93%
	2WW Breast Symptomatic	Mar-22	97%	93%			45%	-2%	91%
	62 Day All	Mar-22	62%	85%			68%	55%	80%
	104 day waits	Mar-22	144	0			63	30	95
	31 Day First Treatment	Mar-22	95%	96%			96%	91%	101%
	31 Day Surgery	Mar-22	79.5%	94%			88%	65%	110%
	31 Day Drugs	Mar-22	95%	98%			97%	87%	107%
	31 Day Radiotherapy	Mar-22	99.1%	94%			99%	93%	106%
	62 Day Screening	Mar-22	59.6%	90%			75%	37%	113%
	62 Day Upgrade	Mar-22	99.1%	90%			81%	58%	104%
Diagnostics (DM01 only)		Mar-22	73%	99%			51%	39%	64%
STROKE	CT Scan within 60 minutes	Feb-22	60%	80%			45%	21%	69%
	Seen in TIA clinic within 24hrs	Feb-22	96%	70%			85%	51%	119%
	Direct Admission	Feb-22	38%	90%			40%	16%	64%
	90% time on a Stroke Ward	Feb-22	62%	80%			73%	57%	88%

Operational Performance Report - Headlines

Operational Performance	Comments
Urgent and Emergency Care (validated)	• In Mar-22, the Trust saw 12,552 patients attend our type 1 sites – an increase compared to the 11,184 seen in Mar-21 (Mar-20 was 8,596 due to first lockdown). • Over the course of the month, there were 25 days where a divert was in place to the Alexandra Hospital. • The trend of special cause concern for our front door metrics continues as the pressure to admit to our hospitals hasn't changed resulting in patients spending time on our corridors and in our ED's whilst they wait for a bed. The average time that a patient was waiting on an ambulance at WRH was 150 minutes; the fourth consecutive month above 100 minutes.
Patient Flow and Capacity (validated)	• The pressure remains on both hospital sites to manage bed capacity and patient flow, particularly to discharge patients before midday and support our long length of stay and medically fit for discharge patients to leave the hospital when they no longer need an acute hospital bed. Admissions, to alleviate patients waiting in our EDs, have been hindered by reduced bed availability driven by increasing numbers of covid patients, infection outbreaks and staffing pressures. • The number of long length of stay patients increased from 46 on the last day of February to 56 on the last day of March; 21 of the 56 were identified as MFFD.
Cancer (validated)	• **Long Waits:** The backlog of patients waiting over 62 days has increase from 330 to 335 and those waiting over 104 days has increase from 113 to 144, with urology contributing the most patients to this cohort of our longest waiters (60%). • Cancer referrals in Mar-22 are the highest of 21/22 – any further growth will see 3,000 patients referred in a month. Lower GI demand is the biggest risk to achieving the waiting times standards. • The 2WW cancer waiting time standard has not been achieved in 21/22 although Breast Services did end the year clearing their backlog and delivering the 2WW standard in Mar-22. • The 28 Day Faster Diagnosis standard has not been achieved in 21/22 and remains at risk with referred patients not being seen by a specialist within 14 days. • The 62 day standard has not been achieved in 21/22 and only 58% of patients starting treatment within 62 days due to delays in the 2WW and diagnostics elements of the pathway in Mar-22. • The delays are impacting the 31 day standard of treatment from decision to treat which continues to special cause concern and below the 96% standard (albeit only by 1.5%).
RTT Waiting List (validated)	• **Long Waits:** Our 5,849 patients waiting over a year for treatment can be broken down as follows; between 52 and 78 weeks (4,414), between 78 and 104 weeks (1,108) and those waiting over 104 weeks (327). Of the 327 patients waiting over 104 weeks, 269 are waiting for orthodontic treatment and therefore our target of 0 was achieved in 21/22; however the submitted H2 target of no more than 387 was achieved. • Although below the H2 plan of no more than 57,151 patients, the RTT waiting list size remains a cause for concern; it is 60% larger than Mar-20's pre-covid submission and over 30,000 patients are waiting over 18 weeks resulting in the % of patients waiting under weeks to decrease.
Outpatients (Second SUS submission)	• **Long Waits:** There are 32,713 RTT patients waiting for their first appointment and 22.8% of them have been dated. • Based on our second SUS submission, Mar-22 saw 46,098 outpatient attendances take place (consultant and non-consultant led). H2 targets for Mar-22 have been achieved for our total outpatient and face-to-face attendances but not for non-face-to-face attendances. This is the same pattern for consultant-led activity only, for both first and follow-up attendances.
Theatres (validated)	• Based on our first SUS submission, we have achieved our H2 target for total elective spells in the month (7,473 over the H2 plan by 261 spells) which can be broken down as day case at +438 to plan and elective as -177 to plan. • 18 eligible patients who had their operation cancelled were not rebooked within 28 days in Feb-22; however 15 patients (45%)were. • The Independent Sector undertook no elective activity in Mar-22 but they did perform 171 diagnostic tests and 114 procedures were undertaken in our Vanguard theatre (702 across 7 months).
Diagnostics (validated)	• **Long Waits:** 2,751 patients are waiting over 6 weeks for their diagnostic test and of the total number of breaches, 1,100 have been waiting over 13 weeks with 59% of our longest waiters attributable to DEXA and Echocardiography. • DM01 performance is at 27% with 6+ week breaches having fallen another 13% to 2,750 and notably CT breaches down from 242 to 87. Activity continues to climb, 12% more than in Feb-22, and at its highest since 2019. • Activity in Mar-22 was 17,992 tests achieving the H2 plan for CT, non-obstetric ultrasound, flexi sigmoidoscopy and echocardiography.

Operational Performance: Urgent and Emergency Care

Percentage of Ambulance handover within 15 minutes	Time to Initial Assessment - % within 15 minutes	Time In Department			
		Average (mean) time in Dept. for Non Admitted Patients	Average (mean) time in Dept. for Admitted Patients	% Patients spending more than 12 hours in A&E	Number of Patient spending more than 12 hours in A&E
40.6%	61.5%	285	739	11.9%	1,494

What does the data tell us?

- **Urgent Care Indicators –** slides 6 and 7 highlight the continued pressure faced by the Trust during Mar-22 with all of the metrics showing special cause concern for the month and for 8 consecutive months.
- **EAS** - The overall EAS performance, which includes KTC and HACW MIUs, was 65.17% in Mar-22 – this is the ninth month of special cause concern. In context of attendances across all system settings they increased by 17% from Feb-22 and 14% at our type 1 settings.
- **EAS Type 1 –** EAS performance at both WRH and ALX was below 60% 50.17% and 53.31 respectively. 6,076 patients breached the 4 hour standard at our two sites 1,400 more than Feb-22's breaches.
- **CYP Attendances**: The proportion of total attendances to WRH in Mar-22 who were children and young people was 25%, no significant change from Feb-22. This is the ninth month since Jan-21 where total paediatric attendances have been special cause concern due to 12 months above the mean. 23% of all paediatric attendances arrived by ambulance continue to be common cause variation after the special cause concern observed in May-21 and Jun-21.
- **Ambulance Handovers** - There were 1,074 60 minute ambulance handover delays with breaches at both sites – a significant increase in breaches from Feb-22 and continues to be special cause concern; this is linked to the capacity, flow and numbers of patients in our ED's which prevented timely offloading. On average, patients waited 150 minutes to be offloaded from an ambulance at WRH.
- **12 hour trolley breaches –** There were 241 validated 12 hour trolley breaches in Mar-22 compared to 221 in Feb-22 – this remains a special cause concern for our processes.
- **Specialty Review times** – Specialty Review times continue to show cause for concern with 10 consecutive months below the mean; the target cannot be met.
- **Total Time in A&E:** The 95th percentile for patients total time in the Emergency departments has increase, albeit not significantly, from 1,201 to 1,231 . This metric shows special cause variation because the last four months are outside the upper control limit and shows a run of 10 months above the mean.
- **Conversion rates** – 3,247 patients were admitted in Mar-22; a Trust conversion rate of 25.87%. The conversion rate at WRH was 28.84% and the ALX was 22.17%. 40,560 patients were admitted in 21/22, an average of 3,380 a month and a conversion rate of 27.81% of attendances.
- **Aggregated patient delay** (total time in department for admitted patients only per 100 patients – above 6 hours) – this indicator continues to show special cause concern for Mar-22 because the value is above the upper control limit for the fourth consecutive month.

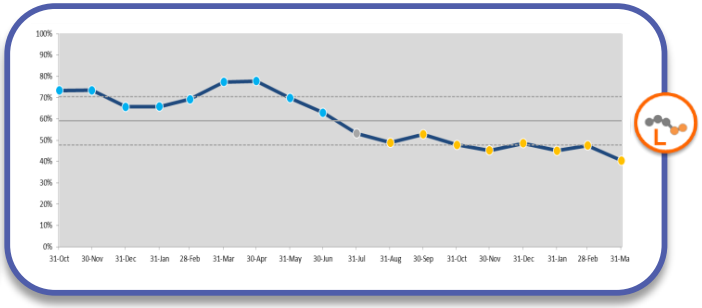
5

Month 12 [March] | 2021-22 | Operational Performance: Urgent and Emergency Care

Responsible Director: Chief Operating Officer | Validated for Mar-22 as 13th April 2022

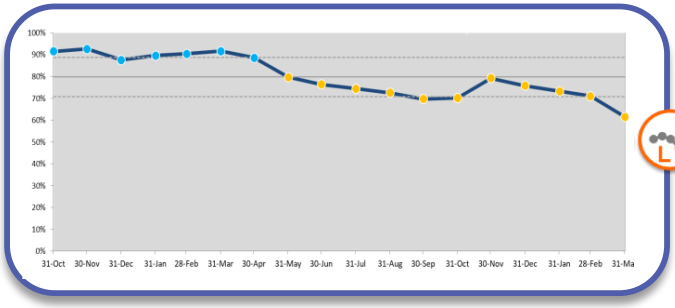
Percentage of Ambulance handover within 15 minutes

40.6%



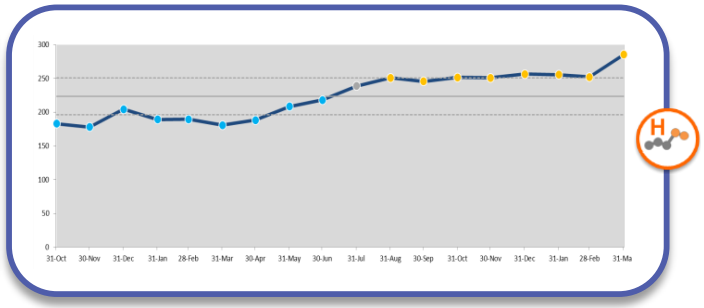
Time to Initial Assessment - % within 15 minutes

61.5%



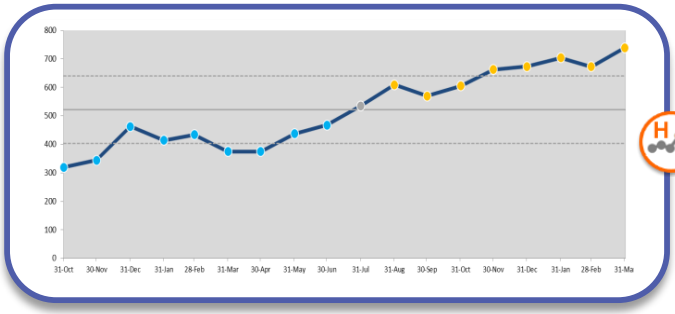
Average time in Dept for Non Admitted Patients

285 mins



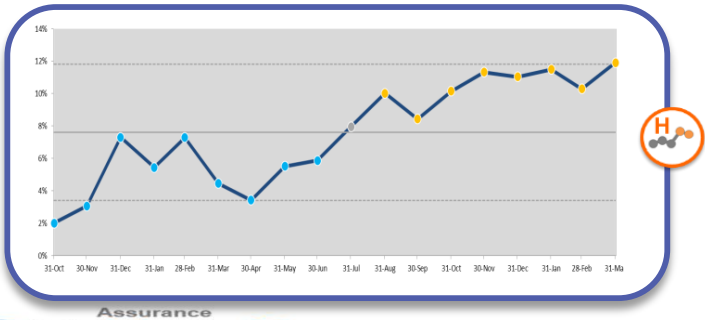
Average time in Dept for Admitted Patients

739 mins



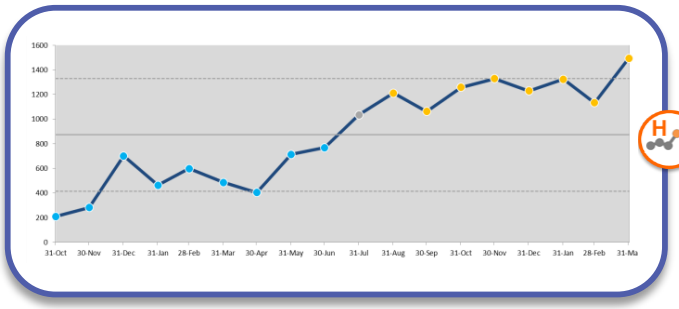
% Patients spending more than 12 hours in A&E

11.9%



Number of Patients spending more than 12 hours in A&E

1,494

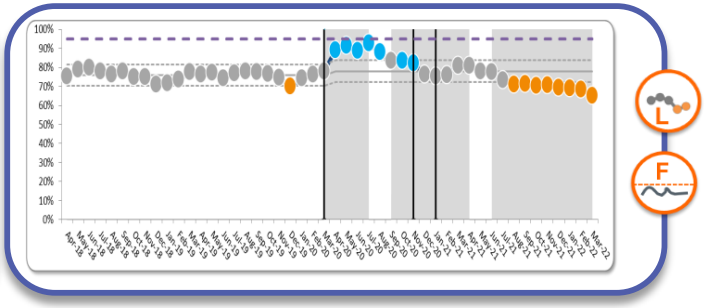


Month 12 [March] | 2021-22 | Operational Performance: Urgent and Emergency Care

Responsible Director: Chief Operating Officer | Validated for Mar-22 as 13th April 2022

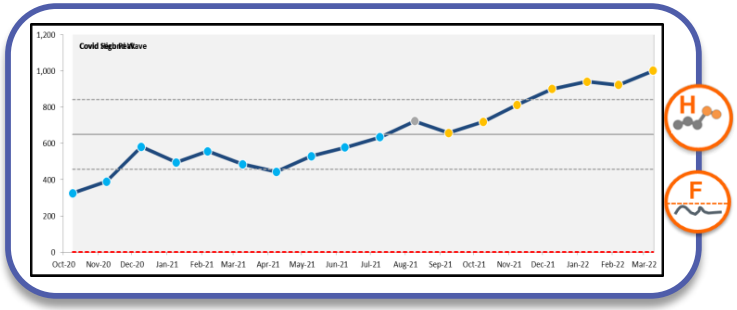
4 Hour EAS (all)

65.17%



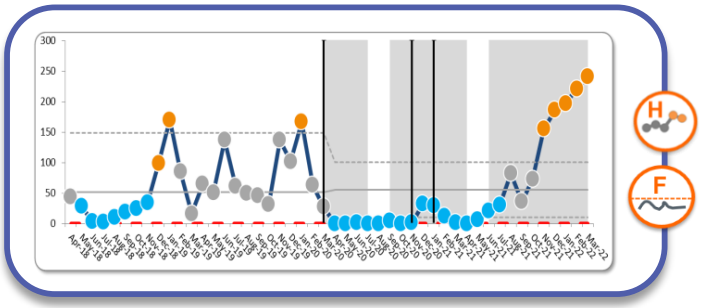
Aggregated Patient Delay (APD)

1,001



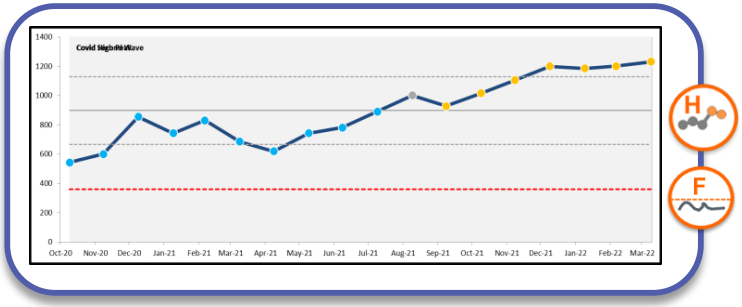
12 Hour Trolley Breaches

241



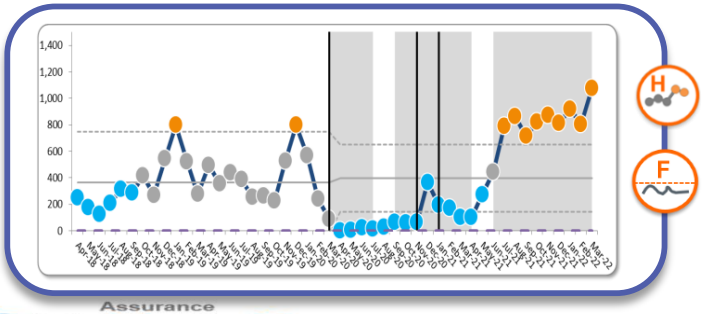
Total time spent in A&E (95th Percentile)

1,231



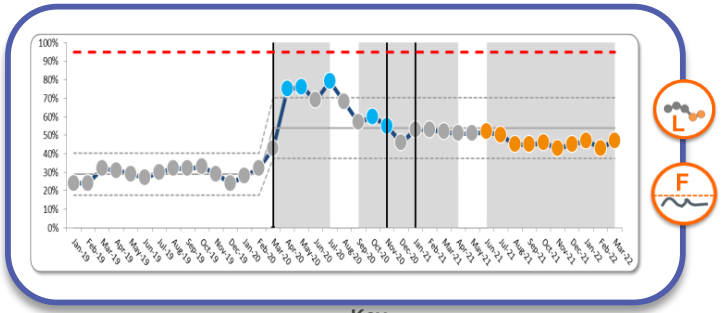
60 minute Ambulance Handover Delays

1074



Specialty Review within 1 hour

47.0%



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

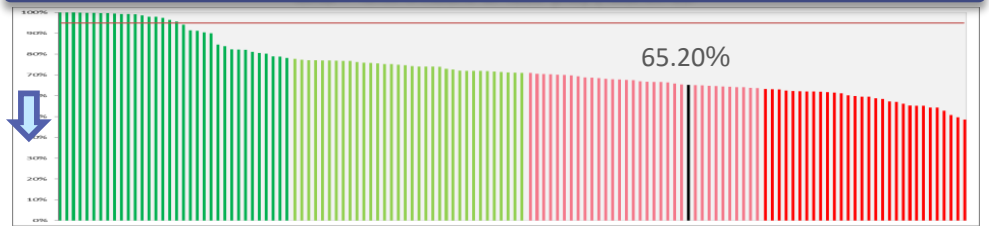
National Benchmarking (March 2022)

EAS (All) –The Trust was one of 10 of 13 West Midlands Trust which saw a decrease in performance between Feb-22 and Mar-22. This Trust was ranked 8 out of 13; we were 7th the previous month. The peer group performance ranged from 50.68% to 78.89% with a peer group average of 65.81%; declining from 66.37% the previous month. The England average for Mar-22 was 71.60% a -1.7% decrease from 73.30% in Feb-22.

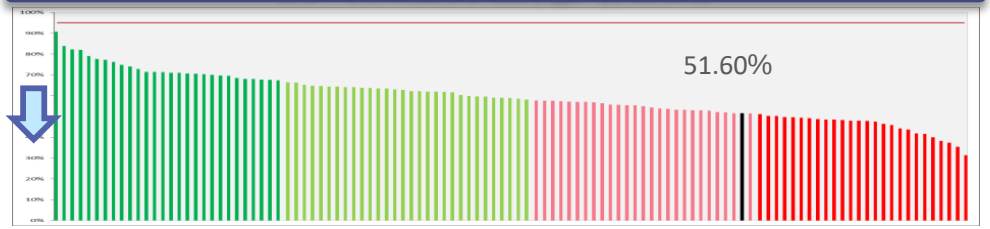
(Type 1) - The Trust was one of 10 of 13 West Midlands Trust which saw a decrease in performance between Feb-22 and Mar-22. This Trust was ranked 8 out of 13; we were 7th the previous month. The peer group performance ranged from 40.05% to 71.02% with a peer group average of 53.74%; declining from 55.38% the previous month. The England average for Mar-22 was 58.60% a -2.2% decrease from 60.80% in Feb-22.

In Mar-22, there were 22,506 patients recorded as spending >12 hours from decision to admit to admission. 241 of these patients were from WAHT; 1.34% of the total.

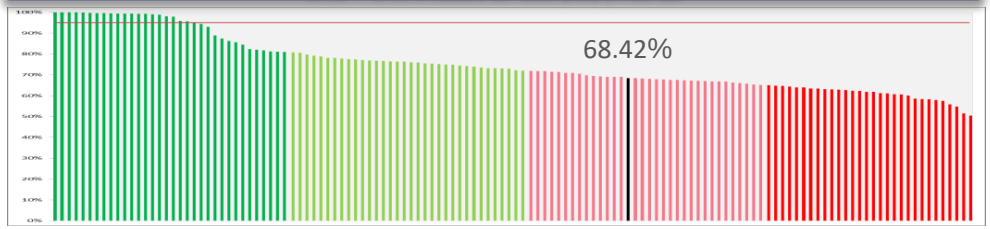
EAS – % in 4 hours or less (All) | March-22



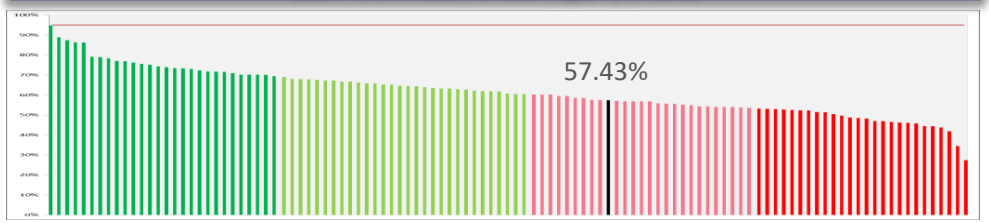
EAS – % in 4 hours or less (Type 1) | March-22



EAS – % in 4 hours or less (All) | Feb-22



EAS – % in 4 hours or less (Type 1) | Feb-22



WAHT — Operational Standard 95%

8

Operational Performance: Patient Flow and Capacity

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

Discharges before Midday (non-covid wards)				Number of patients with a long length of stay (21+ days)				Overnight Bed Capacity Gap (Target – 0)	Average length of stay in hospital at discharge (non-covid)				30 day re-admission rate (Feb-22)	Discharges as a % of admissions IP only | non-covid wards (Target >100%)			
WRH	15.8%	ALX	18.4%	WRH	36	ALX	20	41 beds	WRH	5.0	ALX	3.8	2.9%	WRH	92.9%	ALX	94.1%

What does the data tell us?

- **Discharges** – Before 12pm discharges (on non-COVID wards) is showing special cause concern this month driven by a six percentage point decrease in performance at ALX. As at the last day of the month, the number of patients with a length of stay in excess of 21 days increase to 46 (28-Feb) to 56 (31-Mar). There were an average of 9 patients deemed MFFD with a LOS >= 21 days each day in March across the Trust. The total number of discharges and transfers remained at common cause variation after 10 months above the mean and discharges are still not exceeding the rate of admission leading to a significant capacity gap.
- **Bed Capacity** - Our G&A bed base is 752; beds ring-fenced to Covid patients were maintained at over 90 in the month to provide beds for admitted Covid patients. The number of elective beds at the ALX was maintained despite the increasing numbers of covid patients. However, outbreaks across our ward base continue to result in full and partial closures over the month and the increase in covid positive patients did result in operation ward changes across the month.
- **Medically Fit Patients** – after 11th consecutive months, the number of MFD patients still on our wards 24 hours after becoming medically fit is no longer showing special cause concern as the support packages for care at home, or places in care homes, cannot be realised; it was still 1,020 patients.
- **Length of Stay** – the LOS on our non-covid wards is showing no significant change at 4.5 days in Mar-22 and is the first time in 9 months where it's below the mean and not showing special cause concern.
- **The 30 day re-admission rate** continues to show significant sustained improvement, the seventh month below the lower confidence interval.

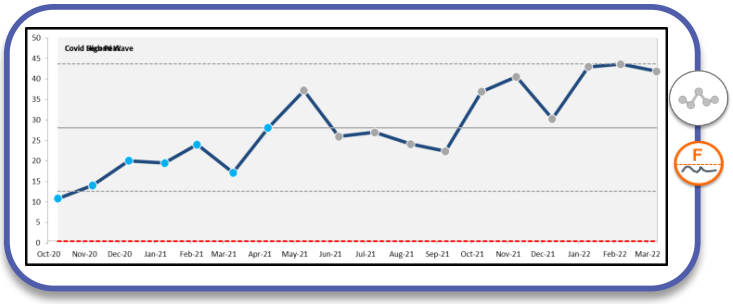
Current Assurance Level: 4 (Mar-22)	**When expected to move to next level of assurance:** This is dependent on the on-going management of the increase attendances and achieving operational standards.
Previous assurance level: 4 (Feb-22) ***Downgraded from 5 to 4 at Finance & Performance Committee (23rd Feb 2022)***	**SRO: Paul Brennan**

Month 12 [March] | 2021-22 | Operational Performance: Patient Flow and Capacity

Responsible Director: Chief Operating Officer | Validated for Mar-22 as at 13th April 2022

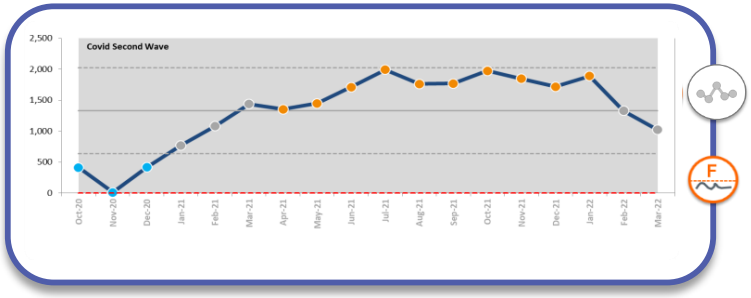
Capacity Gap (Daily avg. excl. EL)

41



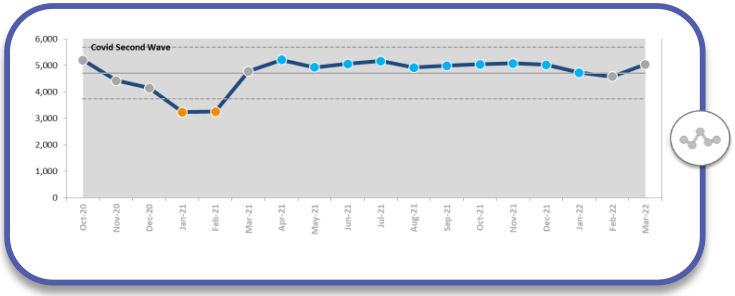
MFFD patients still on the ward 24hrs after becoming MFFD

1,020



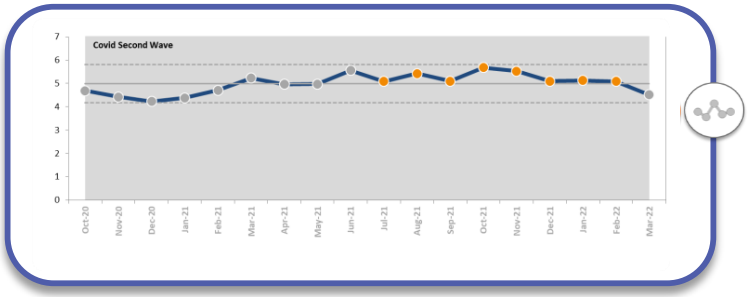
Total Discharges and Transfers

5,037



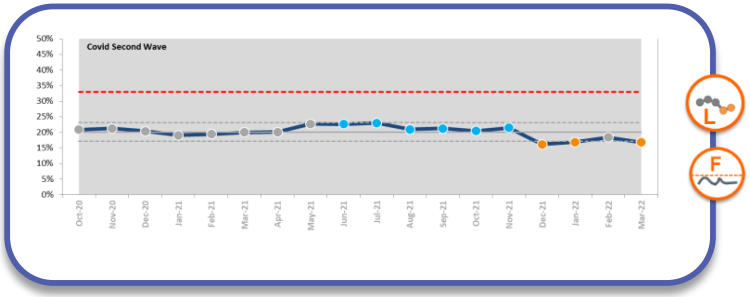
Average Length of Stay in Hospital at Discharge (non-covid wards)

4.5



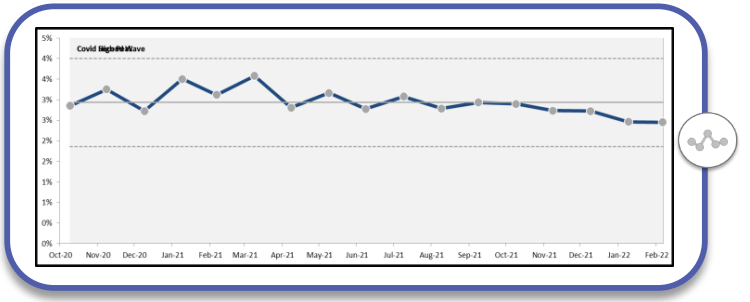
% Discharges before midday (non-covid wards)

16.8%



30 day readmission rate for same clinical condition

2.9%



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

Key

- Internal target
- Operational standard

Operational Performance: Cancer

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

NHS Worcestershire Acute Hospitals NHS Trust

2WW Cancer Referrals	Patients seen within 14 days (All Cancers)		Patients seen within 14 days (Breast Symptoms)		Patients told cancer diagnosis outcome within 28 days (FDS)		Patients treated within 31 days		Patients treated within 62 days		Total Cancer PTL	Patients waiting 63 days or more	Of which, patients waiting 104+ days
2,910	58.10%	2,463 seen	96.62%	148 seen	67.10%	2,389 told outcome	95.00%	320 treated	62.28%	198 treated	3,032	335	144

What does the data tells us?

- **Referrals** increased by 12% from Feb-22, across 8 of 11 specialties, with attributable to 57% to Lower GI, Breast and Skin. Total referrals for the month are the new highest on record (slide 12).
- **2WW:** The Trust saw 58.10% of patients within 14 days. Of the 1,032 breaches, 886 (85%) were attributable to Lower GI and Skin; Haematology, Breast and Breast Symptomatic were the only specialties to achieve the 2WW standard. This overall performance continues to be special cause concern as a result of the high number of breaches despite seeing 2,287 more patients in 21/22 than in 19/20.
- **28 Faster Diagnosis:** The Trust has yet to achieve the FDS target of 75% and will not do so until the timeliness of the 2WW pathway improves.
- **31 Day:** Of the 320 patients treated in Mar-22, 304 waited less than 31 days for their first definitive treatment from receiving their diagnosis. This unvalidated performance is below the CWT target of 96% and continues to show special cause variation due being a run of 7+ months below the mean.
- **62 Day:** There are 197.5 recorded first treatments in Mar-22 with 62.28% within 62 days. This indicator remains special cause concern; the only specialty to achieve the standard was Skin.
- **Cancer PTL:** As at the 31st March there were 3,032 patients on our PTL, increasing due to the volume of referrals received. 181 patients having been diagnosed, 1,801 are still suspected and the remaining 1,050 patients are between 0-14 days.
- **Backlog:** The number of patients waiting 62+ days has increased from 330 at the end of Feb-22 to 335 and the number of patients waiting 104+ days has increased from 113 to 144 patients; both continue to show as special cause concern. Urology and colorectal have the largest number of patients untreated. 51 of the 144 patients waiting over 104 days are diagnosed and the remaining 93 are suspected.

What have we been doing?

- **Do what we say we will do:** 2ww Breast achieved the 2ww performance target for the first time since August 2020 with an actual of 97.97% in March 2022 and 100% (at the time of writing) for April 2022, and at the same time have started to achieve 28 days FDS since February 2022.
- **No delays, every day:** Actively seeking outsourced companies to support 2ww Skin service after March 2022 saw the performance drop due to chronic staff shortage challenges and performance not expected to be easily regained with the start of the Spring and then Summer seasons approaching.
- 31 day treatment continues to be relatively strong at 94% for both February and March 2022 despite increased pressures on our overall bed base due to emergency and Covid-19 admissions.
- **We listen, we learn, we lead:** 2ww Breast service planned to rollout referral assessment service (RAS) and electronic triage functionality via the ERS system, with Skin and Colorectal expected to follow suit for RAS.
- **Work together, celebrate together:** Meeting arranged with Colorectal and CCG colleagues with actions identified seeking to remedy the 2ww Colorectal service performance, including education of GP's and ensuring all referred patients have been seen prior to referral, review of FIT negative policy and referral rates by practice.

What are we doing next?

- **Do what we say we will do:** Follow up above identified 2ww Colorectal actions with a review in a couple of weeks time and view to pulling together a comprehensive communication to GP Practices.
- **No delays, every day:** Further explore offer of support from Breast secretaries to help with significant backlogs in Urology typing, which is potentially delaying patients being informed of their cancer diagnosis and next steps as well as delaying confirmation of non cancer diagnosis conversations.
- **We listen, we learn, we lead:** Cancer Services Manager to assist with an admin review of Urology service with a view to clarifying existing resource and workload levels alongside any gaps.
- **Work together, celebrate together:** Follow up offer of external project management support from NHSEI with a view to providing some focus and support for the Urology cancer pathways as a priority.

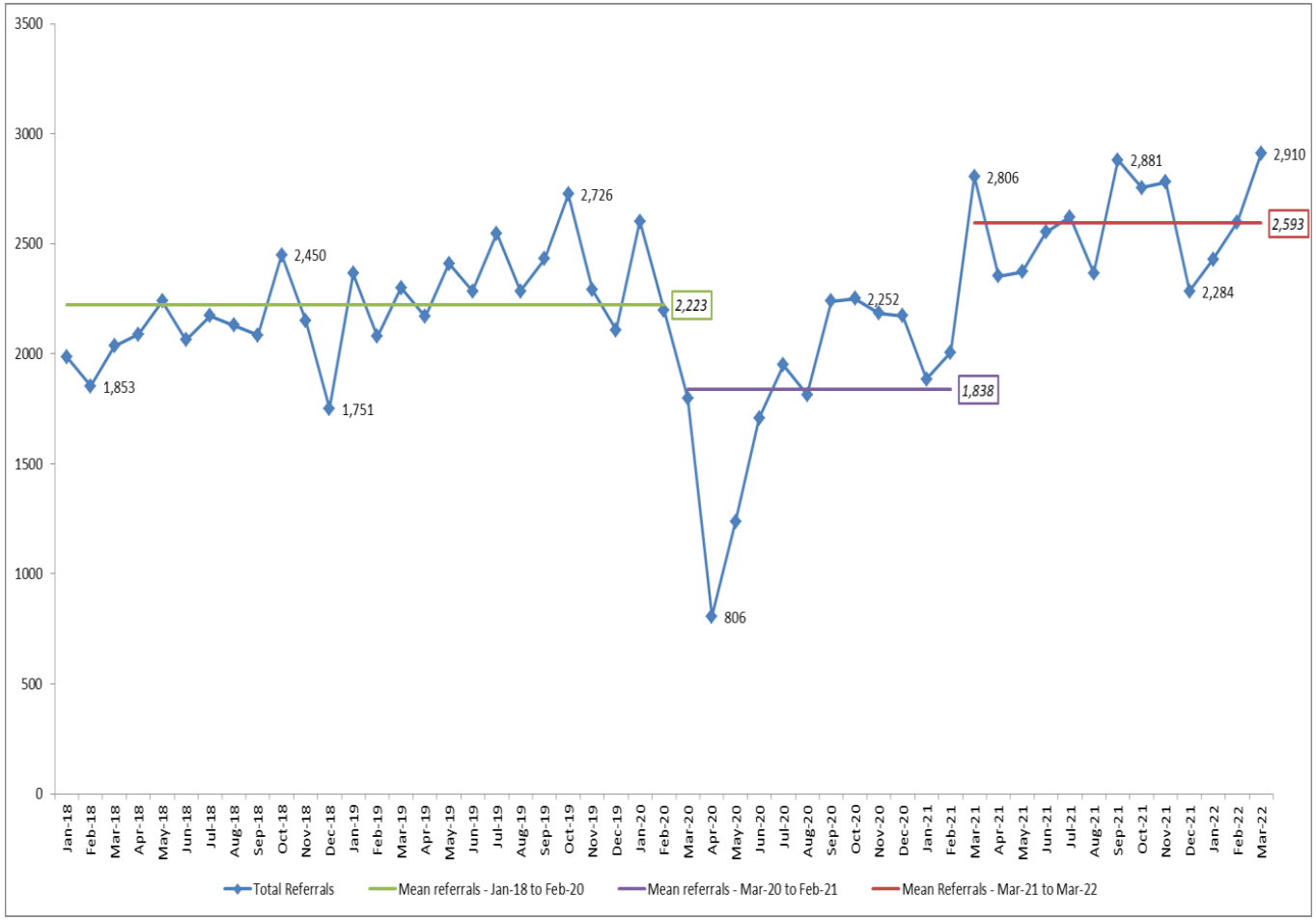
Current Assurance Levels (Mar-22)	Previous Assurance Levels (Feb-22)
2WW – Level 4	2WW - Level 4
31 Day Treatment - Level 5	31 Day Treatment - Level 5
62 Day Referral to Treatment – Level 4	62 Day Referral to Treatment - Level 4

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 for diagnosis / treatment starts to decrease. Improvements in 2WW are expected to be realised in October as a result of Breast services clearing their current backlog and the required 62+ day backlog reduction is to be delivered in Mar-22.

SRO: Paul Brennan

Operational Performance: 2WW Cancer Referrals

Responsible Director: Chief Operating Officer | Validated for Mar-22 as 4th May 2022



This graph shows the changing profile in 2WW referral numbers, comparing the most recent 13 months from Mar-21 to a pandemic period (Mar-20 to Feb-21) and the historic trend from Jan-18 to Feb-20. 5 months in the last 13 are above the previous highest number of referrals received in a month (Oct-19) and all 13 months are above the average for the pre-pandemic period.

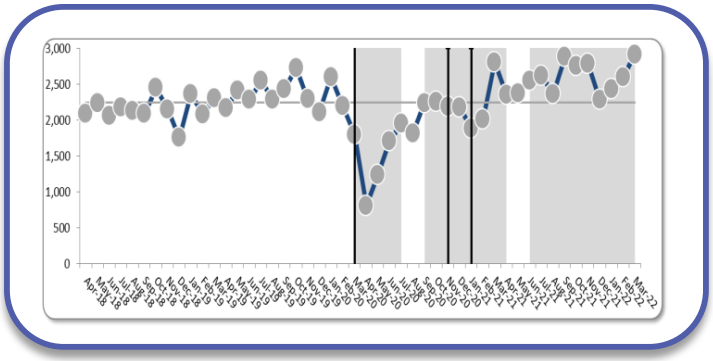
12

Month 12 [March] | 2021-22 | Operational Performance: Cancer

Responsible Director: Chief Operating Officer | Validated for Mar-22 as 4th May 2022

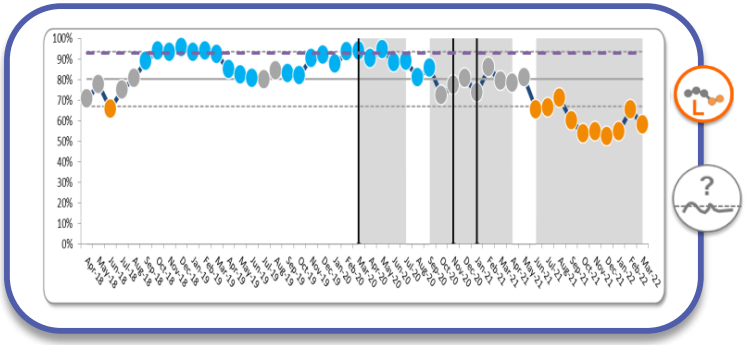
2WW Referrals

2,910



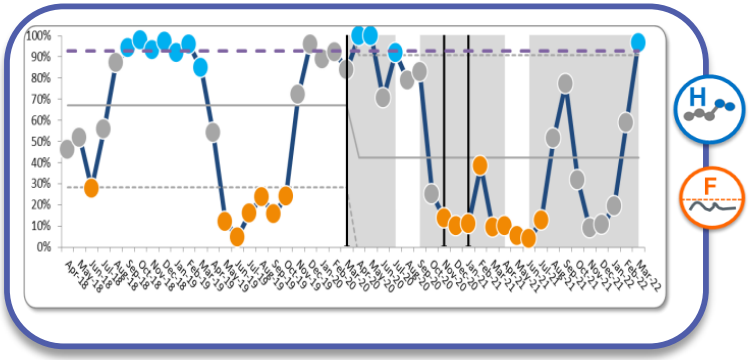
Cancer 2WW All

58.10%



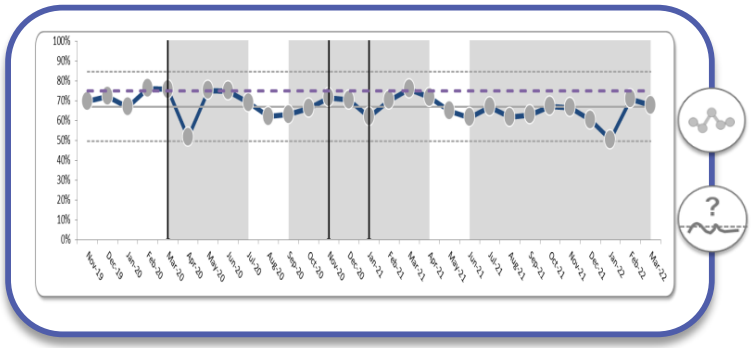
Cancer 2WW Breast Symptomatic

96.62%



Cancer 28 day FDS

67.10%



Key

- Internal target
- Operational standard

COVID Wave

Lockdown

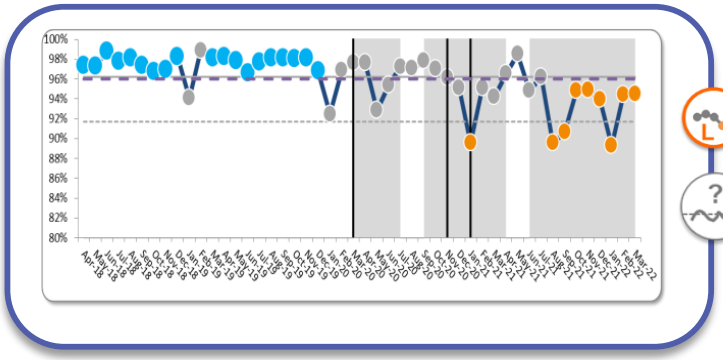
Month 12 [March] | 2021-22 | Operational Performance: Cancer

Responsible Director: Chief Operating Officer | Validated for Mar-22 as 4th May 2022

Worcestershire Acute Hospitals NHS Trust

Cancer 31 Day All

95.00%

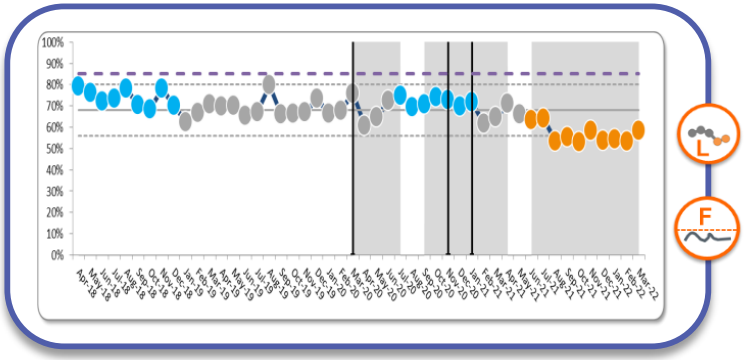


L

?

Cancer 62 Day All

62.28%



L

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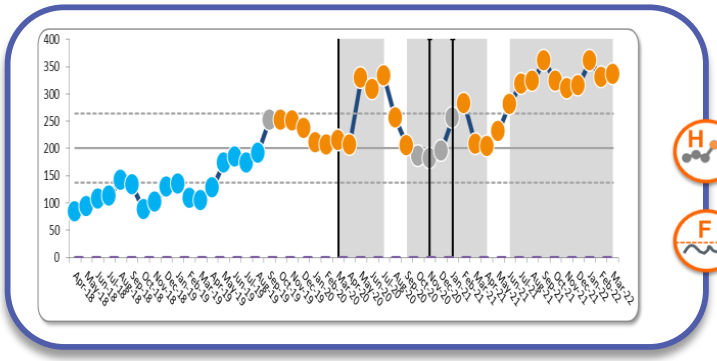
Please note that % axis does not start at zero.

Backlog Patients waiting 62 day or more

335



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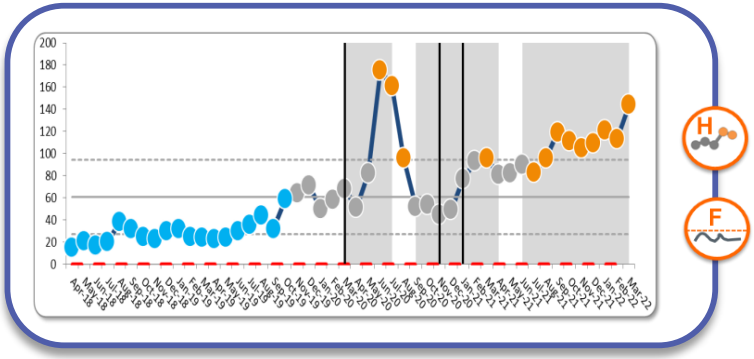
Backlog Patients waiting 104 day or more

144



H

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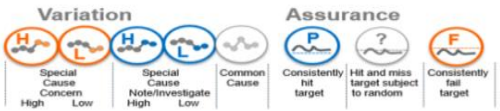
Key

- Internal target
- Operational standard

COVID Wave

Lockdown



Operational Performance: Cancer Benchmarking

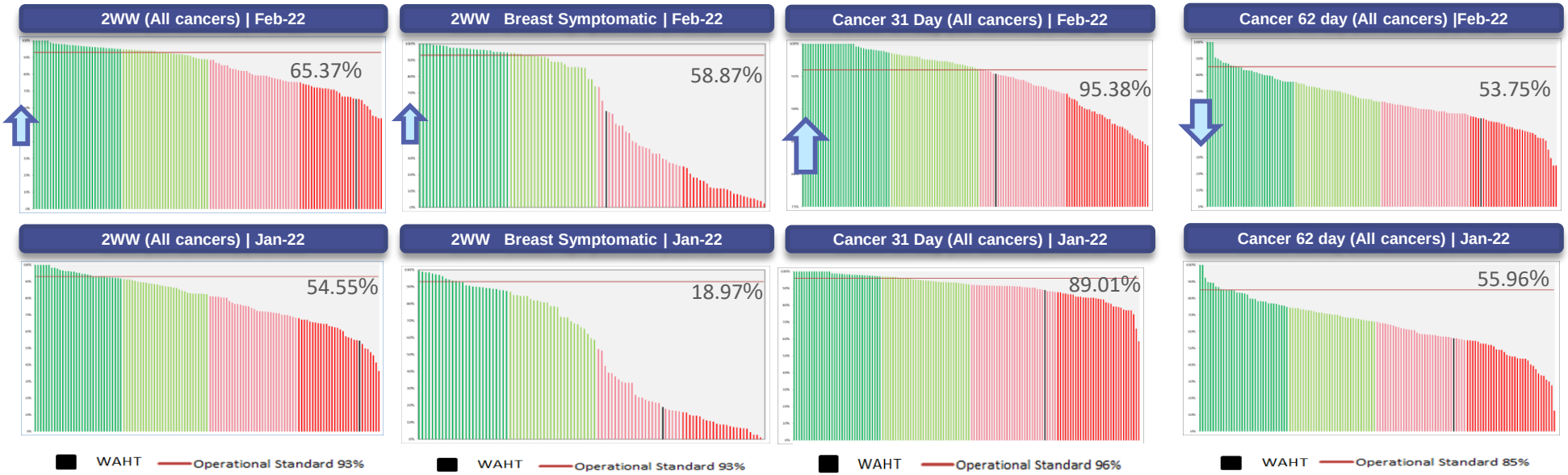
National Benchmarking (February 2022)

2WW: The Trust was one of 2 of 13 West Midlands Trust which saw a increase in performance between Jan-22 and Feb-22. This Trust was ranked 8 out of 13; we were 13th the previous month. The peer group performance ranged from 49.94% to 88.88% with a peer group average of 75.17%; improving from 69.92% the previous month. The England average for Feb-22 was 74.99% a 5.7% increase from 80.66% in Jan-22.

2WW BS: The Trust was one of 10 of 13 West Midlands Trust which saw a increase in performance between Jan-22 and Feb-22. This Trust was ranked 6 out of 13; we were 7th the previous month. The peer group performance ranged from 5.62% to 96.85% with a peer group average of 45.53%; improving from 37.97% the previous month. The England average for Feb-22 was 56.50% a 7.1% increase from 49.40% in Jan-22.

31 days: The Trust was one of 11 of 13 West Midlands Trust which saw a increase in performance between Jan-22 and Feb-22. This Trust was ranked 4 out of 13; we were 6th the previous month.
The peer group performance ranged from 85.00% to 100.00% with a peer group average of 91.21%; improving from 85.60% the previous month. The England average for Feb-22 was 93.68% a 4.0% increase from 89.64% in Jan-22.

62 Days: The Trust was one of 13 of 13 West Midlands Trust which saw a decrease in performance between Jan-22 and Feb-22 This Trust was ranked 7 out of 13; we were 4th the previous month.
The peer group performance ranged from 34.64% to 75.86% with a peer group average of 50.19%; improving from 47.78% the previous month. The England average for Feb-22 was 62.11% a 0.3% increase from 61.79% in Jan-22.



Operational Performance: Planned Care | Waiting Lists

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

Electronic Referral Service (ERS) Referrals		Referral Assessment Service (RAS) Referrals		Advice & Guidance (A&G) Requests (ERS only)	Total RTT Waiting List	Number and 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	Number of patients waiting 52+ weeks	Of whom, waiting 78+ weeks	Of whom, waiting 104+ weeks
Total	8582	Total	6,204	1,514	57,151	26,853	46.99%	5,895	5,849	1,435	327
Non-2WW	5,521	Non-2WW	5,178								

What does the data tells us?

Referrals

- **ERS Referrals:** a total of 8,582 electronic referrals were made to the Trust in Mar-22 and is marginally by working day comparing Feb-22 = 400.7 to Mar-22 = 408.7.
- 5,521 were non-2WW referrals so of the total electronic referrals, 35.7% were 2WW cancer, this has been the norm for 21/22.
- **RAS Referrals:** a total of 6,204 RAS referrals were made to the Trust in Mar-22. 5,1778 were non-2WW and 770.% have been outcomed within 14 working days. Of the 1,026 2WW RAS referrals, 96.1% have been outcomed within 2 working days. 14.2% of RAS referrals were returned to the referrer.
- **A&G Requests:** 1,514 A&G requests were received in Mar-22, the highest in 21/22, with 85.7% responded to within 2 working days and 94.3% within 5 working days.

Referral To Treatment Time (unvalidated)

- The Trust has seen a 2.2% increase in the overall wait list size at the end of Mar-22 compared to Feb-22; from 55,890 to 57,151. Despite the increase, this is below the H2 target of no more than 57,232incomplete pathways.
- The number of patients over 18 weeks who have not been seen or treated within 18 weeks has increased to 30,298. This is 173 more patients than the validated Feb-22 snapshot and a 1.1% increase. RTT performance for Mar-22 is validated at 46.99% compared to 46.10% in Feb-22. This remains sustained, significant cause for concern and the 92% waiting times standard cannot be achieved.
- The number of patients waiting over 52 weeks for their first definitive treatment is 5,849 patients, no significant change from the previous month. Of that cohort, 1,435 patients have been waiting over 78 weeks and 327 over 104 weeks. Of the 104+ week cohort, 269 patients are under the orthodontic specialty with the next highest at 28 (general surgery) and 13 (urology).

Current Assurance Level: 3 (Mar-22)	**When expected to move to next level of assurance:** This is dependent on the programme of restoration of elective activity and reduction of long waiters which are linked to the H2 operational planning requirements (Mar-22).
Previous Assurance Level: 3 (Feb-22)	**SRO: Paul Brennan**

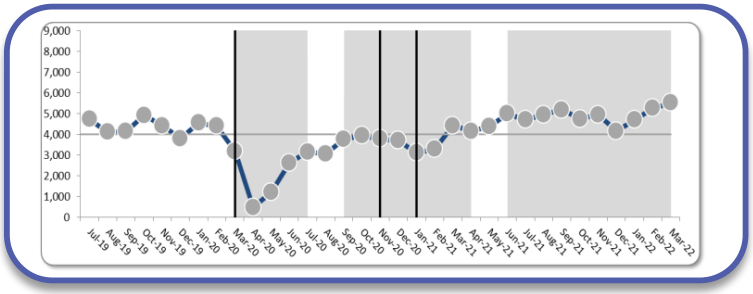
Month 12 [March] | 2021-22 | Operational Performance: RTT

Responsible Director: Chief Operating Officer | Validated for Mar-22 at 4th May 2022

NHS Worcestershire Acute Hospitals NHS Trust

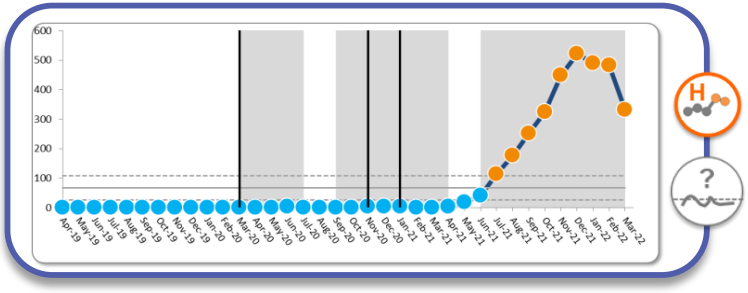
Electronic Referrals Profile (non-2WW)

5,521



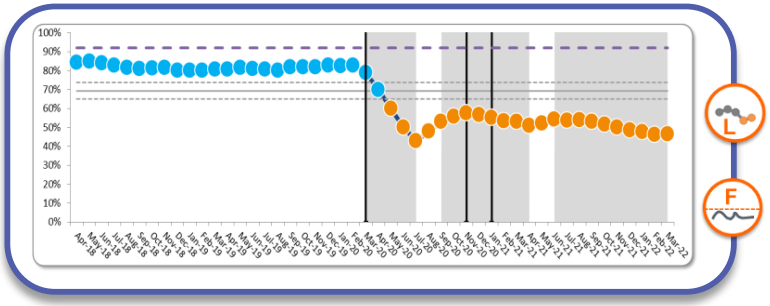
104+ week waits

327



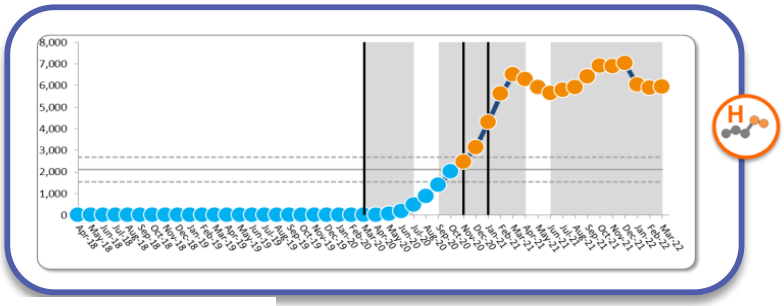
RTT % within 18 weeks

46.99%

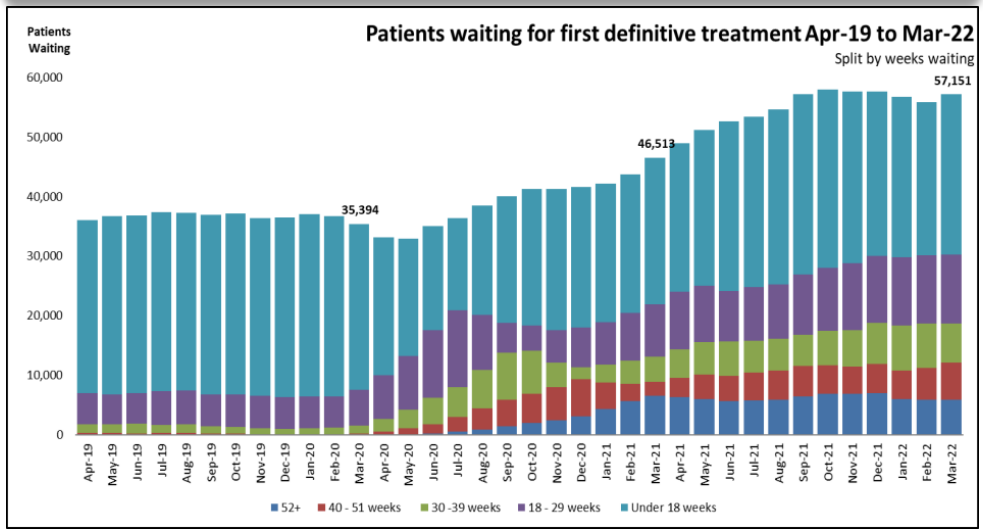


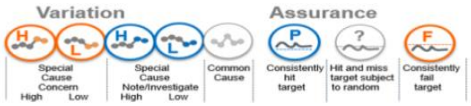
52+ week waits

5,849



RTT waiting list profile by weeks waiting





Key

- Internal target
- Operational standard

Operational Performance: RTT Benchmarking

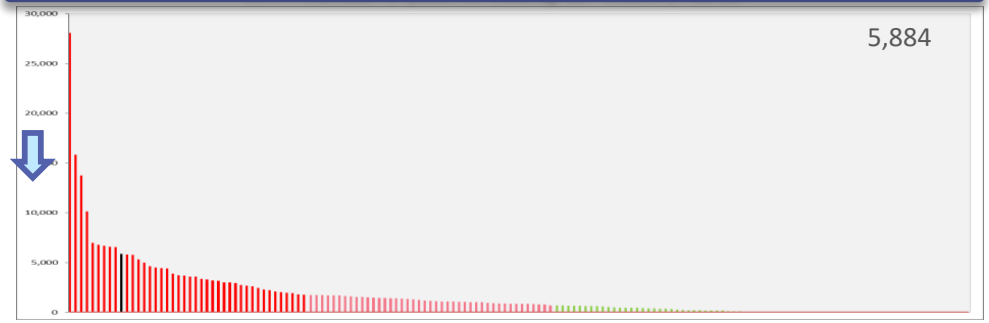
2.4 - Maintain access to all emergency surgery (inc trauma) and triage elective waiting list to prioritise access for those at greatest risk of harm from delay

National Benchmarking (February 2022) | The Trust was one of 8 of 12 West Midlands Trust which saw a decrease in performance between Jan-22 and Feb-22. This Trust was ranked 11 out of 13; no change from the previous month. The peer group performance ranged from 41.30% to 78.80% with a peer group average of 52.13%; improving from 51.63% the previous month. The England average for Feb-22 was 62.90% a 0.1% increase from 62.80% in Jan-22.

Nationally, there were 299,478 patients waiting 52+ weeks, 5,884 (1.96%) of that cohort were our patients.
Nationally, there were 63,724 patients waiting 78+ weeks, 1,479 (2.24%) of that cohort were our patients.
Nationally, there were 20,751 patients waiting 104+ weeks, 466 (2.24%) of that cohort were our patients.

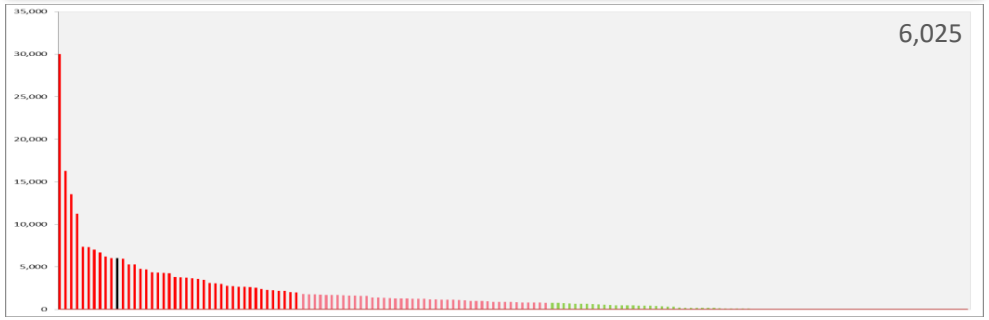
RTT - % patients within 18 weeks | Feb-22

RTT – number of patients waiting 52+ weeks | Feb-22



RTT - % patients within 18 weeks | Jan-22

RTT – number of patients waiting 52+ weeks | Jan-22



Operational Performance: Planned Care | Outpatients and Elective Admissions (2nd SUS Submission)

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 Outpatient Attendances		Total OP Attendances Face to Face		Total OP Attendances Non Face to Face		% OP Attendances Non Face to Face	Consultant Led First OP Attendances		Consultant Led Follow Up OP Attendances		Elective IP Day Case		Elective IP Ordinary	
45,891	+5,653	34,079	+9,357	11,812	-3,704	25.7%	11,497	+1,024	14,281	+1,231	6,919	+430	550	-173

Outpatients - what does the data tell us? (second SUS submission)

- The graphs on slide 21 compare our Mar-22 outpatient attendances to Mar-20 and our H2 activity target. As noted in the top row of this table we achieved the majority of our OP targets. We have reached the point now that we cannot compare Mar-22 to Mar-20 or Mar-21 due to the impact that the pandemic has had on reducing our activity. Mar-21 was the second highest month of activity, Nov-21 was the highest at 48,241; the Trust undertook 45,891 outpatient appointments in Mar-22 (consultant and non-consultant led).
- In the Mar-22 RTT OP cohort, there are 32,713 RTT patients still waiting for their first appointment, 22.8% of them have been dated and of the total cohort, 2,022 patients have been waiting over 52 weeks. 76% of these longest waiters are undated.
- The top five specialties with the most 52+ week waiters in the outpatient new cohort has not changed and are General Surgery, Orthodontics, Urology, Gynaecology and T&O.
- For Patients awaiting 1st outpatient appointment on pathway, the following have been identified as improvements from Feb-22 to Mar-22.
    - Ophthalmology saw a decrease in median wait time of -38.5% from 54 days to 39 days, based on a cohort of 4234 patients in the most recent month, compared with a previous cohort size of 4071 patients. Additionally, the mean wait time has decreased by 17.3% from 87.5 days to 74.6 days and the 95th percentile wait time has decreased by 6.9% from 256.5 days to 240 days.
    - Dermatology saw a decrease in median wait time of -37.5% from 11 days to 8 days, based on a cohort of 656 patients in the most recent month, compared with a previous cohort size of 629 patients.
    - Finally, Trauma & Orthopaedics saw a decrease in median wait time of -28.9% from 49 days to 38 days, based on a cohort of 1041 patients in the most recent month, compared with a previous cohort size of 1098 patients. Additionally, the mean wait time has decreased by 19.0% from 90 days to 75.6 days, the maximum wait time has decreased by 12.5% from 592 days to 526 days, and the 95th percentile wait time has decreased by 22.8% from 285 days to 232 days. The decrease in wait times across all aggregate metrics indicates that Trauma & Orthopaedics is making progress in reducing wait times for this pathway stage.

Planned Admissions - what does the data tell us?

- On the day cancellations shows significant change for the first time since Jun-20 with 10.3% of scheduled procedures for Mar-22 cancelled on the day.
- Theatre utilisation, at 71.6%, remains just below the mean and is not showing positive improvement. Factoring in allowed downtime, the utilisation increases to 76.5%. Lost utilisation due to late start / early finish showed no significant change at 26.3%
- In Mar-22, the number of day cases and elective ordinary cases increased from Feb-22; Day case is above (+430) and EL IP below (-173) the H2 plan. Our overall elective activity is currently unvalidated at +257 to plan.
- 45.5% of eligible patients were rebooked within 28 days for their cancelled operation in Mar-22, with 15 of 33 patients being rebooked within the required timeframe.
- The Independent Sector undertook no elective activity in Mar-22 but they did perform 171 diagnostic tests and 114 procedures were undertaken in our Vanguard theatre.

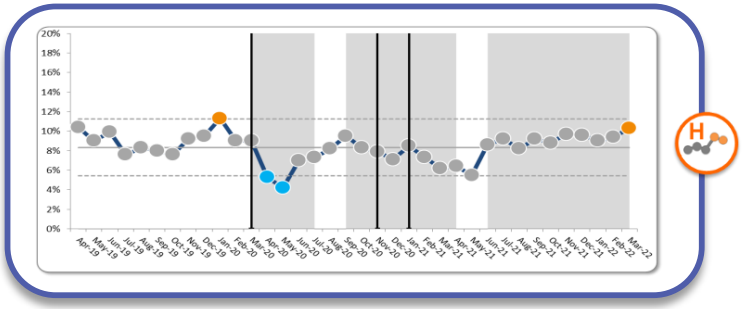
Current Assurance Level: 4 (Mar-22)	**When expected to move to next level of assurance: :** This is dependent on the success of the programme of restoration for increasing outpatient appointments and planned admissions for surgery being maintained and the expectation from NSHEI for H2 (Mar-22).
Previous Assurance Level: 4 (Feb-22)	**SRO: Paul Brennan**

Month 12 [March] | Operational Performance: Theatre Utilisation & Outpatients

Responsible Director: Chief Operating Officer | Validated for Mar-22 as 13th April 2022

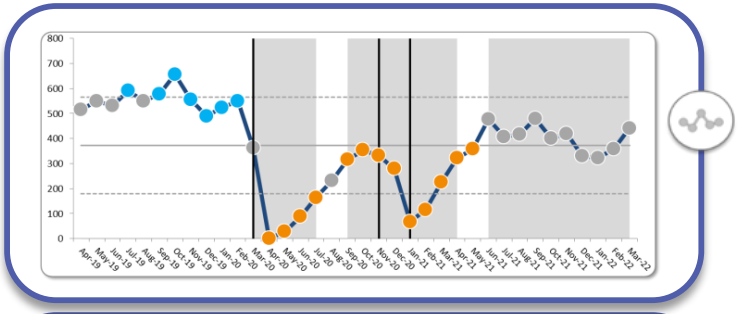
On the day cancellation as a percentage of scheduled procedures (%)

10.3%



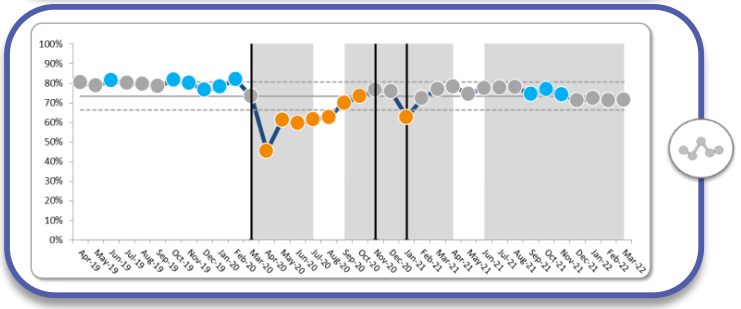
Electives on elective theatre sessions (n)

441



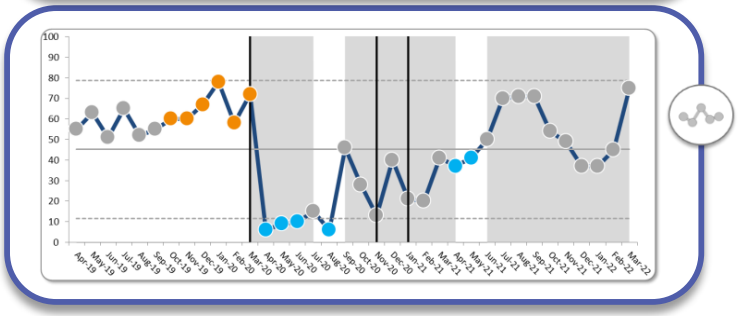
Actual Theatre session utilisation (%)

71.6%



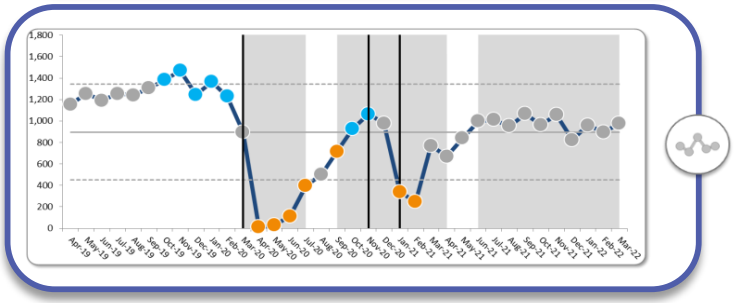
Non-electives & emergencies on elective theatre sessions (n)

75



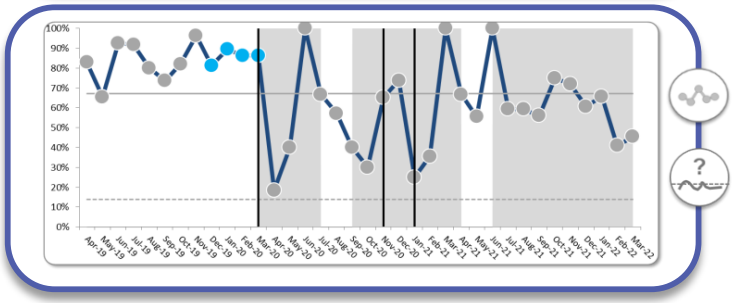
Day cases on elective theatre sessions (n)

976



% patients rebooked with 28 days of cancellation

45.5%

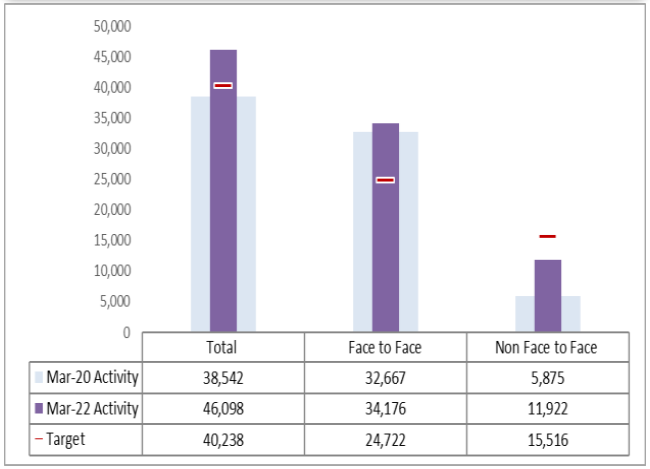


Month 12 [March] | 2021-22 | Operational Performance: Outpatients

Responsible Director: Chief Operating Officer | Unvalidated for Mar-22 as 4th May 2022 (Second SUS Submission)

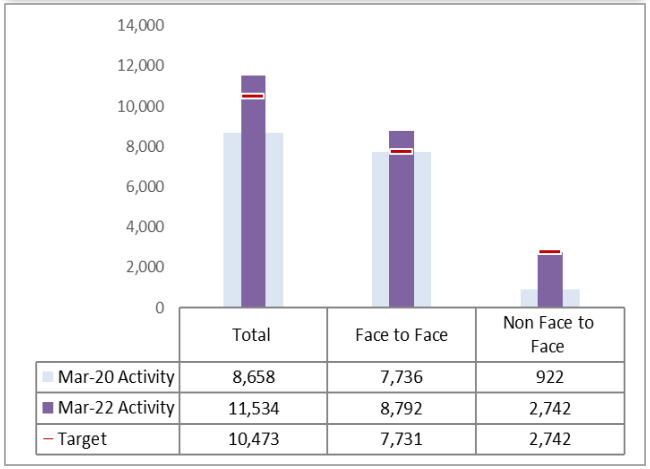
Outpatients| March 2022 attendances compared to 2019/20 and H2 plan

Total outpatient attendances (all TFC; consultant and non consultant led)



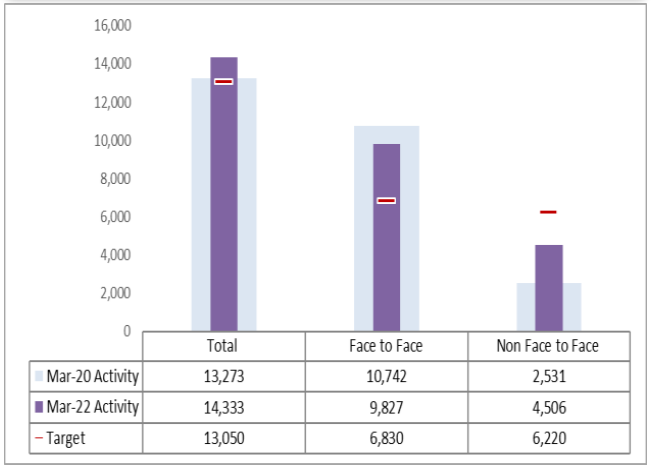
	Total	Face to Face	Non Face to Face
Mar-20 Activity	38,542	32,667	5,875
Mar-22 Activity	46,098	34,176	11,922
Target	40,238	24,722	15,516

Consultant-led first outpatient attendances



	Total	Face to Face	Non Face to Face
Mar-20 Activity	8,658	7,736	922
Mar-22 Activity	11,534	8,792	2,742
Target	10,473	7,731	2,742

Consultant-led follow-up outpatient attendances



	Total	Face to Face	Non Face to Face
Mar-20 Activity	13,273	10,742	2,531
Mar-22 Activity	14,333	9,827	4,506
Target	13,050	6,830	6,220

Operational Performance: DM01 Diagnostics | Waiting List and Activity

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

Worcestershire Acute Hospitals NHS Trust

The total waiting list, the number of patients waiting more than 6 weeks for a diagnostic test, and % of patients waiting less than 6 weeks											
Trust Total			Radiology			Physiology			Endoscopy		
10,039	2,751	72.6%	5,568	1,122	79.8%	3,235	1,160	64.1%	1,236	469	62.1%

What does the data tell us?

DM01 Waiting List

- The DM01 performance is validated at 72.6% of patients waiting less than 6 weeks for their diagnostic test, compared to 68.9% the previous month.
- The diagnostic waiting list has decreased by a further 1.9%, and is a decrease of 195 patients from the previous month.
- The total number of patients waiting 6+ weeks has decreased by 433 patients, now below 3,000 for the first time since pre-pandemic monitoring. There are 1,100 patients waiting over 13 weeks (1,655 in Feb-22) with echocardiography and DEXA contributing 59% of our longest waiters.
- Radiology has the largest number of patients waiting at 5,568, an increase of 75 patients from Feb-22, with those waiting 6+weeks having decreased by 261. Of particular note is CT's improved position with fewer than 100 patients breaching 6 weeks.
- Endoscopy has reduced the number of patients waiting over 6+ weeks by -57 and their total waiting list size by -142.
- Physiological science modalities saw an 128 patient decrease in the total waiting list and the number of patients waiting over 6 weeks by 115.

Activity

- 17,992 diagnostic tests were undertaken in Mar-22, a new high peak for our modalities.
- CT and non-obstetrics ultrasound achieved their H2 plan for Mar-22, and although MRI didn't there were still 12% more tests in the month compared to Feb-20.
- Colonoscopy and gastroscopy missed their H2 plan target but Flexi Sig was +24 to plan.
- Finally, echocardiography achieved it's H2 plan, +486 to plan.

RADIOLOGY

What have we been doing?

- Continued WLI sessions countywide, staff permitting.
- Continued DEXA WLI sessions
- Took delivery of CT mobile scanner
- Offered 9 overseas Radiographer posts
- Offered 14 UK Radiographer posts
- Obtained JNCC approval to commence consultation with IR nurses for OOH component
- Engaged with external agency to provide Radiographers for 6 months while recruitment processes are completed
- Advertised Radiologist posts
- Recruited modality leads

What are we going to do next?

- Identify funds to extend MRI mobile
- Identify funds to extend CT mobile
- Continue WLI session in CT, MRI, DEXA and US.
- Review 2ww capacity, in particular Breast
- Review Radiographer training plans

Issues

- Increase in 2ww CT Colon referrals, specialised Radiographers perform these which minimises capacity, but we also have sickness in this group of staff
- Reduced number of WLI as staff not offering additional sessions and due to sickness
- Increase in Breast 2ww demand for MRI- no available capacity in hours, discussing with Breast how we can utilise OOH available capacity

ENDOSCOPY (inc. Gynaecology & Urology)

What have we been doing?

- Ceased use of 18 Week Support insourcing at ECH
- Self isolation and PCR testing for upper procedures remains challenging
- Continuing to recruit to vacant booking co-ordinator positions.
- Identifying further training needs within the Admin team
- Replaced Urology weekend WLI sessions with GI
- Working toward enhanced sedation lists within the Endoscopy department
- Admin structure review underway
- Working with transformation team to streamline full patient pathway

What are we going to do next?

- Exploring the move from PCR to LFT for upper GI procedures
- Radiology scoping options to increase IR service. Endoscopy exploring options to provide ERCP sessions in an alternative location, however, Radiographer support will still remain in place
- Booking team working further in advance to book procedures

Issues

- Capacity of booking team to book patients continuing to be an issue
- Booking patients is an issue due to covid swab and isolation period – patients declining appointments.

Operational Performance: DM01 Diagnostics | Waiting List and Activity

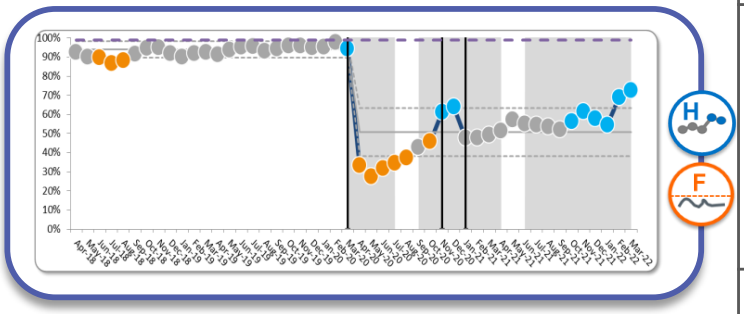
2.4 - Ensure timely access to diagnostics and treatment for all urgent cancer care

NHS Worcestershire Acute Hospitals NHS Trust

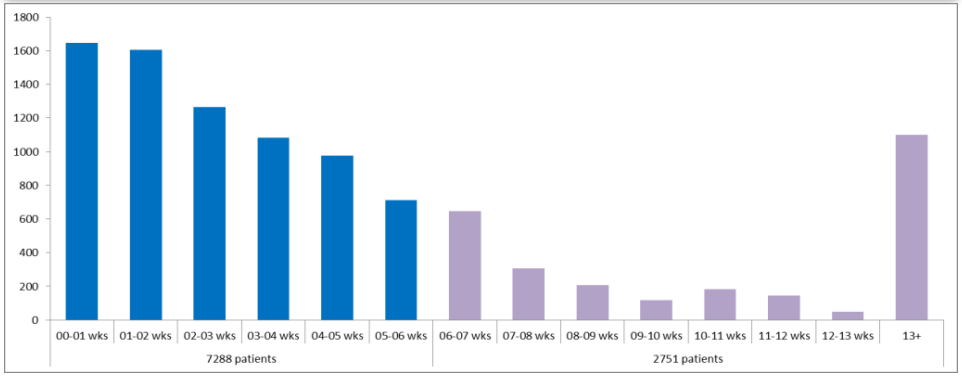
The total waiting list, the number of patients waiting more than 6 weeks for a diagnostic test, and % of patients waiting less than 6 weeks											
Trust Total			Radiology			Physiology			Endoscopy		
10,039	2,751	72.6%	5,568	1,122	79.8%	3,235	1,160	64.1%	1,236	469	62.1%

DM01 Diagnostics % patients within 6 weeks

72.6%



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



NEUROPHYSIOLOGY

What have we been doing?

- Clinical urgency continues to be reviewed
- Clinics are being booked at KTC and ALX once a week.
- Continue to work mixed shift to allow additional patients to be seen

What are we going to do next?

- WLI – approval for a limited amount of clinics, outsourcing staffing these have started
- Identify any opportunities to increase capacity following new IPC guidelines
- 6 day working to help with clinic bookings
- Locum consultant cover to continue reducing EMG w/l

Issues

- Staff shortages due to track and trace

CARDIOLOGY – ECHO

What have we been doing?

- Consultant team have started clinical validation of the waiting list – hopeful completion end of April 22
- Echo service has returned to sites to allow for services close to home, but with change in appointment timings to allow for increased throughput
- WLIs taken place on weekends to help backlogs and will continue throughout this project

What are we going to do next?

- Completion of the clinical validation – early estimations are 15-25% reduction from this
- Continued WLI clinics where possible

Issues

- Staff shortages due to track and trace and high vacancy rate

Current Assurance Level: 5 (Mar-22)

Previous assurance level: 5 (Feb-21)

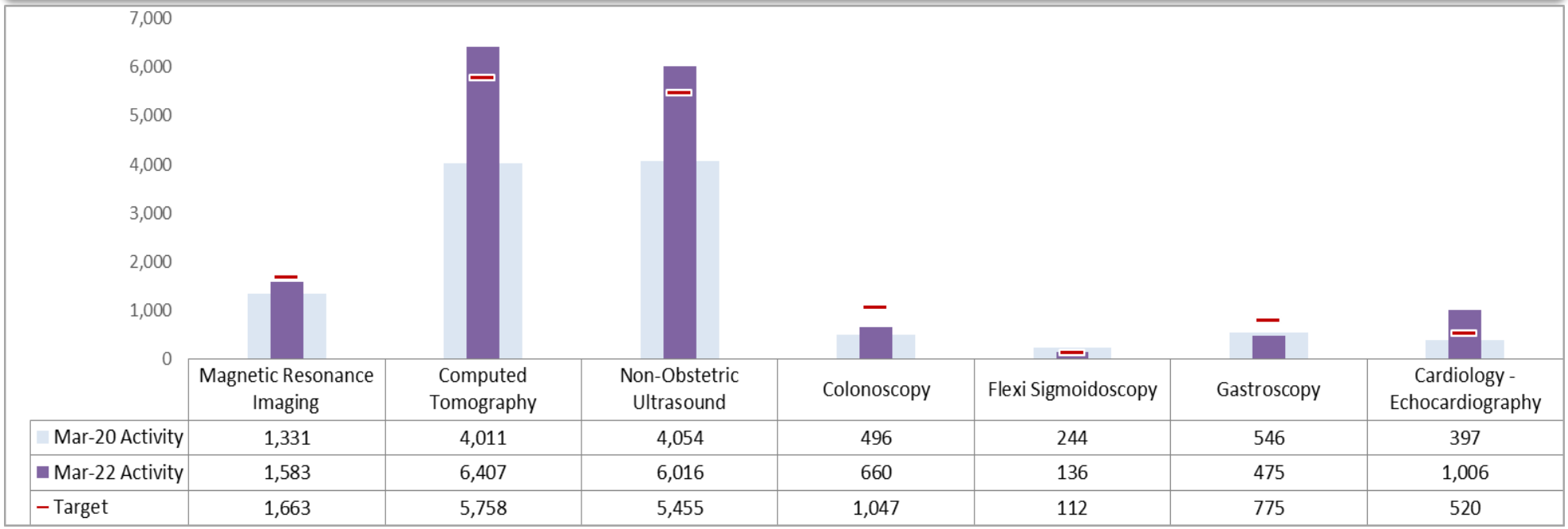
When expected to move to next level of assurance: This is dependent on the on-going management of Covid and the reduction in emergency activity which will result in increasing our hospital and CDC capacity for routine diagnostic activity.

SRO: Paul Brennan

Month 12 [March] 2021-22 | Operational Performance: DM01 Diagnostics

Responsible Director: Chief Operating Officer | Validated for Mar-22 as 19th April 2022

DM01 Diagnostics | March 2022 Diagnostic activity compared to 2019/20 and H2 plan



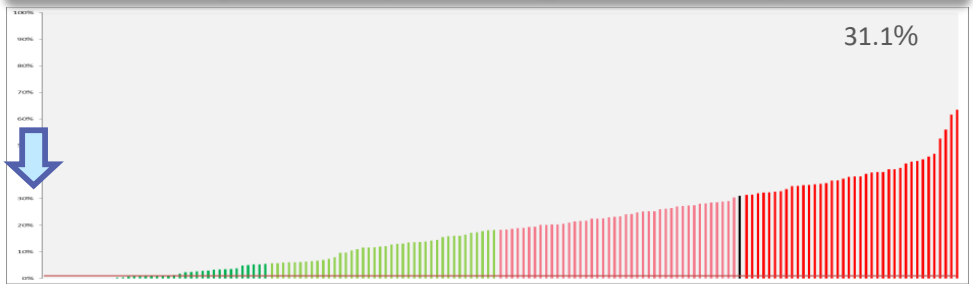
	Magnetic Resonance Imaging	Computed Tomography	Non-Obstetric Ultrasound	Colonoscopy	Flexi Sigmoidoscopy	Gastroscopy	Cardiology - Echocardiography
Mar-20 Activity	1,331	4,011	4,054	496	244	546	397
Mar-22 Activity	1,583	6,407	6,016	660	136	475	1,006
Target	1,663	5,758	5,455	1,047	112	775	520

These graphs represent annual planning restoration modalities only. All other physiology tests, DEXA and cystoscopy were not included in the request from NHSEI.

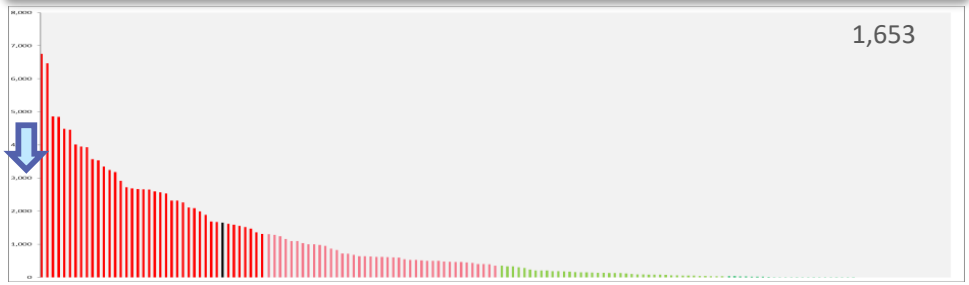
Operational Performance: Diagnostics (DM01) Benchmarking

National Benchmarking (February 2022) | The Trust was one of 0 of 13 West Midlands Trust which saw a improvement in performance between Jan-22 and Feb-22. This Trust was ranked 7 out of 13; we were 12th the previous month. The peer group performance ranged from 2.36% to 52.59% with a peer group average of 29.30%; improving from 33.59% the previous month. The England average for Feb-22 was 24.00% a -6.0% increase from 30.00% in Jan-22.
In Feb-22, there were 153,440 patients recorded as waiting 13+ weeks for their diagnostic test; 1,653 (1.10%) of these patients were from WHAT

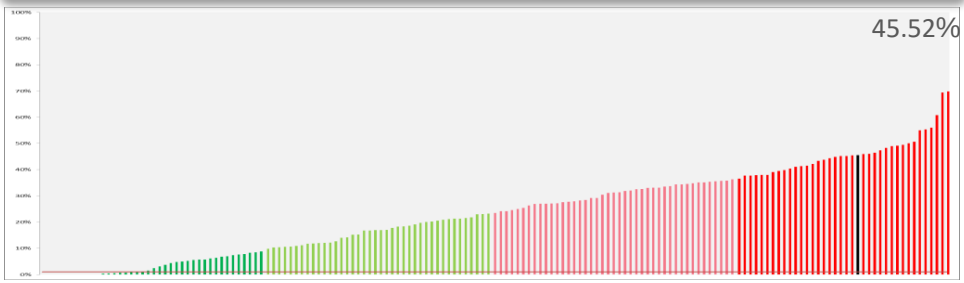
DM01 Diagnostics - % of patients waiting more than 6 weeks | Feb-22



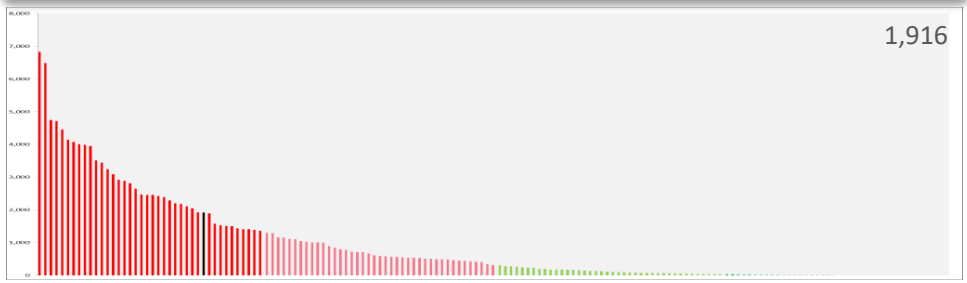
DM01 Diagnostics - number of patients waiting more than 13 weeks | Feb-22



DM01 Diagnostics - % of patients waiting more than 6 weeks | Jan-22



DM01 Diagnostics - number of patients waiting more than 13 weeks | Jan-22



WAHT — Operational Standard 1%

Down arrows represents improvement from previous month i.e. fewer patients waiting > 6 weeks and fewer waiting >13 weeks

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 within 4 hours		% of patients who had a CT within 60 minutes of arrival		% patients seen in TIA clinic within 24 hours		SSNAP Q3 21-22 Oct-21 to Dec-21			
60.47%	E	37.21%	E	58.14%	A	96.30%	N/A	Score	72.0	Grade	B

What does the data tell us?

- Bi-weekly monitoring of SSNAP related metrics and their data quality provide assurance on their accuracy. Although SSNAP is published quarterly, a standalone overall grade for Jan-22 would be a an A.
- The limiting factors, and underpinned by the SPC charts on slide 27, are direct admission and patients spending 90% of their admission on a stroke ward.
- We are consistently graded a E for these two measures. We would need to achieved >55% to increase to a grade D for Direct Admission and >75% for time spent on the stroke ward.
- Although not yet at our target, the current percentage of patients scanned within 60 minutes has increased to 58% - this is a grade A.
- For the fifth consecutive month, patients see in the TIA clinic within 24 hours is above the target.

What are we doing to improve?

- Patients Admitted Within 4 Hours: This is challenging partly due to limited flow to Stroke rehab beds, DTA beds and alternative inpatient beds out of county along with the receipt of timely referrals from ED due to being overwhelmed and the associated flow issues. The team are working with Health & Care Trust to identify appropriate Rehab patients to improve flow out to the Health & Care Trust beds. A joint post (stroke co-ordinator) has again closed with no adverts. Plan to have funding transferred to Acute Trust and for us to employ – discussions ongoing with HACT. This post will provide an overview of stroke capacity across the pathway and support the management of beds across the stroke pathway. Examples of inappropriate pre-alerts have been sent to WMAS and still awaiting a response. Limited stroke consultants continues to be an issue in terms of timely review of both ward patients and new referrals (ED and MAU). A substantive consultant has been appointed (commences May 22). The joint post with WVT has closed for a 2nd time with no applicants. Plan to discuss recruitment strategy at next ICS Stroke Programme Board. A second post, purely WAHT has also gone out to advert closing 5th April currently has 1 strong applicant. Equivalent of 1WTE mutual aid from UHNM in place, along with 1 agency locum and limited support from Neurology team.
- 90% Stay on Stroke Ward: Issues described above impact on this KPI (access to rehab beds/DTA and Community stroke team primarily). To note, the team provides timely therapy and stroke assessment wherever the patient is, not just for those on Stroke unit.
- TIA Patients Seen Within 24 Hours: All referrals now triaged appropriately by Stroke consultant resulting in some rejections. TIA clinics have increased this month weekend (3 slots per day) During weekdays, TIA clinic capacity has been increased by 2 slots per day which is allowing us to maintain achievement of TIA standard. We are improving performance each month and achieving the target of 80% (achieved last 6 months)
- Specialty Review Within 30 Minutes: All referrals to stroke team from ED are reviewed initially by Stroke CNS in consultation with consultant. The Stroke front door team are dedicated to ensuring all stroke patients presenting in ED are assessed by stroke specialist in-hours and are given a swallow screen within 24 hrs as per national guidance. 24/7 CNS cover has now commenced(7th February 2022) which will support improvements in this metric. A local 24/7 stroke on call rota to support thrombolysis decision-making was trialled for the month of February. The impact of this is currently being analysed and has ceased at present due to resource availability. Long term aim for this to be permanently implemented, however this is being run on goodwill at present so is dependent on successful further recruitment and input from Wye Valley Trust consultants – due to their own current resource issues, they are unable to support this at present.

Current Assurance Level: 5 (Mar-22)	**When expected to move to next level of assurance:** Moving to assurance level 6 is dependent on achieving the main stroke metrics and demonstrable sustainable improvements in the SSNAP score / grade. Q3 SSNAP will be published in March 22.
Previous Assurance Level: 5 (Feb-21)	**SRO: Paul Brennan**

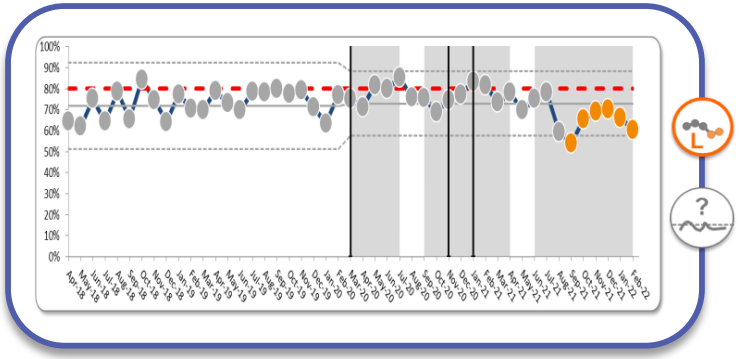
Month 11 [February] | 2021-22 | Operational Performance: Stroke

Responsible Director: Chief Operating Officer | Validated for Feb-22 as 4th May 2022

Worcestershire Acute Hospitals NHS Trust

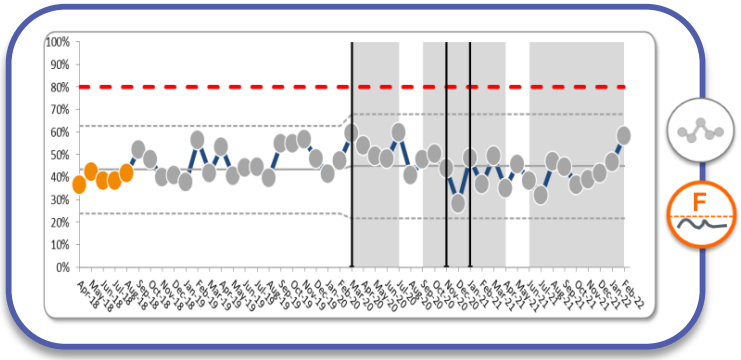
Stroke: % patients spending 90% of time on stroke unit

62.22%



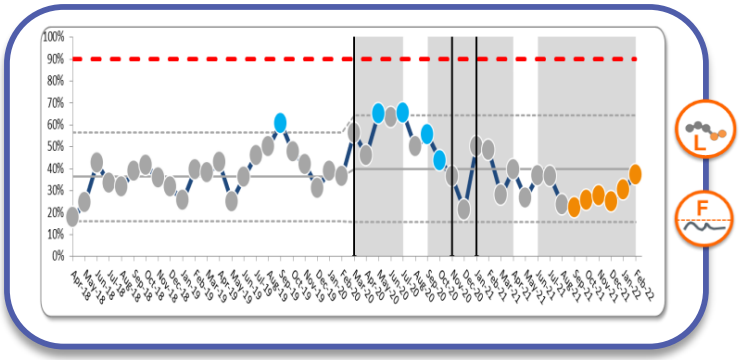
Stroke : % CT scan within 60 minutes

60.00%



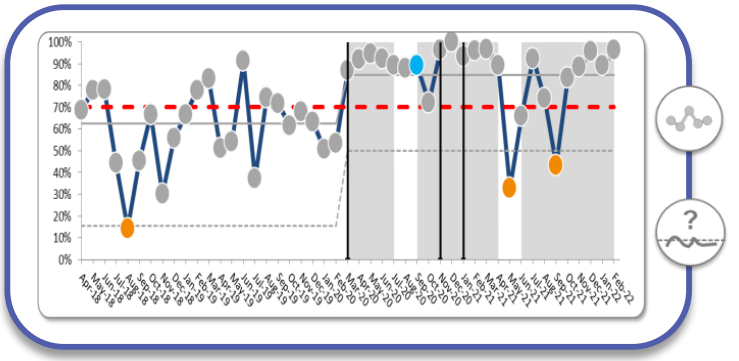
Stroke : % Direct Admission to Stroke ward

37.78%



Stroke: % seen in TIA clinic within 24 hours

96.30%



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.

COVID Wave

Lockdown

Quality and Safety

Summary Performance Table | Month 12 [March] 2021-22

Quality and Safety Metrics		Latest Month	Measure	Target	Performance	Assurance	Mean	Lower process limit	Upper process Limit
Infection Prevention	C-Diff	Mar-22	8	4			5	0	11
	Ecoli	Mar-22	3	4	L		4	0	9
	MSSA	Mar-22	2	0			2	0	6
	MRSA	Mar-22	0	0	L		#N/A	#N/A	#N/A
Hospital Acquired Pressure Ulcers: Serious Incidents		Mar-22	1	-			0	0	2
Falls per 1,000 bed days causing harm		Mar-22	0.1	0.04			0	0	0
% medicine incidents causing harm		Mar-22	6.35	11.71		P	3	0	10
Hand Hygiene	Hand Hygiene Audit Participation	Mar-22	93.75	100			91	79	103
	Hand Hygiene Compliance to practice	Mar-22	99.7	98	H	P	99	99	100
VTE Assessment Rate		Mar-22	92.83	95	L		96	94	98
Sepsis	Sepsis Screening compliance	Feb-22	82.02	95			83	71	95
	Sepsis 6 bundle compliance	Feb-22	48.75	95	L	F	53	29	77
#NOF time to theatre <=36 hrs		Mar-22	66.67	85	L		77	57	97
Mortality Reviews completed <=30 days		Nov-20	35.5	-		P	43	20	67
HSMR 12 month rolling average		Jun-21	95.61	-	L		104	101	107
Complaints responses <=25 days		Mar-22	80.6	80			77	46	108
Ice viewed reports	ICE viewed reports [pathology]	Feb-22	92.51	-	L	P	95	94	97
	ICE viewed reports [radiology]	Feb-22	90.2	-	H	P	86	82	90

Quality and Safety Metrics	Latest Month	Measure	Target	Performance	Assurance	Mean	Lower process limit	Upper process Limit
FFT A&E Response	Mar-22	16.76	20			17.28	12	23
FFT A&E Recommended	Mar-22	77.8	95	L	F	82.18	75	89
FFT Inpatient Response	Mar-22	29.7	30			31.64	24	39
FFT Inpatient Recommended	Mar-22	97.08	95			95.72	94	97
FFT Maternity Response	Mar-22	3.26	30	L		18.47	4	33
FFT Maternity Recommended	Mar-22	100	95			93.65	74	113
FFT Outpatients Response	Mar-22	9.44	10			10.43	7	14
FT Outpatients Recommended	Mar-22	94.03	95			93.34	91	95

Integrated Quality Performance Report - Headlines

Quality Performance	Comments (All metrics on this slide have additional Improvement Statements later in this report)
Infection Control	• Our end of year position is as follows; C.difficle infections – 29 over target. There is currently 1 ward outbreak of C.difficile which is in the monitoring phase. Last positive case 03-03-22. E-Coli BSI – 6 over our Trust internal target. We have achieved the national trajectory. MSSA BSI – 13 over our Trust internal trajectory. There is no national target. MRSA BSI – we have achieved the target. Klebsiella species – we have achieved the target. Pseudomonas aeruginosa - we have achieved the target. • Hand Hygiene Practice Compliance rate continues to perform above the 98% target, with 99% being exceeded for the last 26 months. • Antimicrobial Stewardship overall compliance for Mar-22 remained stable at 87.88% and missed the target of 90%. • Patients on Antibiotics in line with guidance or based on specialist advice in Mar-22 was 91.94% and achieved the target of 90%. • Patients on Antibiotics reviewed within 72 hours in Mar-22 was 94.52% and achieved the target of 90%. • 2 new COVID outbreaks were declared in Mar-22. There are currently 10 ongoing outbreaks and a further 1 in the monitoring phase.
SEPSIS 6	• Our performance against the sepsis bundle being given within 1 hour has decreased in Feb-22 and is showing special cause variation. We will not meet the target without intervention. Also, for the second time this financial year, we have missed the target for antibiotics being given within 1 hour. We are showing normal variation however. • Our sepsis 6 screening performance remained stable in Feb-22. We will not on average hit the target, but not consistently, it may succeed due to random variation.
VTE Assessments	• For the second month running, we have not achieved the Trust target of 95%. However, W&C are now entering VTE assessments via Badgernet which have not yet been factored into the Trust results. • Excluding all W&C data from Mar-22, our compliance is 96.83%, with only the Surgical Division not achieving the target of 95%.
ICE Reporting	• The Target of 95% for viewing Radiology Reports on ICE has not been achieved in the past 23 months (range 80.56% to 91.37%). • The Target of 95% for viewing Pathology Reports on ICE was missed for the eighth month running.
Fractured Neck of Femur	• There were 87 #NOF admissions in March. Our performance within 36 hours was 66.7% and the average time to theatre was 31.8 hours. • There were a total of 29 breaches in March– 48% were due to theatre capacity and 7% were due to bed issues.

Integrated Quality Performance Report - Headlines

Quality Performance	Comments
Friends & Family Test	• The recommended rate for Inpatients has achieved target for 13 months in a row. The response rate has fell just under 30%. • The recommended rate for Maternity has been 100% for 2 months running. However, the response rate for Mar-22 was only 3.26%, which equates overall to 19 responses. • The recommended rate for Outpatients is now showing normal variation but the target was missed at 94.03%. Our response rate for Mar-22 fell just under 10%. • The recommended rate for A&E will not meet the target without intervention. Performance has shown special cause variation since Jun-21. Our A&E response rate in Mar-22 was 16.76% and is showing normal variation.
Complaints	• Complaints responded to within 25 working days is showing normal variation. The target was achieved at 80.6%. • We have received 71 formal complaints in March 22, which is the highest we have seen all financial year. The average number of complaints we usually receive each month is 48. Womens & Children seem to have had the largest increase in complaints received this month.
Hospital Acquired Pressure Ulcers (HAPU)	• We have had one Category 4 SI HAPU in Mar-22. • There were 36 HAPUs in Mar-22, which exceeded the in-month target by 16. • We have achieved our year to date trajectory of no more than 246 HAPU's, as we finished on a total of 222 HAPUs. • There were 59 Cat 3, 4 or Unstageable pressure ulcers on admission in Mar-22 which is showing normal variation.
Falls	• The total number of falls for Mar-22 was 125 which fell above the in-month target. We have breached our 21/22 trajectory by 38 falls. However, we are 21 falls below our 20/21 position. • The number of falls per 1,000 bed days increased in Mar-22 to 6.2 but remains below the national benchmark of 6.63. • There were 2 SI falls in Mar-22 which has led us to meet our end of year trajectory of no more than 6. However, both of these falls remain under investigation and if no omissions in care are identified may be requested for downgrade.
Never Events	• In total, there have been 9 Never Events in 2021/22. Two thirds of those occurred in SCSD areas.
MSA Breaches	• In Mar-22, we had a total of 57MSA breaches (42last month).

2.1 Care that is Safe - Infection Prevention and Control

Embed our current infection prevention and control policies and practices | Full compliance with our Key Standards to Prevent

C-Diff * National target of 61		E-Coli * Trust target of 30		MSSA * Trust target of 10		MRSA		Klebsiella species		Pseudomonas aeruginosa	
Mar actual vs target	Year to date actual / year to date target	Mar actual vs target	Year to date actual / year to date target	Mar actual vs target	Year to date actual / year to date target	Mar actual vs target	Year to date actual / year to date target	Mar actual vs target	Year to date actual / year to date target	Mar actual vs target	Year to date actual / year to date target
8/5	90/61	3/3	36/30	2/0	23/10	0/0	0/0	0/3	17/38	0/3	10/19

What does the data tell us?

- Our end of year position is as follows;
  C.difficile infections – 29 over target. There is currently 1 ward outbreak of C.difficile which is in the monitoring phase. Last positive case 03-03-22.
  E-Coli BSI – 6 over our Trust internal target. We have achieved the national trajectory.
  MSSA BSI – 13 over our Trust internal trajectory. There is no national target.
  MRSA BSI – we have achieved the target.
  Klebsiella species – we have achieved the target.
  Pseudomonas aeruginosa - we have achieved the target.

- The Hand Hygiene audit participation rate has improved since Apr-21. However, we have not achieved 100% participation since Jan-20.
- Hand Hygiene Practice Compliance rate continues to perform above the 98% target, with 99% being exceeded for the last 26 months. This metric will reliably achieve the target.
- 2 new COVID outbreaks were declared in Mar-22. There are currently 10 ongoing outbreaks and a further 1 in the monitoring phase.
- The ventilator associated pneumonia high impact intervention audit was the only audit to not achieve 95% compliance (93.33%). The Alex site achieved 100% and Worcester achieved 90%.
- The wider context with C.difficile is that the overall community numbers have risen across the system and more widely. Overprescribing of antibiotics in the community during the pandemic due to the switch to remote consultation has been reported to be a driving factor in this.
- We have identified a specific issue relating to the removal of radiator covers for deep cleaning on the WRH site. A deep cleaning programme has now commenced.
- The Staphylococcus aureus BSI Quality Improvement Steering Group is making some progress, though operational and staffing pressures have resulted in significant delays. A paper setting out more detail was brought to CGG, TME and QGC in January 22. The team are focussed on implementation of the PVD packs, a new PVD monitoring form, and are planning an awareness campaign on these issues as well as the IVAD guidelines.
- Progress with the enhanced C.difficile action plan has been significantly affected by operational and staffing pressures. These have resulted in significant delays to achievement of actions. A paper setting out more detail was brought to CGG, TME and QGC in January 22. A series of Scrutiny & Learning Meetings has been held to catch-up on delayed reviews to ensure learning is identified and shared.
- A location for the bed and trolley deep cleaning facility has been identified on both sites. Work is progressing to operationalise the Alex site facility. The WRH site location will need capital works to enable it to progress, and that is presently being worked on.

Assurance level – Level 6 COVID-19 / Level 4 for non-Covid (Mar-22)
Reason: Current performance in relation to C.difficile and MSSA BSI

When expected to move to next level of assurance for non Covid:
This will be next reviewed in April 22, when quarter 4 performance can be assessed.

Previous assurance level (Feb-22) –Level 6 COVID-19 / Level 4 for non-Covid

SRO: Paula Gardner(CNO)

Infection Prevention and Control Benchmarking

Source: Fingertips (up to January 2022)

C. Difficile – Out of 24 Acute Trusts in the Midlands, our Trust sits the 4th highest for hospital onset-healthcare associated C. difficile infections. Our rate stands at 24.6 cases per 100,000 bed days, which is above both the overall England and Midlands rate. Wye Valley is the highest Trust and has a rate of 50.3 cases per 100k bed days.
E.Coli – Out of the 24 Acute Trusts in the Midlands, our Trust sits the 7th best. Our rate stands at 15.2 cases per 100,000 bed days, which is below the overall England and Midlands rate.
MSSA – Out of 24 Acute Trusts in the Midlands, our Trust sits the 11th best. Our rate stands at 9.3 cases per 100,000 bed days, which is below both the overall England and Midlands rate.
MRSA – Out of the 24 Acute Trusts in the Midlands, our Trust sits the 12th highest. Our rate stands at 0.4 cases per 100,000 bed days, which is below both the overall England and Midlands rate.

C. Difficile infection counts and 12-month rolling rates of hospital onset-healthcare associated cases| Jan-22

Area	Count	Per 100,000 bed days
England	5,880	18.9
Midlands NHS Region	989	16.9
Worcestershire Acute Hospitals	58	24.6

E. Coli hospital-onset cases counts and 12-month rolling rates | Jan-22

Area	Count	Per 100,000 bed days
England	7,055	22.7
Midlands NHS Region	1,233	21.1
Worcestershire Acute Hospitals	36	15.2

MSSA bacteraemia cases counts and 12-month rolling rates of hospital-onset | Jan-22

Area	Count	Per 100,000 bed days
England	3,722	12.0
Midlands NHS Region	610	10.4
Worcestershire Acute Hospitals	22	9.3

MRSA cases counts and 12-month rolling rates of hospital-onset | Jan-22

Area	Count	Per 100,000 bed days
England	263	0.8
Midlands NHS Region	36	0.6
Worcestershire Acute Hospitals	1	0.4

Month 12 [March] | 2021-22 Quality & Safety - Care that is Safe

Responsible Director: Chief Nursing Officer, Chief Medical Officer | Validated for Mar-22 as 11th April 2022

Worcestershire Acute Hospitals NHS Trust

C-Diff

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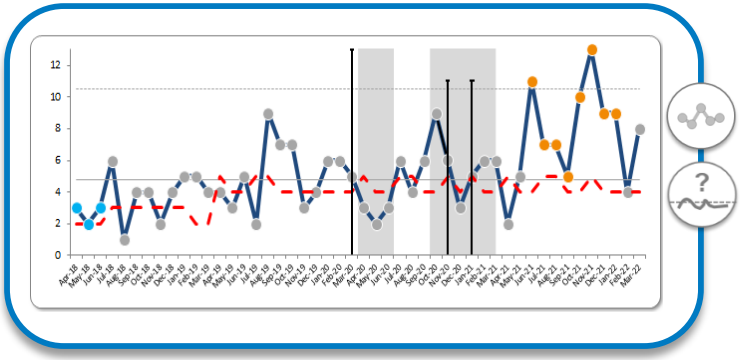

E-Coli

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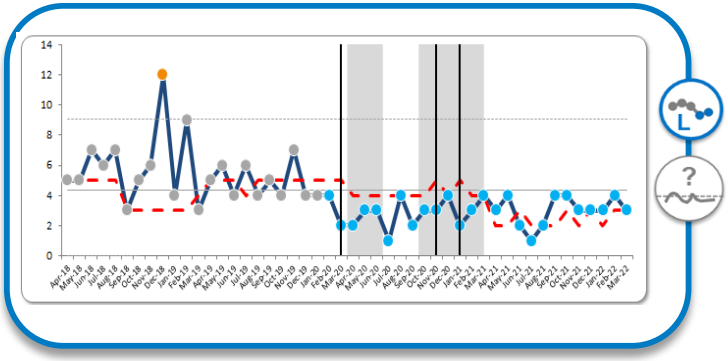

MSSA

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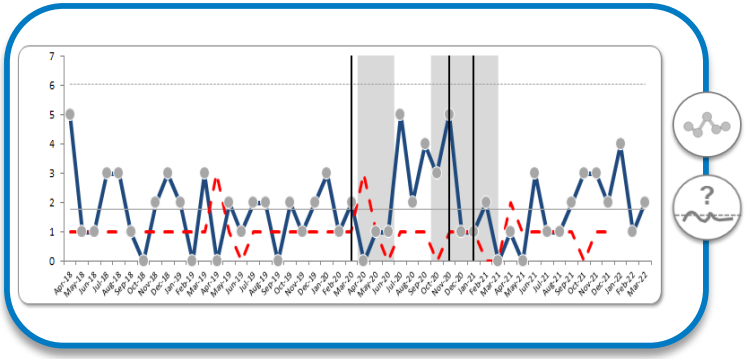

MRSA

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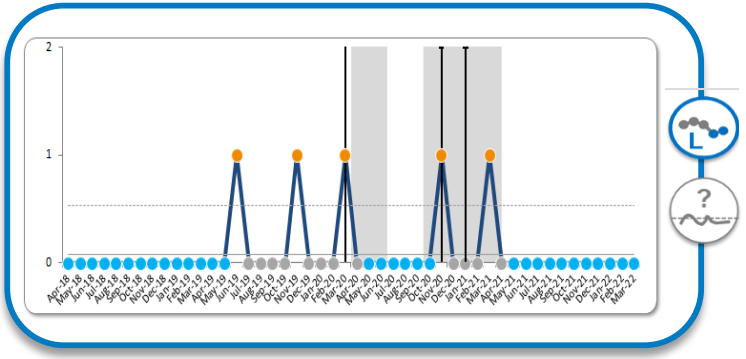


Lockdown Period

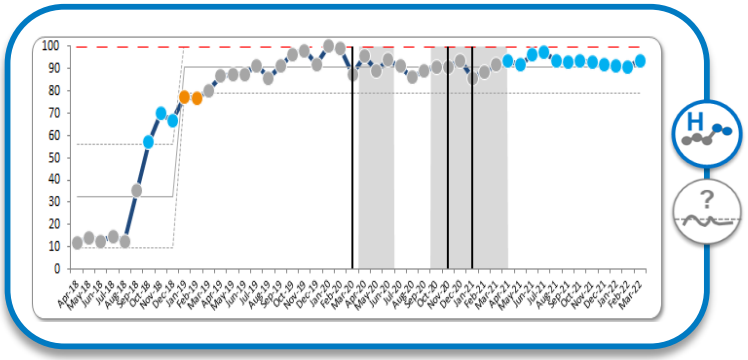
COVID Wave

Month 12 [March] | 2021-22 Quality & Safety - Care that is Safe

Responsible Director: Chief Nursing Officer, Chief Medical Officer | Validated for Mar-22 as 11th April 2022

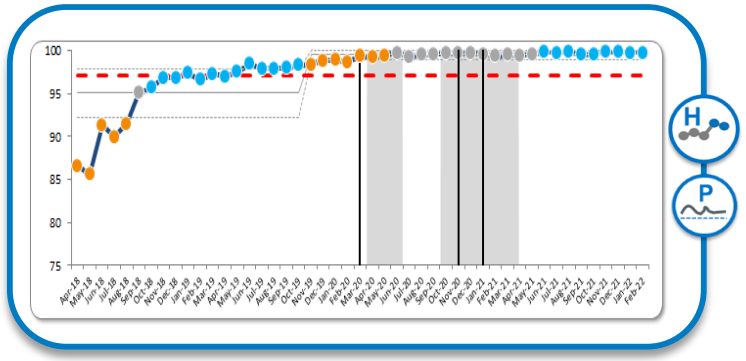
Hand Hygiene Audit Participation (%)

93.75%



Hand Hygiene Compliance (%)

99.7%



Lockdown Period

COVID Wave

2.1 Care that is Safe – Antimicrobial Stewardship

Overall Compliance (Target 90%)		Antibiotics in line with guidance (Target 90%)		Antibiotics reviewed within 72 hours (Target 90%)	
Mar-22	Feb-22	Mar-22	Feb-22	Mar-22	Feb-22
87.88%	87.98%	91.94%	91.31%	94.52%	91.32%

What does the data tell us?

- A total of 352 audits were submitted in Mar-22, compared to 337 in Feb-22.
- Antimicrobial Stewardship overall compliance for Mar-22 remained stable at 87.88% and missed the target of 90%.
- Patients on Antibiotics in line with guidance or based on specialist advice in Mar-22 was 91.94% and achieved the target of 90%.
- Patients on Antibiotics reviewed within 72 hours in Mar-22 was 94.52% and achieved the target of 90%.

What will we be doing?

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

Assurance level – Level 6 COVID-19 / Level 4 for non-Covid (Mar-22) - Antimicrobial stewardship level of assurance is 5 as assessed by ASG on 24/02/2022.
Reason: Current performance in relation to C.difficile and MSSA BSI

When expected to move to next level of assurance for non Covid:
This will be next reviewed in April 22, when quarter 4 performance can be assessed.

Previous assurance level (Feb-22) –Level 6 COVID-19 / Level 4 for non-Covid

SRO: Paula Gardner(CNO)

2.1 Care that is Safe – Falls

Total Inpatient Falls	Inpatient Falls resulting in Serious Harm	Falls per 1,000 bed days	Falls per 1,000 bed days (serious harm)
Year to date: Actual / Year to date target	Year to date: Actual / Year to date target	Mar-22	Mar-22
1273/ 1235 (Target – 1235)	**6/6 (Target – 6)**	**6.2 (National Target – 6.63)**	**0.10 (National Target – 0.19)**

What does the data tell us?

- The total number of falls for Mar-22 was 125 which fell above the in-month target. We have breached our 21/22 trajectory by 38 falls. However, we are 21 falls below our 20/21 position.
- The number of falls per 1,000 bed days increased in Mar-22 to 6.2 but remains below the national benchmark of 6.63.
- There were 2 SI falls in Mar-22 which has led us to meet our end of year trajectory of no more than 6. However, both of these falls remain under investigation and if no omissions in care are identified may be requested for downgrade.

What improvements will we make?

Use of therapeutic observation guideline alongside use of 'stay in the bay'

Falls assessment implemented in all A&E departments

Introduction of E-LfH e-learning relaunch to become essential to role for all registered healthcare professionals with an additional local policy/procedure training pack so all healthcare professionals

Ad-hoc training for wards/departments with increased prevalence on request

Purchase of Ramblegard falls preventative technology for 2 wards

Countywide collaboration of falls services workshops ongoing with a focus on conveyance/admission to hospital avoidance

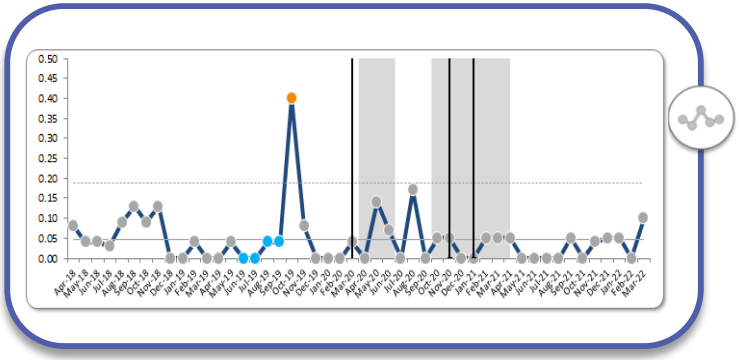
Assurance levels (Quarter 4- 21/22) Falls – Level 5	**When expected to move to next level of assurance** Quarter 2 (22/23)
Previous assurance level (Quarter 3- 21/22) Falls – Level 5	SRO: Paula Gardner(CNO)

Month 12 [March] | 2021-22 Quality & Safety - Care that is Effective

Responsible Director: Chief Nursing Officer, Chief Medical Officer | Validated for Mar-22 as 11th April 2022

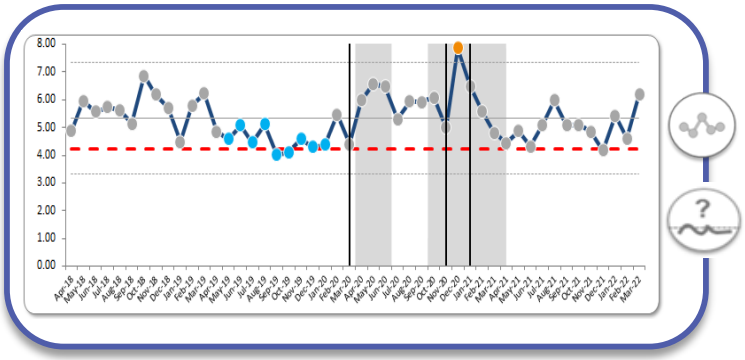
Falls per 1,000 bed days causing harm

0.1



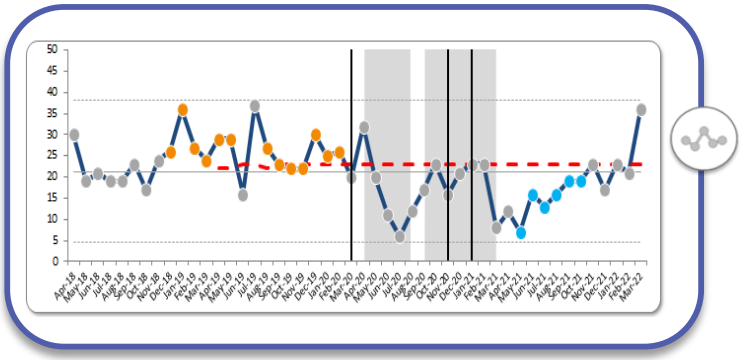
Falls per 1,000 bed days

6.2



All Hospital Acquired Pressure Ulcers

36



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

Sepsis six bundle completed in one hour (Target 90%)	Sepsis screening Compliance Audit (Target 90%)	% Antibiotics provided within one hour (Target 90%)	Urine	Oxygen	IV Fluid Bolus	Lactate	Blood Cultures
48.75%	82.02%	86.25%	57.5%	93.75%	90%	78.75%	76.25%

What does the data tell us?

- Our performance against the sepsis bundle being given within 1 hour has decreased in Feb-22 and is showing special cause variation. **Action: 1& 4**
- Between Apr-21 and Jan-22, there were 849 patients that had a diagnosis of sepsis, of which 212 (25%) unfortunately died.
- Our Crude in-hospital death rate is 15.7%. Nationally, we sit in the lower quarter of reporting Acute Trusts and we have one of the lowest rates seen across the Trusts within the Midlands.
- However, our out-of -hospital death rate is 9.3% and nationally we sit in the top 20 highest reporting Acute Trusts. In the Midlands, we have the 4th highest rate. **Action: 2&3.**
- Our average LOS for patients with sepsis is 10.4 days, which is the 12th lowest nationally and the 3rd lowest in the Midlands. **Action: 2& 3**

Actions:

1. Screening of 'Suspected Sepsis' patients and the 'face to face' review on the same form to avoid duplication in the medical/nursing notes by using the new documentation.
2. A retrospective audit will take place to determine the causes of out of hospital deaths and whether there is any cause for concern.
3. All deaths, including those in community will have mortality review, once additional medical examiners are in post – this will help to identify concerns in real time and ensure learning across divisions.
4. From April 22, Specialty Medicine will be carrying out their own Sepsis audits 'real-time', which will allow for improvements to be made more efficiently.

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

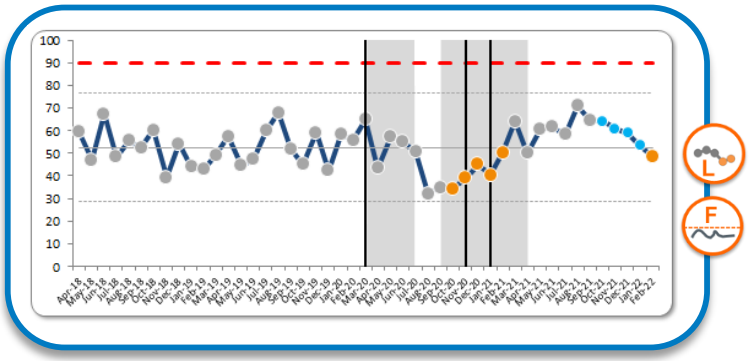
Month 12 [March] | 2021-22 Quality & Safety - Care that is Effective

Responsible Director: Chief Nursing Officer, Chief Medical Officer | Validated for Mar-22 as 11th April 2022

Worcestershire Acute Hospitals NHS Trust

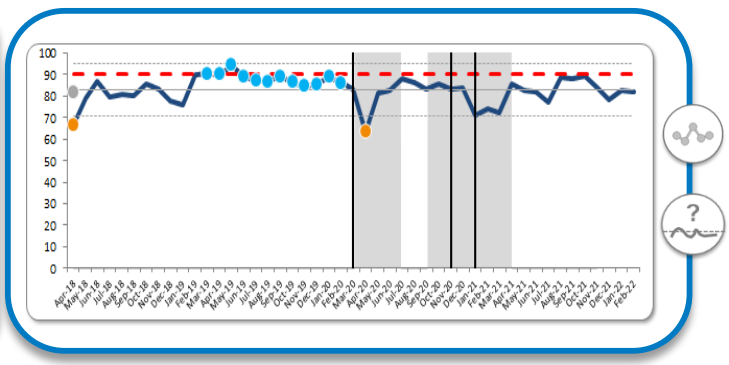
Sepsis 6 Bundle Compliance (audit)

48.75%



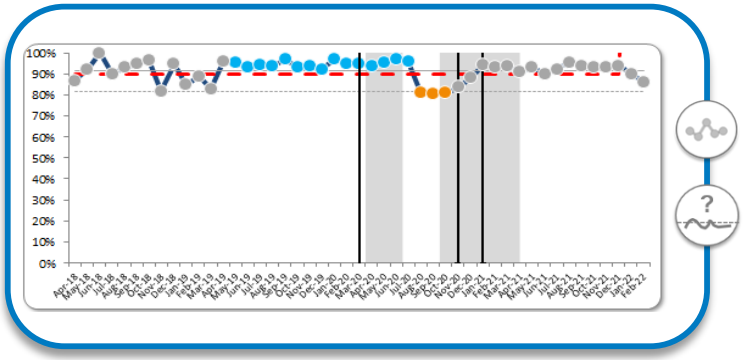
Sepsis Screening Compliance (audit)

82.02%



Sepsis Screening Antibiotics Compliance (audit)

86.25%



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

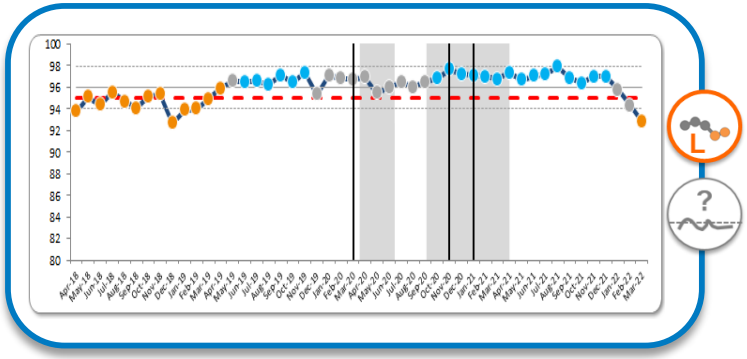
VTE assessment on admission to hospital	
March 2022	Target
92.83%	95%
What does the data tell us? • If all W&C data is excluded from Mar-22 results, our compliance is 96.83%, which is meeting the Trust standard/ • We are aware the inclusion of W&C data means we are not meeting the target. However, W&C are now entering VTE assessments via Badgernet which have not yet been factored into the Trust results.	**What improvements will we make?** • Trust Thrombosis committee are continuing to monitor actions following the completion of VTE assessments to ensure learning and improved practice • A new audit tool has been designed for all to use, which following the last meeting discussion on taking a new approach on what is recorded and lessons learnt. Divisional results will be presented at July's Trust Thrombosis Committee. • Specialty Medicine Division is undertaking a medical engagement incentive and have recruited some quality care champions in the medical cohort, which has attracted some junior doctors in the area of VTE and Hospital Acquired Thrombosis. Other Divisions are exploring options for quality care champions. • Junior doctor to be invited to Thrombosis Committee • No HAT's have been reported.
Assurance Level: 7	**When expected to move to next level of assurance** : N/A
	SRO: Christine Blanshard (CMO)

Month 12 [March] | 2021-22 Quality & Safety - Care that is Safe

Responsible Director: Chief Nursing Officer, Chief Medical Officer | Validated for Mar-22 as 11th April 2022

VTE Assessment Compliance (%)

92.83%



Please note that % axis does not start at zero.

2.2 Care that is effective – EDS Completion

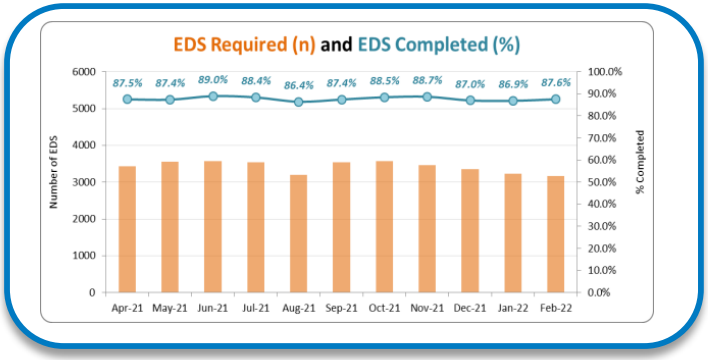
% EDS Completed	% EDS Completed and Uploaded to GP
87.6% - Feb 2022 (86.9% - Jan 2022)	82.8% - Feb 2022 (81.6% - Jan 2022)
What does the data tell us? • The Target of 95% for completion of Electronic Discharge Summaries (EDS) has not been met in 2021/22, ranging from 86.4% to 89.0% • The Target of 95% for completion of Electronic Discharge Summaries (EDS) and uploaded to GP has also not been met in 2021/22, ranging from 80.2% to 84.4%. **What have we been doing?** • The 394 missing EDS's for Feb-22 were reviewed and it was discovered that 328 of these had both Medical and Nursing Assessments completed, but the final EDS document had not been produced. Had these been finalised, the completion rate for Feb-22 would have risen to 97.9%.	**What will we be doing?** • Investigate further whether this is a long standing trend. • Review exclusions to ensure all area's not required to produce EDS's are not being included. • Liaise with Training Department to ascertain whether there is a particular factor causing this issue. • Review current reporting available to staff to flag missing EDS's. • Comms to reiterate importance of finalising EDS's.
Assurance level – TBC	**When expected to move to next level of assurance**: TBC
Previous assurance level: Not previously rated	SRO: Christine Blanshard (CMO)

Month 12 [March] | 2021-22 Quality & Safety - Care that is Effective

Responsible Director: Chief Nursing Officer, Chief Medical Officer | Validated for Feb-22 as 11th April 2022

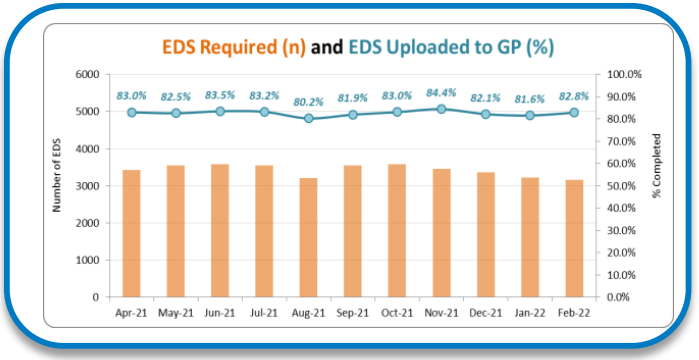
EDS Completed (%)

87.6%



EDS Completed and Uploaded to GP (%)

82.8%



2.2 Care that is effective - ICE Reporting

% Radiology reports viewed - ICE	% Radiology reports filed – ICE	% Pathology reports viewed - ICE	% Pathology reports filed - ICE
90.2% - Feb 2022 (90.85% - Jan 2022)	75.22% (72.82%)	92.51% (92.00%)	69.58% (67.33%)

What does the data tell us?

- The Target of 95% for viewing Radiology Reports on ICE has not been achieved in the past 23 months (range 80.56% to 91.37%).
- The Target of 95% for viewing Pathology Reports on ICE was missed for the eighth month running in Feb-22 at 92.51%.
- Radiology reports filed on ICE has remained above 70% for nine consecutive months.
- Pathology reports filed on ICE has increased slightly in Feb-22 to 69.58%.

What will we be doing?

- On the 24th February 2022, the Digital Team bulk filed all Pathology and Radiology reports up to and including the 31st December 2020. Reports with an abnormal flag were not included and require clinical review and filing manually.
- Filing prompt has gone live to ensure when viewing a result it is then filed appropriately; some amendments need to be made to the system to ensure this does not cause further delays.
- Auto filing of all GP results will be implemented
- It will take a few months for the changes to be seen in the data as the filing is retrospective.

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

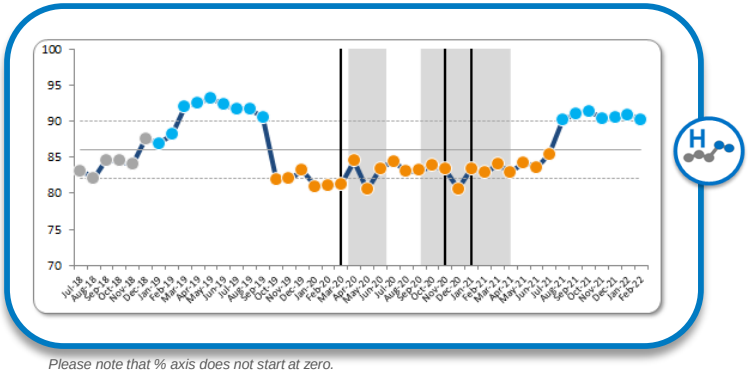
Month 12 [March] | 2021-22 Quality & Safety - Care that is Effective

Responsible Director: Chief Nursing Officer, Chief Medical Officer | Validated for Mar-22 as 11th April 2022

NHS Worcestershire Acute Hospitals NHS Trust

ICE reports viewed radiology (%)

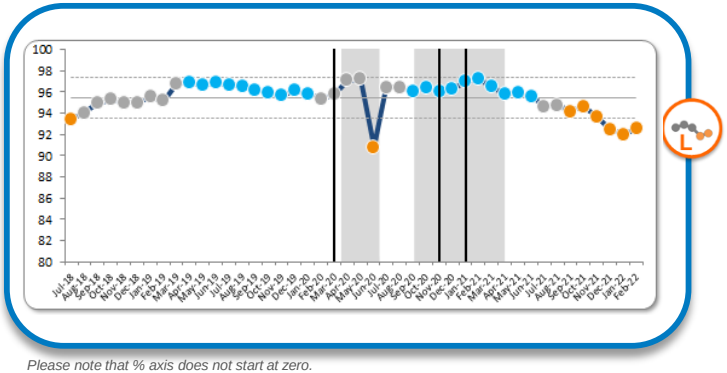
90.2%



Please note that % axis does not start at zero.

ICE reports viewed pathology (%)

92.51%



Please note that % axis does not start at zero.

Lockdown Period

COVID Wave

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

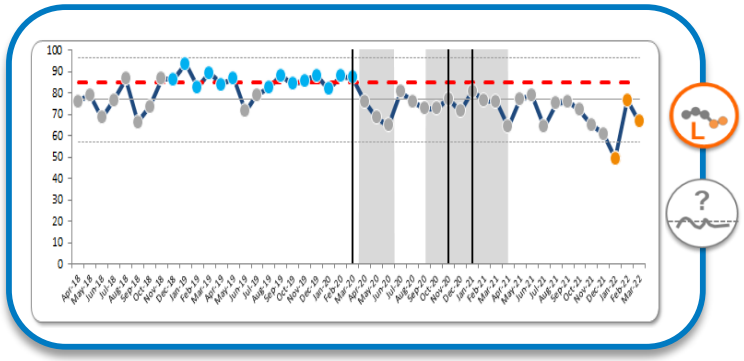
#NOF – Time to Theatre <= 36 Hours	#NOF – Time to Theatre <= 36 Hours Excluding Unfit Patients
66.7% (Mar 2022) 76.6% (Feb 2022)	70.7% (Mar 2022) 81.9% (Feb 2022)
What does the data tell us? • We have seen a decrease in the #NOF compliance in Mar-22, and we are showing special cause variation over the last 3 months. • There were 87 #NOF admissions in March. • The #NOF target of 85% has not been achieved for 2 years. • There were a total of 29 breaches in March (18 in February); 48% of the breaches were due to theatre capacity and 7% were due to bed issues. 17% of our breaches were due to the patient being medically unfit/ non-operative management. Other reasons include further imaging of #NOF site required (17%), surgeon issues (3%), patient withdrew consent (3%) and patient awaiting THR (3%). • The average time to theatre was 31.8 hours (27.6 in February). • Our Crude Death Rate for #NOF is 14.8%. Nationally, we have the 8th highest rate and the 2nd highest rate in the Midlands. Our average LOS is 10.4 days, which is the second lowest nationally and the lowest in the Midlands.	**What will we be doing?** • Centralising all Inpatient Trauma to WRH site from 13th November as a result increasing Trauma theatre capacity by one 4 hour session per day. • Changing consultant on-call pattern to ensure there is always a hip surgeon available to operate. • Increasing weekend Trauma Theatre from 2 sessions to 4 where staffing allows in the short term. Long term business case required to staff additional 2 sessions at weekends. • Escalating the need for ring fenced #NoF beds in the community (previously the department had access to 9 beds) this will ensure constant flow.
Current assurance level: 5 (Mar-22)	**When expected to move to next level of assurance**: Mar-22
Previous assurance level: 5 (Feb-21)	SRO: Christine Blanshard (CMO)

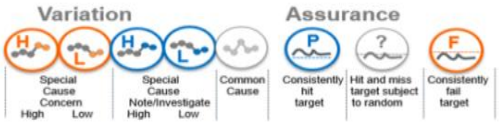
Month 12 [March] | 2021-22 Quality & Safety - Care that is Effective

Responsible Director: Chief Nursing Officer, Chief Medical Officer | Validated for Mar-22 as 11th April 2022

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

66.7%





Lockdown Period

COVID Wave

2.3 Care that is a positive experience – Friends and Family

FFT Inpatient Recommended		FFT Outpatient Recommended		FFT AE Recommended		FFT Maternity Recommended	
Mar-22	Target	Mar-22	Target	Mar-22	Target	Mar-22	Target
97.08%	95%	94.03%	95%	77.8%	95%	100%	95%

What does the data tell us?

- The recommended rate for Inpatients has achieved target for 13 months in a row. The response rate has fell just under 30%.
- The recommended rate for Maternity has been 100% for 2 months running. However, the response rate for Mar-22 was only 3.26%, which equates overall to 19 responses.
- The recommended rate for Outpatients is now showing normal variation but the target was missed at 94.03%. Our response rate for Mar-22 fell just under 10%.
- The recommended rate for A&E will not meet the target without intervention. Performance has shown special cause variation since Jun-21. Our A&E response rate in Mar-22 was 16.76% and is showing normal variation.

What improvements will we make?

- Divisions report quarterly to the Patient, Carer and Public Engagement steering group – presenting patient experience data and actions from feedback. Divisions also report into Clinical Governance Committee.
- The Patient Experience Lead Nurse is reviewing FFT cards available for Xerox to ensure they are up to date ahead of reintroducing cards – once this is complete a paper can proceed to Bronze Command for agreement to reintroduce cards – ensuring wards can order up to date cards.
- Maternity have introduced FFT returns on Badgernet – areas are continuing to use iPads for collection whilst this is trialed. The Informatics team are exploring how the data can be pulled from Badgernet to support feedback returns – without cost implication – alongside FFT providers being explored (Suppliers have been assessed and a Business Case is expected to be presented with a decision in June 2022).
- Badgernet enables increased focus on free text comments which is intended to support timely Quality Improvement in the Division. Progress is underway to support Ward Managers to display the feedback.
- Recommended rates continue to be impacted by family and friends not being able to visit loved ones in hospital National Guidance from NHS England was received in March 2022 giving clear guidance on Visiting Expectations – the Trust position to ease restrictions was presented to the Command and Control Meetings ahead of roll out early April 2022.Booking is via an app and via telephone. Improvements in feedback are anticipated as a result of these measures.

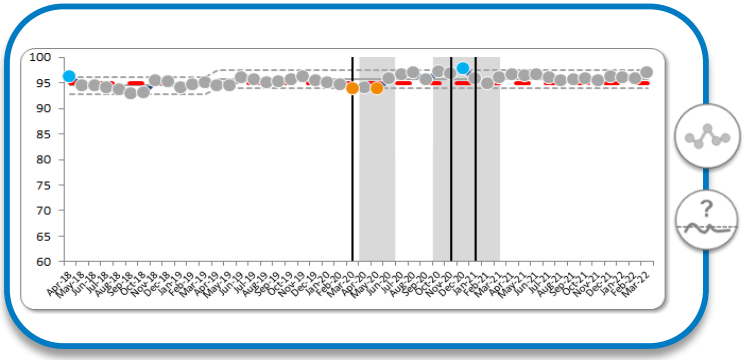
Assurance level – Level 5 (Mar-22)	**When expected to move to next level of assurance: Q4 2021/22**
Previous assurance level – Level 5 (Feb-22)	**SRO:** Paula Gardner (CNO)

Month 12 [March] | 2021-22 Quality & Safety - Care that is a positive experience for patients/ carers

Responsible Director: Chief Nursing Officer, Chief Medical Officer | Validated for Mar-22 as 11th April 2022

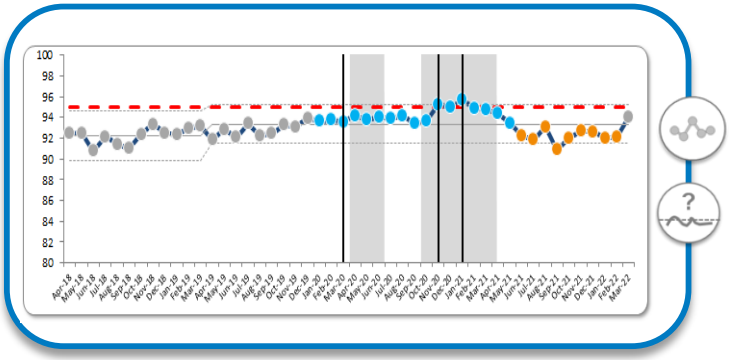
FFT Inpatient Recommended %

97.08%



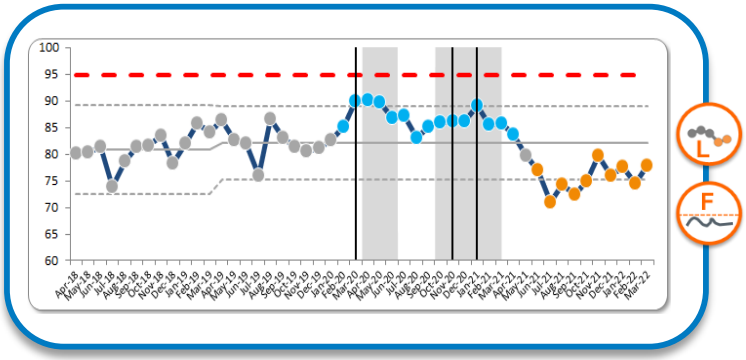
FFT Outpatient Recommended %

94.03%



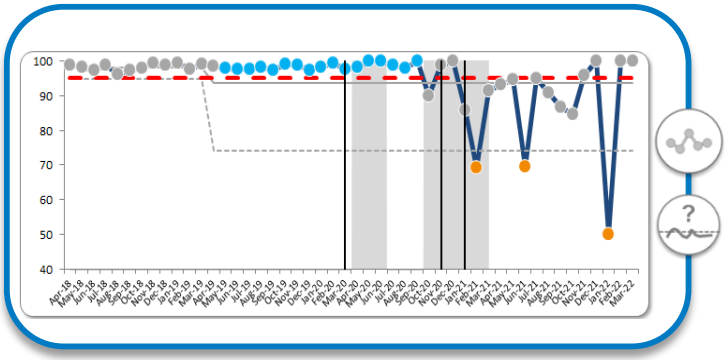
FFT AE Recommended %

77.8%



FFT Maternity Recommended

100%



2.3 Care that is a positive experience – Complaints

Complaints Responded to Within 25 Days	
Mar-22	Target
80.6%	80%

What does the data tell us?	What improvements will we make?
• Complaints responded to within 25 working days is showing normal variation. The target was achieved at 80.6%, which is the first time in the last six months. • We have received 71 formal complaints in March 22, which is the highest we have seen all financial year. The average number of complaints we usually receive each month is 48. Womens & Children seem to have had the largest increase in complaints received this month. • A larger number of complaints were received in Q2, Q3 and Q3, equal to and sometimes in excess of pre-pandemic levels; this has affected the ability of some Divisional Teams to manage the caseload as effectively, whilst dealing with ongoing Covid pressures and additional winter pressures. • The sustained increase in new cases being received has led to a reduction in performance percentage, however annual performance has achieved the target at 80.62%. • The increase in complaints numbers continues to be reflected countywide, and across the West Midlands region.	• The Complaints Team are currently piloting a process in Urgent Care and Women and Children's Divisions to agree "terms of reference" for complaints at the start of the process, in order to produce template responses which will reduce the work for Divisional Teams in completing drafts. • The impact of this pilot on timeliness of response drafts and quality (measured by reopened figure) will be carried out in Q1 2022-2023. • Continuing improvements from the last quarter, all Corporate cases will be reviewed at the earliest opportunity by the Complaints Manager to aim for early resolution. • The total number of overdue complaints has remained reduced through March 2022, demonstrating that the backlog continues to be addressed and the impact on performance should be reduced moving forward. • Continued focus will be devoted to monitoring performance and processing complaint responses ASAP through April.
Current Assurance Level – Level 5 (Mar-22)	**When expected to move to next level of assurance: N/A**
Previous Assurance Level – Level 5 (Feb-22)	**SRO:** Paula Gardner (CNO)

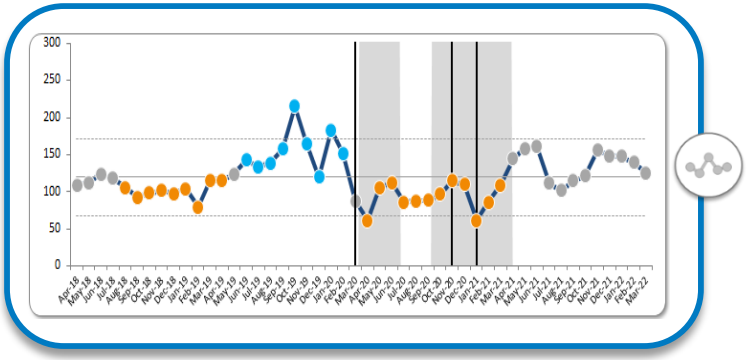
Month 12 [March] | 2021-22 Quality & Safety - Care that is Effective

Responsible Director: Chief Nursing Officer, Chief Medical Officer | Validated for Mar-22 as 11th April 2022

Worcestershire Acute Hospitals NHS Trust

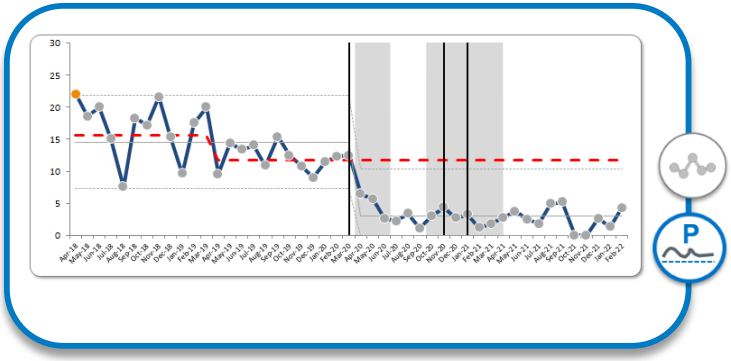
Total Medicine incidents reported

126



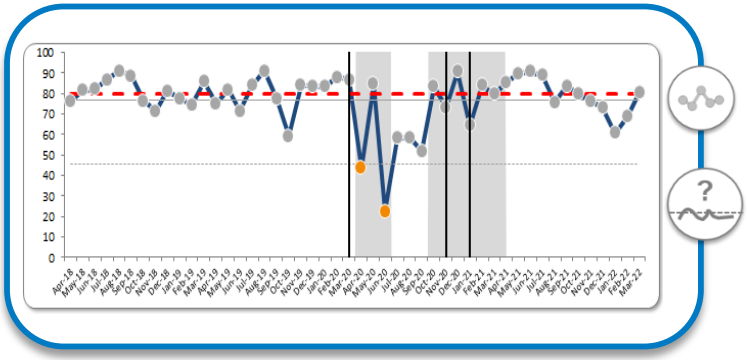
Medicine incidents causing harm (%)

6.35%



Complaints Responses </= 25 days (%)

80.6%



Lockdown Period

COVID Wave

Maternity

Month 12 [March] 2021-22 Maternity

Admission of full-term babies to neonatal care		Neonatal Deaths (>24+0 weeks gestation)	Stillbirths	Maternal Deaths	Pre-term births		Home births		Booked before 12+6 weeks		Births	Babies
4.3%	17	0	4	0	8.0%	32	1.58%	7	77.1%	324	396	398

What does the data tell us?

- In 21/22, 5,010 babies were born and 5,381 women were booked to receive antenatal care for their upcoming birth.
- Booking mothers before 12+6 continues to show special cause concern; the process of data capture for this metric has been reviewed and a new process is being introduced.
- The homebirth rate continues to vary as it dependant on maternal choice and the availability of access to the birth centre and ambulance response times.
- Sadly there were 4 stillbirths but no neonatal deaths or maternal deaths recorded in March.
- Reporting using the Robson criteria to replace c-section monitoring has been identified in BadgerNet – the next step is to address data quality and align to agreed logic for reporting of births.

What have we been doing?

- Service Improvement Plan remains paused due to pandemic however some activities have continued
- Large scale recruitment into new specialist/ leadership roles to support delivery of service improvement plan
- Completed updated Ockenden evidence for return to NHSEI
- Further midwifery recruitment event planned
- Received draft Birthrate+ workforce report

- Restart engagement events for MSIP when staffing allows
- Receive Ockenden Final Report
- Preparing for NHSEI Ockenden Insight visit on May 31st –preceded by LMNS visit early May
- Advertise Public Health Midwife posts
- Commence preparations for MSW training – 1st Cohort

Current Assurance Level: 5 (Mar-22)

When expected to move to next level of assurance:

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

Previous Assurance Level: 5 (Feb-22)

SRO: Paula Gardner (CNO)