Trust Board
There will be a meeting of the Trust Board on **Thursday 9 September 2021** at 10:00. It will be held virtually and live streamed on You Tube.

Sir David Nicholson
Chair

Agenda			Enclosure	Time
076/21	**Welcome and apologies for absence:**			**10:00**
077/21	**Patient Story**			**10:05**
078/21	**Items of Any Other Business** *To declare any business to be taken under this agenda item*			**10:30**
079/21	**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.*			
080/21	**Minutes of the previous meeting** *To approve the Minutes of the meeting held on **15 July 2021** as a true and accurate record*	*For approval*	**Enc A** **Page 3**	**10:30**
081/21	**Action Log**	*For noting*	**Enc B** **Page 12**	**10:35**
082/21	**Chair's Report**	*For noting*	**Enc C1** **Page 15**	**10:40**
083/21	**Chief Executive's Report**	*For noting*	**Enc C2** **Page 16**	**10:45**
Strategy				
084/21	**Covid End of Year Review** Chief Operating Officer	*For assurance*	**Enc D1** **Page 19**	**10:55**
085/21	**Communications Update** Director of Communications and Engagement	*For assurance*	**Enc D2** **Page 54**	**11:10**
086/21	**Board Assurance Framework** Company Secretary	*For approval*	**Enc D3** **Page 60**	**11:20**
Performance				
087/21	**Integrated Performance Report** **Executive Summary/SPC Charts/Infographic** Chief Executive/Executive Directors *Reports from June 2021 are in the reading room*	*For assurance*	**Enc E** **Page 66**	**11:30**

088/21	**Committee Assurance Reports** Committee Chairs		**Page 140**	
Governance				
089/21	**Safest Staffing Report** **a) Adult/Nursing** **b) Midwifery** Chief Nursing Officer/Director of Midwifery *Reports from June 2021 are within the reading room*	*For assurance*	**Enc F1** **Page 147** **Page 153**	**11:55**
090/21	**Maternity Services – Serious Incidents** Director of Midwifery	*For assurance*	**Enc F2** **Page 160**	**12:05**
091/21	**Standing Financial Instructions and Scheme of Delegation** Chief Finance Officer	*For noting*	**Enc F3** **Page 167**	**12:15**
092/21	**Trust Management Executive Report** Committee Chair	*For assurance*	**Enc F4** **Page 171**	**12:25**
093/21	**Audit and Assurance Committee Annual Report 2020/21** Committee Chair	*For assurance*	**Enc F5** **Page 176**	**12:30**
094/21	**Audit and Assurance Committee Report** Committee Chair	*For assurance*	**Enc F6** **Page 181**	**12:35**
095/21	**Any Other Business** *as previously notified*			**12:40**
Close				
	Date of Next Meeting *The next public Trust Board meeting will be held on 14 October 2021, virtually.*			

MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON THURSDAY 15 JULY 2021 AT 10:00 AM HELD VIRTUALLY

Present:

Chair:	Sir David Nicholson	
Board members: (voting)	Waqar Azmi	Non-Executive Director
	Paul Brennan	Chief Operating Officer
	Anita Day	Non-Executive Director
	Paula Gardner	Chief Nursing Officer
	Mike Hallissey	Chief Medical Officer
	Matthew Hopkins	Chief Executive
	Robert Mackie	Interim Chief Finance Officer
	Dame Julie Moore	Non-Executive Director
	Dr Simon Murphy	Non-Executive Director
Board members: (non-voting)	Richard Haynes	Director of Communications and Engagement
	Colin Horwath	Associate Non-Executive Director
	Vikki Lewis	Chief Digital Officer
	Lisa Peaty	Deputy Director of Strategy and Planning
	Rebecca O'Connor	Company Secretary
	Richard Oosterom	Associate Non-Executive Director
	Tina Ricketts	Director of People and Culture
	Sharon Thompson	Associate Non-Executive Director
In attendance	Simon Adams	Healthwatch
	Ross Dowsett	Shadowing Sir David
	Elaine Stratford	Staff – Item 055/21
	Justine Jeffrey	Director of Midwifery - Item 068/21 onwards
Public		Via YouTube
Apologies	Jo Newton	

054/21 **WELCOME**

Sir David welcomed everyone to the meeting, including the public viewing via YouTube and staff members who had joined us. In particular, he welcomed Ross who was shadowing him and Dame Julie who was recovering from surgery.

055/21 **PATIENT STORY**

Sir David welcomed Ms Stratford to the Board to share a patient story regarding the Bereavement Service. Mrs Gardner introduced the poignant story of a gentleman who had passed away in our care, it focussed on the use of language and patient property. Mrs Stratford would share the story on behalf of the family.

Graham was Paul's dad and Dorothy's husband; he passed away suddenly in the Trust. When Paul was 7, he was desperate to buy a gift for his dad's birthday with his pocket money. He chose a crucifix and Dorothy helped to make up the money. Graham loved his crucifix, he never took it off and always had it with him. Paul and Dorothy could not be with Paul when he passed away, but they did have opportunity to spend time with him and say goodbye after. Paul noticed Graham did not have his crucifix, Paul felt under the pillow and it was not there.

Graham was a sudden death following transfer from ED to MAU where he had a cardiac arrest at MAU. The family had said goodbye in the ambulance, but they could not come in due to Covid. They found the language used in the department was difficult to understand and this was upsetting.

Mrs Stratford had a call with Paul and Dorothy where she explained what the acronyms and language meant. This helped the family to piece together the events and answer their queries. Dorothy was led to believe Graham had had a fall, but Mrs Stratford could reassure her this had not happened.

With regards to the missing crucifix, property forms had not been completed and there was nothing in the notes about its removal. Mrs Stratford went with the team to the ED nurses station, where any valuables should be put in the safe, however this was not always the case. There was an attitude of "we were trying to save a life, we can't be responsible" but this changed when the team explained what the crucifix meant to the family. The Bereavement Team used stories from the service to change this; bereavement officers now have caseloads and know what is happening with belongings and valuables; relationships with the mortuary and processes has been improved. Listening to feedback from relatives and sharing positive feedback with the divisions means we are now getting this part of the journey right.

Training has also been expanded. Student nurses were deployed in Covid wave 1, the team had a call from one student saying she had had 7 deaths that day and there was a training need. To address this, on study days we discuss the language we use about death and dying. We have rewritten the bereavement booklet to take account of virtual working. We have dispelled many myths and did a virtual tour of the mortuary for the students and the training addresses the cultural and spiritual needs of the people coming into our care.

Future plans within the team are to address policies and procedures. There are two different property forms on two sites and this will be addressed. The Trust does not have a (lost) property service and contact is usually via PALS when something is lost or mislaid. We are learning from feedback and completing a NACEL audit to address end of life feedback. Bereavement will also be included on all inductions as it touches so many roles.

Sir David thanked Mrs Stratford and the team for their work. This service has a massive impact on families as seen in this story. Mrs Stratford confirmed that the team had completed a search and the crucifix was found inside a pocket in a zipped bag. They only knew it was Graham's as it had some of this medication, hence the changes addressed above.

Mrs Gardner stressed the importance of helping families by considering the use of language and acronyms and joined the whole Board in gratitude for those who persevered to find Graham's crucifix.

Ms Day offered her support and noted there was lots of learning and asked that we take account of family needs and what would make a difference to them. Dame Julie agreed, noting the importance of personal valuables such as phones, especially during Covid, these can be a lifeline for families. Ms Thompson also offered her support on an issue that is not spoken about enough.

Mrs Stratford confirmed that during training we address cultural and spiritual issues, the emphasis being that very often families have their own approaches. We also consider how we involve families once someone has passed away. She reflected upon a gentleman who came to pay respects to his late wife. He said he missed holding her hand, so the mortuary staff helped him to make a handprint, so he can always hold her hand.

Thanks were expressed from Sir David on behalf of the Board who were encouraged to hear progress. The following actions were noted:

ACTION it was agreed for:

- **Mrs Edwards to ensure property forms and common policies and procedures to be put in place across sites**
- **Mrs Gardner to pursue mobile phone issues (stickering etc) as part of the above action**
- **The Bereavement Team to take advantage of Board member expertise (Ms Day and Ms Thompson) and to maximise community resources to make this a richer service**

056/21 **ANY OTHER BUSINESS**

There were no items of any other business.

057/21 **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.

058/21 **MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON 10 JUNE 2021**

A minor typographical amendment on page 7 to state "due" to safety.

RESOLVED THAT subject to the above the Minutes of the public meeting held on 10 June 2021 be confirmed as a correct record and signed by the Chair.

059/21 **ACTION SCHEDULE**

Ms O'Connor presented the action log noting the updates as set out in the paper:

- Action 037/21 in relation to both Oasis and induction were to stay open until we have confirmation of completion

All other actions were either closed as per the log, or not due for update at this meeting.

060/21 **CHAIR'S REPORT**

Sir David referred to his paper setting out the Chair's action undertaken.

The Board were advised that Dr Bill Tunnicliffe had resigned. Sir David thanked him for the fantastic service he had given the Trust; he was a beacon of good sense and focus on improving services in his role as Chair of the Quality Governance Committee.

ACTION: Sir David to write to thank Dr Tunnicliffe and advertise for a Non Executive Director with expertise in clinical service to join the Board.

RESOLVED THAT: Chair's actions were APPROVED by the Board

061/21 **CHIEF EXECUTIVE'S REPORT**

Mr Hopkins joined Sir David and echoed the comments of the executive in thanking Dr Tunnicliffe. He had made great strides in bringing clinical staff into Committee and bringing the front line towards us.

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

Covid/UEC

- Steady rise in patients who are Covid positive requiring the creation of space to cohort patients to reduce the risk of cross infection.
- Early part of surge plan operations
- Community prevalence is continuing to increase and is getting closer to the England average, with a further increase expected over the coming weeks.
- Additionally, there is a 14% increase in attendances and issues with discharges within 24 hours of being deemed medically fit for discharge, which are impacting on flow.
- A key requirement of the ICS is focus on this as patient safety issue. We are working with system leaders regarding how to manage demand

A discussion followed from a question from Mr Azmi regarding the support and outcomes from working with our system partners. Mr Hopkins noted it is hard to see the impact on demand at the current time. 111 referrals to ED are twice pre Covid levels, 24% up from 12% and the Trust is working with partners regarding alternative pathways, to improve MIU utilisation and to accelerate the 2 hour community response team. Demand is outstripping the improvement impact of the initiatives, thus we are coming together to address the issues and way in which the public accesses care. NHSEI attended WRH site yesterday to audit those referred by GPs, they believe some of these patients should be dealt with in other services locally, rather than ED.

Mr Oosterom asked if we have a shared understanding of the urgency of the issue across the system? Mr Hopkins advised a command structure for urgent care is now in place with all partners. We need to make sure we have the right seniority and decision makers and that we see action at the speed required. Supplementing capacity is essential and we need to make sure the clinical risk WMAS and ED are carrying, is the system priority.

Other updates:

- Thanks were expressed to Mr Haynes and the team for the AGM and Staff Awards for their fantastic work in delivering very successful events and thank to the teams themselves for their hard work
- The Trust is working with WVT and UCWT with focus on patient safety
- The new Chief Medical Officer Dr Christine Blanshard will start on 7 October with Mr Graham James acting up in the interim.
- Dr Murphy asked following the successful BAME Network conference, when would the charter come to Board? Mrs Ricketts confirmed the network chairs are working with colleagues to develop and socialise the charter, with a draft to October Trust Board.

ACTION: Discrimination Charter to be received by Trust Board in October.

RESOLVED THAT: the report be noted

STRATEGY

062/21 **Annual Plan Priorities**

Ms Peaty presented the report setting out the Annual Plan priorities for 2021/22 which was taken as read. The following key points were noted:

- The plan had been developed following review of priorities and refreshed due to Covid. Reviews of transformation programmes had also been undertaken and mapped against the BAF. The plan was structured around the key priorities and success measures against each.
- Mr Horwath asked whether an efficiency 1% was ambitious enough in the short term? It was noted that a key development is the of creation of the medium term financial plan and bringing these together; this work is progressing at pace but targets must be achievable. H2 planning indicates an efficiency of 2% and further work will be required to address this in the H2 planning round.
- The key priorities were discussed in detail. They will be communicated across the Trust and are the Chief Executive's personal objectives.
- Environmental sustainability was noted as a key driver The Trust will look to develop a sustainability strategy but this will build on the estates work that is already underway.

Sir David noted the financial issues in relation to H2, both an increased efficiency and a reduction in ERF, both of which will impact of annual planning. The following actions were agreed:

ACTION: Report on Annual Plan in September to take account of increased efficiency and reduction in ERF

ACTION: Report on sustainability in September with an environmental strategy discussion to follow in October.

RESOLVED THAT: the report be received for assurance

063/21 **End of Life Care Strategy**

Mr Hallissey presented the report which was taken as read. He noted the palliative care team have an excellent reputation, however too many people were dying in hospital. The Trust ranks an average position in this regard, however we want to do better and have a number of initiatives underway. The last CQC inspection found the service to be "good" and the strategy and improvement plan aim to take the Trust to "outstanding".

Mr Oosterom noted the comprehensive discussion which had taken place on this item at QGC and reflected how this service adopts the better never stops principle; asking how are we maximising collaboration to reduce the percentage of people dying in hospital? Mr Hopkins referred to the 2 hour response in community which is starting to roll out. Pre Covid discussion had taken place regarding support into nursing homes and these has been reopened. The is a strong push to get respect documentation online and include WMAS. Mr Hallissey noted TME discussions regarding advance care planning and they agreed to focus on how we collect and share data and work with WMAS where there is a respect form in place, but the GP has requested conveyanace to ED.

With regards to cultural needs, Mr Hallissey confirmed the Trust is working with patients and volunteers; we have a truly multi-domination chaplaincy service and are working with community groups.

Sir David welcomed the fantastic work of the team, noting this will make a great impact to patients. He asked if this strategy goes far enough? Aas a strategy in its own right it

is excellent, but we must bring the system with us. Mr Hallissey agreed and would share the feedback with the team for future iterations of the strategy, however confirmed the system engagement is in place.

RESOLVED THAT: the End of Life Care Strategy be APPROVED

PERFORMANCE

066/21 **Integrated Performance Report**

Mrs Lewis presented the month 2 report. The key points highlighted on the executive summary were noted and discussed. The assurance levels had no change and provided an overall level 4 assurance

Sir David reflected on the level of detail in the report and the following areas were flagged as key issues; urgent care, finance, restoration and safety. The earlier urgent care discussion would not be repeated and the other key areas were discussed and the following key points were noted:

Quality & Safety

- Infection prevention and control team are working through non covid targets. We await national targets but will continue to monitor local targets
- C-diff cases were noted – work is ongoing in balancing the use of antibiotics against sepsis

Finance – ERF

- Complicated position related to the H1 income arrangements. As at Month 2, the position is slightly better than expected, due to a combination of factors related to spending less and seeing more income from ERF.
- However, there remains a £6.4m system gap at risk and this has offset some of the gains, meaning the Month 3 position catches up with the revised position
- The changes announced regarding ERF mean the Trust will not recover the ERF expected for months 4, 5 and 6 leaving a £500k gap in plan for H1. The current position with Covid and UEC pressures, means this is an additional risk.
- From a national call last week, a roll forward from H1 to H2 is expected but with reduced funding as efficiency – 3% has been mentioned which is larger than our plan. This ties into the system discussions regarding the best use of resources.
- Overall the position is one of increased risk and there is lots of work to do. The medium term financial plan is crucial but will not answer problems this year.
- Capital spend programme is underway this year, but is not without risk of delivery.
- Cash look positive and delivering on better payments

The Board debated the position, noting concern regarding the increasing level of risk. Focus of the executive is to be on the issues that will make a difference for example bank and agency spending. The basic controls are in place; the challenge is in management capacity to deliver efficiency. Sir David noted that the Trust must control costs and not spend money it has not got. We cannot allow the efficiency gains to slide away.

Restoration and Recovery

- Mr Hopkins advised that despite having achieved most expectations, ERF funding will not now follow as expected, as discussed above
- Modelling in the appendix regarding waiting lists was commended. A discussion followed regarding what are we doing to see the lists reduce and it was noted that

this is being discussed at system and ICS executive including consideration of the independent sector. There was support for vanguard theatres but theatre staffing is a nationally constraint.

- Workforce and the impact of self isolation are immediate issues and plans are being put in place to address this as far as possible in respect of risk assessments etc.

ACTION : IPR report opening summary to be focussed regarding the key issues the Board needs to discuss

ACTION: October Board – analysis of waiting lists and how this will be addressed in the context of the winter plan.

RESOLVED THAT: the report be noted for assurance.

067/21 **Committee Assurance Reports**

The following points were highlighted by Committee Chairs:

- F&P: Committee will follow up the finance workshop and review plans for the MTFP at the next meeting. DCR update and budget issues were noted
- QGC: will receive an analysis if medicines incidents at a future meeting
- P&C: nothing to escalate by exception

RESOLVED THAT: the Committee reports be noted for assurance.

GOVERNANCE

068/21 **Safest Staffing Report**

a) Adult/Nursing

b) Midwifery

Adult/Nursing

Mrs Gardner presented the nursing element of the report which covered the period to June 2021.

Staffing levels have been achieved during this period through the use of temporary bank and agency to ensure safety, this is primarily due to the impact of Covid and most recently increased self isolation; these issues are being worked through in respect of review of risk assessment processes. Overall, staff are anxious regarding the third wave. A pilot Professional Advocate model is helping to provide opportunities for developing reflection and provision of restorative supervision.

Midwifery

Ms Jeffrey presented the midwifery element of the report. There was increased staffing due to reduced sickness, however sickness is still slightly higher than we want, primarily as a result of stress. The team now has good quality data now and thanks were expressed to Mrs Rickett's team for the improvements. Outcomes are reductions in delays of care and staffing incidents. We expect a further 16 midwives to join the Trust in September. It is proposed to remain at assurance level 4 until there are no vacancies and sickness below trust target. The team have seen an in-month reduction which will be reported next month.

Mrs Ricketts noted that stress related sickness is an automatic referral to occupational health, we have not seen a significant increase across Trust, however there are pockets with higher rate. Maternity is circa 5 above the normal run rate and is short term

rather than long term sickness; it was felt this may be fatigue from the pandemic starting to coming through.

RESOLVED THAT: the report be received for assurance.

069/21 **Maternity Services – Continuity of carer**

Ms Jeffrey presented the report which was taken as read and had been received by the Trust Management Executive,

The improved health outcomes of the programme were noted. The current position is 28% against target of 35%, however this has now been superseded and is expected to be the default model by 2023. The division will look at current cultural changes required and identify successes and learning in the roll out. The workstream will be relaunched will consider engagement of all stakeholders in a better way. A business case will be completed to support the roll out.

Ms Day asked whether there is there a case for acceleration and if not what re the inhibitors? Ms Jeffrey noted this is currently under discussion of the divisional teams and feedback from staff will be taken into account. It may be possible in 2022, but there is work to do with teams to enable this. The current pause was well received by staff and we will regather and relaunch once we get to a place of positive feedback from staff.

RESOLVED THAT: the report be received for assurance.

070/21 **Clinical Negligence Scheme for Trusts (CNST) Maternity**

Ms Jeffrey presented the report which was taken as read. These are the final pieces of evidence for submission by noon on 25 July 2021 and were the final outstanding confirmations from the paper submitted to the last Trust Board.

RESOLVED THAT:

- **the evidence presented today and entire submission be APPROVED**

071/21 **KP Sepsis**

Ms Gardener presented the report which was taken as read. This final outstanding evidence in relation to item 070/21. It was confirmed staff have PMRT tools and resources are in place to deliver; this is live on Badgernet.

RESOLVED THAT the report be received for assurance.

072/21 **Bewick Review Update**

Mr Hallissey presented the report which was taken as read. The following key points were noted:

- Number of recommendations had previously been made to the Board to ensure the findings of the Bewick Review have been acted upon and refined.
- Progress is good and we are moving forward on all of the recommendations
- Mortality is around 100 for both metrics, there are no highlighted areas for concern.
- In order to move to level 6 assurance, focus is on the outputs of the learning from deaths group

- Mr Oosterom noted the discussion at QGC in relation to what measurement might be needed within the IPR.

ACTION: Learning from deaths indicator be considered as part of the IPR refresh

RESOLVED THAT: the report be received for assurance.

073/21 **Audit and Assurance Committee Report**
Ms Day presented the paper which was as read.

RESOLVED THAT the report be received for assurance.

074/21 **Remuneration Committee Report**
Sir David presented the paper which was taken as read. He noted Committee's discussion in relation to succession planning to ensure it fully reflects the workforce.

RESOLVED THAT the report be received for assurance.

075/21 **ANY OTHER BUSINESS**
There was no further business to transact.

DATE OF NEXT MEETING
The next Public Trust Board meeting will be held virtually on Thursday 9 September 2021 at 10:00am.

The meeting closed at 12:03 pm

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

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

PUBLIC TRUST BOARD ACTION SCHEDULE – JULY 2021

RAG Rating Key:

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

Meeting Date	Agenda Item	Minute Number (Ref)	Action Point	Owner	Agreed Due Date	Revised Due Date	Comments/Update	RAG rating
10.6.21	Patient story	037/21	Mrs Lewis to raise with WMAS' Chief Digital Officer and the Oasis system supplier	VL	July 2021	Sept 2021	WMAS EPR deployment we are awaiting a further progress report from the CIO at WMAS on their deployment timetable. OASIS upgrade is scheduled for January 2022	
10.6.21	Patient story	037/21	Mrs Ricketts to add to the staff on-boarding programme	TR	July 2021	Sept 2021	On schedule to be included in on-boarding process from 1st October 2021 onwards.	
10.6.21	Comms Update	044/21	Mrs Ricketts and Mr Haynes to consider how we target recruitment and update on plans at a future meeting.	TR/RH	Sept 2021		Targeted recruitment plan in development to support surgical reconfiguration. Campaign to take place in September.	
15.7.21	Patient Story	055/21	Mrs Edwards to ensure property forms and common policies and procedures to be put in place across sites	JE (PG)	Oct 2021			

15.7.21	Patient Story	055/21	Mrs Gardner to pursue mobile phone issues (stickering etc) as part of the above action	PG	Oct 2021			
15.7.21	Patient Story	055/21	The Bereavement Team to take advantage of Board member expertise (Ms Day and Ms Thompson) and to maximise community resources	ES (JE)	Oct 2021			
15.7.21	CEO Report	061/21	Discrimination Charter to be received by Trust Board in October.	TR	Oct 2021	Dec 2021	Propose to bring to Board in December along with wider E&D Plan	
15.7.21	Annual Planning Priorities	062/21	Environmental strategy discussion at Trust Board	PB	Oct 2021			
15.7.21	Annual Planning Priorities	062/21	Report on Annual Plan in September to take account of increased efficiency and reduction in ERF	PB/JN	Sept 2021	Oct 2021	National guidance due on 16 September. Paper to follow next month.	
15.7.21	Annual Planning Priorities	062/21	Report on sustainability to come to Trust Board in September	JN	Sept 2021	Oct/ Nov 2021	ICS net zero green strategy approach to be aligned with the Estates Strategy development.	
15.7.21	IPR	066/21	Analysis of waiting lists and how this will be addressed in the context of the winter plan	PB	Oct 2021			
11.3.21	Patient Story: Family Liaison Service	131/20	Development of a business case and interim plan to maintain the service and address any lessons learned specifically in addressing BAME needs	DK	April 2021	Dec 2021	A new Patient Experience Lead Nurse and Sister have been appointed and joined the Trust in April. The Lead Nurse for PE will lead a review of existing resources to embed actions from the feedback and learning from the temporary Family Liaison Service, operationalised during the second wave of the pandemic.	

10.6.21	Safer Staffing Report	047/21	Mrs Gardner to confirm figures re last minute use of bank and agency die to safety	PG	July 2021		Information appended. Action closed.  bank and agency usage july 2021.docx	
15.7.21	Chair's report	060/21	Sir David to write to thank Dr Tunnicliffe and advertise for a Non Executive Director with expertise in clinical service to join the Board.	DN	Sept 2021		Recruitment underway and letter of thanks sent. Action closed.	
15.7.21	IPR	066/21	IPR report opening summary to be focussed regarding the key issues the Board needs to discuss	VL	Sept 2021		Included in September's IPR report. Action closed.	
15.7.21	IPR	072/21	Learning from deaths indicator be considered as part of the IPR refresh	VL	Sept 2021		Included in September's IPR report. Action closed.	

NHS
Worcestershire Acute Hospitals
NHS Trust

Meeting	Trust Board
Date of meeting	9 September 2021
Paper number	Enc C1

Chair's Report

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

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

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

Report previously reviewed by		
Committee/Group	Date	Outcome

Recommendations	The Trust Board are requested to ratify the action undertaken on the Chair's behalf since the last Trust Board meeting in July 2021.

Executive summary	Mr Azmi, acting on behalf of the Chair during leave, undertook a Chair's Action in accordance with Section 24.2 of the Trust Standing Orders to approve the provision of a Mobile Endoscopy Unit on the Kidderminster site for six months from 1st October 2021 – 31st March 2022. Funding has been secured from NHSEI.

Risk			
Which key red risks does this report address?		**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	*State the full year revenue cost/saving/capital cost, whether a budget already exists, or how it is proposed that the resources will be managed.*									

Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y		N		N/A	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	9 September 2021
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.

Executive summary	This report is to brief the Board on various local and national issues. Items within this report are as follows: • HSJ Awards • Executive team development session • Medical school • Stroke

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						

NHS
Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	9 September 2021
Paper number	Enc C

Introduction/Background

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

Issues and options

HSJ Awards

I'm delighted to announce that our Trust has been shortlisted in two categories for this year's Health Service Journal (HSJ) awards, which recognise healthcare service excellence in the UK.

More than 1,000 entries were submitted for this year's awards from across the country, and we have made it through as finalists in two categories:

- Freedom to Speak up Organisation of the Year Award
- Workforce Initiative of the Year Award (for our ophthalmology team)

The winners will be announced at the awards ceremony in London on 18 November.

Executive team development session

The latest session took place on 5th August 2021 and was focused on creating solutions through teamwork. We explored how *Place* can ensure better outcomes for patients and what this would look and feel like in 3 years' time. This allowed us to develop the framework for our 3 year plan.

Three Counties Medical School at the University of Worcester

The General Medical Council (GMC) has now given the go ahead to recruit the first medical students to study at the Three Counties Medical School at the University of Worcester. Applications for the graduate entry medical school opens shortly for entry in September 2022.

This is great news not just for the University but also for our local health and care system. The University already plays a key role in helping us attract the range of skilled and qualified health and care professionals that we need to keep putting patients first. The Medical School is an important addition to that work and one we have supported from the outset because of the contribution it will make to our efforts to further improve the recruitment of doctors right across our services.

"Congratulations to David Green and the rest of the University team for their work so far and we look forward to supporting them on the next stage of this journey."

Stroke services

Board members will be aware of the clinical strategy for Stroke services across Herefordshire and Worcestershire being to develop an integrated hub and spoke clinical model, with the hub being based at the Worcestershire Royal Hospital (WRH).

Progress in implementing this strategy has been slow, but the clinical model is now agreed with NHSE and the workforce model has recently been approved across the Hereford and Worcestershire Integrated Care System (ICS).

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However, there are immediate medical workforce issues within the service at WRH caused by the loss of locum consultant staff, which have created clinical sustainability risks.

Two recruitment packs are currently with the Royal College of Medicine for approval which include a joint post with Wye Valley Trust and a joint post with University Hospitals Birmingham NHS Trust. We hope these joint appointments will be more attractive to potential candidates, but it should be noted there is a national shortage of stroke consultants. We also plan to advertise for a nurse consultant post following a review of our workforce model and ongoing efforts with overseas recruitment continue.

Following discussions at the ICS wide Stroke Programme Board and with the Regional Integrated Stroke Delivery Network (ISDN), mutual aid arrangements have been secured with three days per week of substantive stroke consultants from University Hospitals of North Midlands NHS Trust.

Support has also been secured for transient ishaemic attack (TIA) clinics (remotely) and weekend ward/front door cover. Regular discussions are taking place with ISDN by the Divisional Director and Director of Operations for Specialist Medicine Division to secure further mutual aid.

A full risk assessment is underway and a service recovery plan will be presented to the Trust Management Executive meeting on 22nd September.

Recommendations

The Trust Board is requested to

- Note this report.

Appendices - None

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COVID-19 final longer view report

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

Accountable Director	**Paul Brennan**, Deputy Chief Executive & Chief Operating Officer		
Presented by	**Paul Brennan**, Deputy Chief Executive & Chief Operating Officer	**Author /s**	**Rebecca Brown**, Trust Incident Commander / Deputy Chief Digital Officer **Nikki O'Brien**, Associate Director Business Intelligence, Performance & Digital **John Reading**, Information Manager **Gordon Stovin**, Information Team

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

Report previously reviewed by		
Committee/Group	Date	Outcome
TME	18 August 2021	Assured

Recommendations	Trust Board are invited to note this report for assurance.
Executive summary	The aim of this report is to provide a broad and long view of the COVID-19 pandemic and its impact on the Trust.

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

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

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

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Introduction/Preface

The aim of this report is to provide a broad and long view of the COVID-19 pandemic and its impact on the Trust. Specifically around inpatient numbers, mortality rates, patient demography, impact on services and implications for a possible third wave.

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

Unless otherwise stated any reference to **Wave 1** has a start date of the 23rd March 2020 and **Wave 2** is the 23rd September 2020. Whilst Wave 1 undoubtedly started some time before this date (refer to Background section), this is the point at which the first national lockdown began. It is also the point from which formalised recording of COVID inpatients commenced.

Also, unless otherwise stated, for the purposes of this report any reference to Wave 2 or the data in general ends at 31st March 2021.

1. Background (Events preceding this report)

The first cases of pneumonia of unknown causes were reported by the World Health Organisation (WHO) on 31st December 2019 as occurring in Wuhan City, China. A new type of coronavirus, SARS-CoV-2, was subsequently isolated on 7th January 2020 and named 'COVID-19'.[1]

On 30th January 2020 WHO declared the novel coronavirus outbreak as a Public Health Emergency of International Concern (PHEIC), and subsequently on 11th March 2020 classified it as a pandemic.[1]

The first two cases of COVID-19 were identified in the UK as an arrival from China on 23/01/2020, and a subsequent contact on 28/01/2020.[2]

As of 31/03/2021 a total of 4,349,489[3] cases have been identified in England, of which 458,177 had been admitted to hospital.[4]

A total of 126,953 people have died within 28 days of a positive test in England, as of 31/03/2021.[4]

2. Overview of Governance Structure

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The Trust acted promptly to set up its incident management governance structure at the start of the COVID pandemic. This included its Gold/Silver/Bronze structure (supported by Bronze level work streams) and incident control centre infrastructure. In all Bronze operational meetings, a full intelligence briefing is given by an information professional, bringing together a wealth of hospital, community and public health information.

This has enabled good intelligence led decision making to take place within the Trust and ICS. Links and liaison with the local public health professionals are strong, with acute attendance at all public health daily huddles where theme, data and epidemiology is discussed. This is fed directly into the acute command and control structure to support robust decision making.

The incident management governance has evolved as the pandemic has progressed, with robust decision making around changes made at each stage of the pandemic. Further detail on each phase can be supplied if required.

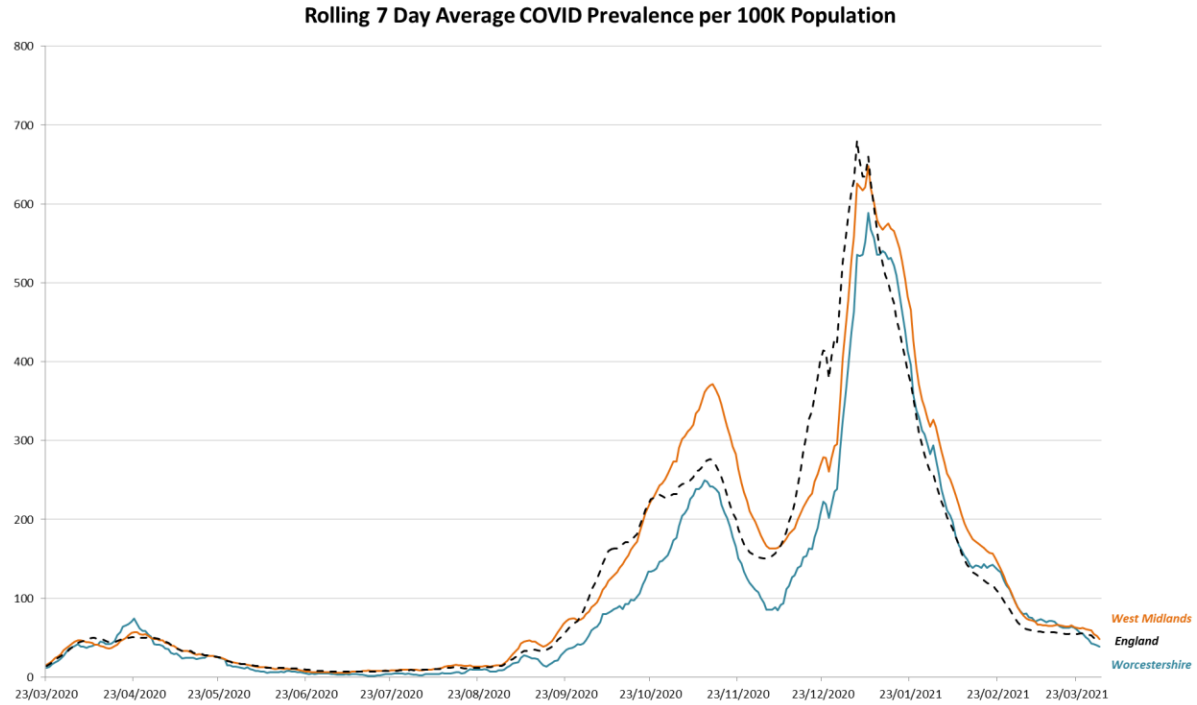
Phase (in reverse order)	**Key Changes**
Phase 6 (14/1/21 onwards)	▪ Level 5 alert at system level, restoration stepped down, star chamber established, wave 2 objectives agreed.
Phase 5 (7/11/20 onwards)	▪ Weekend combined B/S/G meetings (11am), B/S/G every week day, QIA panel re-established, Bronze 1 hour instead of 45 minutes (due to agenda size) ▪ Weekend calls to be Bronze/Silver 1100-1130. Gold call 1130-1200 (from 14/11/20)
Phase 4a (21/9/20 onwards)	▪ Bronze and Silver M/T/W/Th/F ▪ Gold – M/W/F. Ability for exec on call to stand up *ad hoc* meetings as required, Daily sitrep continues 7 days a week
Phase 4 (14/9/20 onwards)	▪ Continue with phase 3 frequency, strengthened links into Phase 3, Winter Planning and High Impact Changes. Increased focus on proactive planning.
Phase 3a (15/8/20 onwards)	▪ Weekend B/S and G ceased, with ability for exec on call to stand up *ad hoc* as required. Daily sitrep continues 7 days a week.
Phase 3a (15/8/20 onwards)	▪ Weekend B/S and G ceased, with ability for exec on call to stand up *ad hoc* as required. Daily sitrep continues 7 days a week.
Phase 2.5 (6/7/20 onwards)	▪ Gold stopped at weekends
Phase 2 (22/6/20 onwards)	▪ Gold M/W/F/S/S; Bronze and Silver M/T/W/Th/F ▪ Combined Bronze / Silver continues at weekends
Phase 1 (April – June 20)	▪ Gold, Silver, Bronze meetings daily ▪ Combined Bronze / Silver at weekends.
Phase 0 (March 20)	▪ Covid-19 Incident Management Team Meeting

An Incident Control Centre was established in February 2020, and continues to run to date (May 2021). Dealing with operational queries and liaison / point of contact with external partners, the Control Centre also included critical cells and work streams: Infection

prevention and control; Procurement and supplies; Intelligence; Workforce and; Communications.

3. National and Community COVID-19 Prevalence

The following chart shows the COVID-19 prevalence in the format of a 7-day rolling average per 100,000 populations for Worcestershire, West Midlands and England.



During the 384 days covered by this report, Worcestershire's COVID prevalence has been below that of the combined West Midlands rate for 90.1% of the time, and below the overall England rate figure for 76.3%.

The only (brief) periods that Worcestershire's community prevalence has been higher than both the West Midlands and England prevalence have been;

- From 16/04/2020 to 29/04/2020 (in Wave 1)
- From 19/05/2020 to 22/05/2020 (also in Wave 1)
- From 01/03/2021 to 16/03/2021 (in Wave 2)

During Wave 1 the peak figures per 100K population were 74.7 on the 23rd April 2020 for Worcestershire. This compared with 66.99 (West Midlands on 22nd September 2020) and 54.75 (England also on 22nd September 2020).

Similarly, during Wave 2 the peak figures per 100K population were 588.97 on the 8th January 2021 for Worcestershire. This compared to 648.02 (West Midlands also on the 8th January 2021) and 680.62 (England on the 4th January 2021).

Of note: Community prevalence rates for Wave 1 are likely to be grossly underestimated as widespread testing was not available at the time. Direct comparisons between prevalence rates for waves 1 and 2 are not advised nor are making any subsequent links to hospitalisations based on community case rates.

Reflecting on the link between community prevalence and subsequent hospitalisation is perhaps only realistic for Wave 2.

This being the case, and with reference to multiple charts/tables throughout this report, the following observations are offered:

- The exponential rise in community prevalence between mid to late December 2020 coincided (albeit with a slight lag) with a sudden jump in inpatient numbers.
- This seemed to coincide with the community prevalence rate exceeding 200 cases per 100k population for the second time.
- However, throughout the period defined by the second wave there was a steady increase in inpatient numbers that (i) did not respond when the community rate first breached 200 cases per 100k pop and (ii) did not reduce when the community prevalence fell to under 100 cases per 100k pop.
- In short, the relationship between community prevalence and hospitalisation is unclear and likely impacted by changes in the predominant variant.
- This relationship is further complicated by the (positive) impact of the vaccination programme.
- A 'safe' assumption would be that community prevalence rates exceeding 100 *and rising* would be a cause for concern.

4. Inpatient numbers and general overview of pandemic

The following tables summarise the total number of COVID inpatients treated from the start of the pandemic through to the 31st March 2021; Their combined length of stay (i.e. total bed days) for discharged (treated) and those who died (in hospital) and also; The crude mortality rate and average length of stay (treated & deceased).

Both waves

Site	Total No. inpatients	Combined LOS (days)	Discharged (treated)	Died (in hospital)	Crude mortality rate	Avg LOS (treated)	Avg LOS (died)
ALX	1363	15879	924	439	32.2%	11.6	11.7
WRH	1571	18619	1184	387	24.6%	11.9	11.6
Trust	**2934**	**34498**	**2108**	**826**	**28.2%**	**11.8**	**11.7**

As the pandemic continued into its second wave we started to see the overall crude mortality rate and average length of stay for all COVID inpatients change.

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

Wave 1

Site	Total No. inpatients	Combined LOS (days)	Discharged (treated)	Died (in hospital)	Crude mortality rate	Avg LOS (treated)	Avg LOS (died)
ALX	420	4511	262	158	37.6%	11.1	10.2
WRH	405	4638	282	123	30.4%	11.6	11.1
Trust	**825**	**9149**	**544**	**281**	**34.1%**	**11.3**	**10.6**

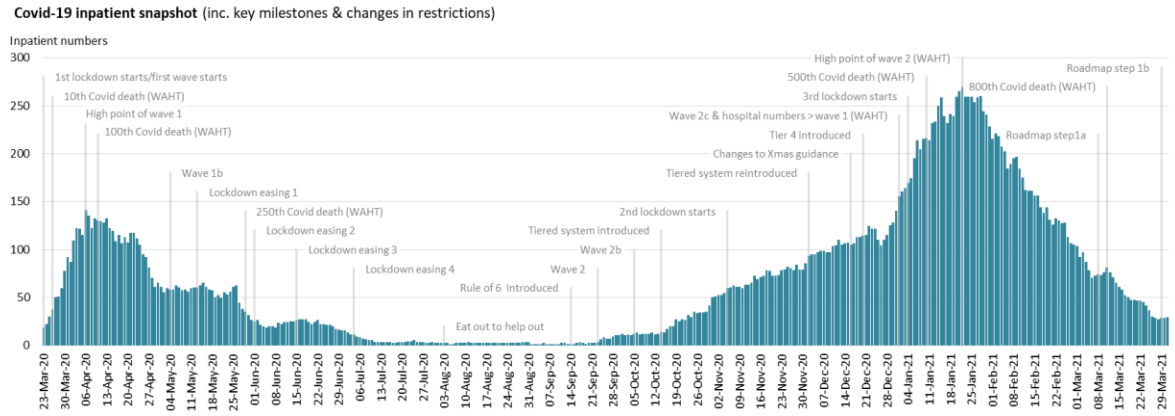
Wave 2

Site	Total No. inpatients	Combined LOS (days)	Discharged (treated)	Died (in hospital)	Crude mortality rate	Avg LOS (treated)	Avg LOS (died)
ALX	943	11368	662	281	29.8%	11.8	12.6
WRH	1166	13981	902	264	22.6%	12.0	11.9
Trust	**2109**	**25349**	**1564**	**545**	**25.8%**	**11.9**	**12.2**

Observations:

- In an almost like for like comparison, wave 2 exceeds wave 1 by 1284 patients and equates to an additional 16.2k bed days (ie. combined LOS).
- The crude mortality rate for the pandemic thus far is 25.8% but has improved substantially from wave 1 where it settled at 34.1%.
- The crude mortality rate for the wave has been relatively stable and remains eight percentage points lower (i.e. better) than wave 1. Of note, the peak inpatient numbers we experienced during the current wave did not result in any sustained worsening of our crude mortality rate for COVID inpatients.
- Average length of stay for the wave 2 continued to show very slight signs of increase. This would suggest that, as new inpatient numbers continue to decline, we are continuing to treat patients admitted from, in some cases, several weeks ago.

The following chart shows the overview of the pandemic in terms of inpatient numbers (as reported on a daily basis throughout the pandemic). It also shows the key milestones, both internally and nationally (i.e. changes in response to the pandemic). Like all charts in this report, a larger, high resolution version of this chart can be found in the accompanying slide deck.



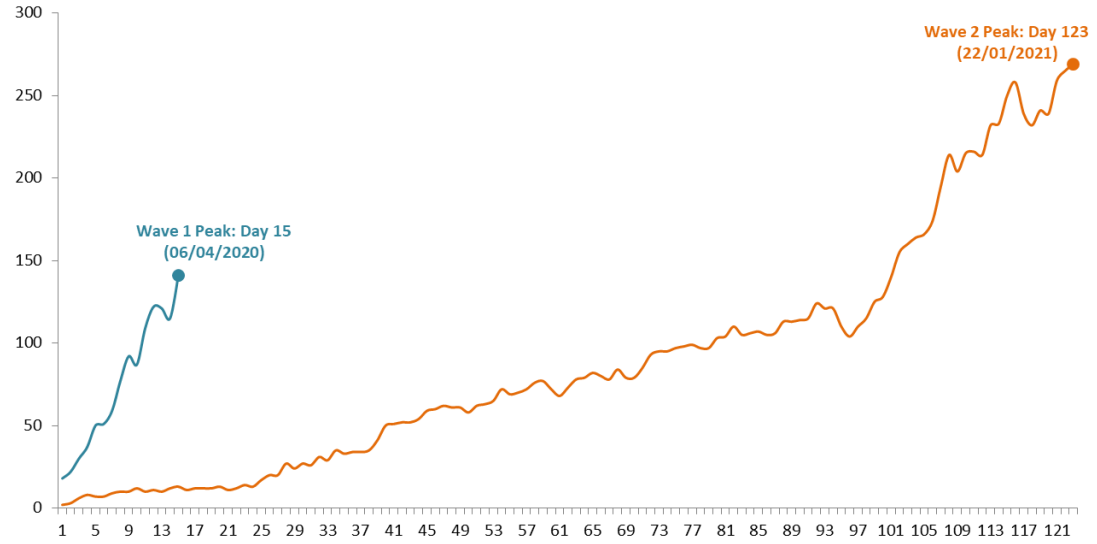
Observations:

- At the point wave 1 commenced the Trust was already reporting 18 inpatients who had tested positive and being treated for COVID-19 and four deaths had already

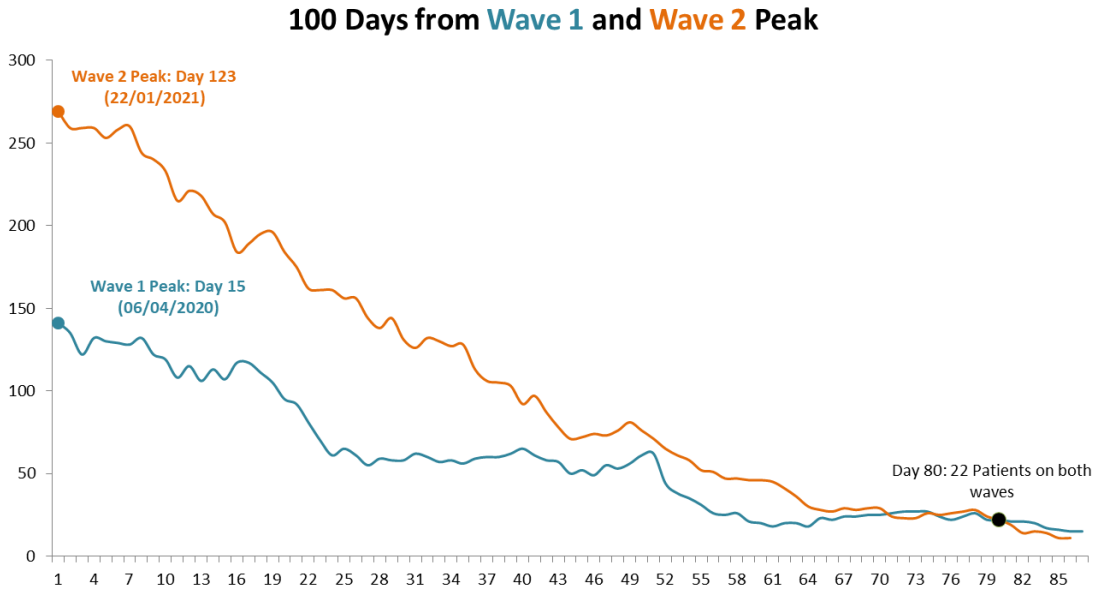
been reported.

- Based on the sample date our first positive patient was identified on the 11th March. Our first death, based on discharge date, was the 20th March.
- The high point for inpatient numbers (wave 1) was on the 6th April 2020. At this point the Trust reported 141 confirmed COVID-19 inpatients.
- From this high point it took 19 days to fall below 100 inpatients and a further 33 days to fall (consistently) below 50 inpatients.
- This plateau or 'doldrum' period is marked by the commencement of wave 1b on or about the 4th May 2020. It is noteworthy that the first easing of lockdown restrictions commenced nine days later and may explain some of this protraction.
- By the 1st June 2020 when the second stage of lockdown easing commenced we were reporting 25 inpatients and had recently marked the 250th COVID death in the Trust.
- Patient numbers consistently fell below ten from 5th July 2020 and remained that way until 29th September.
- At the lowest point in wave 1 we were consistently reporting between one and three inpatients. This lasted for 61 days between the 25th July and the 23rd September. The latter being what we are recording our starting point for wave 2.
- By the 5th October (wave 2b) we were now reporting more than ten inpatients. By the end of October this had risen to 50 with a rate of doubling approximately every two weeks. Shortly thereafter the second national lockdown was announced.
- This second lockdown appeared to result in a slowdown in the rise in inpatient numbers. However by Christmas 2020 we were reporting 110 inpatients.
- On 1st January 2021 (i.e. seven days later) were reported that our inpatient numbers had exceeded the high point of the first wave with 155 inpatients.
- This is the point at which wave 2c commenced and three days later the third national lockdown started.
- On the 22nd of January we recorded our peak number of inpatients at 269. By this point the Trust had also recorded more than 500 COVID deaths.
- From this high point it took 27 days for inpatient numbers to fall below the high point for wave 1 and a further 13 days to fall below 100.
- By the time step 1a of the England 'roadmap' was in place we were reporting 74 inpatients and three days later we would have recorded out 800th COVID death.
- At the end of March 2021 and two days into step 1b of the roadmap our inpatient numbers stood at 29.

The path to the peak of Wave 2 occurred over a much longer period of time than Wave 1. Wave 1 peaked (141) 15 days after the commencement of the wave on 23rd March 2020. Wave 2 took 99 days to match this, but continued to peak at 269 on the 123rd day following the commencement of the wave on 23rd September.



However, despite the fact that the Wave 2 peak was 90.9% larger than the Wave 1 peak, it reduced at a much quicker rate. Both Waves reduced to 22 COVID inpatients on the 80th day following their peaks. This may be partially due to the implementation of the COVID vaccine program.

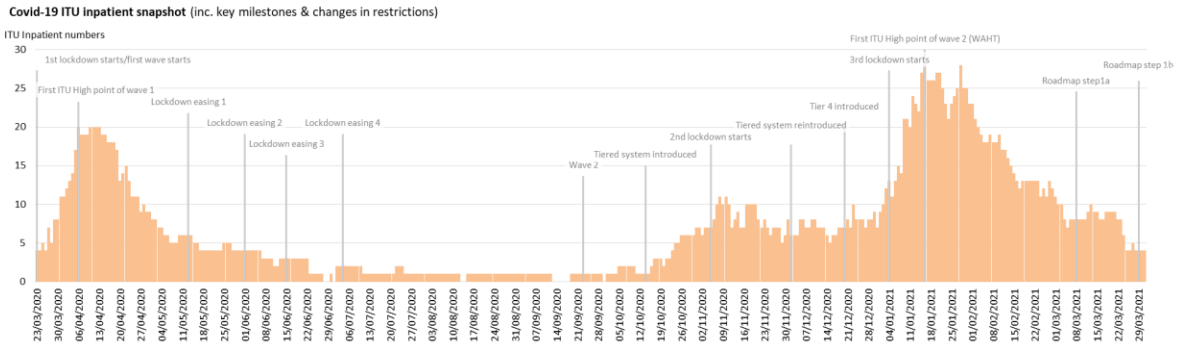


5. ITU patient numbers

The usual number of Level 3 equivalent patients that the Trust is staffed to manage is 15. However, during the highpoint of the Pandemic the Trust peaked at 28 COVID patients on ITU. To accommodate these numbers, plus the non-COVID cohort of patients, additional

surge ITU's were set up in Cedar Ward (Alex), Aconbury 2 (WRH) and Theatre Recovery (WRH). In addition the Trust underwent a redeployment program to increase the staffing levels required to accommodate functioning of the surge ITU's.

The following chart shows the overview of the pandemic in terms of COVID inpatient numbers on ITU (as reported on a daily basis throughout the pandemic). It also shows some of the key milestones throughout this period.



Observations:

- At the point wave 1 commenced the Trust was already reporting 4 patients on ITU who had tested positive (2 on both sites).
- The first high point for ITU inpatient numbers (wave 1) was on the 6th April 2020. At this point the Trust reported 20 confirmed Covid-19 inpatients on ITU. This number was also reached during the period 10th to 13th April 2020.
- Single figure COVID occupancy of ITU was consistently achieved in Wave 1 from 29th April 2020.
- By the 13th May 2020 when the first stage of lockdown easing commenced we were reporting 6 COVID inpatients on ITU.
- By the 1st June 2020 when the second stage of lockdown easing commenced we were reporting 4 COVID inpatients.
- From the 23rd June, through the beginning of Wave 2 on 23rd September, until 16th October 2020, the number of COVID patients on ITU was in the range 0-2.
- From the 17th October 2020 the number of COVID patients on ITU began to rise again, and had reached 7 when the 2nd Lockdown started on 5th November 2020.
- The number of ITU COVID patients had reached 13 when the 3rd Lockdown was implemented on 4th January 2021.
- The number then started to rapidly rise reaching the first high point of Wave 2 on 16th January 2021, when there were 28 COVID patients on ITU. This surpassed the wave 1 peak of 20 patients.
- Following this first high point the COVID ITU occupancy remained in double figures for a further 46 days until 3rd March 2021.
- At the end of March 2021 and two days into step 1b of the roadmap our ITU COVID inpatient numbers had fallen to 4.

ICNARC

The following information is extracted and summarised from the Intensive Care National

Audit and Research Centre (ICNARC) reports on COVID-19 in critical care. These cover admissions from 1st September 2020 to 31st March 2021.

The first summary table shows the inpatient demographics in critical care for this period and compares these to the overall case-mix sample.

Demographics	ALX	WRH	Comparator
No. Patients treated	51	80	n/a
Mean age at admission (SD)	58.6yrs (13)	58.6yrs (12.8)	59.3yrs (13.2)
Female(%)	17 (33.3%)	22 (27.5%)	34.2%
Male (%)	34 (66.7%)	58 (72.5%)	65.8%
Ethnicity - White (%)	48 (94.1%)	71 (88.8%)	72.0%
Ethnicity - BAME (%)	3 (5.9%)	9 (11.2%)	28.0%
Index of multiple derivation is 4 or 5 (%)	25 (49%)	30 (38%)	53.7%
BMI 30-<40 (%)	26 (52%)	37 (46.3%)	37.0%
BMI >=40 (%)	6 (12%)	8 (10%)	11.8%

Observations:

- The age profile, in terms of mean age and distribution, was similar across both sites and with the case-mix sample.
- There is a noticeable sex/gender bias towards male critical care patients (see following section on inpatient demographics). This is in line with the comparison group but noticeably higher at the Worcester site.
- BAME patients requiring critical care represented between six and 11% of patients. This is somewhat lower than the comparison group. This reinforces later points made in this report regarding the lack of bias towards BAME inpatients throughout the pandemic.
- The IMD mix perhaps reflects the heterogeneous nature of the county. Critical care patients at the Alexandra site were more likely to be from more 'deprived' areas than those treated at the Worcester site but broadly in line with the comparator group.
- The BMI data suggests that, on the whole, critical care inpatients at both sites were more likely to be overweight or obese than the case-mix group.

The next table shows the medical history of the critical care patients.

Medical history	ALX	WRH	Comparator
Able to live without assistance (%)	42 (95.5%)	69 (88.5%)	87.9%
Very severe comorbities - combined (%)	2 (4%)	8 (10%)	9.9%
Prior average LOS (SD)	4.1days (5.2)	3.0days (5.0)	3.2days (7.9)
CPR within 24hrs (%)	0 (0%)	0 (0%)	1.0%
Invasively ventilated within 24hrs (%)	22 (43.1%)	33 (41.3%)	30.5%

Observations:

- This would appear to show a lower proportion of frail patients with fewer very severe comorbidities than the comparator group with a broadly similar average prior length of stay.
- It also seems to show that our critical care inpatients were much more likely to require or receive invasive ventilation within the first 24hrs of critical care.

The final summary table summarises the outcomes (inc. survival rates) for critical care patients.

Outcomes	ALX	WRH	Comparator
Discharged (%)	29 (56.9%)	53 (66.3%)	60.90%
Died (%)	18 (35.3%)	24 (30%)	38.10%
Duration of care - survivors	5days	6days	7days
Duration of care - deceased	12days	12days	12days
Discharged alive from critical care (%)			
16-49yrs	14 (100%)	14 (87.5%)	81.5%
50-69yrs	11 (55%)	31 (72.1%)	60.6%
70+yrs	4 (30.8%)	8 (44.4%)	45.1%
Female	9 (60%)	10 (52.6%)	65.7%
Male	20 (62.5%)	43 (74.1%)	59.3%
BMI>=30	22 (73.3%)	33 (76.7%)	65.4%
Assistance required with daily acivities	1 (50%)	5 (62.5%)	52.9%
Any very severe comorbidities	26 (60.5%)	4 (57.1%)	47.0%
Basic respiratory support	19 (100%)	31 (88.6%)	82.4%
Advanced respiratory support	10 (35.7%)	22 (52.4%)	43.8%

Observations:

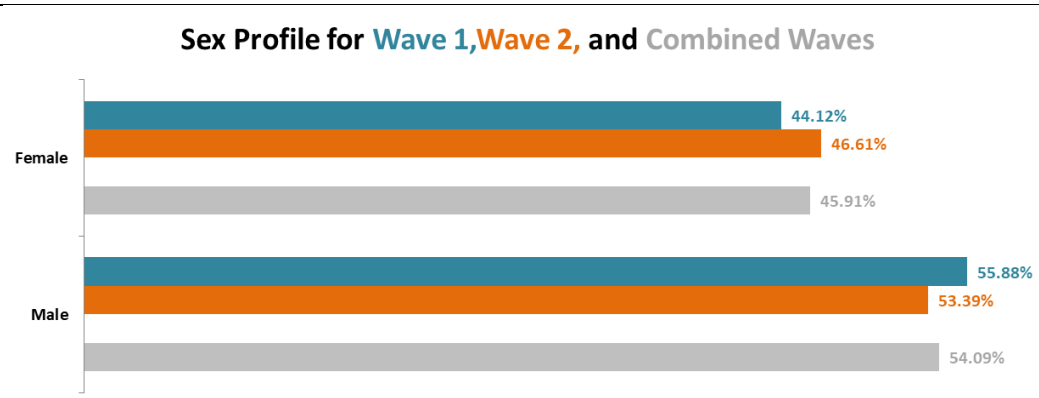
- This seems to show a slightly improved survival rates at the Worcester site compared to both the Alexandra and comparison group. This is most likely explained by higher BMI and IMD scores for patients at the Alexandra.
- Survival rates at the Alexandra are noticeably lower for those patients aged 70 years or older and also for those patients requiring advanced respiratory support.
- Female survival rates are lower than the comparison group for both sites. This is more pronounced at the Worcester site.
- Overall there are no consistent patterns to suggest that survivability differs between the two sites or is worse than the comparison patient case-mix.

6. Inpatient demographics

The following sections cover COVID inpatient demographics. Specifically sex/gender, age and ethnicity.

Sex/gender

Across the pandemic as a whole, there was a slight but consistent bias towards male inpatients (54.09%). However this difference was more pronounced during Wave 1 (55.88% male), than it was during Wave 2 (53.39% male).

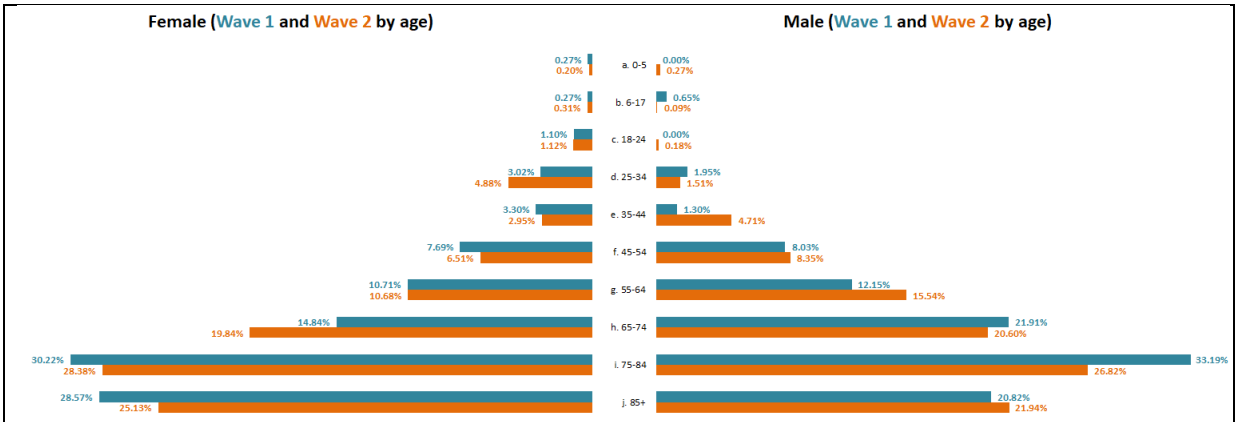


Age

More than 85% of the admissions due to COVID were of patients aged 55 and over. Furthermore, within the age 55+ cohort of patients, the largest proportion was in the 75-84 age range.

Age and Sex

There was a small age shift amongst females admitted during Wave 2 with, with a 1.84% drop in 75-84 year olds, a drop of 3.44% in 85+ year olds, but an increase of 5% in 65-74 year olds.

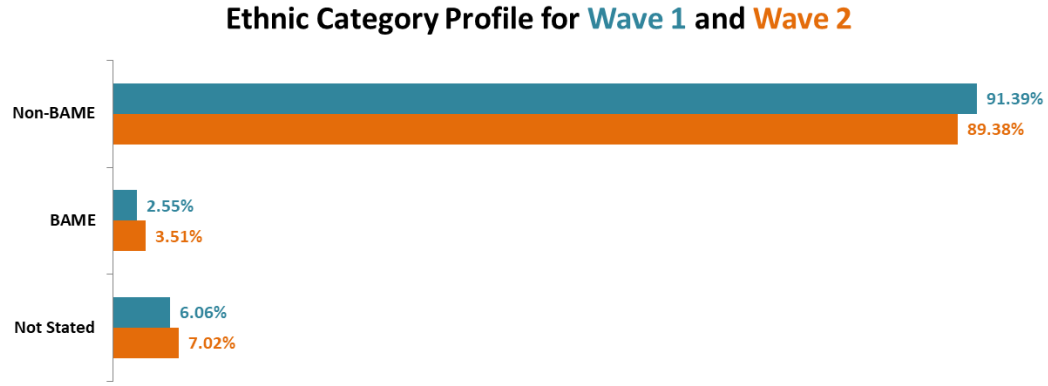


Observations:

- This change in age profile was not mirrored amongst males. There was a similar but larger drop in 75-84 year old males of 6.37%. However, unlike females there was an increase of 1.12% in 85+ year old males, and a decrease in 65-74 year old males of 1.31%.
- The other noticeable differences were that 55-64 year old female admissions was largely unchanged (-0.03%) in Wave 2, but male admissions in the same age bracket increased by 3.39%. And females aged 35-44 dropped slightly during Wave 2 (-0.35%), but admissions of males of the same age increased by 3.41%.

Ethnicity

There was a small increase in admissions of Black, Asian and Minority (BAME) ethnic patients during Wave 2, from 2.55% to 3.51%.

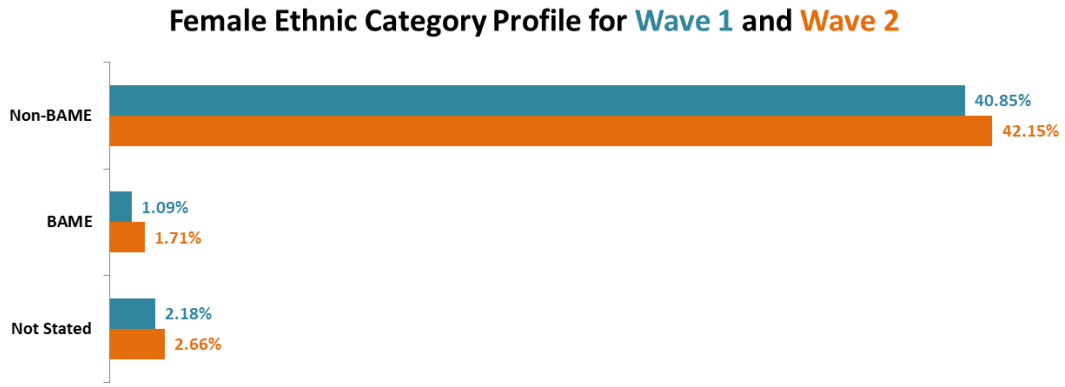


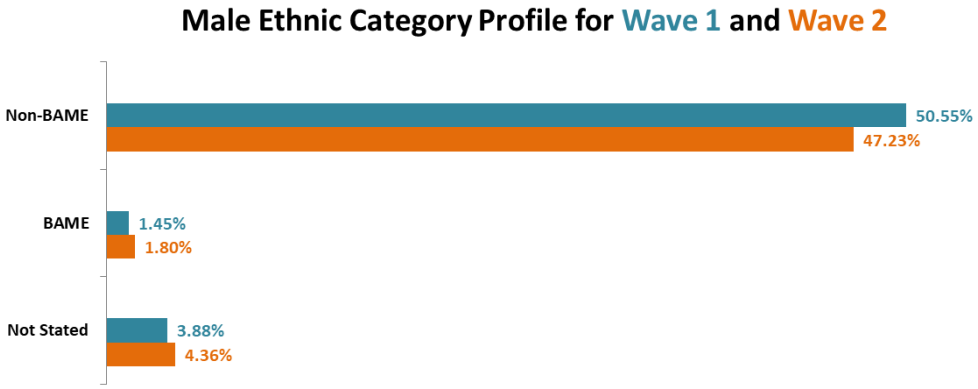
Observations:

- There was a small drop in admissions of Non-BAME patients during wave 2.
- It should be noted that there were over 6% in both waves where the patients Ethnic Category was not stated on the records which could possibly affect these figures.

Ethnicity and Sex

The overall male bias in inpatient numbers (see earlier) is evident regardless of ethnicity.



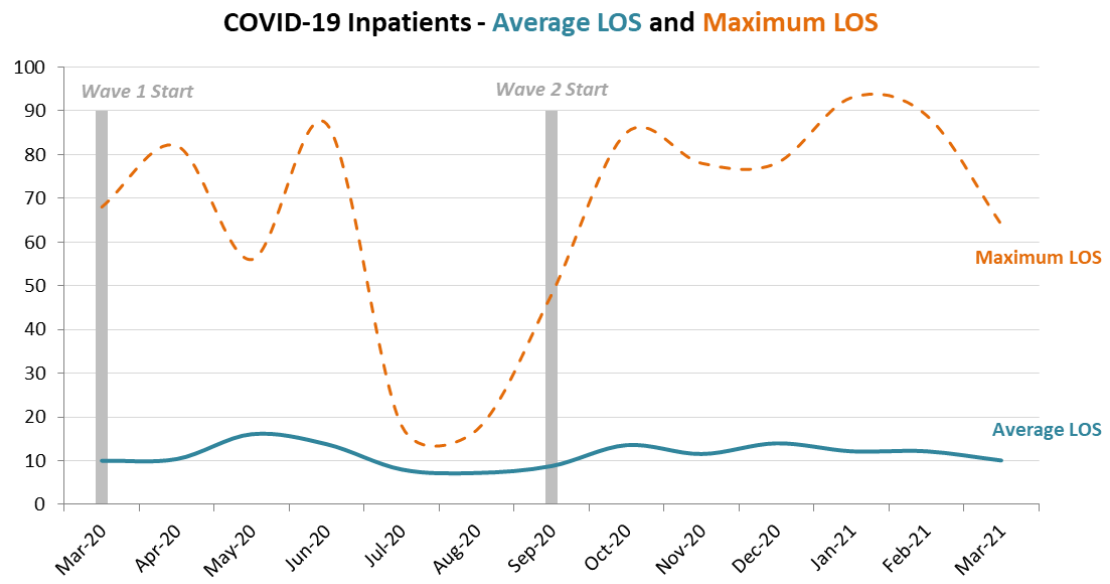


Observations:

- Overall during the Pandemic there were more male admissions in both BAME and Non-BAME patient groups.
- There was a small increase during Wave 2 female admissions in both BAME and Non-BAME patient groups.
- There was a small increase during Wave 2 male admissions in the BAME patient group, but a drop in Non-BAME patients.

7. Inpatient Length of Stay (LOS)

Over the entirety of the Pandemic covered by this report, the Average Length of Stay (ALOS) for inpatients admitted due to COVID-19 has been 11.92 days.

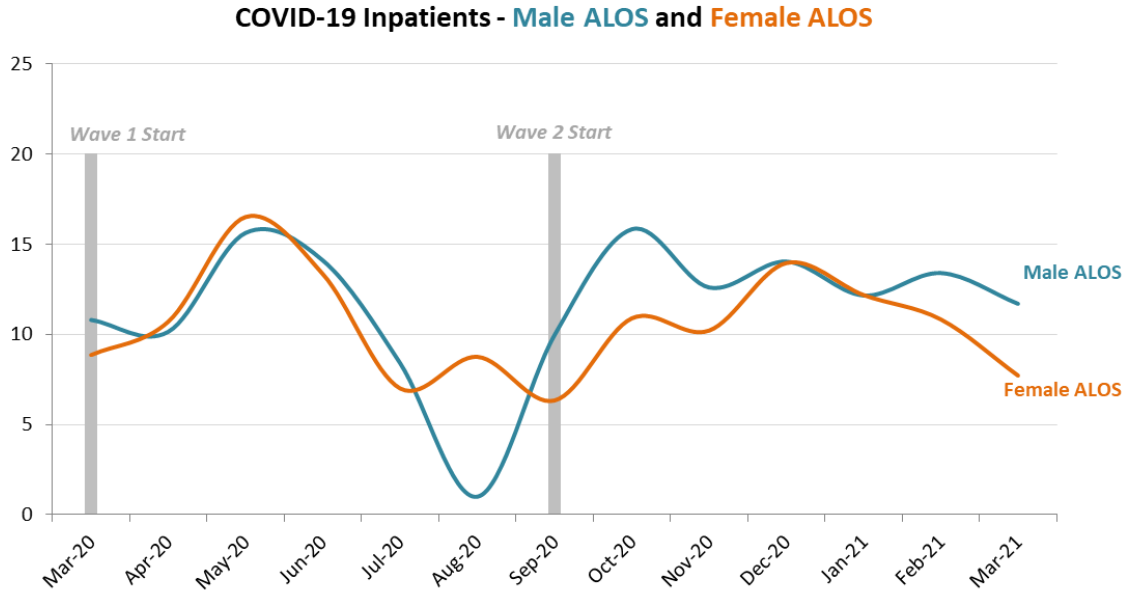


Observations:

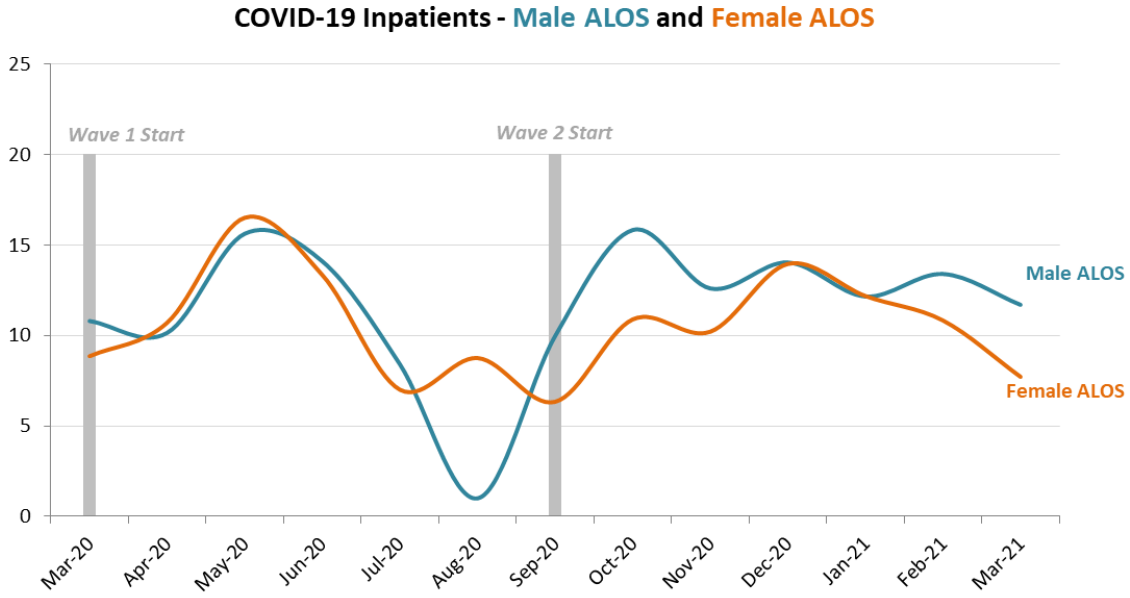
- The ALOS was slightly higher in Wave 2 (12.40 days) than Wave 1 (11.08 days) but the cohort size was more than double the size.
- The maximum length of stay approximates waves 1 and 2 with a noticeable drop during the interstitial period, prior to wave 2.
- This suggests that acuity rose during these times but treatment (success and clinical quality) did not appear to suffer.
- The maximum LOS was also slightly higher during the 2nd wave at 93 days, compared to 87 days in the 1st.
- Further information regarding the LOS for the cohort of deceased patients can be found later in the report.

Length of Stay (LOS) **and Sex**

- Over the entirety of the Pandemic covered by this report, the Average Length of Stay (ALOS) for inpatients admitted due to COVID-19 has been slightly longer for men (12.28 days) than women (11.50 days).
- For both men and women the ALOS was longer in Wave 2 12.90 and 11.83 days respectively) than in Wave 1 (11.10 and 11.03 days respectively).



- Over the entirety of the Pandemic covered by this report, the Maximum Length of Stay for inpatients admitted due to COVID-19 has been higher for men (93 days) than women (83 days).
- For both men and women the Maximum LOS was longer in Wave 2 (93 and 83 days respectively) than in Wave 1 (87 and 68 days respectively).

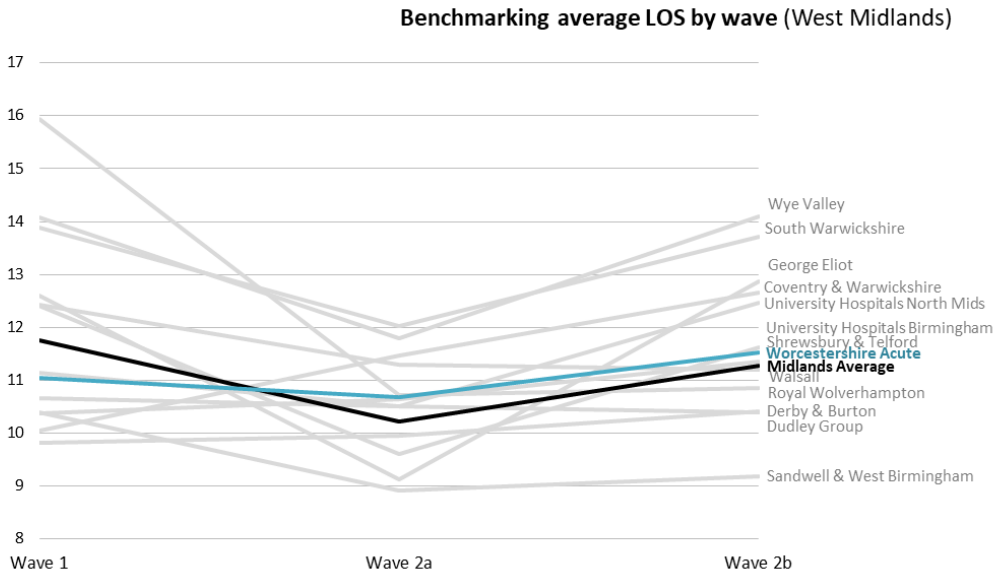


Benchmarking LOS

The following chart shows the average LOS for inpatients with a primary diagnosis of COVID-19 compared to other West Midlands trusts. This data is based on HES/SUS submissions and has been extracted from the HED system hosted by University Hospitals Birmingham.

This comparative information is split into three phases:

1. Wave 1. Covering the period March to August 2020 (inclusive). This is effectively the early stages of the pandemic including the reduction to almost zero inpatients.
2. Wave 2a. From September to December 2020, this covers the period where we saw a gradual but not exponential increase in patient numbers.
3. Wave 2b. From January to March 2021 this covers the period of exponential growth in patient numbers, exceeding that experienced in wave 1.



Observations:

- Our average LOS is not too dissimilar from the overall West Midlands average.
- Our average LOS was highest during the peaks of wave 1 and wave 2. Generally speaking this trend is mirrored across the West Midlands.
- Other trusts have seen noticeably more dramatic changes in average LOS whereas ours has been more consistent.

8. Healthcare Associated Infections

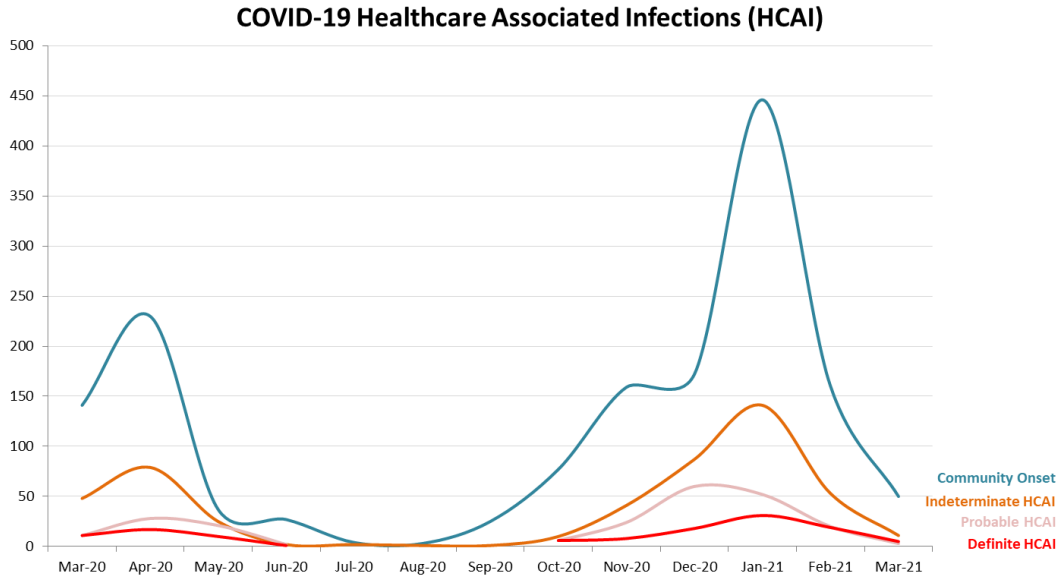
The following table shows the breakdown of our new positive cases by the HCAI category, which is based on the time between admission and the positive swab being taken.

Category		Patients					
		Wave 1		Wave 2		Total	
		Number	%	Number	%	Number	%
Community-Onset	Positive specimen date <=2 days after admission to Trust	449	63.42%	1092	64.35%	**1541**	**64.07%**
Hospital-Onset Indeterminate Healthcare-Associated	Positive specimen date 3-7 days after admission to Trust	158	22.32%	348	20.51%	**506**	**21.04%**
Hospital-Onset Probable Healthcare-Associated	Positive specimen date 8-14 days after admission to Trust	62	8.76%	167	9.84%	**229**	**9.52%**
Hospital-Onset Definite Healthcare-Associated	Positive specimen date 15 or more days after admission to Trus	39	5.51%	90	5.30%	**129**	**5.36%**

Observations:

- Over the entirety of the Pandemic covered by this report, 5.36% of COVID-19 infections amongst Inpatients were definitely acquired during their hospital stay. Wave 2 saw a small reduction compared to Wave 1.
- A further 9.52% were probable hospital acquired infection. Wave 2 saw an increase compared to Wave 2.

The following chart shows the breakdown of our new positive cases by the HCAI category.



- Community-onset cases have been the main source of our inpatient cohort throughout the pandemic
- Increases in probable and definite HCAI cases have, broadly speaking, coincided with those periods where overall inpatient numbers have been elevated and rising.

9. Readmissions

The following table shows the number of COVID-19 patients who were readmitted to the Trust. It breaks down the cohort into 2 groups;

1. Patients who were readmitted within 14 days of their original diagnosis, and were subsequently counted as COVID positive patients again during their readmission spell.
2. Patients who were readmitted more than 14 days after their original diagnosis and

who did not give another positive sample result after readmission, and subsequently were not counted as COVID patients during their readmission spell.

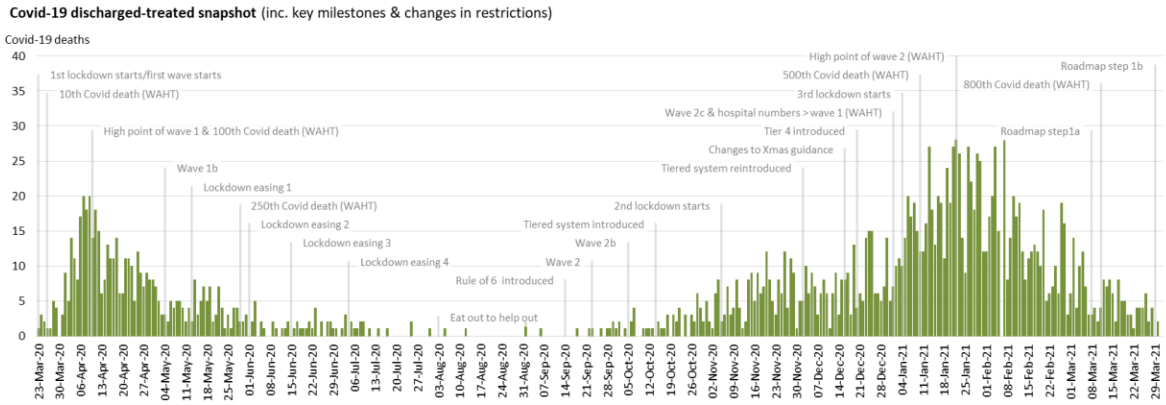
Category	Readmitted Patients					
	Wave 1		Wave 2		Total	
	Number	%	Number	%	Number	%
Readmitted <= 14 days after diagnosis	24	2.91%	45	2.13%	**69**	**2.35%**
Readmitted >14 days after diagnosis	108	13.09%	66	3.13%	**174**	**5.93%**

Observations:

- Over the entirety of the Pandemic covered by this report, 2.35% of COVID-19 patients have been readmitted <=14 days after diagnosis.
- This figure reduced slightly during Wave 2, which could be indicative of improved patient care following experience gained during Wave 1.
- Over the entirety of the Pandemic covered by this report, 5.93% of COVID-19 patients have been readmitted >14 days after diagnosis.
- It must be noted that this figure may increase as time passes following the writing of this report, and probably explains the large drop when comparing Waves 1 and 2 (13.09% and 3.13% respectively).
- Evidence of the longer term physical effects post COVID-19 infection is still being researched. The British Lung foundation uses the definition of Long COVID as *"signs and symptoms that last for longer than 4 weeks after getting COVID-19"* .
- Using this definition, there have been 50 (1.70%) readmissions which could potentially be as a result of Long COVID during the pandemic to date, including 19 (2.30%) during Wave 1, and 31 (1.47%) during Wave 2. (Note again these figures may rise over the longer term).

10. **Treatment Outcomes** (inc. mortality)

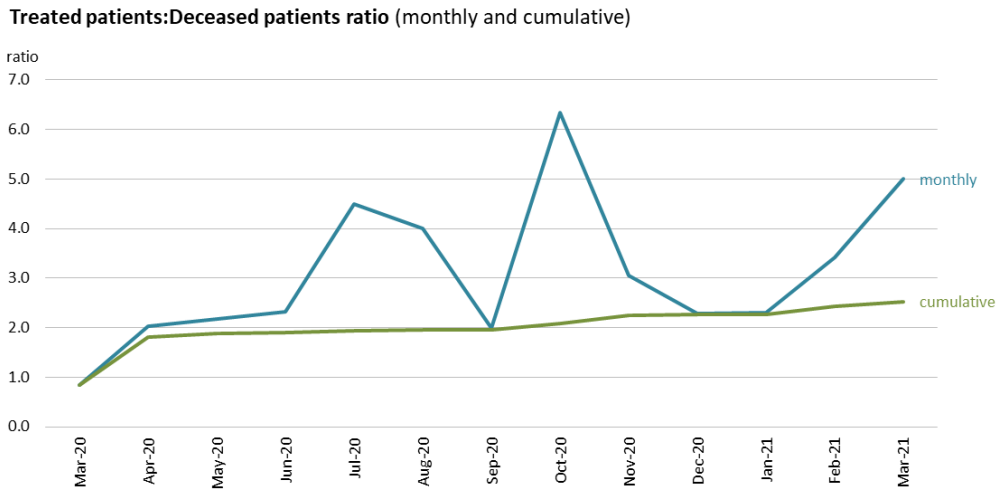
The profile of discharged (treated) patients' mirrors that of the overall inpatient numbers (refer to the first chart in this report).



Throughout the pandemic the 'survivability' of inpatients with COVID-19 steadily improved. Comparing the number of patients discharged (treated) with in-hospital deaths provides a form of ratio where anything above 1 indicates that more patients are treated than die whilst

in our care (this is a sort of reversed version of the crude mortality rate).

This can be seen by month and as a cumulative total in the following chart.

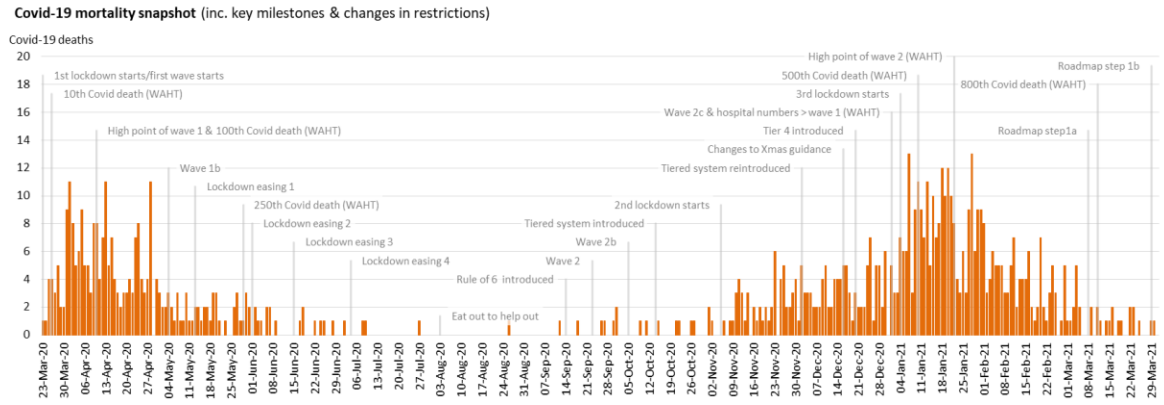


Observations:

- The earliest part of wave 1 saw the lowest treated : deceased ratio. In fact, in March 2020 the ratio was <1 indicating that the crude mortality rate was >50%. However this quickly improved and remained at or above 2 for the remainder of the period under review.
- The lowest survivability ratios coincide, generally speaking, with those peak periods of both wave 1 and wave 2. This is likely to reflect the acuity *in addition to* the volume of patients at these times.
- This ratio improved during the 'quiet' period in-between that preceded the start of wave 2. It then further improved during the early and final phases of the second wave. Even during the peak of wave 2, this ratio did not fall below 2.
- Given the scale of the second phase (patient numbers etc.) of wave 2 this would strongly suggest that the successful treatment of patients improved throughout the pandemic.

11. Mortality

The following chart shows the number of reported deaths by day for the duration of the period under review. Again, much like the overall patient numbers, this clearly demarks the previously outlined phases/waves of the pandemic.

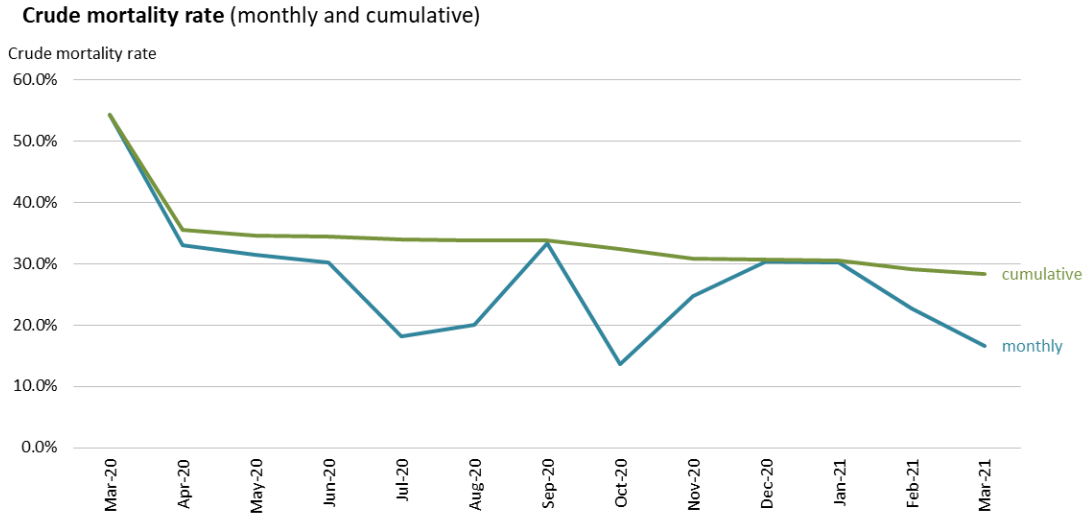


Observations:

- Whilst wave 2 saw significantly more reported deaths than wave 1, this is a function of the protracted nature of the second wave.
- A comparison of the peaks in daily deaths for both waves shows a much smaller, proportionate increase in wave 2 than the inpatient numbers. This is borne out in the survivability (earlier) and crude mortality improvements throughout the pandemic.

Crude mortality rates

The following chart shows the crude mortality rate for COVID inpatients by month along with the cumulative trend throughout the review period.

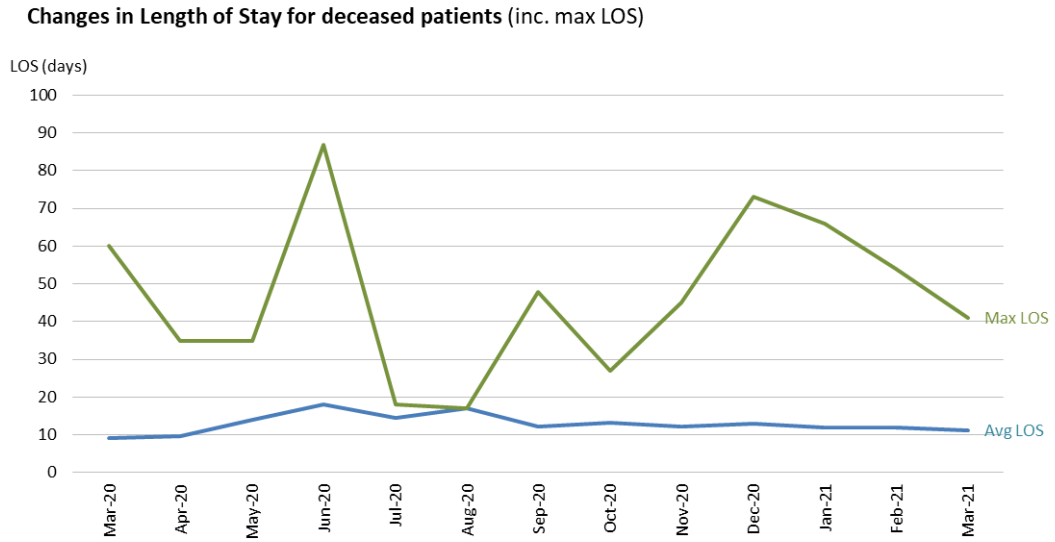


Observations:

- The crude mortality rate at the very start of the pandemic was as bad as this got and quickly improved.
- Aside from this, higher rates of crude mortality are evident during the busier periods of both waves 1 and 2.
- But, despite these, the overall rate continued to improve. Even during the high point of wave 2.

Length of Stay – Deceased Patients

The average length of stay for deceased patients peaked for those patients whose positive sample was taken during the latter part of wave 1. The peaks in maximum LOS show, perhaps, the determined efforts of the clinical staff to treat some of the most acute cases.



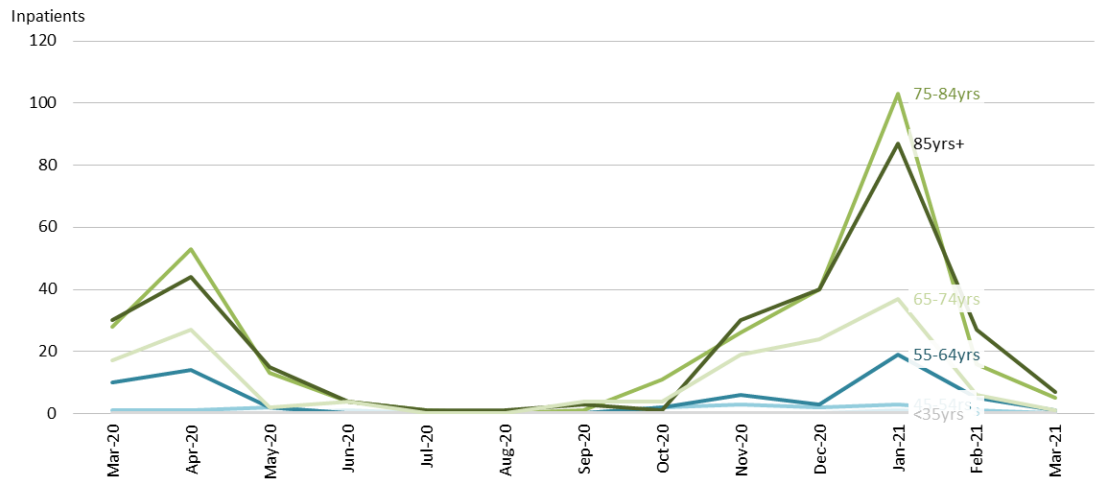
Patient Demographics - Mortality

This is split into three sections. Age, gender and ethnicity.

Mortality by age

The following chart shows the prevalence of the age bias within those patients who sadly died in our care.

Covid-19 deaths x age (group) **over time** (based on sample date)



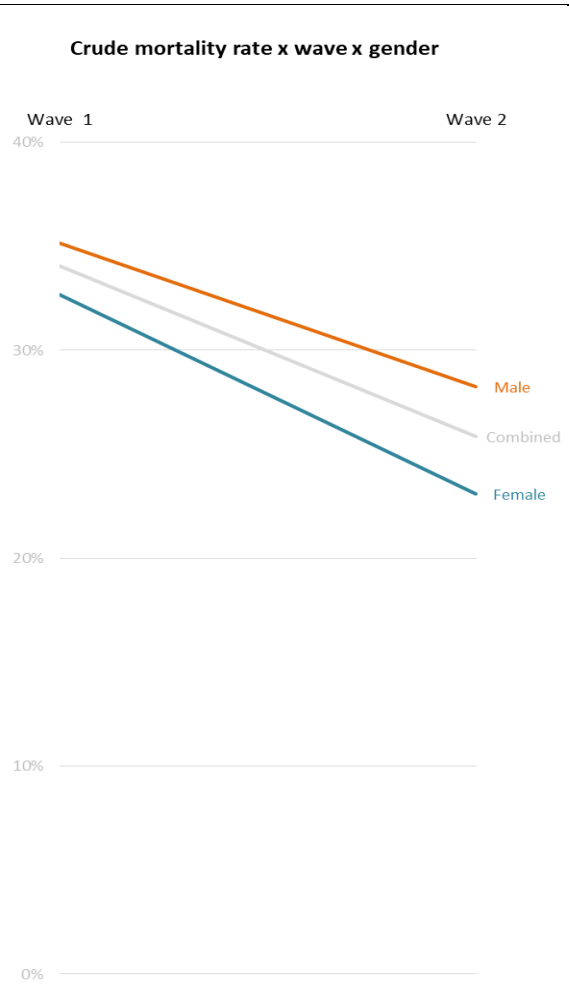
Observations:

- Whilst the mortality trend broadly reflects the bias towards older age groups there is a noticeable cut-off point whereby mortality risk drops sharply for those aged under 54yrs.

Mortality by Gender

Whilst crude mortality rates improved between wave 1 and wave 2 for both males and females there was a distinct male bias within the mortality data.

	Combined		Female		Male	
	Wave 1	Wave 2	Wave 1	Wave 2	Wave 1	Wave 2
Total inpatients	825	2109	364	983	461	1126
Discharged treated	544	1564	245	756	299	808
Deceased	281	545	119	227	162	318
Crude mortality rate	**34.1%**	**25.8%**	**32.7%**	**23.1%**	**35.1%**	**28.2%**



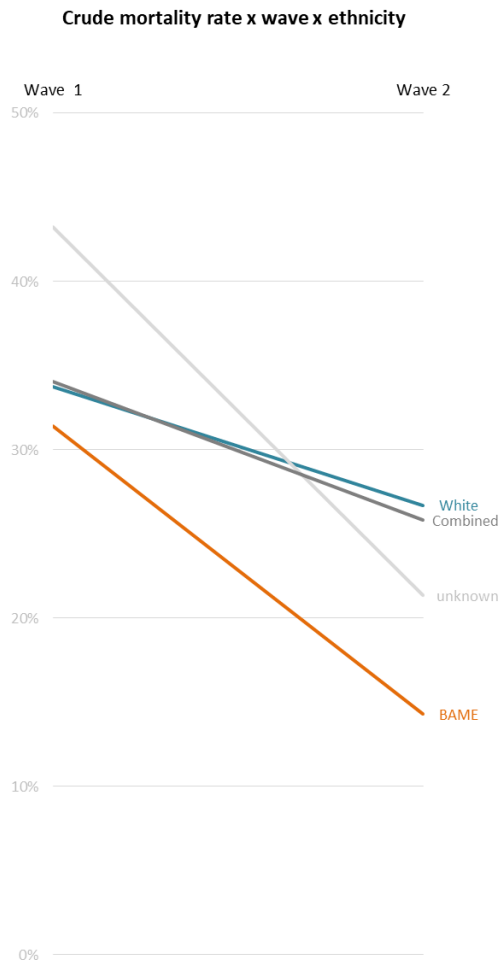
Observations:

- Not only were female inpatients less reflected in the mortality data, their crude mortality rate was also better (i.e. lower) than that of the male crude mortality rate.
- This extends across both waves.

Mortality by Ethnicity

It has been established nationally that a bias exists within the mortality rates for BAME patients. The following table and slope chart shows the prevalence of BAME patients within our COVID numbers (treated and deceased) for both wave 1 and wave 2.

	All inpatients		BAME		White		Unknown	
	Wave 1	Wave 2	Wave 1	Wave 2	Wave 1	Wave 2	Wave 1	Wave 2
Total inpatients	825	2109	35	91	753	1887	37	131
Discharged treated	544	1564	24	78	499	1383	21	103
Deceased	281	545	11	13	254	504	16	28
Crude mortality rate	**34.1%**	**25.8%**	**31.4%**	**14.3%**	**33.7%**	**26.7%**	**43.2%**	**21.4%**



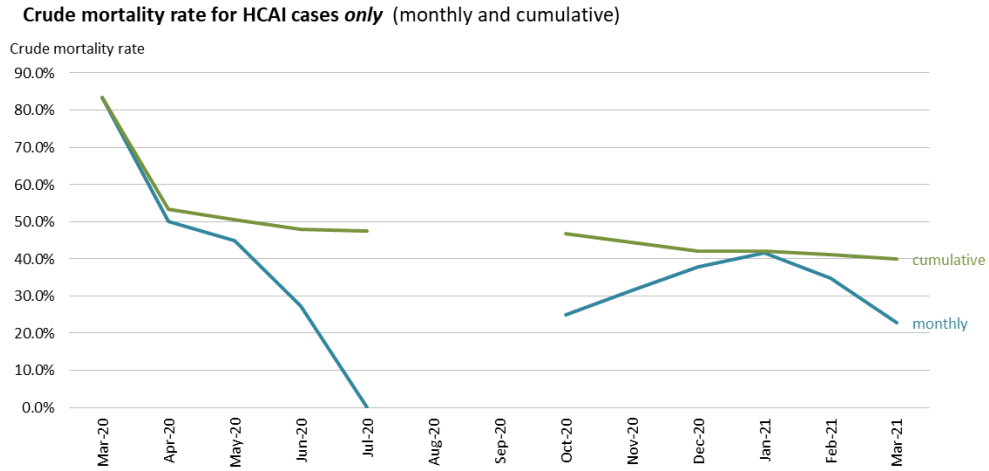
Observations:

- BAME patients represented consistently within the overall patient numbers for both wave 1 and wave 2 (see earlier section of this report) but their representation in the mortality data was reduced and improved between waves 1 and 2.
- Furthermore the crude mortality rate for BAME patients was better than improved more than the similar rate for white or combined patients.
- There may be some indications of a bias in the overall COVID inpatient numbers but this does not translate into increased risk of mortality.

Hospital Acquired Cases and Mortality

Hospital acquired cases and crude mortality (based on definite and probable HCAI cases)

similarly improved (see following chart). Please note that there were no HCAI cases (or deaths) identified in August and September 2020.

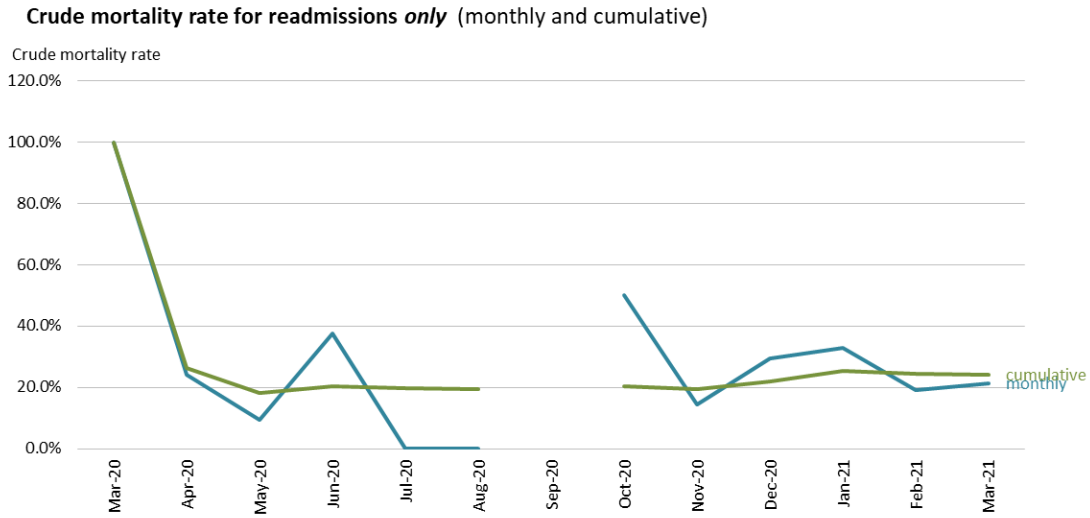


Observations:

- Despite the improving trend, the crude mortality rate for HCAI cases was consistently higher than the overall crude mortality rate.
- There is a correlation between the peaks of both waves, the number of HCAI cases and increases in mortality rate.

Readmissions and mortality

The crude mortality rate for readmissions, whilst initially high, dropped below the overall/average crude mortality rate (see following chart).



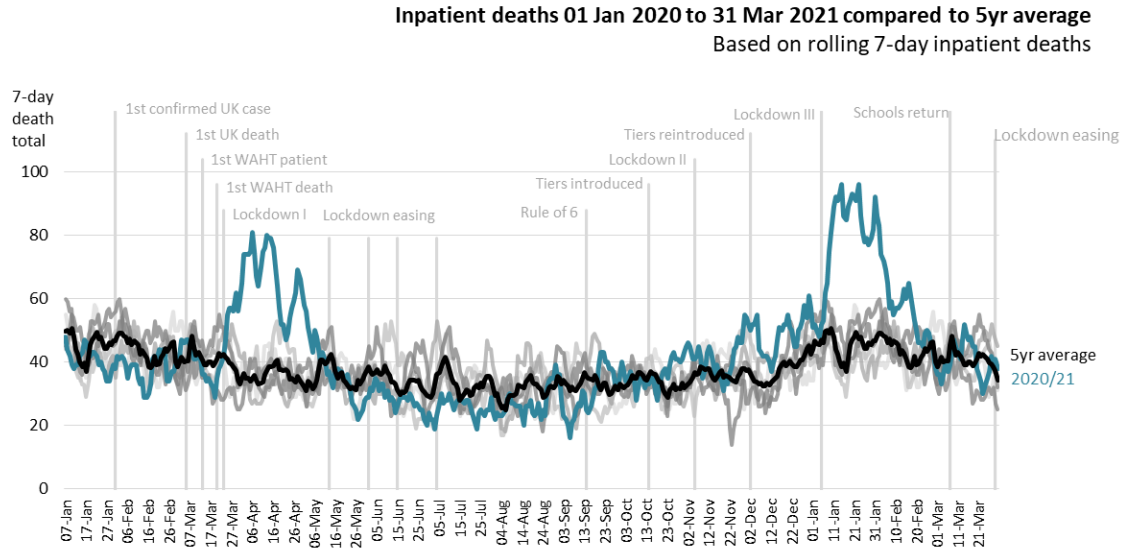
NHS
Worcestershire Acute Hospitals
NHS Trust

Meeting	Trust Board
Date of meeting	9 September 2021
Paper number	Enc D1

Excess deaths

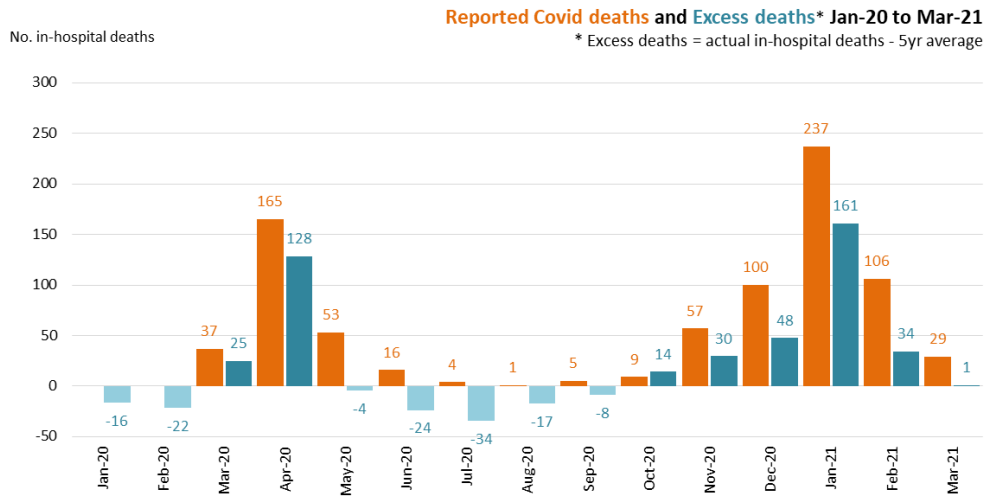
The net effect of this, in terms of its impact on all inpatient deaths can be seen on the following chart.

This shows a wider view of all inpatient mortality across the Trust for review period. This is set against the previous five years data and the five year average (i.e. 2015-2019). The chart uses a 7-day rolling average to smooth out the natural volatility in these metrics. Some of the key 'milestones' of the pandemic thus far are also presented to provide points of reference.



If we reduce this to a monthly view and plot the aggregated difference between the number inpatient deaths and the five year average then we have an accepted estimate of the number of excess deaths.

This is shown in the following chart in **blue**, along with the number of reported COVID deaths (in **orange**) for the same period.



Observations:

- Whilst the county experienced a greater number of 'excess' deaths during wave 1 we saw the most deaths, excess deaths and COVID deaths during the latter part of the second wave. This coincides with a substantially increased number of patients and a greatly reduced crude mortality rate overall.
- Shortly after each of the peaks in inpatient numbers and corresponding increase in mortality, the total number of inpatient deaths has fallen to or below the five year average.
- Between May and September 2020 we recorded negative excess deaths despite still reporting COVID deaths.
- COVID entirely explains those months where we reported excess deaths. Although we do not have information for the recent wave, both our SHMI (up to October 2020) and HSMR (up to December 2020) are within normal parameters and suggest that we are not seeing evidence of wider, non-COVID excess deaths.
- The periodicity of days when we are reporting zero deaths is maintained and the peak days where deaths are recorded are noticeably lower.
- It is likely that, throughout the pandemic so far we have had cause to record approximately 350 more deaths than we might normally have expected.

Benchmarking mortality

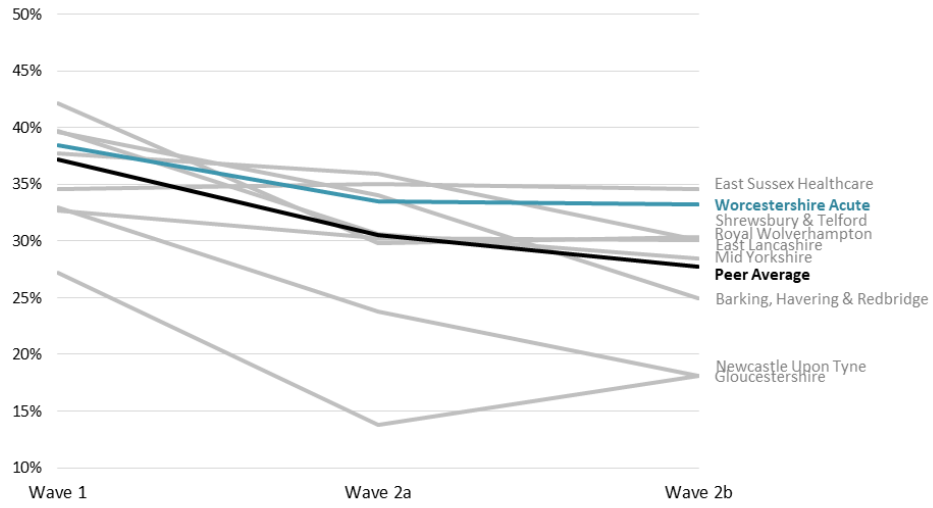
The following charts show our crude mortality rate (overall, in-hospital and out-of-hospital) compared to eight other 'mortality peer' trusts. These have been identified using the Summary-level Hospital Mortality Indicator (SHMI) as trusts with whom we shared a similar expected number of deaths prior to the pandemic.

Like the earlier LOS benchmarking this information is based on trust SUS data, is obtained via HED and has been split into three phases:

1. Wave 1 (March to August 2020)
2. Wave 2a (September to December 2020)
3. Wave 2b (January to March 2021)

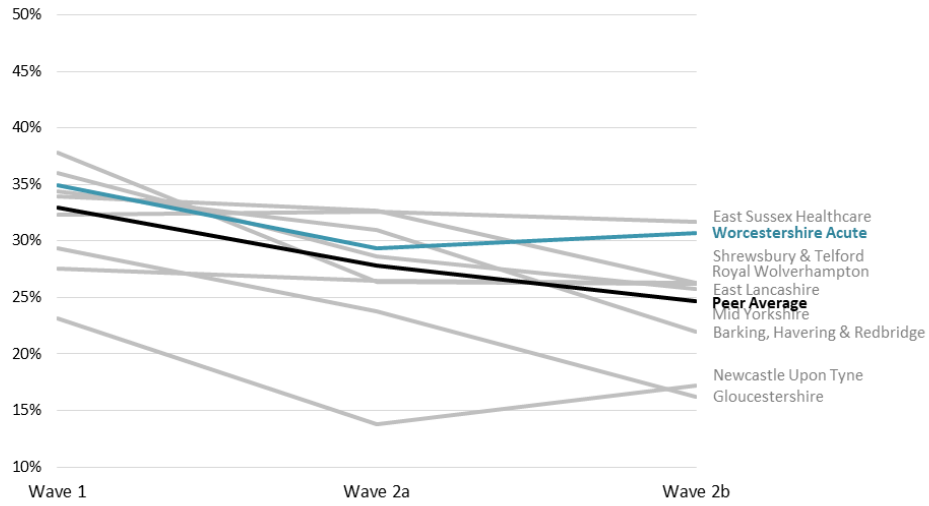
The first chart is for all deaths up to and including 30 days of discharge.

Benchmarking crude mortality rate for Covid inpatients (primary diagnosis)

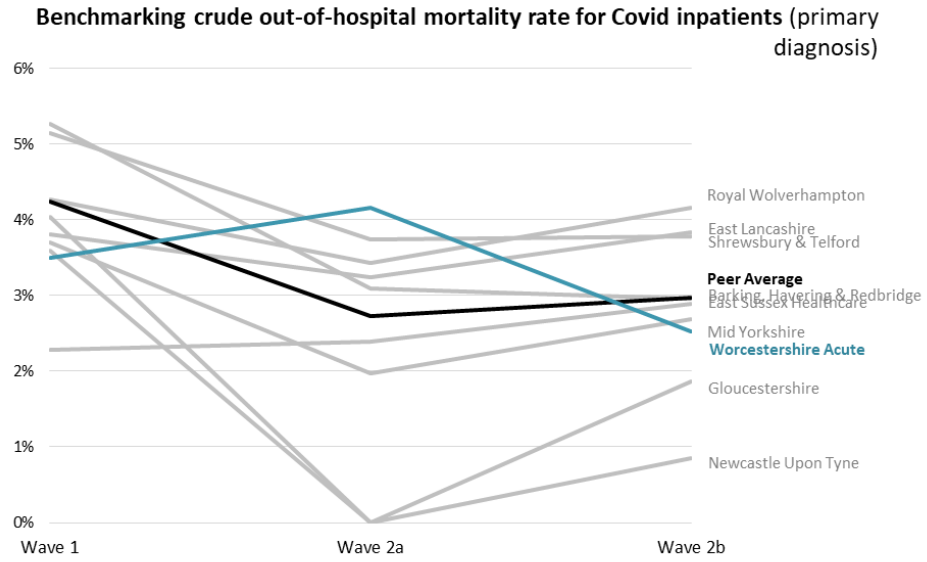


The second chart is for in-hospital deaths *only*.

Benchmarking crude in-hospital mortality rate for Covid inpatients (primary diagnosis)



The final chart in this section is for out-of-hospital deaths within 30 days of discharge.



Observations:

- Our overall crude mortality rate, whilst improved over the course of the pandemic, has been higher than the majority of the identified peers and peer group average.
- Other trust crude mortality rates improved more during the latter part of wave 2. In our case, this is due to an increase in in-hospital crude mortality between January and March 2020.
- Out-of-hospital crude mortality rates are broadly better than our mortality peers.

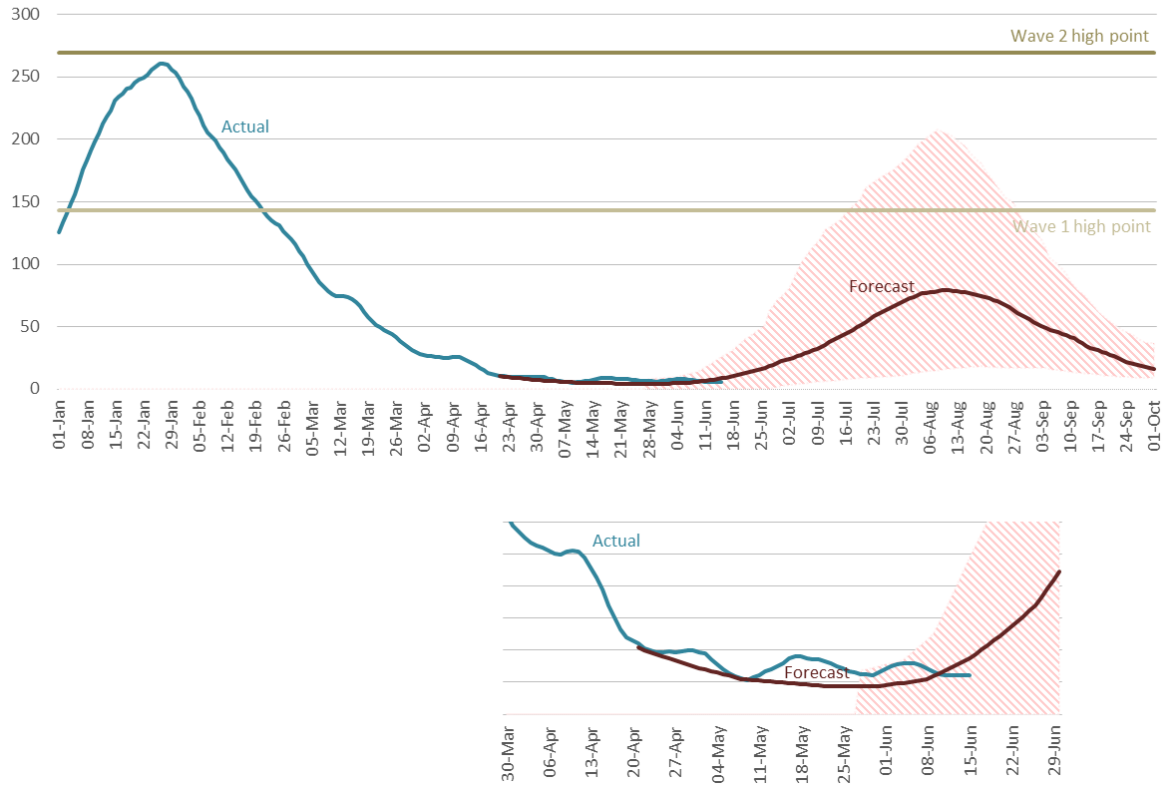
SENSITIVE: TO BE EXCLUDED IF REQUIRED

12. April Onwards (inc. wave 3 predictions)

NHS
Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	9 September 2021
Paper number	Enc D1

Covid-19 inpatient numbers (based on a 7-day avg) **and wave 3 forecast**
Please note: Shaded area shows 95% confidence intervals



Observations:

- Both show an increase shortly before or thereabouts after the final relaxation of COVID restrictions (i.e. Step 4 on 21st June).
- That this will peak in early-mid August.
- That these will likely be much reduced when compared to that experienced in January 2021.
- Although the most pessimistic projections show that these could be as high (or worse) than that experienced in wave 1.

This is built on the following assumptions:

- B.1.1.7 remains the dominant strain (ie. no other novel variants of concern are modelled). **Update:** This is no longer the case and the Delta variant is fast becoming the dominant variant.
- That immunity, be that as a result of vaccine or previous infection, does not wane.
- There is significant transmission reduction as a result of baseline measures remaining in place after Step 4 (21st June).
- There is no seasonal element to transmission other than school holidays.

At the time of writing it is unclear/too early to make any categorical statement on the accuracy of this modelling.

13. Restoration and Reset

Summer 2020

The Trust has worked closely with independent sector (IS) partners throughout the COVID pandemic and has treated almost 3,600 patients between March 2020 and February 2021 across five IS hospitals. Almost 2,400 of this group had an elective or day case procedure undertaken (of which *c.* 50% were patients on a cancer pathway), with the remaining 1,200 having an endoscopy, colonoscopy or cystoscopy to either support a cancer diagnosis or provide surveillance post treatment. Consultants across the 8 surgical specialties involved have shown considerable flexibility to ensure the most vulnerable of patients had access to treatment in a COVID secure environment throughout the pandemic. Prior to March 2020, it was unusual for patients on a colorectal cancer pathway to be treated in the IS. Surgery was therefore introduced slowly and carefully over a number of weeks.

In May 2020, following the first wave of COVID, we engaged widely with staff across the organisation to identify the positive changes in ways of working due to or required by COVID. These were developed as a programme of ten high impact changes (HICs), which aligned well with Phase 3 requirements when these were published.

A full After Action Review was conducted to gather learning from wave 1. This comprised an Interim evaluation (July 2020,) AAR (August and September 2020), Stocktake (29/9/20), CETM debrief (June 2020), and Command and Control debrief (August 2020). A detailed action plan was put in place and monitored at Executive level. The key themes were: leadership, communications, workforce, mental health and wellbeing, BAME and high risk staff, command and control and onwards communication of actions.

Spring 2021

Our priorities for recovery and restoration of services are:

- Maintaining excellent infection prevention processes across all our sites to keep all patients and staff safe
- Focus on treating long waiters, and in particular those who have been waiting for over 52 weeks for elective care and over 104 days for cancer care.
- Ensuring our patients are treated in order of clinical urgency
- Keeping our staff physically and mentally safe and motivated.
- Learning from our response to Covid-19, and integrating this into our 2021/22 planning
- Implementation of approved TME bed reconfiguration in the WRH site and implement initial plans for elective surgery at the ALX site
- Develop plans for creating additional elective capacity on the ALX site
- Work with system partners to deliver the Place and ICS restoration objectives

Whilst we have sustained our operational performance, January 2021 was our most pressured month to respond to in relation to the COVID-19 pandemic and consequently,

nearly all elective and ambulatory activity on the Worcester Royal and Alexandra Hospital sites ceased. We continued to undertake activity in the Independent Sector but at much lower volumes than previously due to the changes in the national IS contract. Services at Kidderminster were maintained and gradually increased throughout January. Reduced capacity for routine surgical treatments and diagnostic testing led to appointments being cancelled and patients being added back to the waiting lists. However, we were able to sustain theatre capacity for non-elective inpatients and undertook 101 elective theatre procedures for cancer patients - routine theatre procedures reduced from 861 in Dec-20 to 185 in Jan-21. Although, there was a reduction in A&E attendances, the Trust witnessed an increase in ambulance conveyances as well as seeing the highest conversion rate to date at 37% which is indicative of the increase acuity of patients presenting to the two emergency departments. It should be noted that 12 breaches and one hour ambulance delays in January 2021 were significantly below the numbers witnessed in January 2020. This put pressure on our capacity and prevented patient flow working to the levels achieved in previous months of 20/21. Discharging COVID-19 patients was an important component of managing the increased demands.

Despite the changes to the national IS contract in quarter 4 2020/21, our local providers have continued to support care and treatment of this vulnerable group. Whilst contract negotiations with the IS for 21/22 are underway to maintain capacity in the system, the Trust aspires to repatriate the majority of cancer related surgery back to the main Trust sites from April 2021. It is proposed that the IS focus on supporting reduction of the backlog of patients that are in Priority 3 and 4 categories which have already waited >52 weeks for their surgery.

The Trust commenced elective work on the AGH site from 15th March with six operating theatres and 103 ring fenced inpatient beds to focus on increased elective work alongside the full utilisation of the 4 operating theatres at KTC. In addition, the trust will be increasing CT and endoscopy capacity across the hospital sites and fully utilising the endoscopy unit at Evesham Hospital. Work is currently under way to increase outpatient capacity on all 3 sites to focus on the new referrals received but not yet seen due to the reduced capacity available during the COVID period. The restoration of services during Q1 has been at a more significant pace than was delivered during the phase 3 restoration programme (July – October 2020).

14. Lessons learned and suggestions for continued good practice

Professional and patient expectations of discharge planning

Discharge tolerance was lowered during wave 1 with changes to the tolerance of Rockwell score implemented across the ICS. The ability to flex these tolerances based on non COVID related demand issues has the potential to improve patient experience and patient flow.

Governance structure

The COVID-19 Command and Control structure allowed for regular and transparent decision making, 7 days a week. The right people to input to, and make, decisions were around the virtual meeting table, and papers were concise. Logging practices meant that decisions made were almost immediately disseminated, in clear form, with clear rationale. Existing

governance structures across the NHS, including at our Trust can take significant lessons from COVID governance structures in terms of a) transparency of the process and rationale, b) speed of dissemination of critical decisions to managers and staff, and c) ability to make collegiate decisions in near real time.

Partnership working

Organisational barriers were broken down as Trusts faced a common enemy in battling the pandemic. The good practice, which was seen at the height of both waves, included shared intelligence and decision making, mutual aid, and increased instances of 'doing the right thing' and 'just getting it done'. Return to business as usual and a focus on organisational priorities has also happened following both waves, but the appetite and ability to increase joined up working has been proven. This should be used to form part of the foundations for the ICS.

Communications Strategies

Communication of critical information through the COVID-19 daily brief represented good practice at a time of significant worry for staff. Other good practice included daily socially distanced briefings at the Alex. Some good practice was evident around cascade, 60 second briefings, and engagement with remote staff – and this should continue to be shared and built upon.

Intelligence led decision making

During the pandemic, there has been a significant shift in data and information being actively used to support and inform ward to board decision making. Information briefings within the Command and Control structure have taken significant volumes of information (both internal and external to the Trust) and provided analysis to allow intelligence led decision making to take place. Access to public health data has supported key Trust decisions, and partnership working across ICS information teams has supported system decision making. Pre-pandemic CQC reports note that the Trust has available information and data, but needs to ensure it is actively used in decision making; the pandemic has shown excellent practice across all areas in this regard.

Emergency Planning and Business Continuity

The pandemic has highlighted the fragility and size of the Trust's emergency planning capacity. Working with partners, enhancing skills in operational teams and other departments, and ensuring that there are no single points of failure all form part of the Emergency Planning Resilience and Response Business Plan for 21/22.

After Action Review and intelligence gathering from staff

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The ability to input to the formal After Action Reviews was received well by staff, and detailed comments and concerns were shared with, and acted upon by senior managers. Following the second After Action Review, the detailed action plan will be reviewed and updated to ensure that additional learning is acted upon in response to staff feedback.

Conclusions

Recommendations	Trust Board are invited to note this report for assurance.

References

[1] https://www.euro.who.int/en/health-topics/health-emergencies/coronavirus-Covid-19/novel-coronavirus-2019-ncov accessed 19th May 2021

[2] Lillie PJ, Samson A, Li A, et al. Novel coronavirus disease (Covid-19): The first two patients in the UK with person to person transmission. *J Infect*. 2020;80(5):578-606. doi:10.1016/j.jinf.2020.02.020

[3] https://coronavirus.data.gov.uk/ accessed 19th May 2021

[4] https://coronavirus.data.gov.uk/details/healthcare accessed 19th May 2021

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Assurance levels Nov 2020

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Communications and Engagement Update

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

Accountable Director	Richard Haynes, Director of Communications and Engagement		
Presented by	Richard Haynes	**Author /s**	Richard Haynes

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

Report previously reviewed by		
Committee/Group	Date	Outcome

Recommendations	Board members are asked to note the report

Executive summary	This report provides Board members with examples of significant communications and engagement activities which have taken place recently as well as looking ahead to key communications events/milestones in coming months. In the spirit of our 4ward behaviour of work together, celebrate together, this report includes a detailed focus on some recent examples of our more successful proactive media and social media work which help to showcase our commitment to putting patients first, and further improve the profile and reputation of our Trust. It also includes an update on some ongoing partnership work with communications colleagues at Place level focussed on urgent and emergency care.

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	BAF Risk 11: If we have a poor reputation then this may result in loss of public confidence in the trust, lack of support of key stakeholders and system partners and a negative impact on patient care
Assurance Level (x)	0 | 1 | 2 | 3 | 4 | 5 x | 6 | 7 | N/A		
Financial Risk	Related activities carried out within the existing communications budget or covered by the budgets of supported projects or programmes		

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Action							
Is there an action plan in place to deliver the desired improvement outcomes?	Y		N	X	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	X			
Timescales to achieve next level of assurance	Communications and engagement priorities for 21/22 are aligned with Trust planning priorities and timelines in ways which are consistent with our Communications Strategy, subject to capacity constraints. Progress and issues will be reflected in future Board updates						

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
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Paper number	Enc D2

Introduction/Background

This report provides Board members with examples of significant communications and engagement activities which have taken place recently as well as looking ahead to key communications events/milestones in coming months.

In the spirit of our 4ward behaviour of work together, celebrate together, this report includes a focus on some recent examples of our more successful proactive media and social media work which help to showcase our commitment to putting patients first, and further improve the profile and reputation of our Trust.

It also includes an update on some ongoing partnership work with communications colleagues at Place level focussed on urgent and emergency care.

Issues and options

Positive proactive media and social media

Drive through service for cardiology patients: This innovative drive through service for patients provided a strong and highly visual case study of putting patients first, as well as demonstrating our commitment to our 4ward behaviour of no delays every day.

With the active support of colleagues from the multi-disciplinary team running the drive through pod at WRH we were able to put together a 4ward Showcase to share internally through our Worcestershire Weekly newsletter as well as a media release and social media content (pictures and video) which were well received and widely shared.

Resulting interest from local media saw us hosting visits from both BBC Radio Hereford and Worcester and BBC Midlands Today which produced some very positive prime time broadcast coverage.

We have also seen continuing high levels of interest in stories which focus on the human interest elements of our teams' focus on putting patients first.

Our story of a four-year-old girl who completed her Leukaemia treatment at Worcestershire Royal after two years of care in our Children's Clinic was 'liked' and shared thousands of times on social media, and was seen by more than half a million people in total.

Following the reaction on social media, this story was also picked up by various local and national news outlets.

We also generated significant national coverage with our story of a treatment-first for our hospitals where our Paediatric allergy clinic provided a 'miracle cure' following Omalizumab therapy to treat a patient with serious Chronic Spontaneous Urticaria.

The teenage girl in the story was previously a champion Irish Dancer but had become virtually bed-bound before our team successfully treated her symptoms and allowed her to return to Irish Dancing.

The story was picked up by a number of outlets including the BBC News website, MSN news and the Mirror group as well as local and regional media.

System/Place Based Working

An ICS Level (Worcestershire and Herefordshire) Communications and Engagement Forum has been in place and meeting regularly for some time to support joint working and effective information sharing at a system wide level.

To support more targeted Place (Worcestershire) based work, a Place Communications and Engagement Group has now also been set up, with the first meeting held in July.

Given the ongoing challenges faced by urgent and emergency care (UEC) services across the county, this has been the priority area of focus for this group.

Supported by colleagues from our Trust's information team, work has begun on a number of targeted pieces of communications and engagement activity which aim to raise public awareness of the urgent and emergency care options available locally and improve understanding of how to make best and most appropriate use of those services.

The Place based approach has supported a pooling of capacity and capability between communications and engagement teams in partner organisations as well as enabling best use of additional funding (for example the budget for the advertising and marketing materials described below came via the CCG. We also have an offer of support from NHSEI for a targeted mail drop and additional publicity in the near future which will be used to support this Place based approach)

Using the geographic and demographic data produced by our information team, we have jointly developed targeted communications including:

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A paid-for advertising campaign (budget c £10,000) encouraging use of Minor Injuries Units and the NHS 111 service, with a number of elements:

Imagery of most common injuries

Physical adverts targeted primarily in hotspot postcode areas (kiosk advertising)

Paid for social media targeted based on demographic data findings - reached over 690k people with over 1.5m impressions so far

Organic social media campaign shared via all Place partner organisations

Targeted information

A5 postcard and business card size info for students at University of Worcester and Heart of Worcester college (distributed during Fresher's Week) – linked to dedicated web information.

Future work being led through the Place-based communications and engagement group:

- Potential leaflet drop in primary school book bags
- Develop scope for more engagement work with key groups to identify key reasons for ED attendance – including parents, working age adults, patients registered with identified GP practices, sports clubs in target areas.
- Working with South Worcestershire Primary Care Limited to develop bespoke GP website information on appropriate healthcare options
- Continued development of joint communications and engagement approach to UEC

Evaluation: The reach and impact of the first stages of the communications campaign are currently being evaluated – analysis and next steps will be reported once the evaluation is complete.

Dr Phil's Bedside Manner

In July, we hosted a visit to Worcestershire Royal by doctor and comedian Dr Phil Hammond visited Worcestershire Royal Hospital to record an episode of his new BBC Radio Show.

Dr Phil spent two days at WRH talking to staff and volunteers, and was regaled with many humorous and touching stories of day-to-day life in our hospitals. He also performed a short stand-up show by way of a thank you to some of the people who spoke to him.

The episode of Dr Phil's Bedside Manner recorded at WRH is due to be broadcast on BBC Radio 4 on Thursday 16 September at 6.30 pm.

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Staff Recognition Awards Ceremony

Our rescheduled Staff Recognition Awards were held on 9 July. Although the Board has met since, this is the first communications update since the awards took place and so provides an opportunity for a final brief reflection on the event.

As Board members will recall the event was held virtually and live streamed, with host and MC Will Mellor joined by our Chairman and Chief Executive to announce the winners.

Colleagues were able to watch the live stream from a variety of locations, including socially distanced gatherings held at each of our three main sites, at home and (in at least one case) from holiday in Mallorca. Those watching were also able to share messages by social media, with several receiving interval 'shout outs' from Will.

More than 900 people watched on the night, and more than 800 have watched the recording since the event. Feedback has been overwhelmingly positive, and although we hope to move back to a live event for the 2022 Awards, holding a virtual event provided many valuable learning opportunities. Thanks to the generous support of our sponsors we also managed to cover all the costs of the event and generate a small surplus for the Worcestershire Acute Hospitals Charity.

Covid Response

We have continued to focus on ensuring that the most up to date information about all aspects of our Covid response is easily available to colleagues – whether working on site or remotely. At the time of writing this report, production of our electronic Covid Update has again been stepped up to three issues a week to reflect the continuing level of our incident response. By the end of August we had reached our 222nd edition of the Update.

Conclusion
Demand for communications and engagement support continues to grow rapidly and with finite capacity we are trying to focus our time and skills on those areas which will provide most value to the Trust's wider strategic and operational priorities. We are also trying, where possible, to quantify the value added by that support to priority projects by measuring benefits realisation/return on investment, although this is not always easy to calculate precisely.
Recommendations
Board members are asked to note the report

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Board Assurance Framework

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

Accountable Director	Chief Nursing Officer		
Presented by	Rebecca O'Connor, Company Secretary	**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
Trust Management Executive	21 July 2021	Endorsed
Audit and Assurance	13 July 2021	Endorsed
Quality Governance	1 July 2021	Endorsed
Finance and Performance	30 June 2021	Endorsed
People and Culture	1 June 2021 & 31 August 2021	Endorsed

Recommendations	To review and approve the Board Assurance Framework (BAF) including as outlined in the report: • Closure of BAF risks 1, 5 and 12 • Opening of new risks BAF 14 to BAF 20 • To note the ongoing development of the BAF and embedding at Committee level

Executive summary	The BAF has been subject to a full review following a series of Committee risk workshops. This is the first iteration of the revised BAF and will remain under ongoing and regular review via Committees and TME. Thus on this occasion it presents a high level summary of the risks as the review process is underway. It builds on the work started in the governance task and finish group, specifically in respect of embedding levels of assurance and progress in tracking improvement. The following changes have been made to the design of the framework: • Risk appetite for all risks has been reviewed or set. A common approach has been implemented whereby a high risk appetite reflects a greater willingness to accept/tolerate risk and a low risk appetite reflects greater caution of approach • A level of assurance has been articulated for each risk with a future assurance rating identified and an anticipated timescale to deliver this. This provides Board with a greater degree of assurance as to the efficacy of the control measures and

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mitigating actions in place via monitoring progress through the assurance levels.

- A cause and effect is articulated for each risks. This is to assist Board and Committee in understanding the factors which are driving the risk and the impact of the same, to assist in their scrutiny of the controls and actions.

A summary of the changes made to the risks themselves are outlined in the report. As part of the Committees' review, a number of risks have been closed and new risks opened in their stead. A summary of those changes is as follows:

New Risks opened	7
Risks Closed	3
Risks Escalating	1
Risks De-escalating	2
Total risks identified	16

A summary of the Trust's risk exposure is below. This shows that whilst the mitigations put in place are slightly reducing the overall risk exposure, this remains very high.

	Extreme	High	Moderate	Low
Current risk score	10	6	-	-
Initial risk score	13	3		

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	*All BAF risks as outlined in this report.*

Assurance Level (x)	0	1	2	3	4	X	5	6	7	N/A	
Financial Risk	*If the Trust does not have a robust BAF and system of monitoring in place there is the risk that the strategic objectives will not be achieved, which could have regulatory, reputation and financial implications and could impact the quality of care that is provided.*										

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

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Introduction/Background

The Trust Board is responsible for identifying and monitoring the risks to the achievement of the Trust's strategic objectives. This is achieved through the development of a BAF, which is monitored by the Trust Board and its Committees for areas of their authority.

Strategic risks on the BAF are those which are of such importance, that failure to control the same, may cause the Trust to fail to deliver its strategic objectives.

Issues and options

Development of the BAF

All BAF risks have been reviewed following a series of Committee risk workshops. A full breakdown of each risk setting out the controls and mitigations is in development and will be reviewed, alongside a programme of deep dives into individual BAF risks by Committees.

BAF Updates

The following changes to the BAF have been endorsed by Committees:

a) Risks Closed:

BAF 12 – Covid:

- As Covid is now considered an issue we must manage, rather than a risk we face, it is proposed to close current BAF risk 12. This has been replaced with new risk BAF 18

BAF1 Demand and BAF 5 Homefirst

- QGC and F&P Committees agreed to close and consolidate the above risks into new risk BAF 19.

b) Risks Opened:

The following new BAF risks have been opened:

Risk	Score (current)	Committee
BAF 18 - Capacity to increase elective activity, remove long waits and reduce waiting list size, within a reasonable timescale and budget	25	QGC & FPC
BAF 16 - Digital Strategy Implementation	20	FPC
BAF 19 - Improving system wide working to enhance patient flow and ensure patient care is provided in the most appropriate environment	16	QGC & FPC
BAF 20 - Internal management of urgent and emergency care processes	16	QGC & FPC
BAF 17 - Effective staff engagement and learning lessons from redesign and transformation of services	16	QGC
BAF 14 - Staff health and wellbeing	12	P&C
BAF 15 - Leadership capability and capacity	12	P&C

The following risk descriptions have been reworded:

- BAF 2 – Engagement - This risk was split it into two risks (revised BAF 2 and new BAF 17) to more accurately reflect the impact of engagement on different groups in relation to both staff and patients. – risk score 16 (both)
- BAF 9 - Workforce – risk score 15
- BAF 10 - Organisational culture - risk score 12.
- BAF 11 - Reputation – risk score 12

c) Risk Escalating/ De-escalating:

The following risk score adjustments have been made:

- BAF 3 has de-escalated from risk score 20 to risk score 16
- BAF 2 risk as redrafted has increased from risk score 12 to 16, due to the impact of the pandemic on service transformation
- BAF 14 as redrafted has decreased from risk score of 12 from 16

d) Risk Exposure

The Trust's risk exposure is increasing. This is due to a number of escalating issues in relation to the ongoing impact of Covid in relation to restoration and recovery, urgent and emergency care pressures, etc as outlined above. Covid is not separately reported here as a risk in itself, the risk having materialised and is now an issue we are managing. However, all risks reported have been reviewed in the context of the impact of Covid.

Mitigating activity, controls and assurance are identified for all risks are being further refined by Committees. The intention being the mitigations in place demonstrate a reduction in risk exposure from the initial to residual risk scores. However, there are times where despite control measures being in place, these are not yet sufficiently effective, nor embedded to enable a reduction in the current risk score. It is not within the Trust's risk appetite to accept risks with no control measures in place.

In order to manage risk exposure, levels of assurance have been identified both for the current time and as a projected position with an associated timescale to move to an increased level of assurance.

e) Risk Appetite

The Trust's risk appetite is not necessarily static, but all risks are expected to have controls and mitigations in place, which aim to reduce the risk exposure to a tolerable level. The Trust Board, on recommendation of the Committee may vary the amount of risk that it is prepared to tolerate depending on the circumstances at the time. The risk appetite for each risk has been reviewed as part of the Committee risk reviews.

The Committee reviews the BAF and makes recommendations to the Trust Board regarding the adequacy of the outlined mitigations and control measures. If the Trust Board is unwilling to accept the level of risk to which it is currently exposed, it is invited to consider further mitigating actions or challenge those already identified.

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f) Mapping of Strategic Risks Against Strategic Objectives

The table below shows a mapping of the Trust's strategic objectives and goals against the risks identified in the assurance framework. All strategic objectives and goals are covered by a range of risks.

		BAF 2	BAF 3	BAF 4	BAF 7	BAF 8	BAF 9	BAF 10	BAF 11	BAF 13	BAF 14	BAF 15	BAF 16	BAF 17	BAF 18	BAF 19	BAF 20
Strategic Objective	Best services for local people	X							X	X			X	X	X		
	Best experience of care & outcomes for our patients		X	X					X							X	X
	Best use of resources				X	X			X								
	Best people						x	x	X		X	X		X			
Goal	Goal – strategy	X							X	X		X	X	X	X		
	Goal – quality		X	X					X							X	X
	Goal - finance				X	X			X								
	Goal – workforce and culture						X	X	x		X	X					

Conclusion
The Trust has a Board Assurance Framework in place which is operational and effective. The Trust's risk exposure is increasing and the headline areas of a risk are identified. The assurance framework covers the breadth of the Board's responsibilities.

Recommendations
To review and approve the Board Assurance Framework (BAF) including as outlined in the report: • Closure of BAF risks 1, 5 and 12 • Opening of new risks BAF 14 to BAF 20 • To note the ongoing development of the BAF and embedding at Committee level

Appendices
High level BAF risk summary

BOARD ASSURANCE FRAMEWORK
24 AUGUST 2021

Risk Number	Theme	Risk Description	Exec Lead	Responsible Committee	Current 24-Aug-2021			Change	Previous Risk Rating	Initial Risk Score	Risk appetite	Level of Assurance
					Likelihood	Consequence	Risk Rating					
Sort	*Sort*	*Sort*	*Sort*	*Sort*	*Sort*	*Sort*	*Sort*	*Sort*	*Sort*	*Sort*	*Sort*	*Sort*
18	Activity	NEW Capacity to increase elective activity, remove long waits and reduce waiting list size, within a reasonable timescale and budget	COO	QGC/F&P	5	5	25			25	Low	5
7	Finance	If we fail to address the drivers of the underlying deficit and fail to respond effectively to the new financial regime (post COVID-19), then we will not achieve financial sustainability (as measured through achievement of the structural level of deficit [to be fully determined]) resulting in the potential inability to transform the way in which services operate, and putting the Trust at risk of being placed into financial special measures.	CFO	F&P	5	4	20	→	20	15	Low	4
13	Cyber	If we do not have assurance on the technology estate lifecycle maintenance and asset management then we could be open to a cybersecurity attack or technology failure resulting in possible loss of service.	Chief Digital Officer	F&P	4	5	20	→	20	20	Low	3
16	Digital	If we do not make best use of technology and information to support the delivery of patient care and supporting services, then the Trust will not be able to deliver the best possible patient care in the most efficient and effective way	Chief Digital Officer	F&P	4	5	20	→	20	20	Low	5
19	System working	NEW - Improving system wide working to enhance patient flow and ensure patient care is provided in the most appropriate environment	COO	QGC/F&P	4	4	16			16	Low	4
20	Urgent care	NEW - Internal management of urgent and emergency care processes	COO	QGC/F&P	4	4	16			16	Low	4
3	Clinical Services	If we do not implement the Clinical Services Strategy then we will not be able to realise the benefits of the proposed service changes in full, causing reputational damage and impacting on patient experience and patient outcomes.	CMO/Dir S&P	QGC	4	4	16	↓	20	15	Moderate	4
17	Engagement with staff	If we fail to effectively involve our staff and learn lessons from the management of change and redesign / transformation of services, then it will adversely affect the success of the implementation of our Clinical Services Strategy resulting in missed opportunity to fully capitalise on the benefits of change and adversely impact staff engagement, morale and performance	COO	QGC/P&C	4	4	16	→	16	12	High	3
2	Engagement with patients, public and partners	NEW SPLIT - If we fail to effectively engage and involve our patients, the public and other key stakeholders in the redesign and transformation of services then it will adversely affect implementation of our Clinical Services Strategy in full resulting in a detrimental impact on patient experience and a loss of public and regulatory confidence in the Trust.	DirC&E/CNO	QGC	4	4	16	↑	12	12	Low	4
9	Workforce	If we do not have a right sized, sustainable and flexible workforce, we will not be able to provide safe and effective services resulting in poor patient and staff experience and premium staffing costs.	Director of People and Culture	People and Culture	5	3	15	→	15	15	Moderate	4
14	Health and Wellbeing	If we do not have the capacity and capacity to implement, or staff do not access, health and wellbeing support then we may be unable to maintain safe staffing levels due to higher rates of absence and staff turnover	Director of People & Culture	People and Culture/Trust Board	3	5	12	↓	15	15	Medium	4
4	Quality	If we do not have in place robust systems and processes to ensure improvement of quality and safety and to meet the national patient safety strategy, then we may fail to deliver high quality safe care resulting in negative impact on patient experience and outcomes.	CMO/CNO	QGC	3	4	12	→	12	20	Low	4
10	Culture	If we fail to sustain the positive change in organisational culture, then we may fail to have the best people which will impede the delivery of safe, effective high quality compassionate treatment and care.	Director of People and Culture	People and Culture	4	3	12	→	12	15	Moderate	4
11	Reputation	If we have a poor reputation this will result in loss of public confidence in the Trust, lack of support of key stakeholders and system partners and a negative impact on patient care.	Director of Communication and Engagement	People and Culture/Trust Board	3	4	12	→	12	16	Moderate	4
8	Infrastructure	If we are not able to secure financing then we will not be able, to address critical infrastructure risks as well as maintain and modernise our estate, infrastructure, and facilities; equipment and digital technology resulting in a risk of business continuity and delivery of safe, effective and efficient care.	CFO	F&P	3	4	12	→	12	15	Low	4
15	Leadership	If we do not have a comprehensive leadership model and plan in place then we may not have the right leadership capability and capacity to deliver our strategic objectives and priorities	Director of People & Culture	People and Culture/Trust Board	3	4	12	→	12	12	Medium	4

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Integrated Performance Report – Months 3 and 4 2021/22

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

Accountable Director	Paul Brennan – Chief Operating Officer, Paula Gardner – Chief Nursing Officer, Graham James – Acting Chief Medical Officer, Tina Rickets – Director of People & Culture, Robert Toole – Chief Finance Officer		
Presented by	Vikki Lewis – Chief Digital Officer	**Author /s**	Steven Price – Senior Performance Manager

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

Report previously reviewed by		
Committee/Group	Date	Outcome
TME	21st July 2021	Approved
Finance and Performance	28th July 2021	Assured
Quality Governance	29th July 2021	Assured
TME	18th August 2021	Approved and Assured

Recommendations	The Board is asked ▪ to note this report for assurance ▪ to note that the Jul-21 IPR (which contains the Learning from Deaths update) has been approved by TME and is available in the reading room.

Key Issues	**Emergency and Urgent care and Patient Flow & Capacity** • The combination of sustained high attendances, new admissions, responding to covid-19 pressures and patients not consistently being discharged in a timely way have continued throughout June and July. • The impact of these complex factors interacting with each other is evident in the outcomes observed in the main metrics. Many are showing special cause concern either as a result of 7+ months above the mean or elevated concern outside of the control limits (e.g.% of ambulance handovers with 15 minutes, average time in department, patients spending 12 hours in A&E, 12 hour trolley breaches, 60 minute handover delays all showed special cause concern). • Although total discharges and transfers, discharges before midday and average length of stay remained within the expected ranges, most noticeable was special cause concern for those MFFD patients remaining on the ward 24 hours after becoming MFFD which over the course of Jul-21 totalled 2,120. **Cancer** • Patients seen within 2 weeks is still significantly below the 93% waiting time standard with Breast and Skin tumour groups significantly impacting the performance. • The conversion of non-2WW clinics, engagement with an independent provider for additional capacity for skin, weekend working and recruitment to vacant posts to create the additional slots required are all actions included in the remediation plans. • Additional weekend clinics have been arranged to support Breast recovery

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	these have made some impact on the backlog with the booking day reducing from 21 days to 17 days. • The backlog of patients waiting 62+ days has now gone back above 300 whilst those waiting 104+ days has remained static. **Recovery and restoration of the elective programme including Outpatients and Diagnostics** • The RTT waiting list has increased again with sustained high numbers of ERS and RAS referrals adding new patients to our waiting lists. • Those patients with the longest waits has increased with 3,093 patients waiting 70+ weeks and of those 186 waiting 100+ weeks (noting that 119 are orthodontic patients). • Potential missed opportunities have been identified where longer waiters or P2 patients could have been treated – these are being investigated as this initial analysis is data driven and needs operational / clinical consideration. • The emergency demands on the Trust are having a knock-on effect on diagnostic capacity which means not as many urgent and routine patients were having their tests. The removal of the CT scanner at Kidderminster, the on-going decontamination issues for endoscopy and staffing issues (vacancies and sickness) in cardiopulmonary have contributed to not achieving the diagnostic H1 targets, with the exception of non-obstetric ultrasound. • The H1 elective activity targets at month 4 (April to June) were above plan for new outpatients (49,436 planned attendances against 51,607 actual) and elective cases (26,596 planned procedures against 27,594 actual).

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

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

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

Recommendations
The Board is asked ▪ to note this report for assurance ▪ to note that the Jul-21 IPR (which contains the Learning from Deaths update) has been approved by TME and is available in the reading room.
Appendices
▪ Trust Board Integrated Performance Report (Jun-21 data) ▪ WAHT June 2021 in Numbers Infographic ▪ Committee Assurance Statements (July Committees) ▪ Trust Board Integrated Performance Report (Jul-21 data) ▪ WAHT July 2021 in Numbers Infographic

Integrated Performance Report

NHS Worcestershire Acute Hospitals NHS Trust

Trust Board

9th September 2021

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

Operational Performance

Summary Performance Table | Month 4 [July] 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	Jul-21	53.30%	-	L	-	69%	54%	85%
	Time to Initial Assessment - % within 15 minutes	Jul-21	74.40%	-	L	-	89%	83%	95%
	Average time in Dept for Non Admitted Patients	Jul-21	239	-	H	-	184	153	215
	Average time in Dept for Admitted Patients	Jul-21	535	-	H	-	361	257	465
	% Patients spending more than 12 hours in A&E	Jul-21	8.00%	-		-	0.04	0.00	0.07
	Number of Patient spending more than 12 hours in A&E	Jul-21	1,034	-	H	-	391	35	748
RTT	Incomplete (<18 wks)	Jul-21	53.50%	92%	L	F	73%	68%	77%
	52+ WW	Jul-21	5,774	0	H	F	1266	752	1,779
CANCER	2WW All	Jul-21	66.34%	93%	L	?	84%	71%	97%
	2WW Breast Symptomatic	Jul-21	12.73%	93%	L	F	41%	6%	77%
	62 Day All	Jul-21	62.99%	85%		F	70%	58%	83%
	104 day waits	Jul-21	88	0	H	F	52	19	85
	31 Day First Treatment	Jul-21	96.11%	96%		?	97%	93%	101%
	31 Day Surgery	Jul-21	75.00%	94%		?	87%	65%	110%
	31 Day Drugs	Jul-21	96.40%	98%		?	98%	88%	109%
	31 Day Radiotherapy	Jul-21	95.30%	94%		?	99%	92%	107%
	62 Day Screening	Jul-21	55.60%	90%		?	73%	36%	111%
	62 Day Upgrade	Jul-21	100.00%	90%	H	?	82%	55%	109%
Diagnostics (DM01 only)		Jul-21	54.33%	99%	L	F	78%	67%	88%
STROKE	CT Scan within 60 minutes	Jun-21	37.10%	80%		F	46%	20%	72%
	Seen in TIA clinic within 24hrs	Jun-21	65.57%	70%		?	86%	56%	116%
	Direct Admission	Jun-21	37.10%	90%		F	46%	15%	76%
	90% time on a Stroke Ward	Jun-21	72.58%	80%		?	76%	62%	90%

Data Quality Risk Matrix – Operational Performance

Data Set	Includes	Likelihood	Impact	Total Score	Context
Urgent Care	• EAS • EAS Type 1 • Total Time in A&E • Bed Capacity • 30 day re-admission rate • Aggregated patient delay • Conversion Rate • 15 minute time to triage	2	3	6	These metrics have regular scrutiny including at patient level. There are audits completed so are calculations based on metrics further down the list.
Urgent Care Exception	Ambulance Handover	2	2	4	We use WMAS data to report on handovers. This data is audited regularly and although there are on the odd occasion differences of 1 or 2 ambulances these are over the change of midnight.
	12 Hour Trolley Breaches	4	2	8	These are reviewed at patient level daily but we still have a number of patients where DTA times are incorrectly recorded, thus indicating a breach which is then validated off and the patient record amended. This has been an issue for a number of years. **Mitigation:** Identify a new location for the data that keeps erroneously being entered, and refresh the knowledge of the standard operating procedure.
	Specialty Review	4	2	8	There are several issues with this data. Timeliness of data capture, accurate data capture of referrals and in particular missing times of arrival. The issue is the allocation of a responsible person(s) for capturing accurate times. This has been an issue for a number of years. **Mitigation:** No clear mitigation until a deep dive has been reviewed in Home First Board.
	Discharges (including Discharges before midday)	3	3	9	This does not impact the patient. This data quality score impacts the ability for the Trust to manage beds using our clinical systems. Whether a patient has been discharged predominantly is shared verbally as opposed to using the real time data from the patient administration system. Timeliness is impacted by administrative staff not being available (particularly during the evening), complexity with the electronic discharge documentation and system configuration. **Mitigation:** A review of administrative cover to be completed and potential improvements to be made as part of the Digital DCR Programme, but impact may not been seen until implementation.

Data Quality Risk Matrix – Operational Performance

Data Set	Includes	Likelihood	Impact	Total Score	Context
Cancer	• 2WW Referrals • 2WW All • 2WW Breast Symptomatic • 31 Day All • 62 Day All • 62+ day • 104+ day	2	3	6	Cancer Services data has recently been reviewed externally and was rated good. The data is captured in a timely manner and is complete.
RTT	• % Within 18 weeks • 40-52 weeks wait • 52+ weeks wait • RTT Referrals	3	4	12	There are several small issues in RTT waiting list management and reporting. However these collectively have resulted in some patients not being managed effectively; and long waits not being transparent facilitating the potential for harm. **Mitigation:** We have been undertaking a systematic review of reporting which will be accompanied by a training programme to ensure that patients are managed in compliance with RTT rules. This will be in place by the end of June 2021 and after a period of testing it is expected that this score would decrease to no more than 4.There is also a national data quality programme on waiting lists which will support Trusts with planning data quality improvements where needed. This will include NON RTT'
Theatre Utilisation	• % Actual theatre sessions • Day cases on elective sessions (n) • Elective on Elective sessions (n) • Non-elective and Emergencies on elective sessions (n) • % rebooked within 28 days	3	1	3	Although data quality is possible, the impact is more on the performance reporting than a risk to the patient hence the consequence score is a 1.
Theatre Utilisation Exception	• % Cancellation on the day	3	3	9	The cancellation process is quite complex and involves a number of clinical systems for the data to be captured across. This means that data capture issues are possible and the impact on the patient could mean that they are not invited back for Surgery. **Mitigation:** There is a detailed report which highlights potential data quality issues that should be reviewed regularly by operational colleagues.

Data Quality Risk Matrix – Operational Performance

Data Set	Includes	Likelihood	Impact	Total Score	Context
Diagnostics	• Radiology waiting list size • Radiology Activity • Endoscopy waiting list size • Endoscopy Activity	2	3	6	Detailed scrutiny at patient level regularly by the Division. Mitigation : Detailed reporting including potential data quality errors on WREN.
Stroke	• % patients spending 90% of time on stroke unit • % seen in TIA clinic within 24 hours • % Direct admission to stroke ward • % CT Scan within 60 mins	1	3	3	The data is scrutinised heavily by the Division and underwent a significant review within the last 2-3 years so currently there are no known issues. An audit of Stroke will occur again within the next financial year.

Operational Performance Report - Headlines

Operational Performance	Comments
Urgent and Emergency Care	• In Jul-21, the Trust saw a plateau in the number of patients attending our sites (albeit still above 13,000), with children and young people attendances contributing 21% of the total (having been 25% in Jun-21). Although there were 196 fewer ambulance conveyances, many more saw delayed handovers; this reduction means that patients walk-ins increased. • The pressures linked to reduced timely discharge of MFFD patients and increased Covid admissions manifested itself in the majority of ED metrics, continuing the trend of special cause concern and reaching levels outside of the control limits as more patients spend more time in department.
Patient Flow and Capacity	• 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. • Discharges before midday remained static but those patients still on the ward 24 hours after being assessed medically fit for discharge increase again; the 8th month in a row. • Long length of stay patient numbers increased.
Cancer	• **Long Waits:** The backlog of patients waiting over 62 days has increased to 305 from 252 and those waiting over 104 days has increased from 81 to 88. • Overall cancer referrals in Jul-21 have increased from Jun-21 which is putting pressure on our capacity to meet the sustained demand (particularly in Lower GI at +110). The impact of that is cancer two week waiting times are now showing special cause concern with Breast Services, Skin and lower GI still not to be able to see the vast majority of their patients within two weeks. • Cancer two week waits for Breast Symptomatic patients remains a concern with the majority of patients still not being seen within 14 days. • Weekend working in July to start to address the Breast backlog has not resulted in an increase in patients being seen but has reduced the polling day from 21 to 17. • Cancer 62 day waits is showing normal variation. Performance will not improve to the operational standard whilst we rightly focus on the cohort of patients requiring treatment.
RTT Waiting List	• **Long Waits:** The number of waiting over 52 weeks for their treatment has increased to 5,774 with 3,093 waiting 70+ weeks and of those 185 waiting 100+ weeks (noting 119 are orthodontic patients). • The RTT waiting list size remains a cause for concern having increased again to just over 53,500. Although Advice and Guidance and RAS triage is offsetting some new referrals, our waiting list is growing month on month with the number of referrals being received remaining high.
Outpatients	• **Long Waits:** There are over 27,000 RTT patients waiting for their first appointment and only 6,642 of them have been dated. • Jul-21 saw 40,765 outpatient attendances take place (consultant and non-consultant led) meaning the H1 target has been met (+233). Comparing to Jul-19 shows we undertook approximately 77% of historic activity and 29% of Jul-21 appointments were non-face-to-face; this remains above the EFR Gateway target of 25%. • Total consultant-led first and follow-up outpatient attendances were above the H1 target in Jul-21. However, despite this achievement, non-face-to-face activity is currently below plan. • Although we are increasing our activity and are in line with plan, the number of patients waiting for their first outpatient appointment is increasing.
Theatres	• In Jun-21, we achieved the combined day case and elective inpatient H1 target (+828 to plan). This was achieved by being +214 to plan in our day case spells which offset being -146 to plan for elective ordinary spells. • 12 eligible patients who had their operation cancelled were not rebooked within 28 days in Jul-21; however 25 patients were. • The Independent Sector and with mutual aid support from Wye Valley Trust, undertook 171 day cases, 9 EL ordinary and 61 diagnostic tests.
Diagnostics	• **Long Waits:** 6,013 patients are waiting over 6 weeks for their diagnostic test and of the total number of breaches, 2,218 have been waiting over 13 weeks and 68% are attributable to DEXA and echocardiography. • Diagnostic testing remains a cause for concern; the process is currently not capable of achieving the 1% target. The proportion waiting under 6 weeks has increases due to an increase in referrals. More activity in Jul-21 has been for emergency diagnostic tests which has offset seeing those patients waiting for 2WW, urgent and routine tests.

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	Number of Patient spending more than 12 hours in A&E	% Patients spending more than 12 hours in A&E
53.25%	74.50%	239	535	1,034	7.96%

What does the data tell us?

- **Urgent Care Indicators –** the metrics on slide 9 highlight the extreme pressure faced by the Trust during Jul-21 with the percentage of ambulance handovers within 15 minutes, average time in department for non-admitted patients and the number of patients spending 12+ hours in A&E all showing special cause concern for the month. Time to initial assessment within 15 minutes and average time in department for admitted patients show continued special cause concern for being outside of the control limits for 3 months and a 7 month run above the mean respectively.
- **EAS** - The overall Trust EAS performance which includes KTC and HACW MIUs was 73.17% in Jul-21 – this is the third month of special cause concern in the context of attendances across all settings remaining significantly high at 18,642.
- **EAS Type 1 –** EAS performance at WRH dropped to below 60% at 58.88% with a new monthly highest attendances at 7,941; there were 3,265 4 hour breaches. The WRH performance dropped below 60% to 58.88% with 39 **more** attendances (highest ever at 7,941) and 446 **more** breaches. The ALX EAS performance dropped below 70% to 67.86% and although there were 100 **fewer** attendances there were 446 **more** 4 hour breaches. Total Type 1 attendances across ALX and WRH were 13,315, not a significant change from Jun-21 but indicative of the sustained pressure on our emergency departments.
- **CYP Attendances**: Total attendances to WRH in Jul-21 who were children and young people dropped to 21% from 25% in Jun-21. Although still comparatively high, it was no longer significantly so; this was also the case for ambulance conveyances which dropped back to expected levels.
- **Ambulance Handovers** - There were 789 x 60 minute ambulance handover delays with breaches at both sites – this further increase in breaches from Jun-21 is significant and is linked to the capacity, flow and numbers of patients in our ED's which prevented timely offloading.
- **12 hour trolley breaches –** There were 30 validated 12 hour trolley breaches in Jul-21 – this is now special cause concern for our processes.
- **Specialty Review times** – Specialty Review times are now highlighted as a cause for concern with 8 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 increased from 781 in Jun-21 to 891 in Jul-21. This metric shows special cause variation because the last 8 months have been above the mean and Jul-21 is outside of the upper control limit.
- **Conversion rates** – 3,509 patients were admitted in Jul-21; a Trust conversion rate of 27.02%. The conversion rate at WRH was 28.66% and the ALX was 24.69%. The conversion rate at WRH in Jun-21 compared to Jun-19 is 2.96 percentage points higher.
- **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 Jul-21 both because the Jul-21 value is above the upper control limit and it's the 8th month in a row above the mean.

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				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 (Jun-21)	Discharges as a % of admissions IP only (Target >100%)			
WRH	20.67%	ALX	24.38%	WRH	34	ALX	15	26 Beds	WRH	5.8	ALX	5.2	3.38%	WRH	98.87%	ALX	98.18%

What does the data tell us?

- **Discharges** – Before 12pm discharges (on non-COVID wards) is showing no significant change however the process will not achieve the target of 33% at either site As at the last day of the month, the number of patients with a length of stay in excess of 21 days increased from 40 to 49 with 22 patients deemed medically fit for discharge.
- **Bed Capacity** - Our G&A bed base is 752; with beds allocated to Covid patients, closed wards, unused beds during Jul-21 our average number of G&A beds occupied per day was 580, down from 600 and the month before and the average midnight occupancy was 81.23%.
- **Medically Fit Patients** – for the 4th consecutive month, the number of MFD patients still on our wards 24 hours after becoming medically fit is showing special cause concern. Over the course of Jul-21 this totalled 2,120 patients.
- **Length of Stay** – the LOS on our non-covid wards is showing no significant change at 5.6 days in Jul-21.
- **The 30 day re-admission rate** shows no significant change since Jun-20; the process limits have widened and this indicates a change during COVID-19 that we have not yet got control of.

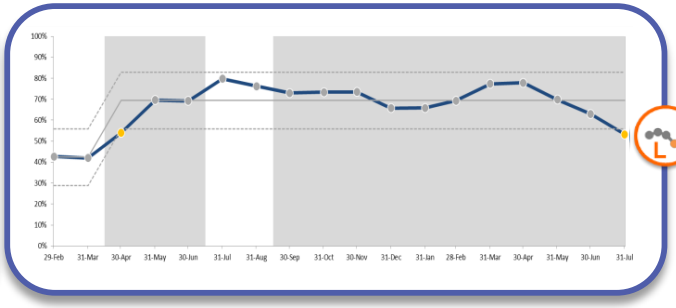
Current Assurance Level: 5 (Jul-21)	**When expected to move to next level of assurance:** This is dependent on the on-going management of the increase attendances and achieving operational standards.
Previous assurance level: 5 (Jun-21)	**SRO: Paul Brennan**

Month 4 [July] | 2021-22 | Operational Performance: Urgent and Emergency Care

Responsible Director: Chief Operating Officer | Validated for July-21 as 2nd August 2021

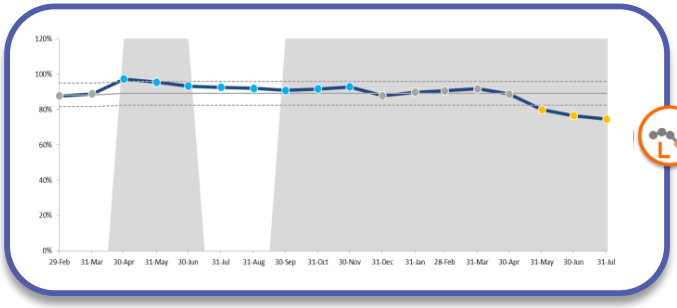
Percentage of Ambulance handover within 15 minutes

53.25%



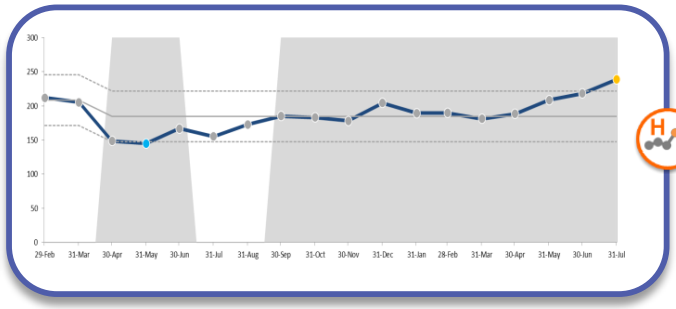
Time to Initial Assessment - % within 15 minutes

74.50%



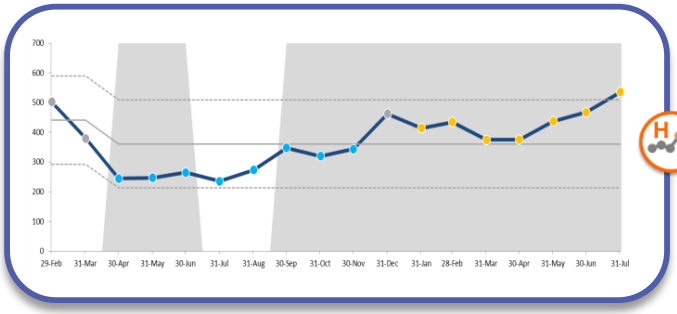
Average time in Dept for Non Admitted Patients

239



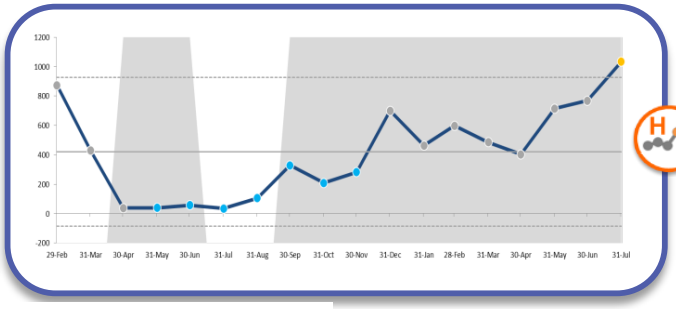
Average time in Dept for Admitted Patients

535



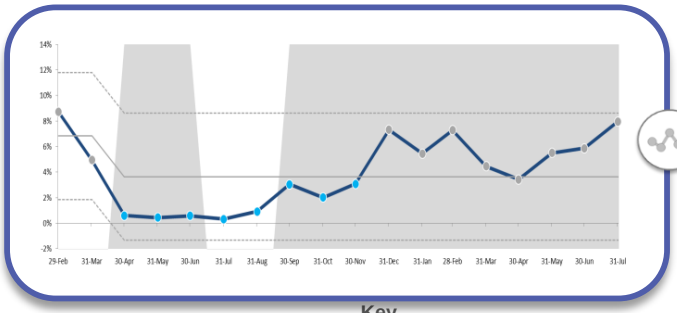
Number of Patients spending more than 12 hours in A&E

1,034



% Patients spending more than 12 hours in A&E

7.96%



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

Key
- Internal target
- Operational standard

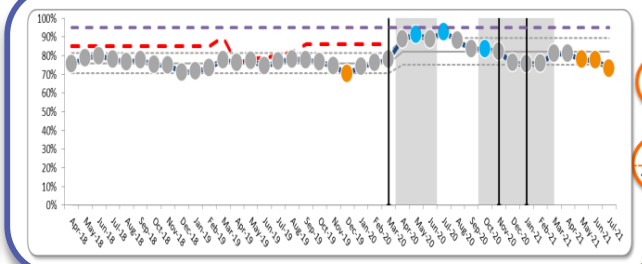
Month 4 [July] | 2021-22 | Operational Performance: Urgent and Emergency Care

Responsible Director: Chief Operating Officer | Validated for July-21 as XX August 2021

Worcestershire Acute Hospitals NHS Trust

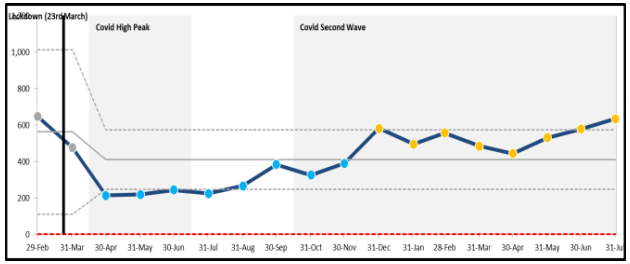
4 Hour EAS (all)

73.17%



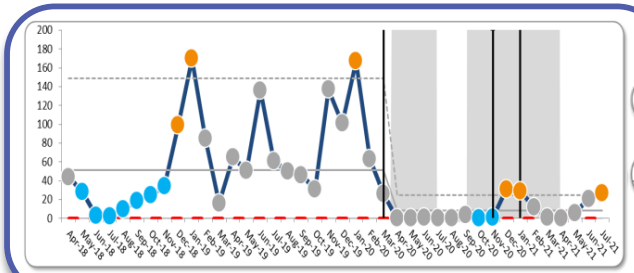
Aggregated Patient Delay (APD)

634



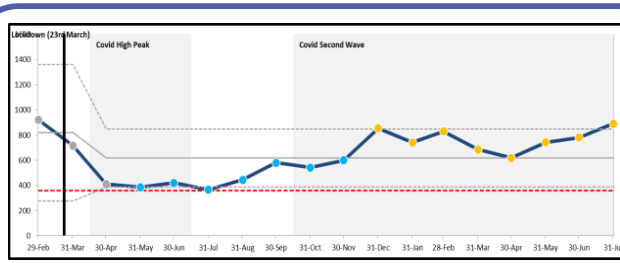
12 Hour Trolley Breaches

30



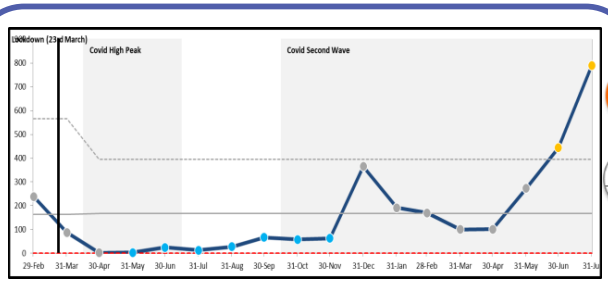
Total time spent in A&E (95th Percentile)

891



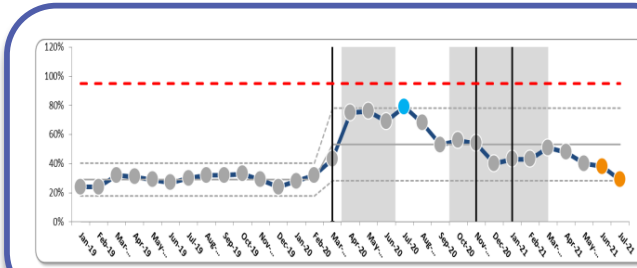
60 minute Ambulance Handover Delays

789



Specialty Review within 1 hour

29.00%



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

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

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

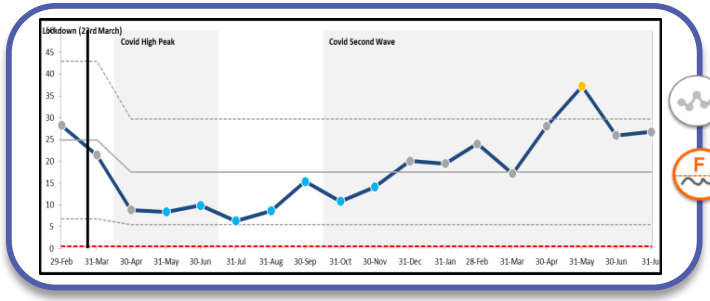
Key
- Internal target
- Operational standard

Month 4 [July] | 2021-22 | Operational Performance: Patient Flow and Capacity

Responsible Director: Chief Operating Officer | Validated for July-21 as 2nd August 2021

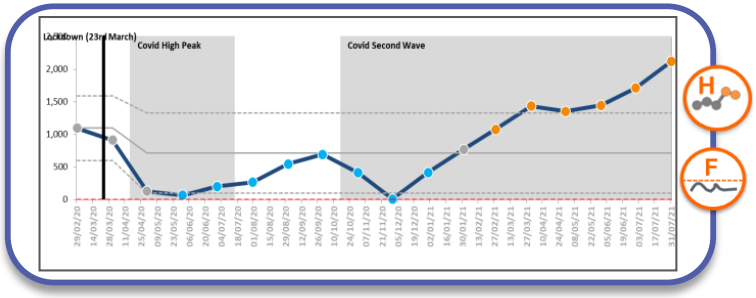
Capacity Gap (Daily avg. excl. EL)

26.3



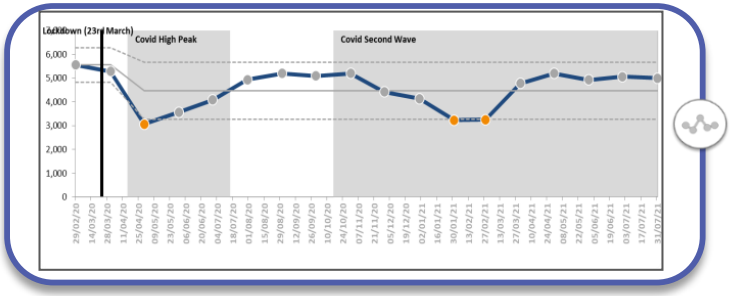
MFFD patients still on the ward 24hrs after becoming MFFD

2,120



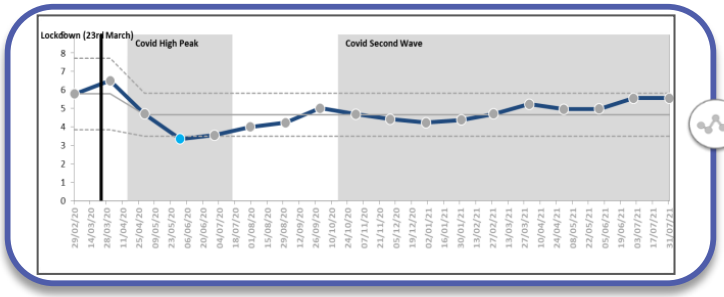
Total Discharges and Transfers

5,001



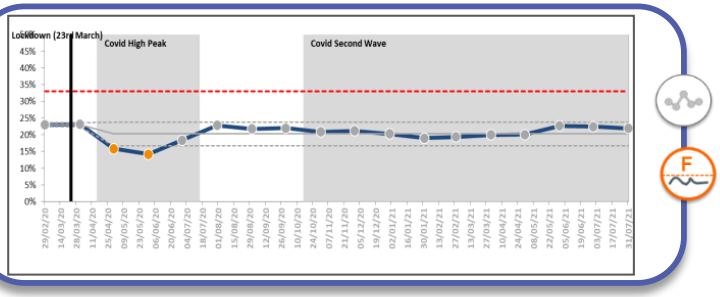
Average Length of Stay in Hospital at Discharge (non-covid wards)

5.6



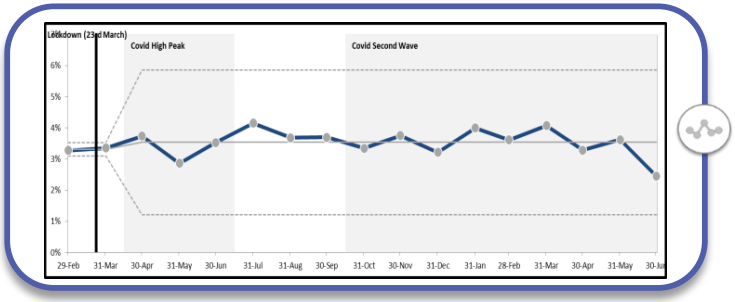
% Discharges before midday (non-covid wards)

21.93%



30 day readmission rate for same clinical condition

2.45%



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 (July 2021)

EAS (All) -The Trust was one of 12 of 13 West Midlands Trust which saw a decrease in performance between Jun-21 and Jul-21 This Trust was ranked 8 out of 13; where we were 8 previous month. The peer group performance ranged from 56.21% to 88.03% with a peer group average of 70.92%; Declining from 74.49% the previous month. The England average for Jul-21 was 77.70% a -3.6% decrease from 81.30% in Jun-21

EAS (Type 1) - The Trust was one of 12 of 13 West Midlands Trust which saw a Decrease in performance between Jun-21 and Jul-21 This Trust was ranked 8 out of 13; where we were 8 previous month. The peer group performance ranged from 49.75% to 83.95% with a peer group average of 60.80%; Declining from 66.43% the previous month. The England average for Jul-21 was 67.70% a -5.5% decrease from 73.20% in Jun-21.

In July-21, there were 2,215 patients recorded as spending >12 hours from decision to admit to admission. 30 of these patients were from WAHT; 1.35% of the total.

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

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

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

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

WAHT — Operational Standard 95%

Operational Performance: Cancer

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

NHS Worcestershire Acute Hospitals NHS Trust

Cancer Referrals	Patients seen within 14 days (All Cancers)		Patients seen within 14 days (Breast Symptoms)		28 Days Faster Diagnosis		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
2,459	66.34%	2,216 seen	12.73%	110 seen	67.07%	2,047 diagnosed	96.11%	283 treated	62.99%	177 treated	2,820	305	88

What does the data tells us?

- **Referrals:** Although there was a 3.5% reduction from the previous month in overall referral numbers, Lower GI saw a 20% increase between Jun-21 and Jul-21; over 600 in a month for the first time ever.
- **2WW:** The Trust saw 133 fewer patients in Jul-21 than Jun-21 and 66.34% were within 14 days. Of the 746 breaches, 264 (35%) were attributable to Breast Services and 398 (53%) to Skin. Across all tumour sites, only 56 2WW breaches were due to patient choice with 757 due to the Trust's capacity issues. For the second month, this performance is special cause concern as a result of the high number of breaches.
- **2WW Breast Symptomatic:** The Trust's waiting time performance returned to normal variation at 12.73%. Although performance is back within the confidence limits, this is the 10th consecutive month below the mean, which was already rebased due to the impact of Covid.
- **28 Faster Diagnosis:** The Trust has yet to achieve the FDS target of 75%.
- **31 Day:** Of the 283 patients treated in Jul-21, 271 waited less than 31 days for their first definitive treatment from receiving their diagnosis. This performance is at the CWT target of 96%; although the target can be achieved is not happening consistently.
- **62 Day:** There have been 177 recorded first treatments in Jul-21 to date and 62.99% within 62 days. This does continue the trend of no significant change in variation since Aug-19 and, currently, the 85% target is not achievable.
- **Cancer PTL:** As at the 2nd August there were 2,820 patients on our PTL with 176 having been diagnosed and 1,674 still suspected. The remaining 970 patients were between 0-14 days.
- **Backlog:** The number waiting 62+ days for their diagnosis has been increased from 252 at the end of Jun-21 to 305 at the end of Jul-21; the number of patients waiting 104 days or more is 88, an decrease of 2 patients from Jun-21 and is showing as a special cause concern again. The number of patients waiting is special cause variation of concern.

What have we been doing?

- **Do what we say we will do:** Breast are continuing to deliver the reduction of their 2ww backlog with the current polling of day 17 down from day 21, with polling day reducing by one day each week. Service remains on track to return to performance by end of September / October 2021.
- Skin continuing to run additional WLI weekend super clinics via Medinet and conversion of routine appointments to reduce their 2ww backlogs.
- **No delays, every day: E**xternal funding secured to appoint 7 x Patient Navigators within the specialties of Urology, Colorectal, Lung, Gynae and Haematology (Upper GI already in place) to improve the delivery of the 28 day FDS standard.
- Additional funding also secured to enable further CNS triage for Urology cancer pathways and training to deliver template biopsies.
- Successful bid to boost the Cancer Services leadership team and 2ww Booking Office team to bring greater focus on every suspected and confirmed cancer patient and the team structures in line with increased referrals into the service over a sustained period.
- **We listen, we learn, we lead:** Rollout of MS Teams for MDT meetings continuing to progress well with changes made the MDT room layout further improving the experience for all in the room and those remote working.
- **Work together, celebrate together:** Cancer Services Manager undertaking to support the 2ww Booking Office team ahead of the formal handover of line management in light of significant process and staffing challenges being faced.

What are we doing next?

- **Do what we say we will do:** Work now underway to fully scope and implement a community-based Breast Pain clinic following confirmation of funding to support this. Dermatology still looking to recruit 2 WTE Consultant Dermatologists.
- Recovery Action Plan (RAP) template produced by the Cancer Services manager to be rolled out to all Directorates to identify clear actions and delivery dates for improvement by specialty against the cancer standards, with deadline for first draft being the next PMG on 17/08/2021. The same template is to be modified to also accommodate RTT and DM01 recovery with the same deadline for first submission.
- **No delays, every day:** Project Manager position re-advertised after failing to appoint in July 2021, this is to support gap analysis and implementation of Best Practice pathways, with Urology being prioritised. Interviews now planned for September 2021.
- **We listen, we learn, we lead:** Review to commence against the recently published 'Streamlining of MDT Meetings' guidance by the Cancer Alliance which seeks to develop and implement standards to care is each MDT meeting.
- **Work together, celebrate together:** External visit by Cancer Services Manager to Wye Valley Trust to review arrangements and processes in place for their 2ww Booking Office, with objective to share knowledge and good practice.

Current Assurance Levels (Jul-21)	Previous Assurance Levels (Jun-21)
2WW – Level 5	2WW - Level 5
31 Day Treatment - Level 5	31 Day Treatment - Level 5
62 Day Referral to Treatment – Level 5	62 Day Referral to Treatment - Level 5

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

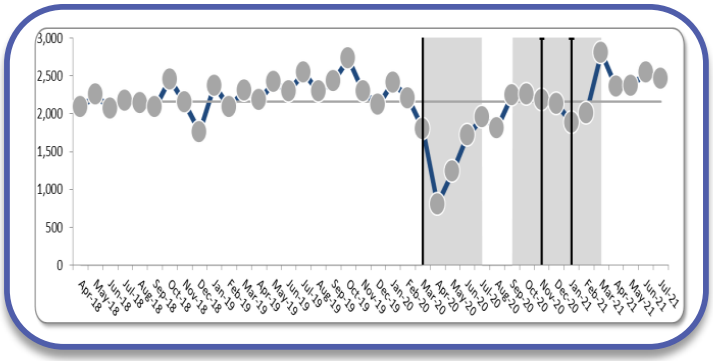
Month 4 [July] | 2021-22 | Operational Performance: Cancer

Responsible Director: Chief Operating Officer | Validated for July-21 as 1st September 2021

NHS Worcestershire Acute Hospitals NHS Trust

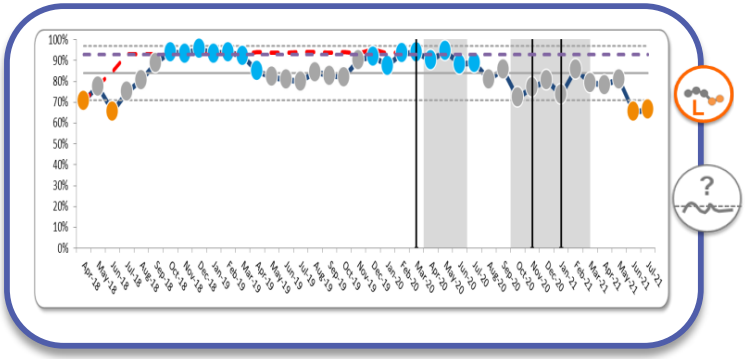
2WW Referrals

2,459



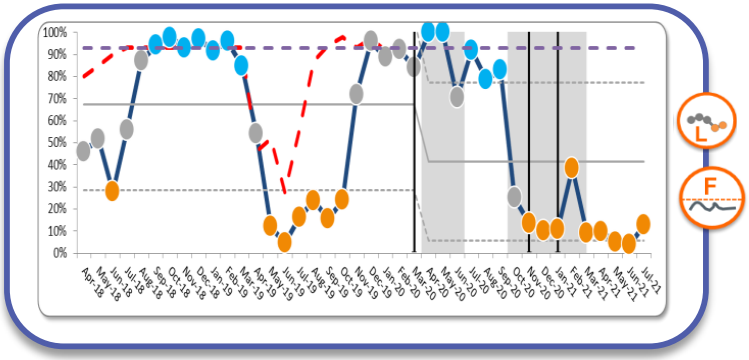
Cancer 2WW All

66.34%



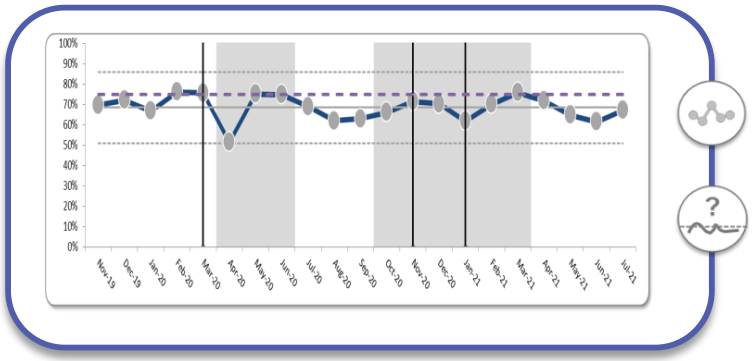
Cancer 2WW Breast Symptomatic

12.73%



Cancer 28 day FDS

67.07%



Key

- Internal target
- Operational standard
- Lockdown Period
- COVID Wave

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