NHS
Worcestershire
Acute Hospitals
NHS Trust

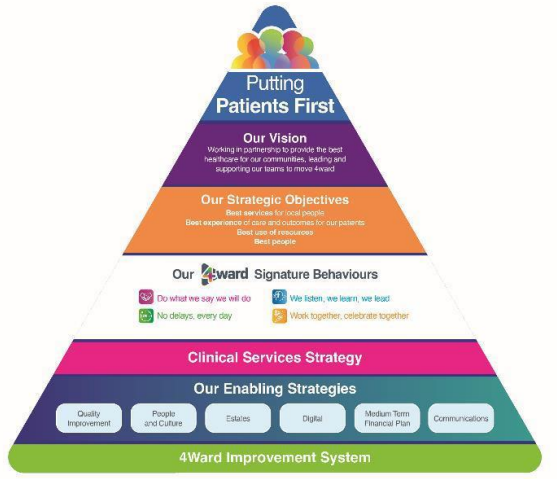
A G E N D A

TRUST BOARD

Thursday 12th January 2023

10:00 – 12:00

via MS Teams and streamed on YouTube



Due to the current operational pressures, papers will be taken as read and presented on an escalation only basis.

Anita Day
Chair

Item		Assurance	Action	Enc	Time
140/22-23	**Welcome and apologies for absence:**				**10:00**
141/22-23	**Patient Story**				**10:05**
142/22-23	**Items of Any Other Business** To declare any business to be taken under this agenda item				**10.30**
143/22-23	**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.				
144/22-23	**Minutes of the previous meeting** *To approve the Minutes of the meeting held on 8th December 2022*		*For approval*	**Enc A** **Page 4**	**10:35**
145/22-23	**Action Log**		*For noting*	**Enc B** **Page 14**	**10:40**
146/22-23	**Chair's Report**		*For ratification*	**Enc C** **Page 15**	**10:45**
147/22-23	**Chief Executive's Report**		*For noting*	**Enc D** **Page 17**	**10:50**
	Best Services for Local People				
148/22-23	**Annual Planning** Director of Strategy & Planning	Level 3	*For noting*	**Enc E** **Page 19**	**11:00**

149/22-23	**Provider Collaborative with HWHCT** Director of Strategy & Planning	Level 4	*For approval*	**Enc F** **Page 33**	**11:10**
	Best Experience of Care and Outcomes for our Patients				
151/22-23	**Integrated Performance Report** Executive Directors	Level 4	*For assurance*	**Enc G** **Page 55**	**11:20**
152/22-23	**Committee Assurance Reports** Committee Chairs		*For assurance*	**Page 138**	**11:35**
153/22-23	**Independent Review of East Kent Maternity Services** Director of Midwifery		*For noting*	**Enc H** **Page 147**	**11:40**
	Best Use of Resources *BAF 7, 8, 11*				
154/22-23	*No matters escalated outside of Integrated Performance Report*				
	Best People *BAF 9, 10, 11, 15, 17*				
155/22-23	**Safest Staffing Report** Chief Nursing Officer **a) Adult/Nursing** **b) Midwifery**	 Level 6 Level 5	*For assurance*	 **Page 151** **Page 157**	**11:45**
	Governance				
156/22-23	*No matters escalated*				
157/22-23	**Any Other Business** *as previously notified*				**11:55**
158/22-23	**Closing Remarks** Chair				
	Close				

Reading Room:

- Annual Planning appendices
- East Kent Report

Seven Levels of Assurance

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

Board Assurance Framework

Strategic Objective	*Assigned BAF Risks*
Best Services for Local People	BAF 2 – Public engagement BAF 11 – Reputation BAF 13 – Cyber BAF 14 – Health & wellbeing BAF 16 – Digital BAF 17 – Staff engagement BAF 18 – Activity BAF 21 – ICS
Best Experience of Care and Outcomes for our Patients	BAF 3 – Clinical Services BAF 4 – Quality BAF 11 – Reputation BAF 19 – System (UEC) BAF 20 – Urgent Care
Best Use of Resources	BAF 7 – Finance BAF 8 – Infrastructure BAF 11 – Reputation
Best People	BAF 9 – Workforce BAF 10 – Culture BAF 11 – Reputation BAF 15 – Leadership BAF 17 – Staff engagement

** Note - assurance against BAF risks is as stated on each report and risks/objectives may overlap*

MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON THURSDAY 8 DECEMBER 2022 AT 10:00 AM HELD AT THE CHARLES HASTINGS EDUCATION CENTRE, WORCETSER ACUTE HOSPITALS NHS TRUST, CHARLES HASTINGS WAY, WORCESTER, WR5 1DD

Present:		
Chair:	Anita Day	Chair
Board members: (voting)	Paul Brennan	Chief Operating Officer
	Matthew Hopkins	Chief Executive
	Simon Murphy	Non-Executive Director
	Neil Cook	Chief Finance Officer
	Christine Blanshard	Chief Medical Officer
	Richard Oosterom	Associate Non-Executive Director
	Dame Julie Moore	Non-Executive Director
	Waqar Azmi	Non-Executive Director
	Colin Horwath	Non-Executive Director
Board members: (non-voting)	Richard Haynes	Director of Communications and Engagement
	Jo Newton	Director of Strategy and Planning
	Rebecca O'Connor	Company Secretary
	Tina Ricketts	Director of People and Culture
	Sue Sinclair	Associate Non-Executive Director
In attendance	Jo Ringshall	Healthwatch
	Jo Wells	Deputy Company Secretary
	Justine Jeffery	Director of Midwifery
	Rebecca Brown	Deputy Chief Digital Information Officer
	Alison Robinson	Deputy Chief Nursing Officer
	Sue Smith	Deputy Chief Nursing Officer
	Julie Booth	Deputy Director, IPC
	Nafeesah Shafiq	Directorate Support Manager
	William	Patient
	John	Patient
	Bal Singh	ED Consultant
	Anna Sterckx	Head of Patient, Carer & Public Engagement
	Rev. David Southall	
	BSL Interpreter	
Public		Via YouTube
Apologies	Paula Gardner	Chief Nursing Officer
	Vikki Lewis	Chief Digital Information Officer

123/22 **WELCOME**

Ms Day welcomed everyone to the meeting, including the press, observers and staff members.

124/22 **PATIENT STORY**

Ms Sterckx introduced William and John who were members of the local d/Deaf community who were attending to present a short session on d/Deaf awareness and share their experiences and that of the local community.

William shared with the Board how the lockdown had an impact and caused problems for people in the d/Deaf community, a number of which suffer from mental health issues, which Covid heightened. A new British Sign Language Act had been introduced but there were still failings within healthcare. Healthcare information leaflets were often hard to understand and difficult to read and this information needed to be made assessable. William added that the wearing of masks made it impossible to lip read and he gave an example of this by using an oven glove which restricted his hand gestures and used to cover his mouth.

John gave a numbers of examples of d/Deaf patient experiences when attending the hospital:

- A pen and paper had been offered to use for communication, but often English is not the first language.
- An interpreter not being available, which resulted in the Receptionist suggesting to a patient with a suspected broken arm to go home and come back the next day.
- Lack of communication whilst on the ward as an inpatient impacted upon mental health and the patient did not know what was happening. Staff who can sign or access to an interpreter is paramount.
- Feedback from one patient was that communication was so bad, she never wanted to come back to hospital again.

John advised that Ms Sterckx had been trying to provide support for the community and make improvements. He reiterated that sign language is paramount to positive communication and there was often miscommunication with the use of a pen and paper.

Rev. Southall meets with the d/Deaf community weekly and was aware of the barriers that they face in society. Hospital experience has not always been positive but the d/Deaf community did not tend to complain though PALS. Rev. Southall had regularly provided interpreter support short notice support when there was not an interpreter available. Interpreters are fantastic but they only convey information and for a short period of time. There was plenty of feedback which related to patients feeling isolated and depressed and he found that staff were talking to him, rather than the patient, when he was interpreting.

Mr Singh thanked William and John for reminding us of what we need to do. Mr Singh attended a clinical case earlier this year for a deaf patient who had chest pain. An interpreter was not available but Rev. Southall attended the ED and was able to put the patient at ease. Mr Singh researched deafness and was surprised by his own lack of awareness. He shared his learning and how we could make changes within the department. A communications box had been created with resources to support communication which included a white board, clear masks, hearing aid batteries and quick fire guidelines on how to rapidly arrange interpreters. Hardware was required to run programmes to operate interpretation software however.

William asked whether consideration could be given to appoint a d/Deaf Awareness Officer and an action plan created as he had presented to the Board previously but little action appeared to have been taken. William extended his thanks to Rev. Southall for his support and involvement helping the d/Deaf community.

Mr Murphy gave thanks for the presentation and asked what more we could do and what best practice looked like elsewhere. Ms Sterckx replied there was an app available on an I-pad mounted on wheels which has just been implemented and will be piloted in January and would provide immediate interpreting support. It could be utilised by both ED and inpatient areas and had been successfully piloted in other Trusts. Gloucester use cards that we are also trialling which details that the patient is deaf and includes information on how to book interpreters.

Mr Oosterom asked what we were doing to make sure that there is more awareness within the Trust. Ms Sterckx stated that there is an ignorance and a lack of confidence. Staff have communication days and some face to face training will be introduced as part of it.

Mr Horwath was embarrassed to hear of the poor experiences shared and queried if there was a training need, which also included receptionists. Mr Murphy added that a number of receptionist roles were covered by volunteers, who should also be considered for training opportunities.

Mr Hopkins advised that there was a sense of discomfort around the experiences described and improvements needed to be made.

Ms Day echoed the comments made and gave thanks for sharing feedback and experiences, which was sobering to hear. Steps needed to be taken to make sure that we do better.

125/22 **ANY OTHER BUSINESS**
There was no other business.

126/22 **DECLARATIONS OF INTERESTS**
There were no additional declarations pertinent to the agenda. The full list of declarations of interest is on the Trust's website.

127/22 **MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON 10 NOVEMBER 2022**
The minutes were approved.

RESOLVED THAT the Minutes of the public meeting held on 10 November 2022 were confirmed as a correct record and signed by the Chair.

128/22 **ACTION SCHEDULE**
There was only one open action which was not yet due for completion.

Mr Haynes shared a video summary reflecting on the last year, which was shared at the recent staff awards.

129/22 **CHAIR'S REPORT**
Ms Day informed that she had taken a Chair's action following the recommendation by the Finance & Performance Committee regarding contract awards for the Alex Theatre projects.

Ms Day recognised that all were aware that the coming weeks will be difficult and referenced both those staff who feel they have no alternative but to take industrial action in the coming days, and those who feel they have no alternative but to not do so. Ms Day asked all to be mindful that all our staff are professionals who take their commitment to our patients seriously and should be treated with respect and compassion, regardless of their personal decisions. As a trust, we must ensure that there are no divisions between staff groups and that we come together to continue focusing on our patients once this difficult period is over. In response to the industrial action, the Trust would be asking staff to take on roles that are not within their normal remit and Ms Day extended her thanks for their flexibility. The video shared by Mr Haynes was reflective of the fantastic staff we have at the Trust. The Patient Choice Award at our recent Staff Awards had received over 700 nominations from members of the public which was extraordinary, and reflected how valued our staff were by our patients.

RESOLVED THAT: the Chair's update was noted

130/22 **CHIEF EXECUTIVE'S REPORT**

Mr Hopkins presented his report and the following key points were highlighted:

- The Staff Recognition Awards was an important event and it was great to see staff supporting each other.
- Thanks were expressed to teams in their endeavour to ensure there is adequate cover over the coming weeks in relation to industrial action. Nursing and operational teams have been involved in preparations for the strikes this month. Incident Command is managing the controls being put in place. Silver and gold meetings had taken place today and were updating on progress. Mr Hopkins reiterated that everyone should be treated respectfully and with compassion.
- There was an unannounced CQC inspection two weeks ago. The CQC inspected both A&E departments and medicine wards. This was the start of a system inspection including the West Midlands Ambulance Service, General Practice, Social Care and Community which will take place over the coming months. Post inspection feedback was quite limited but crucially there was no immediate safety concerns to escalate. It was reported that members of staff were welcoming and keen to share experiences. The pressures they are working under were recognised. A formal report was expected at the end of March 2023. There were some points of note regarding discharge lounges on each site and focused improvements had been made.
- Leadership events had been held and teams were working through the next steps this week and next in regard to common themes of the care of frail patients which had been identified as an area of focus.
- The Trust remained in segment 3 of the System Oversight Framework. Improvements were required within ambulance handover times and cancer waiting times.
- The first floor of the UEC was on schedule to open this weekend and the move of Acute Medical Unit and Ambulatory Care into that space. A multi-specialty assessment area will be moved where patients can bypass A&E under certain criteria.

Mr Horwath referenced the Productivity and Effectiveness Programme approach and asked if there was enough collaboration of resources across the system. Mr Hopkins replied that there is a lot of good intent from partners. Focus was on attendance avoidance at ED and working with general practice to ensure the right patients are referred. There were real pressures around getting patients home quickly. The new discharge taskforce is a combined approach, focusing on individual patients delayed in beds and trying to get them home as quickly as possible.

RESOLVED THAT: the report was noted.

Best Services for Local People

131/22 **COMMUNICATIONS & ENGAGEMENT REPORT**

Mr Haynes introduced the report and highlighted the following key points:

- The Staff Awards had taken place and gave thanks to the incredible work of the Communications team and the Charity for organising the event. The event was very close to making a profit.
- There were issues around urgent and emergency care and therefore significant press coverage, as there would be during the industrial action. The team were trying to provide as much clarity as possible, though it was a changeable situation.
- A deep dive on communications support had taken place regarding various recruitment activities

Mr Murphy advised that the uptake of the staff food vouchers had been low. Feedback had been received that people did not want to be seen collecting or spending the vouchers and he asked if anything else could be done. Mr Haynes replied that alternatives were being explored. Over 200 vouchers had been issued and messages were being managed sensitively.

Mr Azmi noted that the report referred to a targeted approach to different recruitment campaigns and asked how that was being undertaken. Mr Haynes replied that the team had been reviewing social media groups to pitch advertising

The assurance level of 5 was approved.

RESOLVED THAT: The report was noted for assurance.

132/22 **BOARD ASSURANCE FRAMEWORK**

Ms O'Connor presented the updated Board Assurance Framework (BAF). She advised the Board that following executive and committee reviews there had been one change in BAF score relating to an increase with BAF risk 8. BAF risks 19 and 20 had reduced from level 4 to 3 assurance in light of the current challenges and a new industrial action risk had been added to the BAF, this was being kept under review and would be escalated as required.

RESOLVED THAT: The report was noted for assurance.

Best Experience of Care and Outcomes for Patients

133/22 **INTEGRATED PERFORMANCE REPORT**

Operational Performance

Mr Brennan highlighted the following key points:

- A review of every patient had taken place to ascertain why they were here and what was stopping them from going home.
- The AMU moves were scheduled for next week, starting with moves to AEC scheduled for 6pm on Saturday night. The AEC and AMU will open on Sunday morning at 8am. A deep clean would commence on Monday morning and the whitespace opening as the multi-specialty unit on Tuesday.

Dame Julie queried why the ward sisters were not doing more to get patients home. Mr Brennan replied that there was a level of desire to do everything. Dame Julie asked why patients could not wait at home for results. Mr Oosterom observed there seemed to be a ~~is~~ reluctance with some staff to make decisions. Mr Brennan replied that some staff were fearful of doing the wrong thing and therefore sometimes reluctant to manage the risk of sending a patient home.

Ms Day asked if there was any reason to believe there are any patient concerns from the actions being currently taken. Mr Brennan replied that there was not. Dr Blanshard advised that the readmission rates following discharge are as expected and were regularly reviewed. There was a question about risk appetite amongst staff. Many didn't have the trust and confidence that patients were being followed up once they have been discharged. There is a degree of anxiety knowing the pressures in primary care. There is a relative lack of hot clinics and urgent return clinics compared to what we would like to see. Consultants would like to know that patients are bought back for a check-up. Dame Julie queried whether the

Executives have a higher risk tolerance than ward staff and encouraged putting clinics in place and having those conversations.

Mr Murphy advised that the Finance and Performance Committee had reviewed patient flow charts which were excellent and looked at how many people presented at both sites. Mr Murphy asked whether there was an update on the community team that the Health & Care Trust were putting in place. Mr Hopkins replied that there were a number of attendees who are not an emergency. The availability of alternative places for people with urgent care needs is not good within Worcestershire. The Health & Care Trust have recruited more staff into neighbourhood teams who can allocate patients from the ambulance service stack into a referral to a neighbouring team and small numbers had started to be seen deferred away from A&E. The scheme did rely on ambulance crews having confidence that the referral will be safe. The UEC build would assist with deferring patients also. The data is helpful in identifying patient groups to move away from presenting at A&E.

Mr Horwath informed the Board that he had attended a rapid improvement workshop feedback session, noting there were good ideas developing which should be utilised. Staff who do the roles day by day should be encouraged to come up with ideas for improvement. Mr Horwath asked if there was any feel for what it will look like after the modelling of the impact and tracking of it been completed. Mr Brennan replied that he could share the outcome of the model following the workshops.

Ms Day asked if there were clear documented pathways for patients arriving at the front door. Mr Brennan responded that there is a referral protocol for patients who self-present at ED in the assessment units. There was a challenge around paediatrics as there had been an increase in presentation in ED over the last week. All patient pathways are documented, though it was recognised that work is still underway to refine them in the light of experience.

Mr Oosterom commended the good initiatives and asked what was being done to mitigate the risk of patient moves. Mr Brennan replied that there was a comprehensive list of go and no go scenarios. Some risks have materialised and been offset. There were risks around equipment which have all been resolved. There were also risks around air units, taking possession and clinical cleans completion. Additional colleagues were coming in to provide support and risks were reviewed daily. Mr Brennan informed that following a review of today's discharge cell, it was clear that some patients are not discharged as early as they might because of family wishes.

Ms Day gave thanks for the update, noting a marked improvement in data quality had been seen which is helpful and looked forward to the opening of the UEC. There was assurance that plans are in place.

There were no 104 breaches reported in October. The 78 week end position if nothing was done was 5201. There was confidence that the Trust was on track to have 0 patients waiting 78 weeks by the end of March 2023 which was in line with national requirements of validation.

Cancer performance was starting to improve. Skin now had extra capacity online and based on the trajectory, it was anticipated there would be no waiters over 62 days by the first week of February 2023. The Urology prostate cancer pathway had been reviewed and issues identified are being worked through. An extra clinic is now running and is seeing patients faster. An MRI scanner at Kidderminster had been allocated for prostate. Colorectal had extra capacity at the Alex starting next week which was allowing for more biopsies to be done to clear the backlog. A Centre in Nottingham have capacity to do

robotic surgery and revenue for biopsies had been secured. Outsourcing options to help resolve the backlog in lower GI were being reviewed.

Mr Murphy asked if there was anything hindering achievement of the target for theatre utilisation. Mr Brennan advised that information over a 25 week period had been reviewed, following which, the team had drafted an accountability framework. This would be reviewed and signed off at the next session with the staff.

Mr Hopkins noted for the Board that he and Ms Day reviewed the data weekly for an additional level of assurance.

Quality & Safety

Ms Booth highlighted the following:

- C-diff is still challenged and the team were awaiting the NHSEI report from the visit that took place in October.
- Prof Wilcox had completed a review of medical prescribing and the report was awaited.
- There had been an increased level in scrutiny and level of cleanliness at Worcester. A meeting was scheduled to review cleaning, how it is delivered and points of escalation.
- A blood stream infection review had taken place and no themes were discovered. The biggest challenge is a combination of infections. There are outbreaks of norovirus.
- No MRSA incidents had been reported.

Dame Julie asked who was responsible for cleaning what and asked for an update regarding bed washing. Ms Booth replied that anything attached to a patient is the responsibility of nurses, environmental is estates including bed washing. There was a bed washing facility at the Alex but not at Worcester. Dame Julie asked which was the most problematic. Ms Booth replied that it was a mixture. Dame Julie encouraged more progress to be made and had requested a plan to be reviewed at the next Quality Governance Committee.

Dr Blanshard noted that performance in timely surgery of fractured neck of femur was disappointing. The data was illustrative of the general issues in the trauma pathway, utilisation of ambulatory pathways, post-operative care and discharge. Process mapped pathways have been undertaken to review delays. An away day had taken place on 18th November where Trauma & Orthopaedics, anaesthetics and everyone involved in the pathway came together to review it. There was excellent engagement and a plan of action drafted. Immediate actions were already underway and the longer term actions needed to keep momentum.

Dr Blanshard advised that the VTE screening rate has declined. There was a known issue with pulling data from Badgernet. The issues have now been corrected and a retrospective correction of the data had been done which should result in more accurate reporting.

People & Culture

Ms Ricketts noted a reduction in turnover rate. Teams were focusing on recruitment and retention. Bank spend was higher than agency spend and was driven by high acuity and an increase in sickness.

Mr Horwath referred to the breakdown of turnover and was surprised that medical areas were reported as having 31% turnover and asked if there were any issues in this area. Ms Ricketts informed that the junior doctor rotation was a driver for the figure.

Finance

Mr Cook drew attention to the following key points:

- In month 7, there was an actual deficit of £1.9m against a plan of £1.5m deficit, which was an adverse variance of £0.4m. A key driver was the pay award.
- There had been further PEP slippage. A bottom up forecast from divisions is £25m. Mitigations were being drafted.
- Opportunities within the balance sheet were being identified and ICB system conversations continued.
- Capital pressures were driven by UEC overspend.
- It was unlikely the Trust could spend all centrally funded initiatives in this financial year and discussions were ensuing with NHSE on brokerage. A meeting was scheduled with the Joint Investment Committee next week regarding ASR.

Mr Murphy noted the risk of capital funding for planned maintenance which should be highlighted, adding that it may adversely push the ERF position further.

Level 4 assurance was approved.

RESOLVED THAT: The report was noted for assurance.

134/22 **COMMITTEE ASSURANCE REPORTS**

The following points were highlighted by Committee Chairs:

- Finance & Performance Committee: Committee discussed run rate. Some issues have shifted to next year and will affect capital. An update was reviewed in relation to the Robot and funding.
- Quality Governance Committee: The A&E flow diagram was welcomed. Items for escalation have been discussed.
- People & Culture Committee: Items for escalation have been discussed.

RESOLVED THAT: The Committee reports were noted for assurance.

Best People

135/22 **SAFEST STAFFING REPORT**

a) Adult/Nursing

Ms Smith informed the Board that safe staffing was achieved. The teams were aware of the upcoming strike action; plans were in place and the acuity and dependency of patients would be reviewed.

Mr Murphy asked if there had been any improvement with HCA recruitment. Ms Smith noted that some had been recruited recently. The team were working with HR to look at options to attract new starters into the role. Dame Julie asked if there was a retention issue. Ms Smith replied that there were factors such as pay as the role was a band 2. People had left for other roles where incentives related to no unsocial hours, more money and free parking.

Mr Oosterom queried whether the North Bristol or Push model has led to our having to increase staffing levels. Ms Smith replied that it had. Dr Sinclair asked if there had been any negative responses from staff following recent press. Mr Hopkins noted there had been some anxieties raised by staff in relation to the increased numbers of patients on wards and as a result communications had been issued directly to nursing and medical staff about the support of the Board in making difficult decisions. Letters had also been issued from the Chief Nursing Officer and the Chief Medical Officer. Executives should be visible on the wards and providing support.

The assurance level 6 of was approved.

b) Midwifery

Ms Jeffrey highlighted the key points:

- There had been a reduction in sickness, turnover and vacancies.
- Reduced red flag reporting
- The Birthrate+ report was included within the report and compliance was met.
- Ockenden funding has allowed an increase in workforce.

The assurance level of 5 was approved.

RESOLVED THAT: The report was noted for assurance.

Governance

136/22 **RESPONSIBLE OFFICER REPORT**

Dr Blanshard presented the report noting the annual requirement to give the Board assurance that doctors are participating in the annual revalidation process and to raise any concerns about the conduct or performance of doctors. The Trust was also required to produce evidence that there is an adequate number of appraisers to meet the needs of the organisation.

The report detailed the number of doctors who delayed appraisals which had agreed exceptions for legitimate reasons such as long term leave or sabbatical. There were 7 doctors who did not have an appraisal nor an agreed exception, but a delayed appraisal had now been carried out. One continues to not engage fully and is receiving additional support following discussion with the GMC Advisor.

Ms Day queried whether the one who is not engaging disagreed with the process and Dr Blanshard replied that the individual had other interests.

Assurance level 6 was approved.

RESOLVED THAT: The report was noted for assurance.

137/22 **AUDIT & ASSURANCE REPORT**

Mr Horwath advised that Committee had received an internal audit report which provided a no assurance rating. Receiving such a report was both rare and disappointing. There had been a positive response from Executives and further discussion would take place at Private Trust Board.

Assurance level 5 was approved.

138/22 **ANY OTHER BUSINESS**

Ms Day invited Ms Ringshall to share any comments or questions.
Ms Ringshall asked whether communications would be issued about what patients can expect during the industrial action. Mr Hopkins replied that when we are as clear as we can be, communication will be issued to patients.

Ms Day noted this was Mr Azmi's last Board meeting and thanked him for his contribution to the Trust. Mr Azmi thanked all noting it had been a privilege to work with the teams.

Ms Day advised that the Board would meet face to face three times per year starting in 2023.

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

The meeting was closed.

Signed _____ **Date** _____
Anita Day, Chair

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

PUBLIC TRUST BOARD ACTION SCHEDULE

RAG Rating Key:

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

Meeting Date	Agenda Item	Minute Number (Ref)	Action Point	Owner	Agreed Due Date	Revised Due Date	Comments/Update	RAG rating
13.01.22	Charter	158/21	Mrs Ricketts and Mr Hopkins to continue the conversation regarding meaningful action and outcome measures and report back to Board in two months	MH/TR	March 2022	Feb 2023	Regular updates on progress against implementation of the Charter are provided to the People & Culture Committee. A Board Development agenda item about Culture will cover the topic.	

NHS
Worcestershire Acute Hospitals NHS Trust

Meeting	Public Trust Board
Date of meeting	12 January 2023
Paper number	Enc C

Chair's Report

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

Accountable Director	Anita Day Chair		
Presented by	Anita Day Chair	**Author /s**	Rebecca O'Connor 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 December 2022.

Executive summary	The Chair, undertook a Chair's Action on the recommendation of Finance and Performance Committee and in accordance with Section 24.2 of the Trust Standing Orders to: 1. Approve TIF 2 accelerated capital spend. In order to mitigate the risks of underspend on external capital funds, a further £1.78m of spend on capital schemes needs to be identified. Following a review, 5 schemes with a total estimated spend of £2.54m have been identified, which allows for slippage if not all the spend is delivered. 2. Approve the appointment of Kidderminster Treatment Centre CDC contractors, as stated in the Contract Award Governance paper of £1,882,878.00 inc. VAT and delegated authority to execute the contracts in line with the approved business case The F&P paper and Contract Award Governance reports are enclosed within the Private Trust Board Reading Room for information

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

Worcestershire Acute Hospitals NHS Trust

Meeting	Public Trust Board
Date of meeting	12 January 2023
Paper number	Enc C

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	Public Trust Board
Date of meeting	12 January 2023
Paper number	Enc D

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: • UEC Pressures/Critical Incident • High levels of flu and COVID-19 • Elective Surgery • Staff farewell and welcomes

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	Public Trust Board
Date of meeting	12 January 2023
Paper number	Enc D

Introduction/Background

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

UEC Pressures/Critical Incident

Pressure within the Trust's two Emergency Departments has continued to increase with significant levels of congestion and continued use of the corridors to manage patients which creates serious problems for both patients and staff. Whilst the new AEC/AMU has opened on the first floor in Aconbury the AEC has actually been used to care for inpatients due to the pressure and this has impacted on the ability to receive patients direct and pull from ED.

The pressure ED colleagues have faced was intense on the 20th December when a decision was made to offload all ambulance waiting outside the ED at Worcester which led to 18 patients being taken in to the corridor which at the time was managing 12 patients.

During the four weeks in December, based on WMAS data, the hours lost due to handover delays was 558 (5/12), 1104 (12/12), 547 (19/12) and 1473 (26/12).

High levels of flu and COVID-19

We continue to have large numbers of patients in our hospitals who have influenza or covid-19. At the time of writing we have 90 inpatients with covid and 85 with flu – flu numbers are falling slowly but covid cases are continuing to rise. The majority of patients with Covid have it as a secondary diagnosis.

Elective Surgery

As Board members are aware we started the year with a potential 23,000 patient who could breach 78 weeks by the 31st March 2023 and as at the 5th January 2023 the number of patients potentially breaching 78 weeks has reduced to 3,985. So positive progress but it still remains a challenge to reach zero by the end of March 2023 as 2,650 of these patients being in three specialties – General Surgery at 1219, Urology at 749 and Gynaecology at 682. The Trust reported no 104 week breaches for December 2022.

Staff farewell and welcomes

I would like to thank Sally Millet who retires this month as our guardian of safe working. She has provided excellent pastoral and practical support for our junior doctors and worked hard to ensure they are not exceeding their rostered hours and are able to access their teaching and training. Dr Alag Raajkumar will be taking over this week.

We welcome back Jackie Edwards from her retirement who has returned to the Trust as Interim Chief Nursing Officer.

Issues and options

Recommendations

The Trust Board is requested to

- Note this report.

Appendices – None

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Public Trust Board
Date of meeting	12 January 2023
Paper number	Enc E

Draft annual plan for 2023/24 and 2024/25: update

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

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

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	14 December 2022	Noted
Finance & Performance Committee	21 December 2022	Noted

Recommendations	It is recommended that Trust Board: • Note the content of the national operational planning guidance • Note the progress made to date with annual planning for 23/24 and proposed next steps • Note the issues and risks with their mitigating actions • Agree the proposal for delegated sign off of our plan prior to submission

Executive summary	NHS England (NHSE) published the NHS Priorities and Operational Planning Guidance for 23/24 on 23rd December 2022. The guidance sets out three key tasks for the next financial year: to recover our core services and productivity; make progress in delivering the key ambitions in the NHS Long Term Plan (LTP) and to continue transforming the NHS

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Public Trust Board
Date of meeting	12 January 2023
Paper number	Enc E

	for the future. The detailed guidance and technical specifications are due to be published by NHSE sometime week commencing 9th January. We commenced planning for 22/23 in the late summer. The approach to annual planning for 23/24 including principles, assumptions and timeline was the subject of a paper considered at the November Finance and Performance Committee meeting. An update was provided to the December meeting when we also reported slippage in our timescales for the development of the capacity plan, and actions relating to business cases and PEP due to a range of factors, including operational pressures, industrial action and CQC. This paper sets out the priorities and key points from the guidance, our planned response and associated issues, risks and mitigations. In order to comply with revised governance timelines for the trust and system it is proposed that final sign off is delegated to Finance & Performance Committee on 29th March 2023

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

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

Financial Risk						

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

NHS
Worcestershire
Acute Hospitals
NHS Trust

Assurance levels Nov 2020

Meeting	Public Trust Board
Date of meeting	12 January 2023
Paper number	Enc E

Introduction/Background: national guidance

The NHSE document – NHS priorities and operational planning guidance 2023/24 - can be found in the Trust Board Reading Room, along with a summary (Appendices 1 and 2 respectively). Key points include:

1. Recover our core services and productivity

- Improve patient safety, outcomes and experience:
  - Improve ambulance response and A&E waiting times
  - Reduce elective long waits and cancer backlogs, improve performance against core diagnostic standard
  - Make it easier to access primary care services
- Improve productivity and whole system flow critical to achieving above. Essential actions:
  - Reducing bed occupancy to 92% and increasing bed capacity, reduce medically fit for discharge patients in hospital with the Better Care Fund supporting timely discharge
  - Reducing OP follow ups relative to firsts by 25% relative to 19/20 baseline
  - Increasing day case rates (to 85%)
  - Improving theatre utilisation (to 85%)
  - Increase diagnostics – 10% improvement in pathology and imaging network productivity by 24/25
  - Deliver 30% more elective activity by 24/25 then before the pandemic
  - Implement and maintain priority cancer pathways, with increased diagnostic and treatment capacity
  - Develop and extend cancer screening programmes and lung health check programmes
  - Continue to deliver actions from Ockendon, develop personalised, safe maternity care
- In doing so, narrow health inequalities in access, outcomes & experience plus maintain quality and safety, especially in maternity services

The associated metrics for improvement are:

Meeting	Public Trust Board
Date of meeting	12 January 2023
Paper number	Enc E

Area	Objective
Urgent and emergency care*	Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25
	Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25
	Reduce adult general and acute (G&A) bed occupancy to 92% or below
Elective care	Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)
	Deliver the system- specific activity target (agreed through the operational planning process)
Cancer	Continue to reduce the number of patients waiting over 62 days
	Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days
	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028
Diagnostics	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%
	Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition
Maternity*	Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury
	Increase fill rates against funded establishment for maternity staff
Use of resources	Deliver a balanced net system financial position for 2023/24
Workforce	Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise
Prevention and health inequalities	Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024
	Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%
	Continue to address health inequalities and deliver on the Core20PLUS5 approach

There has been a considerable reduction in requirements from the 22/23 guidance. These are shown in Appendix 3 below.

2. Deliver the Long Term Plan ambitions and transform the NHS
    - Prevention and management of long term conditions set out in LTP
    - Workforce sustainability
        - Improved staff experience and retention through focus on all aspects of the People Promise
        - Increase productivity by fully utilising skills, adapting skills mix and accelerating introduction of new roles
        - Flexible working practices and flexible deployment of staff across organisational boundaries
    - Digital infrastructure – digital first and NHS app developments, with focus on infrastructure for population health management data
    - Transformation needs to be accompanied by continuous improvement
    - Prevention focused on LTP priorities – cardiovascular disease, smoking cessation and diabetes
    - Tackle health inequalities

Whilst we await the detail in the technical guidance, the published information to date indicates that:

- We will receive two year revenue (including COVID & ERF) allocations 23/24 and 24/25 - flat in real terms with additional funding available to expand capacity
- Capital allocations 22/23-24/25 already published, but top up funding is available for those systems that deliver their agreed budgets in 22/23
- Ordinary, day, outpatient procedures and first OP appointments paid at unit prices (Payment by Results) for activity delivered – but not OP follow ups. Provider activity targets will be agreed as part of allocating ERF. NHS E cover additional costs for systems exceeding agreed activity levels
- Deliver balanced net system financial position for 23/24, 2.2% efficiency target
- Reduce agency spend across NHS to 3.7% of total pay bill in 23/24
- Reduce corporate running costs, procurement and supply chain costs and improve inventory management

The planning guidance, particularly the reduction in requirements and revised performance metrics, provide us with a more realistic, but still ambitious, framework for performance improvement. The guidance clearly sets out system-wide actions designed to increase capacity and improve patient flow to ease urgent care pressures and improve elective productivity, although this is set against a requirement to also deliver a 30% increase in activity. Whilst the move from a block contract to PBR for elective activity (except for outpatient follow ups and non elective activity) is welcomed, the planning guidance also emphasises the importance of delivering a balanced net system financial position in 2023/24, meeting the 2.2% efficiency target and reducing agency spend to 3.7% of the total pay which will be challenging. In addition, the two-year revenue allocations are likely to be flat in real-terms.

Issues and options

Our approach to annual planning for 23/24 is outlined in the section below and differences to our 22/23 approach are highlighted.

We have changed our approach to **activity planning** so that our activity plans are based on our capacity. A capacity tool (Pythia) has been built and populated to provide the information required to develop a capacity-backed activity plan. Work has been progressing with operational divisions to cleanse and validate the capacity information. The next step will be for activity to be modelled by the Business Intelligence Team against performance targets in the guidance. Discussions will then focus on how the gap between capacity and performance targets can be closed. An early indication of 23/24 activity levels based on the outturn position from 22/23 and gap to performance target is also being developed to provide an initial estimate of the gap to performance.

HR Business Partners have worked alongside divisional colleagues to complete the first draft of the **workforce** plan. An indicative plan has been developed but has to be validated further following development of PEP schemes and prioritisation of business case ideas. Triangulation of the workforce plan with activity and budgets is a key piece of work which is to be undertaken supported by the use of the NHSE triangulation tool.

The national guidance states that the **PEP** target should be 2.2%. However, we aim to develop a plan for 3% (c. £18.7m). Divisions and Corporate teams have reviewed their pre-populated PEP information. The PMO are currently supporting scheme leads to develop their PEP schemes to level four verify whether the schemes identified are credible and deliverable ideas. A fundamental change in our approach to PEP is a focus on a smaller number of areas where we can reduce waste and improve productivity. PEPs based on productivity will be the foundation of the approach for closing the gap between the capacity plan and performance targets and are, therefore, a crucial part of activity planning including triangulation of different elements of the overall plan. It was agreed by CETM on 30th November, with support from Finance & Performance committee, to source a 3rd party to support SROs with this work due to limitations of operational and corporate capacity to progress the work in line with the revised approach to transformational PEP proposed to TME last month. Scoping of work has been undertaken with Commissioning Support Units and to focus work on opportunities in non-operational division, Best People, theatres and outpatients is about to commence. The ICB have committed financial support for this approach.

Lists of **business case** ideas for 23/24 and 24/25 have been received from most divisions/directorates. The lists will be reviewed and prioritised to produce an overall short list of essential business cases week commencing 9th January.

Divisional **finance** teams have been working with their Divisions to produce an exit position from 22/23 for review at their PRM meetings. Consolidation of Divisional positions is in progress, as is scoping of the impact in 23/24 of agreed Business Cases (e.g. UEC, Robotic Assisted surgery) and pay and non pay inflation. The budget setting policy provides a framework under which the Trust's financial plan and budgets are set. It has been updated and was approved by Finance and Performance Committee on 21st December 2022.

Plan timeline and governance

It is acknowledged that we are undertaking annual planning at a time where there have been/are unprecedented pressures which have reduced the clinical, operational, executive and corporate bandwidth to progress the activities required to develop our plan. These pressures include:

- November 22 – January 23: reintroduction of command & control, operational pressures, industrial action, CQC well led review, RPIW, Operation Willow, winter plan, sickness and annual leave
- A decision was made by CETM on 16th November to slip the annual planning timeline by 4 weeks. The ICB have been briefed as this means that our timescales no longer align with those of the system
- The HR Team were stood down to focus on industrial action
- The scale of the PEP ask is greater than before and it is getting harder to address
- Business Intelligence capacity was reviewed and it was agreed at CETM on 23rd November that some business intelligence activity would be passed elsewhere and that there would be a freeze on new reporting

- Vacancy rates are high in corporate and operational teams which is reducing capacity for annual planning
- PRMs for operational divisions were cancelled in November due to operational pressures, although December PRMs will take place week commencing 19th December.

These pressures have caused slippage from our original timeline and mitigating actions, such as the divisional planning workshops in the first two weeks of January, are being implemented to try and ensure that we balance the development of a credible plan on time with ongoing pressures. Although we await the detailed national guidance and national submission dates and confirmation of timescales for submission to the ICB, the timeline we are currently working to is summarised in Appendix 4 below, but top down approach will be adopted if there are further delays.

PRMs in November and December should have provided an opportunity for divisions to enter into a check and challenge discussion for their plans to date. This will now take place in January PRMs. Appendix 5 proposes the approach to sign off of the draft and final plans through our governance processes, including proposed delegated Trust Board sign off of the plan to Finance and Performance Committee.

We will continue to work in conjunction with our partners to ensure that governance of individual organisations and the system are aligned and will review expectations and dates as the planning round continues. A system-wide planning workshop on 13th January is being organised by the ICB during which system-wide approaches and timescales will be agreed.

In order to comply with revised governance timelines for the trust and system it is proposed that final sign off is delegated to Finance & Performance Committee on 29th March 2023

The following risks and issues are being monitored:

Risk or Issue	Description	Mitigation
I	Capacity across the Trust means not all planning deadlines are met, resulting in tighter timescales to meet overall plan deadline.	Corporate leads utilise professional judgment to develop information where capacity means a response is difficult Offer tailored corporate support to teams who are struggling Discussion via PRMs or annual planning exec huddle if PRMs stood down Adopt top down approach
I	There are no equivalent monthly PRMs for Corporate, E&F and Digital Divisions where the plans/PEPs will be discussed at Executive level	Planning leads arrange corporate check & confirm meetings for PEP and business cases Utilise PRM for E&F and Digital

Meeting	Public Trust Board
Date of meeting	12 January 2023
Paper number	Enc E

I	The timescales given to Divisions are extremely tight and there is concern that if there is Industrial action and/or Level 4 escalations then they will not have the time to complete the work to the agreed timescales	Corporate leads utilise professional judgment to develop information where capacity means a response is difficult Offer tailored corporate support to teams who are struggling Discussion via PRMs or annual planning exec huddle if PRMs stood down Adopt top down approach
I	No contingency plan in place in the event of PRMs being cancelled due to site pressures.	Stand up Annual Planning executive huddle to manage risk escalations Half-day division annual planning workshops (without execs)
I	Lack of attendance at APSG due to operational and corporate pressures leads to further delay and key information not being received	Send email communication following APSG meetings and ensure that business partners/business advisors support communication of core messages
R	Risk of having to revert to Plan B if we do not get sufficient engagement to build a bottom up activity plan which will have an adverse knock on impact on workforce and finance plans	Corporate leads continue to monitor and escalate engagement with the capacity work Continue to offer dedicated corporate support Adopt top down approach
R	The detail for system requirements required to develop Trust plan may not be available in a timely manner.	Corporate leads request clarity on system assumptions and timelines from ICS leads.
R	Delays to development of the plan will impact upon the route through internal Trust governance	Company Secretary potential to agree to extraordinary committees to ensure plan can be signed off
R	Annual leave (including February half term) further limits capacity to develop plan	Divisions and corporate leads confirm leave arrangements for Jan – Feb and align work to ensure completed on time

Conclusion

NHS England (NHSE) published the NHS Priorities and Operational Planning Guidance for 23/24 on 23rd December 2022 which provides the framework in which we will develop out plans. Whilst we commenced planning in the summer, including the development of a capacity model through to enable the development of capacity-backed plans, a series of pressures have impacted on the progress of annual planning. Corporate planning leads will continue to support Divisions and Corporate Teams to develop their plans further. Updates will be provided to CETM on a weekly basis. We continue to await the detailed guidance and technical specifications and will review and adapt our approaches and timeline in light of the guidance as required.

Recommendations

It is recommended that Trust Board:

- Note the content of the national operational planning guidance
- Note the progress made to date with annual planning for 23/24 and proposed next steps
- Note the issues and risks with their mitigating actions
- Agree the proposal for delegated sign off of our plan prior to submission

Meeting	Public Trust Board
Date of meeting	12 January 2023
Paper number	Enc E

Appendices

Appendix One: National guidance (Reading Room)
Appendix Two: Summary of national guidance (Reading Room)
Appendix Three: Comparison of 22/23 and 23/24 requirements
Appendix Four: High level timeline
Appendix Five – proposed governance timeline

Meeting	Public Trust Board
Date of meeting	12 January 2023
Paper number	Enc E

Appendix Three – comparison of 22/23 and 23/24 requirements specific to Acute Trusts

	2022/23	2023/24
Number of objectives	130	35
Urgent & Emergency	Reduce 12 hr waits towards zero (max 2%)	76% A&E patients seen within 4 hrs by Mar 24
	65% handovers within 15mins of arrival	
Elective care	Eliminate waits over **104 weeks** by Mar 22 Reduce waits **>78 weeks** with 3 month review, extended to >52 week waiters from July22 Develop plans to support reduction in **52 week** waits, where possible	Eliminate waits over **65 weeks** (except patient choice or specific specialities) Deliver system-specific activity target
	Reduce outpatient follow-ups by **25%** v 19/20 by Mar 23	Reduce outpatient follow up activity by 25% from 19/20 levels
		Reduce general and acute bed occupancy to 92% or below
		85% theatre and day case utilisation
Cancer	Complete work from H2 2021/22 planning guidance	Continue to reduce number of patients waiting > 62 days
	Maintain and restore cancer screening programmes by Mar 22 or end June latest (in 3 yr cycle)	Implement priority pathway changes for certain cancers Roll out extensions to screening programmes and expand lung health check programme Meet faster diagnosis standard by March 24 so that 75% patients urgently referred by GP are either diagnosed or have cancer ruled out within 28 days
		Increase % of cancers diagnosed at stages 1 &2 in line with 75% early diagnosis ambition by 2028
Diagnostics	Increase diagnostic activity to min 120% pre-pandemic levels	Increase cancer diagnostic capacity by 25% and treatment capacity by 13% Increase % diagnostic test within 6 weeks (to 95% by Mar 25)
	Develop investment plans for further community diagnostic centres (CDCs) in 2023/24 and 2024/25	Deliver diagnostic activity levels to address elective & cancer backlogs and the diagnostic waiting time ambition

Meeting	Public Trust Board
Date of meeting	12 January 2023
Paper number	Enc E

		10% increase in productivity for pathology and imaging networks by 24/25
Maternity	Embed and deliver 7 Ockenden immediate & essential actions	Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain industry
		Increase fill rates against funded establishment for maternity staff
Use of resources	Systems to return to financial balance	Deliver a balanced net system financial position for 23/24 2.2% efficiency target Reduce agency spend to 3.7% of total pay bill
Workforce		Improve retention & staff attendance through a systematic focus on all elements of the NHS People Promise
Prevention & health inequalities		Increase % of patients with hypertension treated to NICE guidance to 77% by Mar 24
	In line with LTP, develop plans for prevention	Increase the % of patients aged 25-84 with a CVD risk score greater than 20% on lipid lowering therapies to 60%
	Focus on socio-economic deprived and ethnic minority groups	Continue to address health inequalities & deliver on the Core20PLUS5 approach

DROPPED TARGETS	**2022/23**
	LTP targets
	Increase number patients referred to post-Covid services
Workforce	Supportive health & wellbeing conversations
	Funding mental health hubs for staff to access
	BAME targets on recruitment & promotion practices
Outpatients	Expand patient initiated follow ups (PIFU) to all major OP
	Moving or discharging 5% OP attendances to PIFU pathways
Digital	Shared care record with information exchange by Mar 23
	National information exchange Mar 24

Meeting	Public Trust Board
Date of meeting	12 January 2023
Paper number	Enc E

Appendix 4 – high level timeline

Milestone	Date
Divisional half day annual planning workshops Gap to expected activity/performance levels identified by Business Intelligence plus work on merging in PEP information (productivity) Modelling against activity and performance targets sent out to divisions by business intelligence for checking Prioritisation of divisional and cross-trust business cases	w/c 2nd - w/c 9th January
Technical guidance and non-functional templates published	w/c 9th January
All bottom up PEPs developed to level 4 by scheme owners	20th January
Iterative discussion undertaken between BI & divisions of interventions to close gap between activity/performance targets & capacity Workforce templates reviewed by business partners & divisions Corporate triangulation divisional & cross-trust undertaken	12-20th January
Functional templates made available and NHS portal opened for draft plan submission	16th January
Plans reviewed at corporate and operation division PRMs – 1st cut plan discussion	16th – 27th January
Draft plan submitted to ICB (Assumed date)	9th February
Plans reviewed at operation division PRMs	20th – 27th February
Draft plan submitted to NHSE by ICB	23rd February
NHSE portal opened for final template submissions	2nd March
Final plan submitted to ICB (Assumed date)	16th March
Final plans reviewed at operation division PRMs	27th – 31st March
Final plan submitted to NHSE	30th March

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Public Trust Board
Date of meeting	12 January 2023
Paper number	Enc E

Appendix 5 – proposed governance timeline

Milestone	Date
Trust Board update paper outlining guidance	12th January
TME update paper	18th January
F&P update paper	25th January
Trust Board paper – sign off of draft plan	9th February
Assume submission to ICB	9th February
TME review of draft plan iterations	15th February
F&P review of draft plan iterations (and delegated sign off of any changes post-Board on 9th February subject to Board agreeing delegation)	22nd February 2022
Submission draft plan to NHSE by ICB	23rd February
Trust Board update on draft submitted plan and any updates since last Trust Board meeting	9th March
NHSE feedback on plan received	TBC
TME update paper	15th March
Assume submission to ICB	16th March
F&P update paper – draft plan prior to final submission to NHSE (and delegated sign off of any changes post-Board)	29th March
Final plan submitted to NHSE by ICB	30th March
Trust Board presented with final submitted plan	13th April

NHS
Worcestershire Acute Hospitals
NHS Trust

Assurance levels Nov 2020

Meeting	Public Trust Board
Date of meeting	12 January 2023
Paper number	Enc E

NHS
Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Public Trust Board
Date of meeting	12 January 2023
Paper number	Enc F

Provider Collaboratives – MoU with Herefordshire & Worcestershire Health & Care Trust

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

Accountable Director	Jo Newton, Director of Strategy, Improvement & Planning WAHT		
Presented by	Jo Newton, Director of Strategy, Improvement & Planning	**Author /s**	Sue Harris, Director of Strategy & Partnerships HWHCT Jo Newton, Director of Strategy, Improvement & Planning, WAHT Gill Harrad, Company Secretary, HWHCT Rebecca O'Connor, Company Secretary WAHT

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	14/12/22	Endorsed
F&P	21/12/22	Endorsed noting benefits & risks Recommended consideration of frailty as a first area for joint working

Recommendations	Board is asked to: • Note the context in which provider collaboratives are being developed • Note the options for closer working with Herefordshire & Worcestershire Health & Care Trust • Note the commitment for cross organisational development required • Approve the Memorandum of Understanding between Herefordshire & Worcestershire Health & Care Trust and Worcestershire Acute Hospitals Trust

Executive summary	Provider collaboratives are part of national policy to improve service resilience, reduce unwarranted variation in outcomes and access, reduce population health inequalities and support workforce recruitment and retention between providers.

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Public Trust Board
Date of meeting	12 January 2023
Paper number	Enc F

	Consistent with our Three Year plan and Clinical Services strategy, this paper proposes endorsement of a Memorandum of Understanding (MoU) with Herefordshire & Worcestershire Health & Care trust (HWHCT) to provide a framework for service collaboration. Following the recent Leadership strategy event, it is proposed that the initial focus be on frailty and stroke. Further ideas are outlined in the addendum to the MoU in the reading room.

Risk			
Which key red risks does this report address?	BAF 3,7,16,17, 18, 19, 20	**What BAF risk does this report address?**	BAF 3 Clinical Services Strategy BAF 4 Quality & safety BAF 9 Workforce BAF 21 ICS

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

Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y	x	N		N/A	
Are the actions identified starting to or are delivering the desired outcomes?	Y	x	N			
If no has the action plan been revised/ enhanced	Y		N			
Timescales to achieve next level of assurance	**October 2022**					

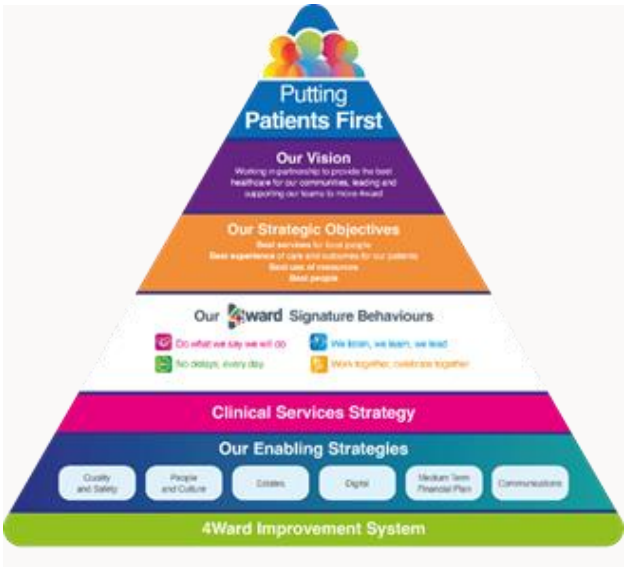
Introduction

Our Three year plan and Clinical Services strategy recognise the importance and interdependence of working in partnership with system partners to deliver both our strategic objectives and as a leading provider within the Herefordshire & Worcestershire Integrated Care system. Partnership working can take many forms at both operational and strategic level, with colleagues, both clinical and non-clinical, having demonstrated the strength where this has been done successfully together. Recent examples might include International Nurse Recruitment and COVID vaccinations.

Boards from the respective trusts met in the summer to explore whether there was appetite to take this collaboration further. Subsequently, discussion has continued at executive level. In addition, the trust hosted a visit from the Chair and non-executive members of HWHCT to the WRH site to go on the *genba* to understand the flow of patients through urgent and emergency care.

With the Integrated Care Board (ICB) (the successor regime to CCGs) gaining statutory status in July 2022, there is greater expectation for clarity and prioritisation surrounding Provider collaboratives. This presents an opportunity for us to build the voice of the provider in developing and sustaining service development for our patients. Nowhere was this more clearly articulated than at our recently held Leadership Strategy event.

Meeting	Public Trust Board
Date of meeting	12 January 2023
Paper number	Enc F



Issues and options

Why form a Provider collaborative?

A provider collaborative can be defined as a partnership that brings together two or more NHS trusts to work together at scale to benefit their populations[1]. As part of the Health & Care act 2022, NHSEI policy mandated that all providers join a provider collaborative. The initial assumption was that these would be acute to acute trusts. Indeed, our trust joined the SWFT Foundation group as an associate member of their improvement collaborative in early 2022, and we will bring a proposition for WVT in the New Year. Any collaboration arrangement is intended to align with national and local expectations to provide mutual aid and sustainability, including to more challenged trusts, with the policy emphasis on networked, collaborative service provision. Specifically, the aim is to:

- Improve service resilience
- Reduce unwarranted variation in outcomes and access
- Reduce population health inequalities
- Improve workforce capability, easier recruitment, more options to offer staff we want to retain

Benefits of working in collaboration

Benefits from working in collaboration can be defined in general terms as a means to:

- Ensure patients experience more joined up and reliable services
- Ensure patients access wider range of services working to common standards and service models
- Through working collectively, manage recruitment and retention whilst offering more varied roles in teams with wide ranging skills and services
- Increase service resilience – develop prior agreements to help/work together when necessary
- Learn from best practice amongst collaborators, clinical and administrative

Meeting	Public Trust Board
Date of meeting	12 January 2023
Paper number	Enc F

[1] *Provider collaboratives: explaining their role in system working* Kings Fund Explainer, Charlotte Wickens, April 2022

Memorandum of Understanding (MoU)
Consistent with this approach, it is proposed that a memorandum of understanding will provide the framework by which formal commitment is made by both HWHCT and WAHT at board level to work together for the mutual benefit of the patients and communities of Worcestershire.

The MoU (Appendix 1 in the Reading room) outlines the framework for collaboration, references successes to date and areas for potential working in the addendum.

Risks
Three key risks have been identified in achieving success in provider collaboration for both trusts:

1. Operational pressures undermining the ability to build a collaborative way of working and transformational change
2. A lack of understanding and agreement of the vision and level of collaboration being sought – this is a board level requirement
3. A lack of willingness and risk appetite to 'step into' a new way of working

The NHS at national and local level has identified working collaboratively as both a benefit and latterly a requirement in delivery of services. The success is often dependant on three key dimensions – the quality of relationships; the identification of the scope and agreement of areas of work; and the approach to how participants choose to work together. Research by the Strategy Unit identifies these areas for further development as shown in the Figures 1&2 below.

Next Steps
Following approval of support from the respective boards in January 2023, a Steering group will be convened to identify the appropriate jointly agreed approach to address the risks as identified above and agree priorities as part of joint plan for the benefit of patients

Conclusion

Consistent with national and local policy and our strategic plan, the opportunity exists to develop a provider collaborative with the Herefordshire & Worcestershire Health & Care trust to improve the outcomes for patients and our communities. The MoU provides a framework under which further work will be required to manage and overcome the risks identified.

Recommendations

F&P is asked to:

- Note the developments for provider collaboratives
- Note the options for closer working with HWHCT
- Note the commitment for cross organisational development required
- Endorse the Memorandum of Understanding between Herefordshire & Worcestershire Health & Care Trust and Worcestershire Acute Hospitals Trust

Appendices

Figure 1

Figure 2

Three Dimensions of Collaboration

Dimension	Conventional Collaboration	Stretch Collaboration
RELATIONSHIPS	Focus on the good of the whole	**Embrace both conflict and connection**
WORK	Agree on the problem and the solution	**Experiment with multiple emergent possibilities**
PARTICIPATION	Directing - getting others to change what they think/do	**Co-creating – stepping into the game and being open to changing**

DRAFT Memorandum of Understanding:

Provider Collaborative Agreement between Herefordshire and Worcestershire Health and Care NHS Trust and Worcestershire Acute Hospitals NHS Trust

Version Control:

Version	Date	Action	Who
V0.1	27.10.22	First Draft	Sue Harris, Director of Strategy HWHCT
V0.2	06.12.22	Updated post comments	Jo Newton, Sue Harris
V0.3	03.01.23	Updated	Sue Harris

Contents

Part One: Memorandum of Understanding

1. Overarching Principles:

1.1. This Memorandum of Understanding (MoU) is based on the same principles as our Place collaboration in Worcestershire and these are:

- At the heart of strategy development and service improvement are patient, service user and citizen voices and clinician and practitioner leadership
- Clinical engagement and leadership is key to drive change
- Principal of subsidiarity - right service planned and delivered at the right level
  - Operating model and governance will seek to build on what works well, and seek to minimise duplication and bureaucracy
  - Data evidence and analysis at Place, to support District/PCN level
- Voluntary and community sector (VCS) recognised as a partner at all levels; making use of VCS assets
- Resources are allocated in place to deliver best value for the Worcestershire pound, risk and reward is jointly managed and protects against personal financial risk

1.2. This MOU commits to and recognises the following:

- The importance and potential of 2 NHS providers working collaboratively across Worcestershire to maximise the positive impacts on healthcare provision and integrated pathways
- Supporting Place as the primary planning footprint for both delivery of population health and integration of NHS, and adult and children's social care services.
- The pivotal role of the Worcestershire Health and Wellbeing Board in setting health and wellbeing strategies to reduce health inequalities.

1.3. This MoU is not:

- A legal contract. It is not intended to be legally binding and no legal obligations or legal rights shall arise between the Provider Collaborative from this MoU.
- Intended to replace or override the legal and regulatory frameworks that apply to statutory NHS organisations.

2. Parties to the Memorandum

2.1. The members ("the Partners") of this Provider Collaborative ("the Provider collaborative") to this Memorandum of Understanding, are:

- Herefordshire and Worcestershire Health and Care NHS Trust (HWHCT)
- Worcestershire Acute Hospital NHS Trust (WAHT)

2.2. Both organisations subscribe to the vision, principles, values and behaviours stated below, and agree to participate in the governance and accountability arrangements set out in this MoU.

3. Definitions and Interpretation

3.1. This Memorandum is to be interpreted in accordance with the Definitions and Interpretation set out in **Schedule One**, unless the context requires otherwise.

4. Term

4.1. This MoU shall commence on the date of signature of the Partners. At the point of any delegated budget, this MOU will terminate. This MOU can be terminated by the agreement of the provider Collaborative at any point, but with no less than 3 months' notice.

4.2. This MOU will be under regular review at 3 and 6 months and in advance of any proposed delegation from the Integrated Care Board to Worcestershire Executive Committee which may require a more formal governance structure at Place between the Provider Collaborative.

5. Purpose

5.1. The purpose of this MoU is to formalise and build on our existing place arrangements and relationships, strengthening the collaboration of the 2 Worcestershire NHS providers as part of the maturing place based arrangements. It does not seek to introduce a hierarchical model; rather it provides a mutual accountability framework, based on principles of subsidiarity, to ensure we have collective ownership of delivery. It also provides the basis for a refreshed relationship with national oversight bodies.

5.2. The MoU outlines how the Partners will work together as NHS organisations in a Provider Collaborative to maximise the impact of place delivery and performance, to deliver best quality outcomes and value to our patients.

5.3. The Partners to this MoU recognise the need to move from a transactional model of provision to a model of collaboration between health and care providers based on population health outcomes; and to transform healthcare services from a focus purely on treatment to one that also prevents ill health from occurring and has a strengths-based approach.

5.4. The Partners intend this MOU to provide pragmatic solutions to Place based partnership working and avoid adding extra unnecessary layers of governance, bureaucracy or

complexity. We aim to avoid creating rigid long term structures that are unable to evolve over time or which undermine the existing governance and statutory responsibilities of our individual organisations.

5.5. The MoU is not a legal contract. It is not intended to be legally binding and no legal obligations or legal rights shall arise between the Partners from this MoU. It is a formal understanding between the Partners who have each entered into this MoU intending to honour all their obligations under it.

5.6. Nothing in this MoU is intended to, or shall be deemed to, constitute a Partner as the agent of another, nor authorise any of the Partners to make or enter into any commitments for or on behalf of another Partner.

6. Our Vision and Ambition

6.1. The Partners have developed a shared vision for health and care services across the Herefordshire and Worcestershire ICS system. All proposals, both as Provider collaborative organisations and at a Place level should be supportive of the delivery of the ICS vision:

"Working together with our communities to enable everyone to enjoy good physical and mental health and live independently for longer'

6.2. This is underpinned by four system objectives:

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience and outcomes
- Enhance productivity and value for money
- Support broader social and economic development

6.3. These align with the Health and Wellbeing Board vision for Worcestershire

"Working together for better health and wellbeing in Worcestershire".

6.4. The anticipated benefits for Worcestershire residents include:

- Improved wellbeing
- Better experience of accessing health and care
- Reduced health inequalities
- Increased value of Worcestershire pound
- Increased social value
- Sustainable local services

6.5. Our collective ambition is to maximise the opportunities for collaboration at Place through:

- Inclusive leadership and culture
- Better use of resources through less duplication and focus on shared priorities
- Our ICS outcomes framework driving positive population health and addressing inequalities
- Strengths based approach to address real life problems
- Flexing system, place and organisational leadership to best meet needs of our population
- Enhancing the role communities can play in improving and sustaining good health

- Embedding our commitment to co-production, working together to facilitate and support change.

7. Our Priorities

7.1. The Partners to this MOU will initially focus on a number of key areas which contribute to Place priorities as well as strengthening NHS pathways. This are captured in **Schedule Two** this MoU.

7.2. The scope of the provider Collaborative will continue to develop and evolve over the coming year with the agreement of the Partners.

Part Two: Ways of Working

8. Our Commitments

8.1. In order to deliver upon the priorities set out in this MOU, the Partners make the following commitments as the Provider Collaborative:

- To put patients first; acting with the best interests of our patients and citizens who are at the heart of this Provider Collaborative
- To ensure the voice of patients and clinical leaders are heard
- To ensure that safe, effective and quality care is provided in the most appropriate and cost effective setting
- To ensure that quality and equality impact assessments, taking account of the impact on Partners in the Provider Collaborative, are undertaken for any decision that impacts on patient care
- To not make decisions which impact on Partners within the Provider Collaborative without first discussing these with Partners, seeking a system solution and taking account of their views in decision making
- To ensure that waste is minimised at every opportunity and that we make the best use of the resources we have
- To maximise the realisation of benefits across the system
- To promote sustainability and social value in all elements of our Provider Collaborative
- In committing to the above, to accept that organisational risk appetites may need to shift to deliver greater benefits for patients, our citizens and the system at Place level

9. Our Behaviours

9.1. The Partners appreciate the link between behaviours, good governance and the impact of the same on the success of our Provider Collaborative. The Partners commit to working together as follows to:

- Put patients and our citizens first and at the heart of our Provider Collaborative
- Value the integral role of clinical leadership
- Recognise what has gone well and to constructively challenge when things have not
- Conduct our business in an open, honest and transparent way, upholding the Nolan Principles in all that we do
- Listen to and respect everyone's point of view, even when we disagree
- Recognise each other's expertise and the value, richness and diversity this brings
- Communicate clearly and openly with honesty and integrity
- Learn from each other and be open to changing our approach to bring about improvement and change
- Be open to constructive challenge
- Champion diversity and inclusivity
- Take responsibility for our actions and be open to feedback
- Take account of the impact of our actions on others and to discuss this with them in an open way
- Promote good governance
- Be role models in all that we do and support each other

10. Use of Resources / Financial Controls

10.1. The Partners intend to establish a shared understanding of the issues faced between the 2 organisations, in a financially challenged environment and adhere to the following principles and ways of working:

- Achieving better outcomes and better value – improving system productivity and efficiency
- Transparency through open book accounting and shared data – creating a collective understanding of the financial position and resource utilisation.
- Agree the best use of local resources including collective agreement on significant investment and disinvestment decisions
- No charges between Partners above actual demonstrable costs

10.2. The overarching approach initially will be through the following areas specific to this Provider Collaborative:

- Pathway transformation (areas identified in the addendum)
- Productivity and efficiency gains
- Workforce / use of resources

10.3. Subject to compliance with confidentiality and legal requirements around competition sensitive information and information security the Partners agree to adopt an open-book approach to the alignment of financial planning and on issues that have a material impact on the availability of system financial incentives

11. Risk Management

11.1. Through this MoU the Partners commit to demonstrate robust risk management through a collaborative approach in the sharing of risk exposure and mitigation for the benefit of the population.

11.2. This includes agreeing to support and collaborate in the development of action or mitigation plans to be mobilised between the Partners, in the event of the emergence of risks outside plans.

11.3. In time, the Partners commit to the development of formal risk sharing agreements to sit alongside those of Place and the ICS.

12. Quality Oversight

12.1. The quality governance will work within the management of quality governance in Worcestershire Place principles which are as follows:

- Quality functions are primarily delivered at Trust level and will continue to be
- Quality governance at Place should be robust but recognising that existing organisational governance remains the cornerstone of quality governance at this stage whilst provider Collaborative are working in collective stewardship

- Many of the issues around quality are related to the interfaces between teams and organisations and working together at Place provides an opportunity to take a collective approach

12.2. The Partners will continue to manage quality as currently, however this agreement will identify actions specific to the Provider Collaborative around quality improvement.

12.3. The Worcestershire Clinical Practitioner Forum will also have a role in quality improvement; bringing together insights from information and transformational resources to direct joint improvement efforts, provide opportunity for joint learning from risks, incidents and complaints and through shared reporting.

13. Infrastructure

13.1. The Partners will look to align and maximise infrastructure capacity across the 2 organisations and deploy to the Partner's areas of focus. This will link into Place structures as appropriate e.g. Business Intelligence (Worcestershire Intelligence Cell) and Programme Management.

Part Three: Place Governance

This section of the document describes in more detail the ways of working and governance groups that exist.

14. HWHCT and WAHT Provider Collaborative

14.1. The Provider Collaborative does not replace or override the authority of the Partner Boards.

14.2. The Provider Collaborative supports Worcestershire Executive function as the mechanism for collaborative action and common decision-making for issues which are best tackled at Place level.

14.3. The focus is on specific actions at Place, specific to the 2 Trusts including NHS pathway improvement and transformation.

14.4. Partners have an accountability to the Health and Wellbeing Board for delivery of locally agreed plans

15. Mutual accountability

15.1. This MoU has no direct impact on the roles and respective responsibilities of the Partners which all retain their full statutory duties and powers.

15.2. Mutual accountability arrangements specific to this Provider Collaborative will focus on delivery of key actions that are specific to the 2 Trusts.

16. Resolving Issues

16.1. The Provider Collaborative will use its best endeavours to make decisions by consensus, noting the decisions reached will only be in relation to agreeing recommendations for onwards approval by the Partners.

16.2. The Partners will attempt to resolve in good faith any issues between them in respect of Provider collaborative related matters, in line with the principles set out in this MoU.

16.3. The Partners commit to taking all reasonable steps to reach a mutually acceptable resolution to any issue that arises, however issues that cannot be resolved despite the best endeavours of the Provider Collaborative will be escalated to the Partner's Trust Boards.

17. Variations

17.1. This MoU, including the Schedules, may only be varied by written agreement of the Partners.

18. Charges and Liabilities

18.1. Except as otherwise provided, the Partners shall each bear their own costs and expenses incurred in complying with their obligations under this MoU.

18.2. By separate agreement, the Parties have agreed to share specific costs and expenses arising in respect of the Provider Collaborative between them in accordance with a "Contributions Schedule", developed by the Provider Collaborative and approved by the Partners.

18.3. Partners shall remain liable for any losses or liabilities incurred due to their own or their employee's actions.

19. Information Sharing

19.1. The Partners will provide to each other all information that is reasonably required in order to achieve the objectives and take decisions within the confines of this MOU.

19.2. The Partners have obligations to comply with competition law. The Partners will therefore make sure that they share information, and in particular competition sensitive information, in such a way that is compliant with competition and data protection law.

19.3. The Partners accept they are subject to the Freedom of Information Act 2000 and agree to assist and cooperate to enable each Partner to comply with their obligations under the Act.

19.4. Each Partner may be obliged to comply with its obligations under the Freedom of Information Act without informing or consulting the other. However, the Partners will take reasonable steps to inform and consult before responding to an information request in relation to the Provider collaborative and shall take into account any views expressed by the other Partner. Where it was not possible to inform and/or consult the other Partner in advance of a disclosure, it shall draw the disclosure to the Partners attention after the event.

20. Confidential Information

20.1. Each Partner shall keep in strict confidence all Confidential Information it receives from another Partner except to the extent that such Confidential Information is required by Law to be disclosed or is already in the public domain or comes into the public domain otherwise than through an unauthorized disclosure by a Partner.

20.2. Each Partner shall use any Confidential Information received from another Partner solely for the purpose of complying with its obligations under this MoU in accordance with the principles and objectives and for no other purpose. No Partner shall use any Confidential Information received under this Memorandum for any other purpose including use for their own commercial gain in services outside of the Provider Collaborative or to inform any competitive bid without the express written permission of the disclosing Provider collaborative.

20.3. To the extent that any Confidential Information is covered or protected by legal privilege, then disclosing such Confidential Information to any Provider collaborative or otherwise permitting disclosure of such Confidential Information does not constitute a waiver of privilege or of any other rights which a Provider collaborative may have in respect of such Confidential Information.

20.4. The Parties agree to procure, as far as is reasonably practicable, that the terms of this paragraph (Confidential Information) are observed by any of their respective successors,

assigns or transferees of respective businesses or interests or any part thereof as if they had been party to this MoU.

20.5. Nothing in this paragraph will affect any of the Partners regulatory or statutory obligations, including but not limited to competition law.

21. Signatures

21.1. This MoU may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this MoU, but all the counterparts shall together constitute the same document.

21.2. The expression "counterpart" shall include any executed copy of this MoU transmitted by fax or scanned into printable PDF, JPEG, or other agreed digital format and transmitted as an e-mail attachment.

21.3. No counterpart shall be effective until each Partner has executed at least one counterpart.

Signed:	Position	Organisation	Date
	Chair CEO	**Herefordshire & Worcestershire Health & Care Trust**	
Print:			

Signed: Print:	Position	Organisation	Date
		Worcestershire Acute Hospitals Trust	

22. Schedule One: Definitions and Interpretation

22.1. The headings in this MoU will not affect its interpretation.

22.2. Reference to any statute or statutory provision, to Law, or to Guidance, includes a reference to that statute or statutory provision, Law or Guidance as from time to time updated, amended, extended, supplemented, re-enacted or replaced.

22.3. Reference to a statutory provision includes any subordinate legislation made from time to time under that provision.

22.4. References to anybody, organisation or office include reference to its applicable successor.

23. Schedule Two: Addendum to MoU

Herefordshire & Worcestershire Health & Care NHS Trust

Worcestershire Hospitals Acute NHS Trust

Addendum to Memorandum of Understanding

Current examples of success

Corporate/back office enablers	Service improvement/integrated pathways
Workforce initiatives including • Working together access the system to deliver the People Plan • Recruitment programmes with funding and support from NHSEI for International Recruitment, Healthcare Support Workers and the Reservist programmes	Homefirst programme *(improving urgent care through a system approach)* including the implementation of the Onward Care Team, 2 hour response, discharge pathways and role of minor injury units
Joint funding for launch and first cohort of compassionate leadership programme	Hospital liaison services for people with a learning disability and people with mental ill health
WAHT delivery of occupational health services for HWHCT	Joint pathways in place for patients with a fractured neck of femur
Enabling diversity and inclusion – joining up staff networks and sharing of best practice	Joint stroke pathway and oversight from Worcester Acute Stroke team into Evesham Community Hospital
Signed Memorandum of Understanding for Worcestershire Executive Committee in place	Integrated maternal mental health pathway with hosted roles and joint leadership
Joint flu and COVID vaccination delivery programme for staff	Community dentistry and Oral Surgery partnership to support dental care under general anaesthetic
System wide mental health wellbeing hub	Sexual health services in the community and GUM collaboration

HWHCT deliver Mental Health Act and legal services for WAHT	Orchard service for Children and Young People with a life limiting condition or post an acute episode

Future opportunities (23/24)

Corporate	Service improvement
HWHCT & WAHT MoU	Frailty pathway including joint roles across the pathway, Joint Respect form protocol, Virtual Ward developments and phase 2 of the Intermediate care service and Onward Care Team
Information governance sharing agreement	Phase 2 of the stroke pathway development (including demand and capacity modelling)
Risk sharing agreement	Explore the potential for integrated physical and mental health beds on the WRH site
Joint performance management framework (flow – management / reporting)	Joint phlebotomy outreach clinics (with PCNs)
Shared elements of corporate infrastructure and support	Opportunities to consider greater integration of some therapy services – particularly OT and Physio
Developing a provider collaborative governance structure for Place	Pathways for people with dementia
Integrated care record	Completion of the outpatients redesign

Developing a partnership - OD opportunities

	Purpose/ action	Who	Lead
1.0	**To build understanding of key /shared issues**		
		Non-executive	ROC / GH

1.1	Observation board / committee meeting	committee chair / Company secretary	
1.2	Share committee structure	Company secretary	ROC / GH
1.3	Share BAF	Company secretary	ROC / GH
1.4	Table joint ICS comms/briefings *To develop consistent messaging*	DoS	JN / SH
1.5	To identify secondment opportunities	All staff grade 7 and above	Execs
1.6	To share PDR objectives	Exec to exec	Execs
2.0	**Delivering for patients**		
2.1	Sharing best practice of improvements	**All**	**All**
2.2	Identifying joint valuestream for 4ward Improvement system (VMI) *Example:* *Outpatients, Flow*	DI (4IS) / DoS	JC / SH
2.3	Explore opportunities to improve patient outcomes Use BI / PHM to target patient groups to reduce health inequalities	Execs	COOs/DOS

2.4	Share Green Plans	CFO / DoS	RM/ JN

NHS
Worcestershire Acute Hospitals NHS Trust

Meeting	Public Trust Board
Date of meeting	12 January 2023
Paper number	Enc G

Integrated Performance Report – Month 8 2022/23

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

Accountable Directors	Paul Brennan – Chief Operating Officer, Paula Gardner – Chief Nursing Officer, Christine Blanshard - Chief Medical Officer, Tina Ricketts – Director of People & Culture, Neil Cook – Chief Finance Officer, Vikki Lewis – Chief Digital Information Officer		
Presented by	Vikki Lewis – Chief Digital Information Officer	**Author /s**	Steven Price – Senior Performance Manager Nikki O'Brien - Associate Director – Business Intelligence, Performance and Digital

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

Report previously reviewed by		
Committee/Group	Date	Outcome
TME	14th December 2022	Approved
Finance and Performance	21st December 2022	Assured
Quality Governance	22nd December 2022	Assured

Recommendations	Trust Board are asked to: ▪ Note this report for assurance

Key Issues

Operational Performance
Year End Forecast

Elective Activity	22/23 Submitted Plan	22/23 Bottom Up Plan	22/23 Predicted Year End Scenario 1	Scenario 2	Scenario 3
Outpatient New	202,369	167,089	194,027	182,089	195,352
Outpatient Follow-up	315,965	363,446	365,501	386,673	399,330
Day Case	90,339	76,692	83,404	79,103	82,492
Elective Inpatient	8,491	7,082	7,175	6,628	6,063

Table 1

The table above compares our 22/23 submitted and bottom-up plans to three different year end scenarios. Scenario 1 is comprised of our Apr to Nov actuals plus the Dec - Mar submitted plan. Scenario 2 is comprised of our Apr to Nov actuals plus the Dec - Mar bottom-up plan. Scenario 3 is Apr to Nov actuals plus an adjusted forecast to Dec – Mar based on activity gains observed in Oct and Nov and applying them to the number of working days in each month. As Oct and Nov were our months of highest activity, this is hopefully a more realistic view on what our year end position could be.

Reducing the number of potential 78+ week breaches is one of our other significant annual plan targets. From a starting position of 23,901, this has reduced to 4,895 as at 9th December. Although the rate of decline across the first 37 weeks of the year is linear, the week to week variation is not. The rate of decrease has slowed in the last 6 weeks thus requiring in

NHS
Worcestershire Acute Hospitals NHS Trust

Meeting	Public Trust Board
Date of meeting	12 January 2023
Paper number	Enc G

excess of 300 clock stops a week for 16 weeks in order to achieve the target. The does mean there is a risk of not achieving the target of zero.

Elective Recovery

Elective Activity			Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	YTD Total
Outpatients	News	Plan	12,488	16,562	18,621	17,547	16,572	18,322	17,713	17,484	15,642	17,837	16,156	17,424	135,310
	(Target 104%)	Actual	13,158	16,084	15,467	15,014	15,629	16,610	17,217	18,087					127,266
	Follow-ups	Plan	29,456	24,904	27,523	27,755	25,715	27,713	26,651	25,847	22,988	27,257	24,001	26,156	215,564
	(Target 75%)	Actual	30,172	34,009	32,784	31,841	33,248	34,333	33,483	36,449					266,319
Inpatients	Day Case	Plan	5,824	7,293	8,287	8,251	7,650	7,930	7,803	7,902	6,930	7,786	7,248	7,435	60,941
	(Target 104%)	Actual	5,835	6,661	6,286	6,437	7,129	7,082	6,942	7,660					54,032
	Elective Spells	Plan	455	584	697	707	646	744	663	824	744	766	808	853	5,320
	(Target 104%)	Actual	450	526	525	449	500	500	524	522					3,996
Diagnostics	Imaging	Plan	12,565	13,208	12,444	12,711	13,554	14,646	15,215	15,357	14,739	16,584	14,904	16,254	109,700
	(Target 120%)	Actual	11,723	13,515	13,155	13,608	13,540	14,108	14,400	14,734					108,783
	Endoscopy	Plan	1,392	1,613	1,596	1,769	1,495	2,390	2,310	1,934	1,338	1,847	1,760	1,966	14,499
	(Target 120%)	Actual	1,022	1,285	1,158	1,278	1,374	1,543	1,583	1,313					10,556
	Echocardiography	Plan	806	842	916	684	1,025	982	1,025	1,259	1,001	1,693	1,216	1,151	7,539
	(Target 120%)	Actual	1,001	1,150	1,008	1,072	1,150	1,227	1,360	1,250					9,218

Table 2

We are above the OP New activity target which continues the focus on mitigating activities such as reduction of DNAs and cancellations. OP follow-ups continue to be over our plan.

Both day case activity and inpatient (ordinary) are below plan. However, we did deliver the most day cases in a month since recovery monitoring began. This reinforces the view from the previous report that the focus on productivity and efficiency improvements in theatres are starting to deliver; achieving 85% theatre utilisation is a key component of this.

Our DM01 Diagnostics waiting list at the end of Nov-22 was 8,404. The number of patients waiting 6+ weeks decreased to 1,643, specifically due to the volume of activity being completed by radiology. For the first time we completed over 19,000 DM01 reportable diagnostic tests during the month. CT exceeded their annual plan targets and we remain within 2.4% of achieving our full year plan.

Elective Performance

Elective Performance			Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
RTT	104+ week waiters	Plan	250	120	88	0	0	0	0	0	0	0	0	0
	(Zero by July 2022)	Actual	254	161	40	31	12	0	0	1				
	78+ week waiters	Plan	1,600	1,545	1,450	1,212	1,024	865	670	540	696	333	157	0
	(Zero by April 2023)	Actual	1,574	1,631	1,505	1,200	1,093	979	1,115	1,321				
	52+ week waiters	Plan	6,600	6,450	6,274	6,194	6,024	5,864	5,773	5,600	5,553	5,577	5,469	5,400
	(Zero by March 2025)	Actual	6,488	7,127	7,826	7,695	7,633	7,772	7,957	8,194				
	Total Incomplete Waiting List	Plan	55,835	55,495	55,290	55,670	55,140	54,369	54,209	52,783	52,546	52,986	52,160	51,713
		Actual	60,056	61,895	63,391	64,284	65,264	65,420	66,703	68,894				
Cancer	63+ day waiters	Plan	The annual plan trajectory has been replaced following an Oct-22 NHSE request to submit revised recovery trajectories for 62+ day Cancer backlog - this is being monitored weekly.											
		Actual												
	28 Day | Patients Told Outcome	Plan	71%	72%	73%	74%	75%	75%	75%	75%	75%	76%	75%	75%
	(CWT Standard - 75%)	Actual	58%	57%	50%	52%	52%	45%	54%	67%				

Table 3.1

		30/10/22	06/11/22	13/11/22	20/11/22	27/11/22	04/12/22	11/12/22	18/12/22	25/12/22	01/01/23	08/01/23	15/01/23	22/01/23	29/01/23	05/02/23	12/02/23	19/02/23	26/02/23	05/03/23	12/03/23	19/03/23	26/03/23	02/04/23
63+ day waiters	Recovery Trajectory	810	819	836	856	868	844	814	770	752	740	695	669	637	606	561	526	493	467	436	393	370	350	328
	Actuals	797	763	731	668	551	572	551																

Table 3.2 – Urgent Suspected Referral backlog only

NHS
Worcestershire Acute Hospitals
NHS Trust

Meeting	Public Trust Board
Date of meeting	12 January 2023
Paper number	Enc G

Consultant-led referral to treatment time

The validated number of patients waiting over 104 weeks for Nov-22 was one (Gynaecology). The overall incomplete RTT waiting list continues to increase at a rate of 500 per month. The level of clocks starting continues to be higher than clock stops.

Cancer

The number of 2WW referrals in Nov-22 remained above the mean. Overall 2WW performance have transitioned to normal variation. We saw over 3,000 patients for the second month in a row with 4 specialties achieving the 2WW operational standard and forecasted Dec-22 performance is that we will achieve 93% overall. The focus on best practice pathway has improved timely diagnostic testing and reports which in turn has benefitted the 28-day faster diagnosis standard; at its highest performance this year.

At the end of Nov-22, we recorded 733 patients who have been waiting over 63 days for diagnosis and / or treatment and 275 of those patients have been waiting over 104 days.

Elective Benchmarking

Elective Benchmarking		Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
2WW Cancer Patients Seen	Trust	2,255	2,261	2,525	2,066	2,653	2,294	2,298	2,335	2,977	3,003		
	Peer Average*	1,749	1,906	2,256	2,075	2,184	2,030	2,087	2,323	2,205	2,142		
	WAHT Rank**	5	5	5	6	5	6	6	6	4	4		
2WW Cancer Breast Symptomatic	Trust	116	141	149	66	97	87	70	89	80	82		
	Peer Average*	88	92	101	79	80	77	72	70	73	71		
	WAHT Rank**	5	3	3	8	4	4	6	4	6	5		
28 Day FDS Patients Told Outcome	Trust	2,286	2,110	2,403	1,882	2,376	2,121	2,251	2,169	2,582	2,896		
	Peer Average*	1,774	1,832	2,096	1,943	2,038	1,888	1,983	2,151	2,111	2,117		
	WAHT Rank**	5	6	6	5	6	6	6	6	4	4		
62 Day Patients Treated	Trust	151	154	196	152	165	177	182	154	168	203		
	Peer Average*	111	112	129	118	127	119	113	122	130	123		
	WAHT Rank**	5	4	3	5	4	4	3	5	5	3		
Diagnostics Waiting List	Trust	10,719	10,229	10,031	9,609	10,496	10,312	9,683	10,077	9,000	9,598		
	Peer Average*	13,760	14,410	15,152	14,933	15,832	16,464	16,400	16,217	16,593	16,677		
	WAHT Rank**	6	6	6	6	6	6	6	6	6	6		
Diagnostics Activity	Trust	17,068	16,048	17,956	15,094	17,572	16,963	17,596	17,696	18,468	18,969		
	Peer Average*	14,820	14,557	16,147	14,623	16,024	15,389	16,463	16,772	16,472	17,162		
	WAHT Rank**	5	5	5	6	6	6	6	6	5	5		
RTT 104+ weeks	Trust	489	466	327	253	161	40	31	12	0	0		
	Peer Average*	314	266	323	243	121	45	28	57	66	41		
	WAHT Rank**	11	10	6	6 of 9	8 of 9	4 of 6	4 of 6	6 of 8	N/A	N/A		
RTT 52+ weeks	Trust	6,025	5,884	5,844	6,481	7,205	7,816	7,683	7,623	7,766	7,946		
	Peer Average*	4,359	4,132	4,341	4,467	4,526	4,747	4,992	5,000	5,061	5,030		
	WAHT Rank**	12	12	12	12	12	12	12	12	12	11		

Table 4

- Benchmarking shows that increases in activity from Sep-22 to Oct-22 were not always mirrored by the WM peer Trusts. WAHT's rank improved for 2WW BS patients seen and 62 Day Patients Treated (up to 3rd). Our rank did not decrease for any activity metric.
- Our Diagnostics waiting list decreased but the peer average waiting list size increased.
- 4 trusts, not including WAHT, recorded having patients breaching 104+ weeks at the end of Oct-22.
- The number of patients waiting over 52+ weeks increased for the Trust whilst the average of our peers decreased. However, our rank improved from 12th to 11th.

NHS
Worcestershire Acute Hospitals NHS Trust

Meeting	Public Trust Board
Date of meeting	12 January 2023
Paper number	Enc G

Referrals, Bed Occupancy & Advice & Guidance

Referrals, Bed Occupancy & Advice & Guidance			Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	YTD Total
Referrals	The total number of referrals made from GPs for first consultant-led outpatient appointments in specific acute treatment functions	Plan	6,011	5,581	5,509	5,842	5,369	6,144	5,893	5,727	6,984	6,264	5,824	4,952	46,076
		Actual	4415	5952	5493	6012	5674	4977	4286	4660					41,469
	The total number of other (non-GP) referral made for first consultant-led outpatient appointments in specific acute treatment functions	Plan	3,183	3,067	2,851	3,203	3,163	3,568	3,275	3,450	3,449	3,095	3,343	2,795	25,760
		Actual	2832	3135	3008	2851	2908	2853	3042	3053					23,682
Bed Occupancy	Average number of overnight G&A beds occupied	Plan	678	678	678	678	678	678	692	692	692	692	692	678	678
		Actual	682	682	682	731	731	731	720	730					711
	Average number of overnight G&A beds available	Plan	721	721	721	721	721	721	721	721	721	721	721	721	721
		Actual	721	721	721	754	754	754	754	754					745
	Bed Occupancy - Percentage	Plan	94%	94%	94%	94%	94%	94%	96%	96%	96%	96%	96%	94%	94%
		Actual	95%	96%	95%	97%	97%	97%	95%	97%					96%
A & G	Advice & Guidance - Plan	Plan	2,383	2,314	2,591	2,531	2,512	2,468	2,436	2,542	2,503	2,500	2,493	2,509	19,777
	Advice & Guidance - Actual	Actual	2,269	2,769	2,523	2,633	2,716	2,729	2,747	3,139					21,525

Table 5

We continue to receive c8,000 referrals of which 75% went through the referral assessment service and 11% are returned to the referrer. Monitoring up to Jun-22 shows that approximately 73% of A&G requests do not result in a further request to the same specialty (within 90 days of the initial request).

Urgent and Emergency Care

UEC		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Type 1 Attendances	Plan	12,576	13,845	14,251	14,303	13,125	13,661	13,296	12,998	13,287	12,656	11,869	13,399
(excluding planned follow-up attendances)	Actual	11,729	12,800	12,259	12,291	11,835	11,859	12,128	11,929				
Patients spending >12 hours from DTA to admission		222	248	277	268	254	176	335	336				
Patients spending more than 12 hours in A&E		1,584	1,537	1,749	1,722	1,787	1,693	1,953	2,038				
Ambulance Conveyances		3,911	4,305	3,944	3,903	3,885	4,020	3,782	3,683				
Ambulance handover delays over 60 minutes		1,108	1,094	1,288	1,202	1,281	1,025	1,380	1,316				
Conversion rate		26.7%	26.0%	26.9%	26.1%	27.3%	29.1%	28.3%	28.5%				

Table 6

All performance metrics remain special cause for concern. The daily discharge targets (slide 8 of the main IPR) show that we achieved 16 of 30 days above the target and the overall performance was 93%. However, Monday and Tuesday were consistently the days of the week that the daily targets were not achieved.

Quality and Safety
Fractured Neck of Femur (#NOF)

There were 56 #NOF admissions in Nov-22 and a total of 12 breaches (44 in Oct-22). #NOF compliance increased in Nov-22 to 78.6% which is the highest performance since Jun-21. The reasons for delay were: 66.7% (8 patients) due to patients being medically unfit, 16.7% (2 patients) due to bed issues and 16.7% (2 patients) due to requiring further imaging. The average time to theatre in Nov-22 was 35.4 hours (46.2 in Oct-22).

Infection Prevention and Control

We were compliant with all of the in-month infection targets in Nov-22. We have breached 3 of the year to data infection targets: C-Diff (actual 76 vs target 52), E-Coli (actual 23 vs target 21) & MSSA (actual 12 vs target 8). Three new COVID outbreaks and two D&V/Norovirus outbreaks were declared in Nov-22.

Worcestershire Acute Hospitals NHS Trust

Meeting	Public Trust Board
Date of meeting	12 January 2023
Paper number	Enc G

Sepsis (reported a month in arrears)

Our performance against the sepsis bundle being given within 1 hour has increased in Oct-22 to 68% but remains non-compliant with the 90% target. The Sepsis screening compliance dropped in Oct-22 and failed to meet the target for the first time in 5 months. A review is to be undertaken to ascertain whether the decline is related to the delays in ED assessment or additional boarding on our wards.

People and Culture

We have continued to make progress against our workforce plan with 37 wte more staff in post this month. We are now ahead of our trajectory by 165 wte from the original workforce plan set in April.

This month has also seen further improvement in our staff turnover rate which has now reduced to 12.99%. However, we have not seen the expected reduction in bank and agency usage due to the establishment increasing by 37 wte which predominately relates to the Pathway Discharge Unit.

We are focusing on getting the basics right as we have seen a slight reduction in mandatory training, job planning and individual occupational health risk assessment compliance.

Our Financial Position

Month 8

The position outlined below is based on the revised national planning submission of the 20th June 2022 with a full year deficit of £19.9m.

In M8 the actual **deficit £1.4m** against a plan of **£1.5m deficit**, a favourable variance of £0.1m. This brings the year to date M8 actual **deficit to £13.5m** against a plan of **£13.0m deficit,** an adverse variance of £0.6m (4.6%).

Statement of comprehensive income	Nov-22 Plan £'000	Nov-22 Actual £'000	Nov-22 Variance £'000	Year to Date Plan £'000	Year to Date Actual £'000	Year to Date Variance £'000
INCOME & EXPENDITURE						
Operating income from patient care activities	47,440	48,998	1,558	379,447	387,525	8,078
Other operating income	2,689	2,334	(355)	20,705	19,366	(1,339)
Employee expenses	(29,843)	(31,422)	(1,579)	(238,849)	(246,165)	(7,316)
Operating expenses excluding employee expenses	(19,907)	(19,580)	327	(159,595)	(160,009)	(414)
OPERATING SURPLUS / (DEFICIT)	**379**	**330**	**(49)**	**1,708**	**717**	**(991)**
FINANCE COSTS						
Finance income	0	79	79	0	416	416
Finance expense	(1,165)	(1,141)	24	(9,320)	(9,299)	21
PDC dividends payable/refundable	(681)	(682)	(1)	(5,450)	(5,451)	(1)
NET FINANCE COSTS	**(1,846)**	**(1,744)**	**102**	**(14,770)**	**(14,334)**	**436**
Other gains/(losses) including disposal of assets	0	0	0	0	251	251
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**(1,467)**	**(1,414)**	**53**	**(13,062)**	**(13,366)**	**(304)**
Add back all I&E impairments/(reversals)	0	0	0	0	0	0
Surplus/(deficit) before impairments and transfers	**(1,467)**	**(1,414)**	**53**	**(13,062)**	**(13,366)**	**(304)**
Remove capital donations/grants I&E impact	11	10	(1)	83	81	(2)
Adjusted financial performance surplus/(deficit)	**(1,456)**	**(1,404)**	**52**	**(12,979)**	**(13,285)**	**(306)**
Less gains on disposal of assets	0	0	0	0	(251)	(251)
Adjusted financial performance surplus/(deficit) for the purposes of system achievement	**(1,456)**	**(1,404)**	**52**	**(12,979)**	**(13,536)**	**(557)**

The Combined Income (including PbR pass-through drugs & devices and Other Operating Income) was £1.2m (2.4%) above the Trust's Operational Plan in November and £6.7m above year to date (1.7%)

The key favourable variances in November relates to the pay award adjustment £0.7m (additional central funding of 1.7% taking the uplift for the pay award from 2.1% to 3.8%) and the NI Contribution change (£0.2m) from November onwards, pass through Drugs & Devices £0.8m for ICBs and NHS England and additional Investment of £0.6m including the Robot £0.1m and KGH MRI scanner extension funding from Cancer Alliance £0.3m.

The adverse variance of £0.3m (£1.5m year to date) relating to the AMU/PDU funding continues as there is still no resolution with Commissioners to fund this development in 2022/23. Lower reimbursement for COVID PCR testing (£0.4m) as a result or lower costs explains the remainder.

The Trust has reported the full value of the Elective Recovery Fund (ERF) income (YTD £11.1m) in the position on the continued assumption that these funds will be passed through. The Trust's actual performance is well below this level and we estimate that had the ERF not been fixed we would have lost c.£9m (75%) of the available ERF income to date against target.

Employee expenses in Month 8 were £1.6m (5.3%) adverse to plan and year to date £7.3m (3.1%) adverse to plan.

Of the adverse variance £0.5m in month (£5.6m YTD) is due to the additional cost of the pay award which was not in the plan but is income backed and £0.3m underachieved PEP (£3.4m YTD) - net of the £0.9m YTD underspend against investments declared in month. £0.1m Winter pressures costs (offset by income), and £0.3m in month relates to the retrospective impact of prior month Medics shifts, increased workforce £0.2m, nursing pay award £0.2m, partially offset by ERF benefit £0.2m.

Operating expenses in Month 8 were £0.3m (1.6%) favourable and £0.4m (0.3%) adverse year to date.

The key driver of the favourable variance in month is within General Supplies and Services (£1.3m in month, £1.6m YTD) of which £1.1m relates to the release of old year provisions/accrual.

Other favourable variances include Covid Pathology testing (£0.3m in month, £1m YTD) offset by reduced income above and Non PbR Devices (£0.3m favourable in month but £0.2m adverse YTD) due to a correction to stock – full reconciliation to income position to be undertaken in M9

Favourable variances are partially offset by adverse variances in month due to:

- Non PbR Drugs – offset by income (£0.5m in month, £2.9m YTD) and linked to higher activity
- Tariff Drugs (£0.2m in month, £1m YTD) linked to higher activity
- Cost pressure of £0.3m relating to ERF offset by old year provision release.
- Premises (£0.1m in month due to unachieved PEP)

NHS
Worcestershire Acute Hospitals
NHS Trust

Meeting	Public Trust Board
Date of meeting	12 January 2023
Paper number	Enc G

Full Year Forecast

The Finance and Performance Committee was provided with a projection to year end which had been prepared with the support of Divisions and which reflected a potential risk of £5.2m to delivery of the plan.

M8 and YTD actual performance is favourable to the operational forecast, however, this has been achieved by a combination of fortuitous non recurrent benefits including a £1.9m balance sheet release out of a total of £3m available which was included in the forecast scenario leaving £1.1m to release in M9-12.

Productivity and Efficiency

Our Productivity and Efficiency Programme target for 22/23 is £15.7m. In Month 8 we delivered £1.580m of actuals against the plan of £1.067m, a positive variance of £0.513m (48.1%).

The improvement in M8 actuals is as a result of a finance review of non-recurrent investment under spends for the year, details of which were shared with the Finance Committee.

The cumulative position at M8 is therefore £ 5.810m of actuals against a plan of £ 7.808m, a negative variance of £1.998m (25.6%).

The 22/23 full year forecast at Month 8 is £10.609m which is £5.091m (32.4%) under plan.

Capital

The total capital plan submitted for 2022/23 was £62.1m. The revised forecasted expenditure at M8 of £61.9m is estimated to be £2.5m overspent against our projected Capital Resource Limit (CRL) of £59.4m. This is due to a forecast increase in UEC expenditure with no compensating source of funding. This is being reviewed urgently with work stream leads.

Capital Position	22/23 Plan £'000	Revised Internal plan £'000	Total YTD Valuation £'000	M9 - M12 Spend Forecast £'000	22/23 Full Year Forecast £'000	Mitigated Variance Against Revised Plan £'000
Property & Works	3,961	3,961	392	1,174	1,566	2,395
Digital	11,648	12,815	1,933	8,928	10,861	1,954
Equipment	826	1,006	525	379	903	103
Strategic Developments	34,635	11,356	9,385	11,341	20,726	(9,370)
TIF2 Theatres bid		18,886	147	16,359	16,506	2,380
Lease Additions	10,785	10,785	-	10,785	10,785	-
IFRIC 12 PFI Lifecycle replacement	326	552	517	35	552	-
Total Capital Expenditure	**62,181**	**59,361**	**12,898**	**49,001**	**61,899**	**(2,538)**

Our Capital Position at month 8, being the value of works complete, is £12.9m. This is an increase of £1.2m since month 7.

Each month, all work stream leads are providing more detailed monthly profiles of expenditure to enable decisions to be made on re-profiling and brokerage of spend to support achievement of the CRL.

It should be noted that any slippage into 2023/24 will be the first call on any internal capital available in 2023/24 financial year.

There remain a number of risks around the strategic capital programmes particularly:

NHS
Worcestershire Acute Hospitals NHS Trust

Meeting	Public Trust Board
Date of meeting	12 January 2023
Paper number	Enc G

- Risks remain regarding the financing of the UEC scheme. Discussions are being held regarding brokerage solutions with ICB and Region to try and avoid using a significant proportion of the Trusts own internally generated funds thus delaying a significant proportion of spend on backlog maintenance and equipment replacement in particular.
- The timing of the release of funds to support the centrally funded schemes in particular ASR Business Case, Frontline Digitisation and the TIF2 Theatres project.

There are ongoing discussions with NHSE/I to support the Trust with capital funding for 22/23 linked to the forecast overspend due to the UEC project.

Cash

At the end of November 2022 the cash balance was £25.8m against an in-month plan of £47.5m. The plan assumed external capital funding of £17.6m which has not been drawn down yet due to the slippage on capital schemes above. The remaining variance is mainly due to higher income accruals compared to plan.

The relatively high cash balance remains the result of the timing of receipts from the CCG's and NHSE under the continuing COVID era arrangements together with timing of creditor / supplier payments. Requests for PDC in support of revenue funding this year are reviewed based on the amount of cash received in advance under this arrangement, the Trust has not requested any revenue cash support YTD due to the high cash reserves being held.

Aster

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

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

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

Recommendations
Trust Board are asked to: ▪ Note this report for assurance
Appendices
▪ Integrated Performance Report (up to Nov-22 data) ▪ WAHT At A Glance – Nov-22

Worcestershire Acute Hospitals NHS Trust

Meeting	Public Trust Board
Date of meeting	12 January 2023
Paper number	Enc G

- WAHT November 2022 in Numbers Infographic
- Committee Assurance Statements – December 2022 meetings

Integrated Performance Report

NHS Worcestershire Acute Hospitals NHS Trust

Trust Board

12th January 2023

Data: Up to November 2022

The use of this NHS icon denotes a metric that is included in the NHS System Oversight Framework

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

1

SUCCESSES

Area	Comments
Cancer	• We maintained the delivery of over 3,000 2WW appointments in a month. Our 2WW performance has improved as a result and we are currently on track to achieving the operational standard of 93% in Dec-23. • 4 specialties have achieved the 2ww operational standard this month. • Our 62+ day backlog, and those waiting over 104 days, has reduced. • Best Practice Pathway reporting is in place for colorectal and prostate, with Upper GI reporting current being tested and Lung identified as the next specialty to be worked on.
G&A Bed Discharges	• Our daily discharge targets were achieved on 16 of the 30 days in Nov-22 with an overall performance of 93%
Diagnostics	• We delivered over 19,000 tests in Nov-22.
Recovery	• We exceeded our outpatient new target meaning we delivered more than 104% of Nov-19 activity. • We have delivered the most day cases in a month since recovery started being monitored and were only 9 cases below that achieved in Nov-19.
Stroke	• We achieved a grade A for Q2 22/23 SSNAP with a score of 82.0

Operational Performance

Operational Performance Headlines

STRATEGIC OBJECTIVE TWO: BEST EXPERIENCE OF CARE AND BEST OUTCOMES FOR OUR PATIENTS

Operational Performance	Comments
Patient Flow	• The vast majority of headline metrics remain of statistical concern. • Walk-in attendances are at their seasonal highest on record partially driven by ambulances unable to handover patients to our hospitals. • Our daily discharge targets were achieved on 16 of the 30 days in Nov-22 with an overall performance of 93%. Mondays and Tuesdays show the biggest gap between actuals and target (slide 8). • Medically fit and patients who do not have a reason to reside continue to contribute to our bed pressures and impact successful flow from ED to admission and discharge.
Elective Recovery	**Cancer** (validated) • **Long Waits:** The backlog of patients waiting over 62 days is 733, 275 of those waiting 104+ days, with urology and skin contributing the most patients to this cohort of our longest waiters. • Cancer referrals continue to be significantly high compared to pre-covid referral rates, and although the cancer waiting time standard for 2WW has not been achieved, four specialties achieved the 93% standard and performance has increased to 75%. This has been achieved by delivering over 3,000 appointments for the second consecutive month. • The 28 Day Faster Diagnosis standard has not been achieved and remains at risk with referred patients not being seen by a specialist within 14 days. • The 62 day standard has not been achieved and the delays are also impacting the 31 day standard of treatment from decision to treat which continues to show special cause concern and below the 96% standard.
	RTT (validated) • Long Waits: Our 8,103 patients waiting over a year for treatment can be broken down as follows; between 52 and 78 weeks (6,818) and between 78 and 104 weeks (1,284). One patient waiting over 104 weeks will be reported for the end of Nov-22. • The rate at which clock stops are being recorded for patients who are potential 78+ weeks breaches at the end of Mar-23 has slowed – this puts achieving the annual planning national target of zero at risk (slide 18).
	Outpatients (2nd SUS submission) • Long Waits: There are over 34,000 RTT patients waiting for their first appointment and 25% of the total cohort waiting for a first appointment have been dated. • Based on our second SUS submission for Nov-22, we have achieved our submitted plan target for OP New appointments but not reducing our follow-ups delivering more appointments than Nov-19. • The validation programme has continued and been broadened out to the next cohort of patients. To date, 12% of batch 1 (157 patients) and 10% of batch 2 (102 patients) have indicated an appointment is no longer required.
	Inpatients (2nd SUS submission) • Based on our second SUS submission, we have not achieved our 22/23 annual plan targets for total elective spells in the month with both elective inpatient and day case falling short. • However, we did deliver more day cases than Nov-19.
	Diagnostics (validated) • **Long Waits:** 1,632 patients are waiting over 6 weeks for their diagnostic test with 25% waiting for a colonoscopy. • Total DM01 activity in Nov-22 was 19,765 tests – the highest on record. • CT, flexi sigmoidoscopy and echocardiography achieved their annual plan activity targets. MRI, CT, non-obstetric ultrasound colonoscopy and gastroscopy exceeded Nov-19 levels of testing. • We have delivered sufficient activity to be at 2.4% of the YTD submitted activity plan (to achieve 120% of 19/20).

Patient Flow

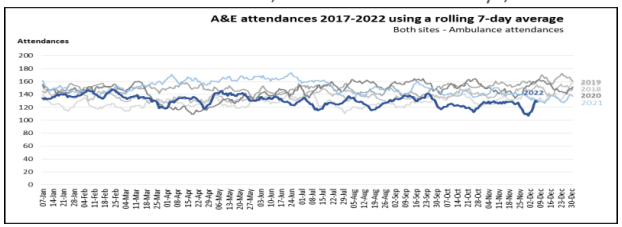
STRATEGIC OBJECTIVE TWO: BEST EXPERIENCE OF CARE AND BEST OUTCOMES FOR OUR PATIENTS | BEC2: flow and discharge

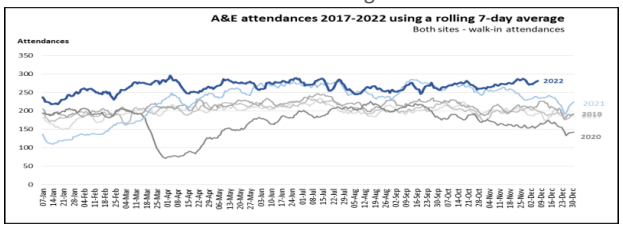
Percentage of Ambulance handover within 15 minutes	60 minute Ambulance Handover Delays	Time to Initial Assessment - % within 15 minutes	Time In Department				12 Hour Trolley Breaches	4 Hour EAS (Type 1)
			Average (mean) time in Dept. for Non Admitted Patients	Average (mean) time in Dept. for Admitted Patients	% Patients spending more than 12 hours in A&E	Number of Patient spending more than 12 hours in A&E NHS		
L	H	L	H	H	H	H	H	L

Aggregated Patient Delay (APD)	Total time spent in A&E (95th Percentile)	Patients discharged to usual place of residence NHS	NEL Average LOS in Hospital at Discharge (excl. same day discharge)	EL Average LOS in Hospital at Discharge (excl. same day discharge)	% Discharges before midday
H	H		H		

What does the data tell us?

- Slides 10 and 11 highlight that the patient flow metrics in this report continue to show special cause concern.
- Ambulance attendances, due to handover delays, remain low in **2022** but walk-in attendances are high.





Additional metrics

- The conversion rate of attendances to admission was 32% at WRH (2,256 admissions) and 23% at ALX (1,138 admissions). The Midlands 6 week (27th Oct to 7th Dec) average is 27.5%.
- On the 30th November, there were 111 patients who had a LOS of 21+ days. 44 of those patients had been identified as medically fit for discharge.
- On average for Nov-22, 10% of patients were classified as not having a reason to reside.
- 6.6% (790 patients) of all attendances in Nov-22 were recorded as having left before treatment / being seen.

What have we been doing?

- Planning for the ward structure changes.
- Continued refinement of the North Bristol model, including the specialty matrons moving into the site management team.
- Recruitment progressing for ED Acute physicians.
- A root cause review of LLOS over 21 days was completed, with the recommendations that a winter patient flow matron is recruited and discharge progress chasers are being recruited.

What are we doing next?

- The BI Team will develop further the patient flow diagram to include MFFD
- Monitor the impact of changes to ward structures
- The system to consider an increase in the community bed capacity.
- The Onward Care Team to continue to collaborate with the Acute and the ensure that Patient Tracker is implemented quickly to aid tracking of pathway patients.
- The recommendations from the LLOS 21 days to be implemented.

Current Assurance Level: 4 (Nov-22)	**When expected to move to next level of assurance:** This is dependent on the on-going management of the increased attendances and achieving operational standards.
Previous assurance level: 4 (Oct-22)	**SRO: Paul Brennan**

Patient Flow | Month 8 [November] | 2022-23

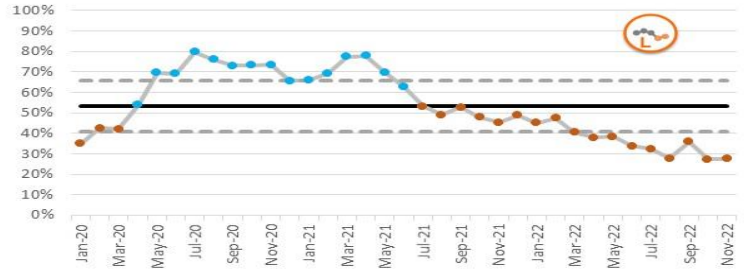
Responsible Director: Chief Operating Officer | Validated for Nov-22 as at 8th December 2022

NHS Worcestershire Acute Hospitals NHS Trust

Percentage of Ambulance handover within 15 minutes

28%

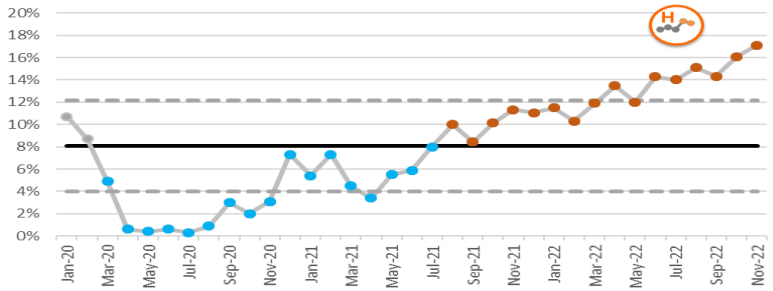
Ambulance handovers within 15 minutes



Patients spending more than 12 hours in ED

17%
2,038 patients

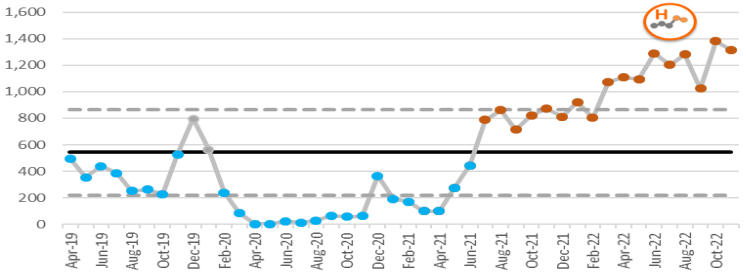
Patients spending 12+ hours in ED



60 minute Ambulance Handover Delays

1,316

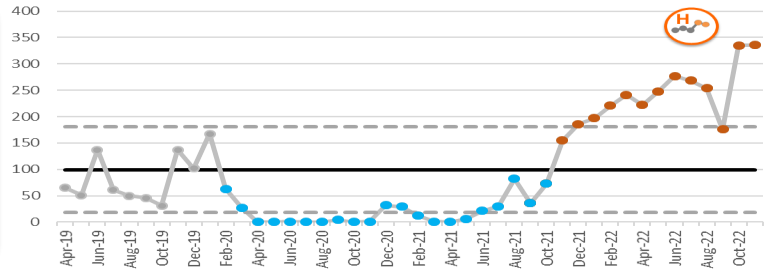
60 minute ambulance handover delays



12 Hour Trolley Breaches

336

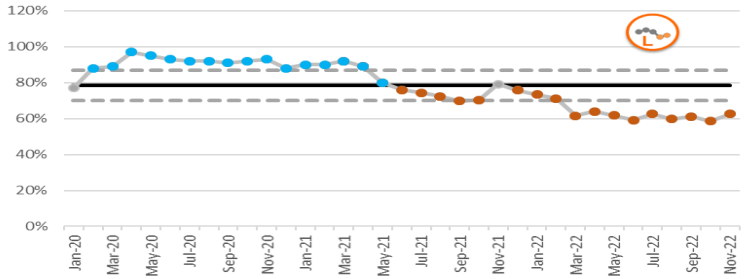
12 hour breaches



Time to Initial Assessment - % within 15 minutes

63%

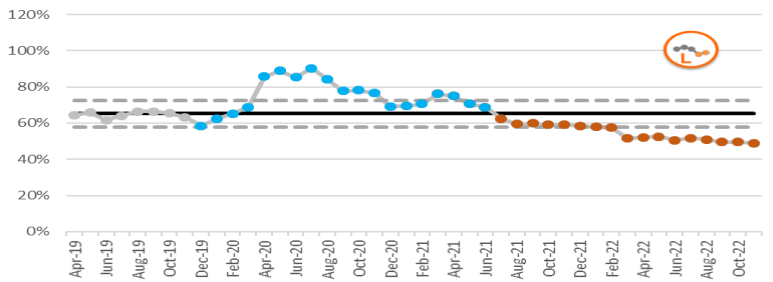
Time to initial assessment within 15 minutes



4 Hour EAS (Type 1)

49%
6,078 of 12,205

EAS Type 1 - 4 hour performance



All graphs include Nov-22 data

Patient Flow | Month 8 [November] | 2022-23

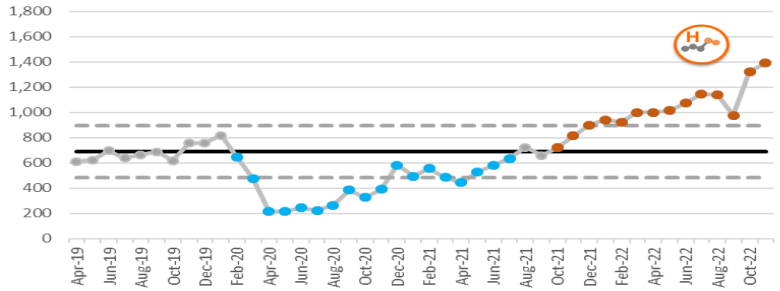
Responsible Director: Chief Operating Officer | Validated for Nov-22 as at 8th December 2022

NHS Worcestershire Acute Hospitals NHS Trust

Aggregated Patient Delay (APD)

Aggregated Patient Delay (APD)

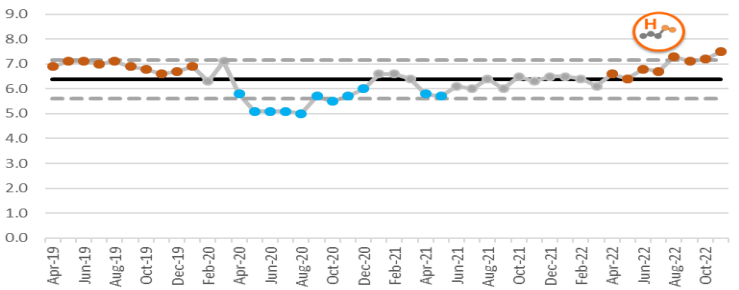
1,391



AVG LOS - NEL

Average LOS in Hospital at Discharge (NEL excl. same day discharge)

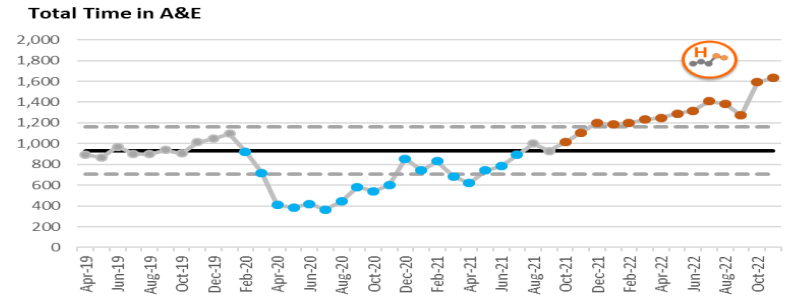
7.5 days



Total Time in A&E

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

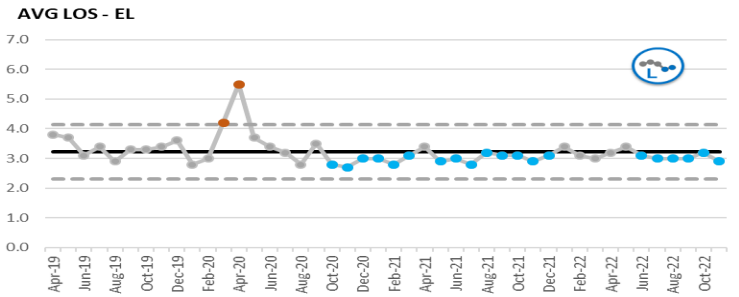
1,632



AVG LOS - EL

Average LOS in Hospital at Discharge (EL excl. same day discharge)

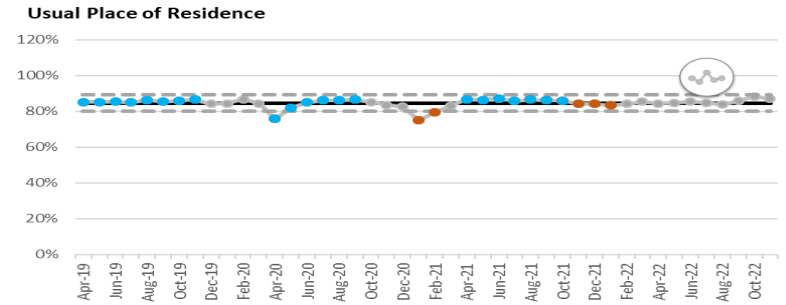
2.9 days



Usual Place of Residence

Patients discharged to usual place of residence

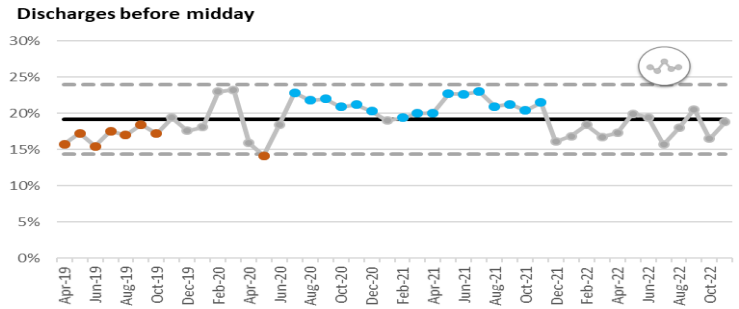
87%



Discharges before midday

% Discharges before midday

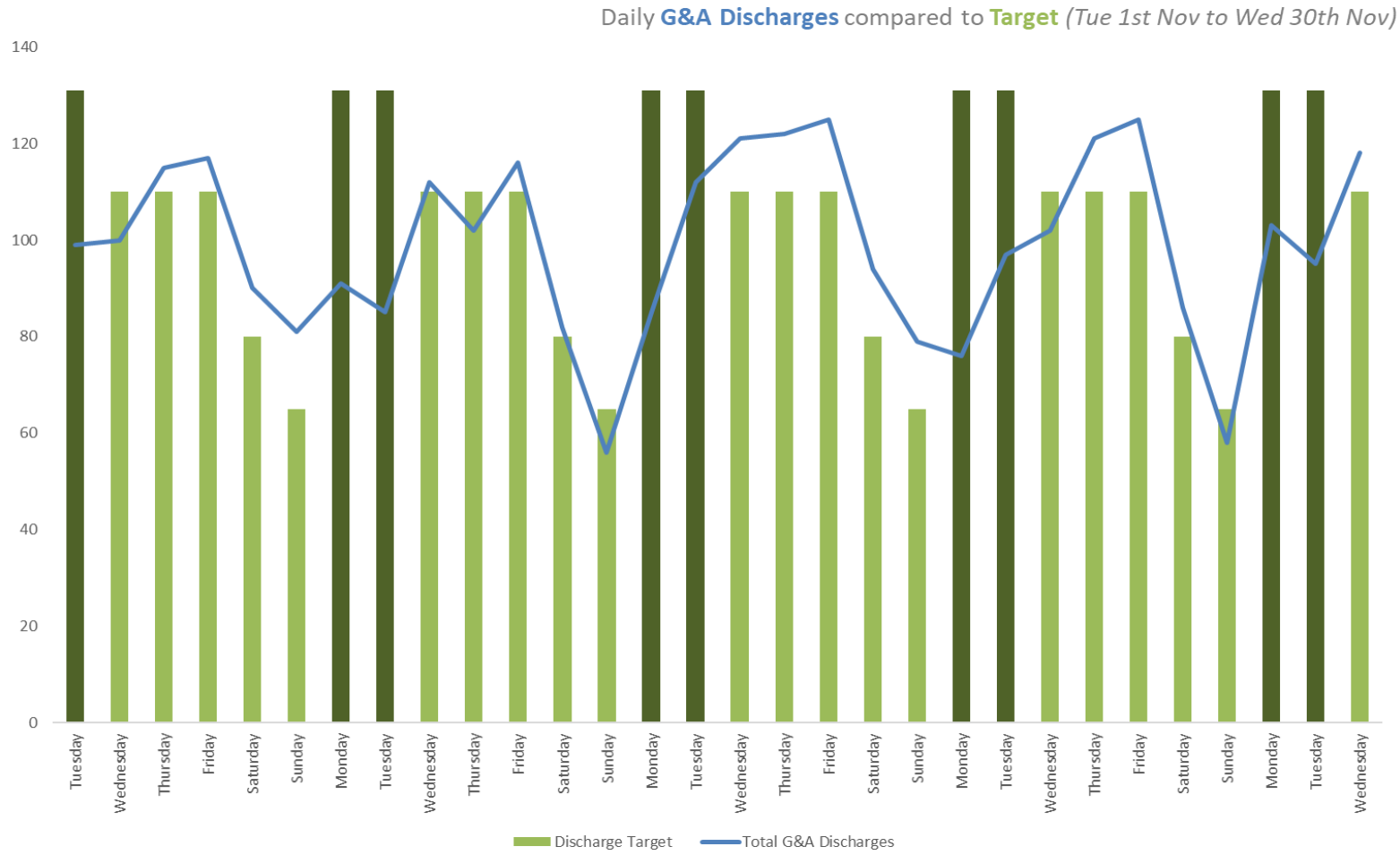
19%



All graphs include Nov-22 data

Patient Flow | Month 8 [November] | 2022-23

Responsible Director: Chief Operating Officer | Validated for Nov-22 as at 8th December 2022



Our overall discharge performance was 93% (2,965 against a target of 3,189). and our daily targets were achieved or exceeded on 16 of 30 days in Nov-22.

The shortfall in discharging to our targets is consistently happening on Monday and Tuesday.

EAS Benchmarking

STRATEGIC OBJECTIVE TWO: BEST EXPERIENCE OF CARE AND BEST OUTCOMES FOR OUR PATIENTS | BEC2: flow and discharge

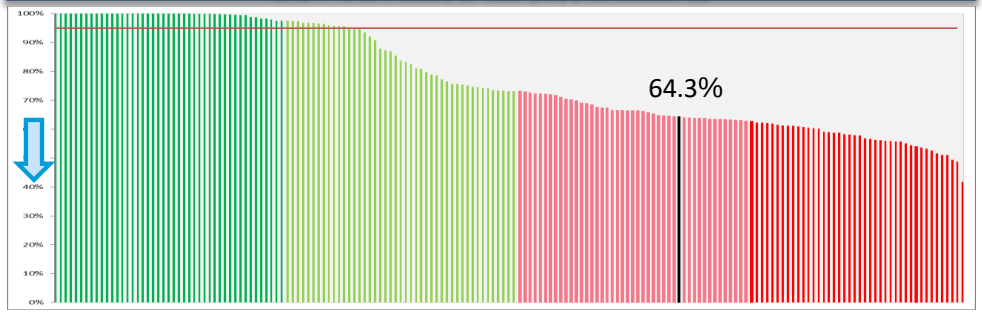
National Benchmarking (October 2022)

EAS (All) –The Trust was one of 8 of 13 West Midlands Trusts which saw a decrease in performance between Oct-22 and Nov-22. This Trust was ranked 7 out of 13; we were ranked 6 the previous month. The peer group performance ranged from 48.8% to 76.5% with a peer group average of 64.0%; declining from 65.0% the previous month. The England average for Nov-22 was 68.9%; a 0.4% decrease from 69.3% in Oct-22.

EAS (Type 1) – The Trust was one of 7 of 13 West Midlands Trusts which saw a decrease in performance between Oct-22 and Nov-22. This Trust was ranked 10 out of 13; no change from the previous month. The peer group performance ranged from 38.70% to 70.54% with a peer group average of 52.46%; declining from 53.12% the previous month. The England average for Nov-22 was 54.5%; a 0.3% decrease from 54.8% in Oct-22.

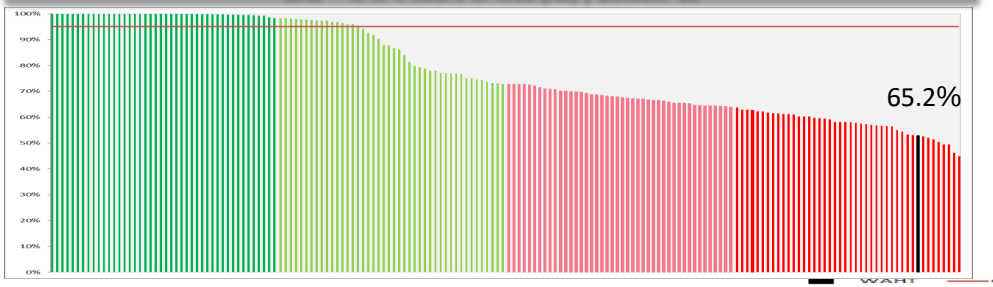
In Nov-22, there were 43,792 patients recorded as spending >12 hours from decision to admit to admission. 335 of these patients were from WAHT; 0.76% of the total.

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



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

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



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

Elective Recovery - Cancer

STRATEGIC OBJECTIVE TWO: BEST EXPERIENCE OF CARE AND BEST OUTCOMES FOR OUR PATIENTS | BEC1: elective recovery and reset

2WW Cancer Referrals	Patients seen within 14 days (All Cancers) NHS		Patients seen within 14 days (Breast Symptoms)		Patients told cancer diagnosis outcome within 28 days (FDS) NHS		Patients treated within 31 days		Patients treated within 62 days		Total Cancer PTL	Patients waiting 63 days or more NHS	Of which, patients waiting 104 days
													

What does the data tells us?

- **2WW referrals** continues to show statistically significant variation as there has been a continued upward trend and shift above the mean since Mar-21.
- **2WW:** This metric has changed to normal variation with 4 specialties achieving operational standard. However, the target will not be achieved without further intervention, particularly in skin and breast.
- **28 Faster Diagnosis:** This metric has changed to normal variation with 3 specialities achieving operational standard. The target is unlikely be achieved without further intervention.
- **31 Day:** This metric is still deteriorating and the target is unlikely be achieved without intervention.
- **62 Day:** This metric is still deteriorating and the target will not be achieved without intervention and will be limited by needing to reduce the backlog of patients over 62 days.
- **Cancer PTL** is showing a statistically significant variation as there has been a continued upward trend and shift above the mean. Although a reduction from October as at the 30th November there were 3,765 patients on our PTL. 303 patients having been diagnosed and 3,462 are classified as suspected.
- **Backlog:** Although reducing in number this metric is deteriorating and the target lies below the current process limits so the target will not be achieved without change. The number of patients waiting 63+ days is 733 and the number of patients waiting 104+ days has decreased to 275. Urology (138) and skin (69) have the largest number of patients waiting over 104 days. 105 of the 275 patients waiting over 104 days are diagnosed and the remaining 167 are suspected.
- Reducing our backlog to the annual plan target of 160 by the end of Mar-23 will require intervention although we are making progress against the NHSE mandated weekly trajectory.

What have we been doing?

- At the time of writing (09/12/22) , overall Trust 2ww performance for the month of December stands at 94.12% against the 93% standard, and should it continue this way will be the first time this important target has been achieved since May 2020. This is in no small part to the recovery actions taken to address performance in Skin, Colorectal and Breast, Upper GI and Urology, all of whom are above 90 as per today's report. Average time to book for these key services stand at 2-3 days for Colorectal, 7 days for Skin and Urology, 10 days for Breast and 14 days for Upper GI.
- The newly implemented start of the Urology prostate pathway is working well with 2ww appointment up to 7 days and subsequent MRI being booked within a further 7 days.
- Focus for Urology prostate now focusing on eradicating the prostate biopsy backlog with an external outsourcing company contracted to commence from the weekend of 10th and 11th December and into January 2023.

What are we doing next?

- There remains concern regarding the timely ability to treat diagnosed Urology patients so increased focus will be on ensuring all such patients are dated. In addition, work is underway to scope the possibility of outsourcing some RRP's for patients willing to attend the private clinic Park in Nottingham, whilst our in-house RRP service is being developed and implemented.
- Despite significant improvements in performance both from a 2ww and a backlog reduction perspective, the suspect Skin cancer service remains extremely fragile given its reliance on a long-term locum and two outsourcing companies (soon to be one) to deliver the bulk of the service. Work on substantive recruitment and a further contingency plans needs to be realised at pace, especially given that recent scoping and trajectory work suggests a return to non-performance and significant backlogs from April 2023 when the one remaining outsourcing contract will come to an end.
- The Gynae pathway remains vulnerable and work between the Directorate and Imaging to work up what additional one-stop clinics resources are required is set to be undertaken in the coming two weeks.
- The overall cancer workforce contains a significant number of fixed term posts, both administrative and clinical, that were secured from one-off support monies, either from the Cancer Alliance or other sources. Work is to be undertaken to review the full extent of this workforce, their current contribution and size of the risk to performance should a way to substantively fund these posts (if deemed to be required) is not realised.

Current Assurance Levels (Nov-22)	Previous Assurance Levels (Oct-22)
2WW – Level 4	2WW - Level 4
31 Day Treatment - Level 5	31 Day Treatment - Level 5
62 Day Referral to Treatment – Level 3	62 Day Referral to Treatment - Level 3

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.

SRO: Paul Brennan

Elective Recovery - Cancer | Month 8 [November] | 2022-23

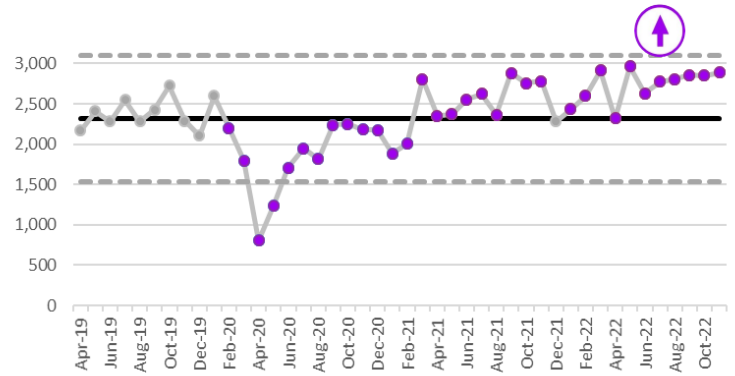
Responsible Director: Chief Operating Officer | Validated for Nov-22 as at 5th January 2023

NHS Worcestershire Acute Hospitals NHS Trust

2WW Referrals

2,890

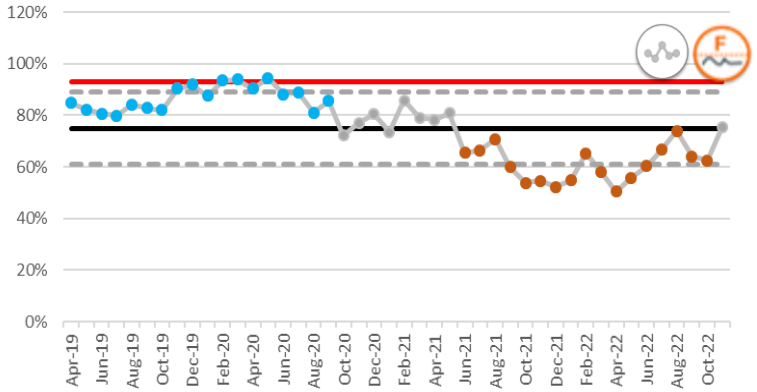
2WW Cancer Referrals



2WW Cancer

75%
3,250
patients seen

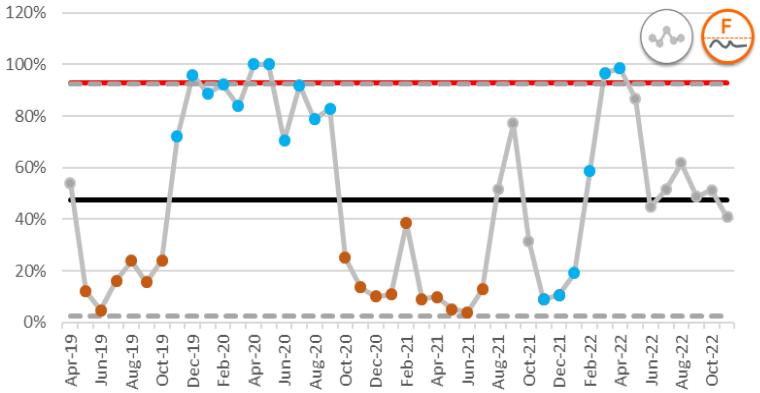
2WW Cancer (All)



2WW Breast Symptomatic

41%
142 patients seen

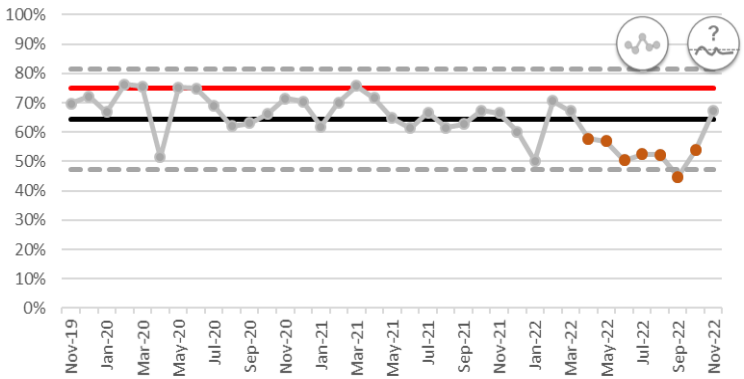
2WW Cancer Breast Symptomatic



28 Day Faster Diagnosis

67%
3,070
patients told

28 Day Faster Diagnosis



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

All graphs include Nov-22 data

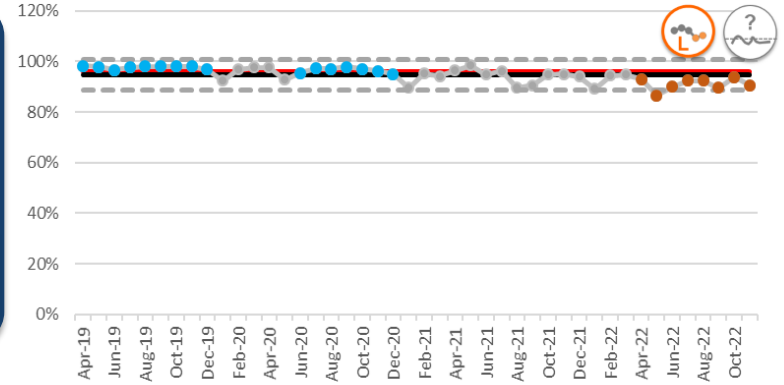
Elective Recovery - Cancer | Month 8 [November] | 2022-23

Responsible Director: Chief Operating Officer | Validated for Nov-22 as at 5th January 2023

NHS Worcestershire Acute Hospitals NHS Trust

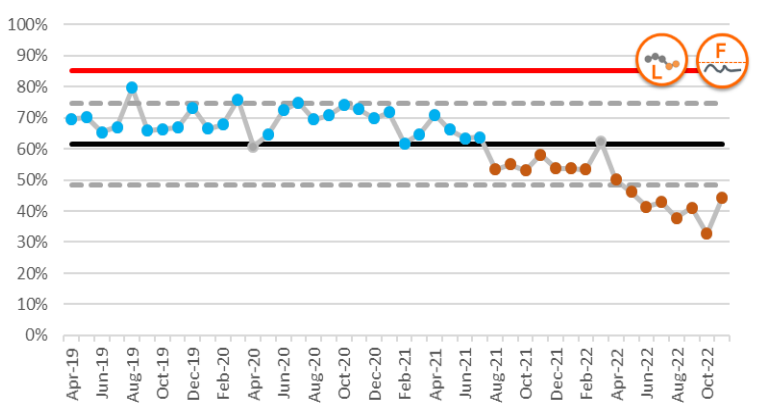
31 Day Cancer

92%
358 patients treated



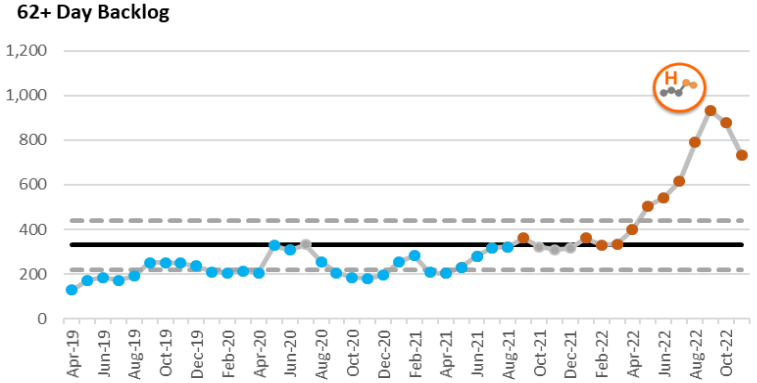
62 Day Cancer

44%
246 patients treated



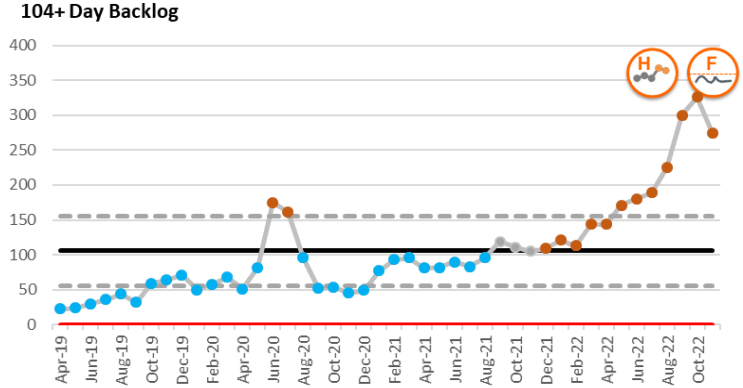
Backlog Patients waiting 63 days or more*

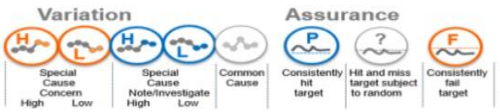
733



Backlog Patients waiting 104 day or more*

275





Key

- Internal target
- Operational standard

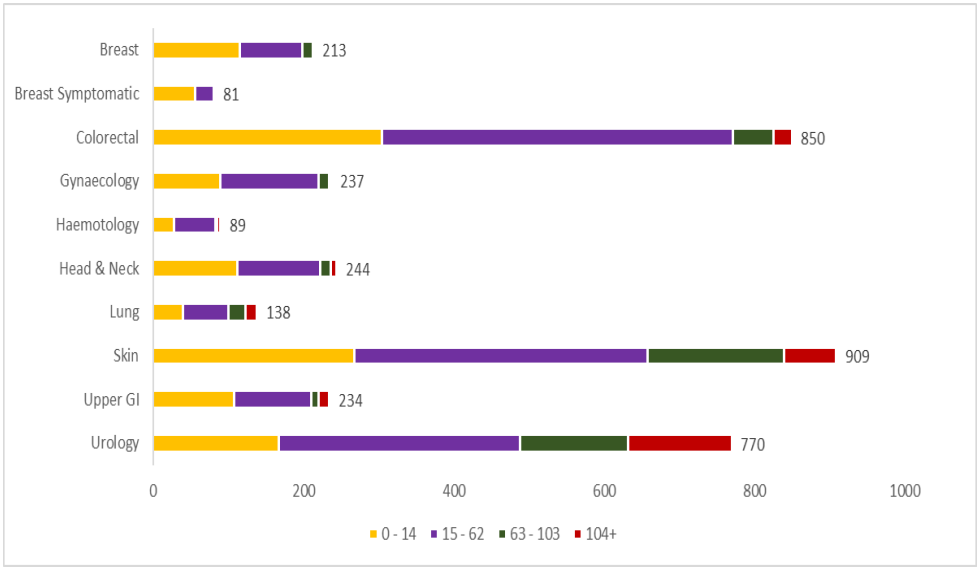
All graphs include Nov-22 data

Elective Recovery - Cancer | Month 8 [November] | 2022-23

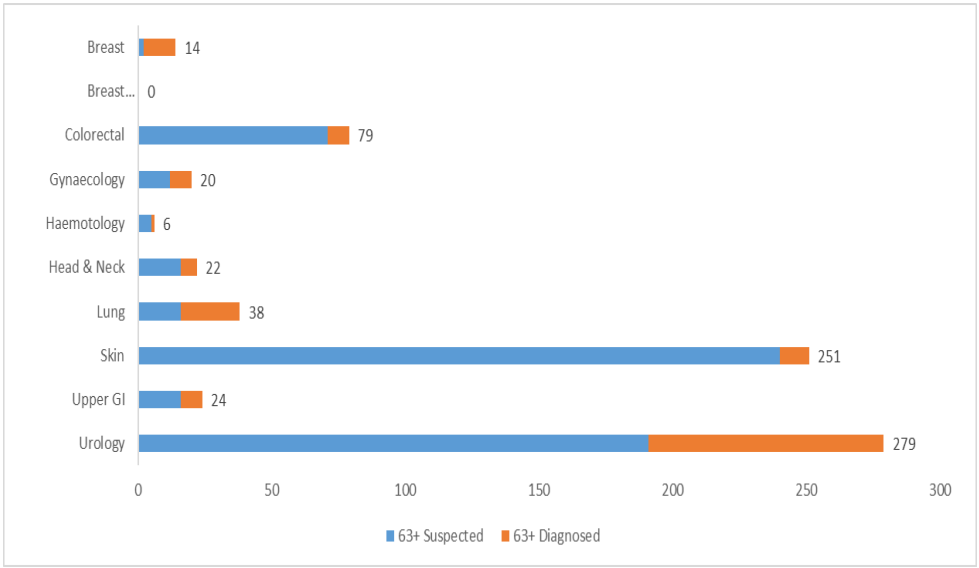
Responsible Director: Chief Operating Officer | Validated for Nov-22 as at 5th January 2023

NHS Worcestershire Acute Hospitals NHS Trust

Cancer PTL by Specialty and Days Wait



Cancer Long Waiter Backlog by Specialty and Status



The graphs above show the number of cancer patients on our PTL and split by days waiting. Colorectal, Skin and Urology have the largest PTLs and patients waiting over 63 days. These specialties are being supported by the best practice pathway work.

Cancer Benchmarking

STRATEGIC OBJECTIVE TWO: BEST EXPERIENCE OF CARE AND BEST OUTCOMES FOR OUR PATIENTS | BEC1: elective recovery **and reset**

National Benchmarking (September 2022)

2WW: The Trust was one of 3 of 13 West Midlands Trusts which saw a decrease in performance between Sep-22 and Oct-22. This Trust was ranked 13 out of 13; we were ranked 10 the previous month. The peer group performance ranged from 62.5% to 95.3% with a peer group average of 77.1%; improving from 69.8% the previous month. The England average for Oct-22 was 77.1%; a 5.2% increase from 72.6% in Sep-22.

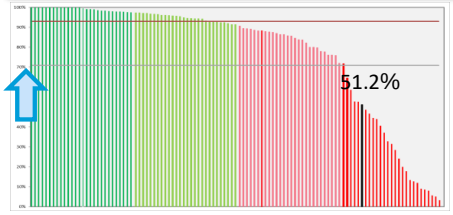
2WW BS: The Trust was one of 8 of 13 West Midlands Trusts which saw an increase in performance between Sep-22 and Oct-22. This Trust was ranked 10 out of 13; no change from the previous month. The peer group performance ranged from 13.3% to 100.0% with a peer group average of 76.6%; improving from 74.8% the previous month. The England average for Oct-22 was 75.8%; a 8.0% increase from 67.7% in Sep-22.

31 days: The Trust was one of 7 of 13 West Midlands Trusts which saw a decrease in performance between Sep-22 and Oct-22. This Trust was ranked 5 out of 13; we were ranked 4 the previous month. The peer group performance ranged from 84.3% to 100.0% with a peer group average of 89.3%; improving from 86.9% the previous month. The England average for Oct-22 was 92.0%; a 0.9% increase from 91.1% in Sep-22.

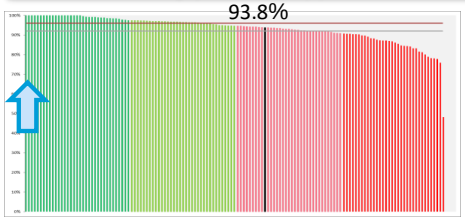
62 Days: The Trust was one of 7 of 13 West Midlands Trusts which saw an increase in performance between Sep-22 and Oct-22. This Trust was ranked 13 out of 13; we were ranked 11 the previous month. The peer group performance ranged from 34.0% to 80.5% with a peer group average of 47.6%; improving from 49.2% the previous month. The England average for Oct-22 was 60.3%; a 0.2% decrease from 60.5% in Sep-22.

2WW (All cancers) | October-22

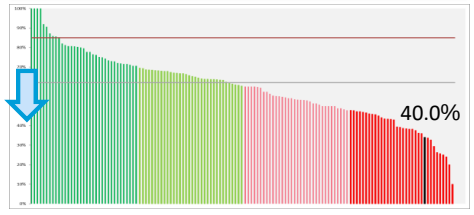
2WW Breast Symptomatic | October-22



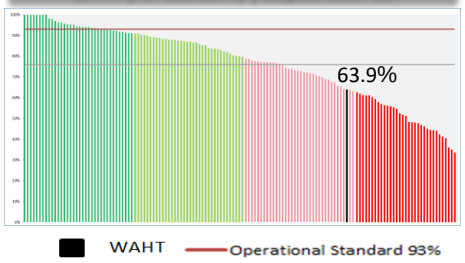
Cancer 31 Day (All cancers) | October-22



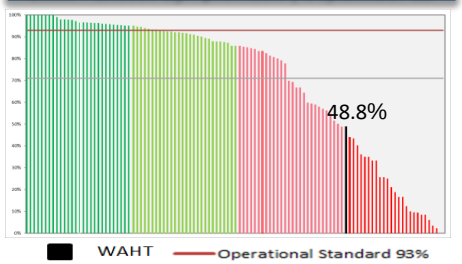
Cancer 62 day (All cancers) | October-22



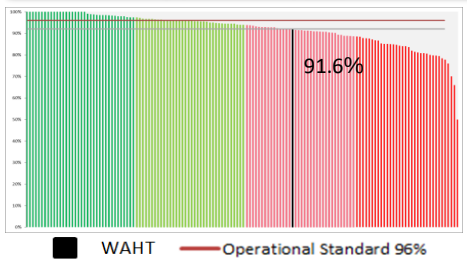
2WW (All cancers) | September-22



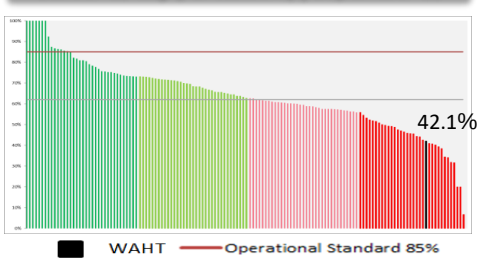
2WW Breast Symptomatic | September-22



Cancer 31 Day (All cancers) | September-22



Cancer 62 day (All cancers) | September-22



Elective Recovery – Referral to Treatment

STRATEGIC OBJECTIVE TWO: BEST EXPERIENCE OF CARE AND BEST OUTCOMES FOR OUR PATIENTS | BEC1: elective recovery and reset

Electronic Referral Service (ERS) Referrals		Referrals to Referral Assessment Service (RAS)	Advice & Guidance (A&G)		Total RTT Waiting List	Patients on a consultant led pathway waiting less than 18 weeks for their first definitive treatment		Number of patients waiting 52+ weeks NHS	Of whom, waiting 78+ weeks NHS	Of whom, waiting 104+ weeks NHS
Total	8974	8,188	3,139	87% responses within 2 working days						
Non-2WW	5,931									

What does the data tells us?

Referrals (validated)

- **Non-2WW ERS Referrals** are showing special cause variation indicating a sustained increase.
- **Referral Assessment Service:** a total of 8,188 referrals to RAS were made in Nov-22. Only 71% of the 2WW RAS referrals have been outcomed within 2 working days – normally we achieve over 90%.
- **A&G Requests** are within normal variation and above the performance threshold.

Referral To Treatment Time (validated)

- The RTT Incomplete waiting list is validated at 68,628. This is not a significant change from previous months but is the 8th month in a row it has increased.
- RTT performance for Nov-22 is validated at 45.5% compared to 45.4% in Oct-22 and the operational standard target of 92% will not be achieved without change.
- The number of patients waiting over 52 weeks for their first definitive treatment is 8,103, a 237 patient increase from the previous month. Of that cohort, 1,321 patients have been waiting over 78 weeks, increased from 1,115 the previous month, and there was 1 patient over 104 weeks.

What have we been doing?

- Continuation of the capacity review for Outpatients, identifying more efficient approaches to ensuring that our physical capacity and staffing is at optimum utilisation.
- The Access Policy is being reviewed and we are awaiting confirmation regarding whether the Choice Guidance should be included.
- We have been monitoring the application of the Access Policy.
- We continue to focus on the longest waiting patients to achieve the Mar-23 78+ week breaches target.
- We have been reviewing the impact of increasing Cancer referrals on the RTT waiting list as diagnostic capacity becomes stretched.
- We have had sent the first phase of administration validation texts and letters out are removing patients who have responded advising they no longer need their appointments.

What are we doing next?

- A administration review of the active monitoring patients.
- A review of the impact on our waiting list as we support vulnerable services at another Trust.

Current Assurance Level: 3 (Nov-22)	When expected to move to next level of assurance: When the RTT incomplete waiting list growth starts to reverse, as system plans start to impact on the reduction of referrals and internal plans start to increase the clock stop to start ratio.
Previous Assurance Level: 3 (Oct-22)	**SRO: Paul Brennan**

Elective Recovery – Referral To Treatment | Month 8 [November] | 2022-23

Responsible Director: Chief Operating Officer | Validated for Nov-22 as at 19th December 2022

NHS Worcestershire Acute Hospitals NHS Trust

Electronic Referrals Profile (non-2WW)
5,931

RTT Incomplete PTL
68,628

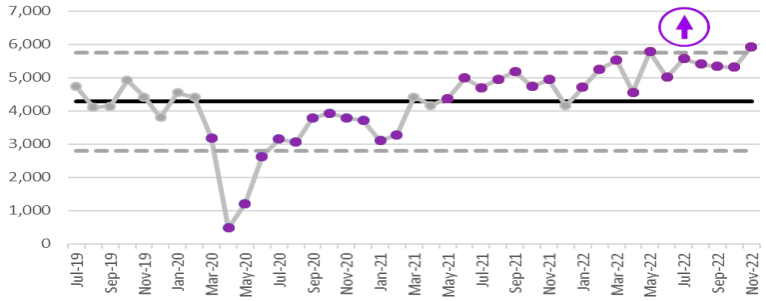
52+ week waits
8,103

RTT % within 18 weeks
45.5%

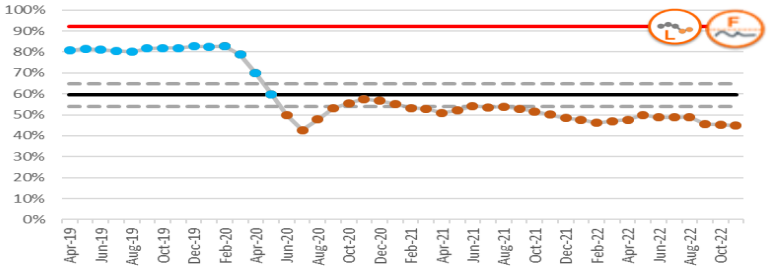
78+ week waits
1,285

104+ week waits
1

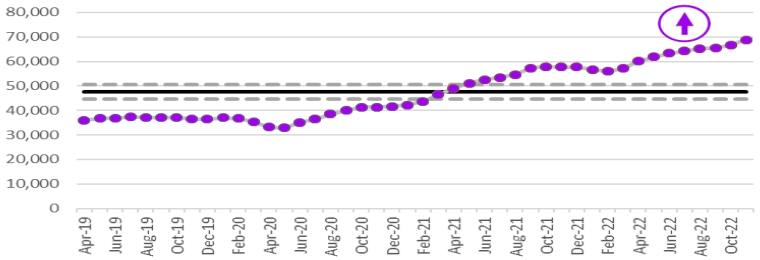
Non-2WW Electronic Referrals



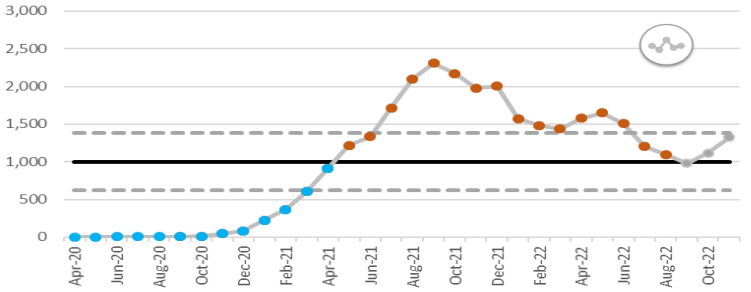
RTT - % Incomplete



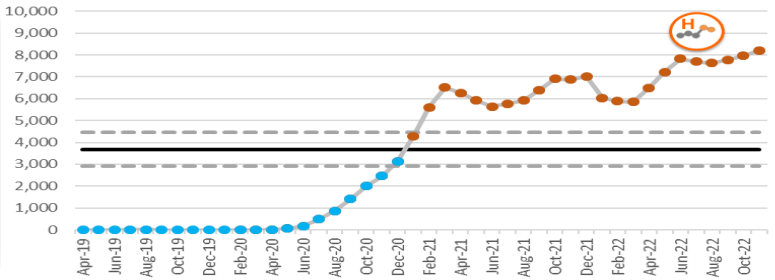
RTT Waiting List



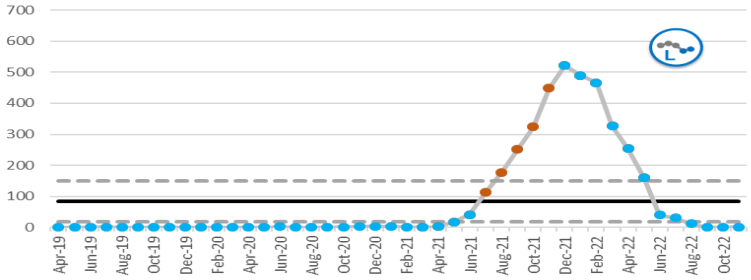
78+ Week Waits



52+ Week Waits



104+ Week Waits



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

All graphs include Nov-22 data

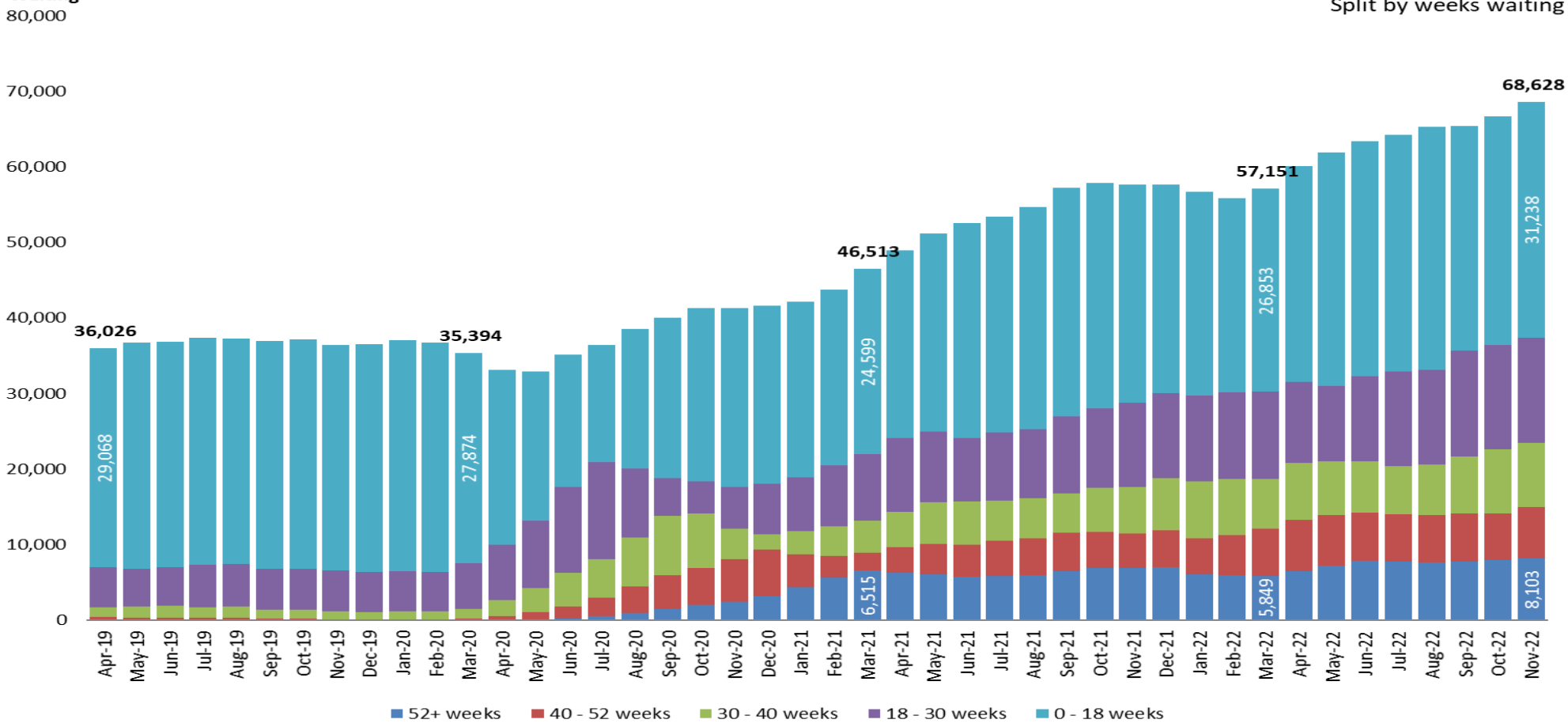
Elective Recovery - RTT Incomplete Waiting List | Month 8 [November] | 2022-23

Responsible Director: Chief Operating Officer | Validated for Nov-22 as at 19th December 2022

NHS Worcestershire Acute Hospitals NHS Trust

Patients waiting for first definitive treatment Apr-19 to Nov-22

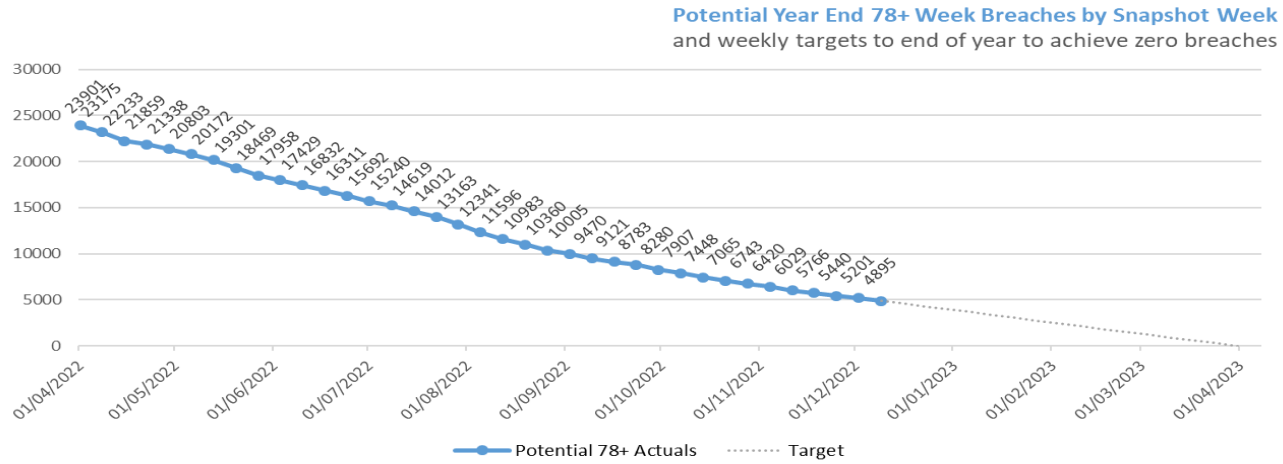
Split by weeks waiting

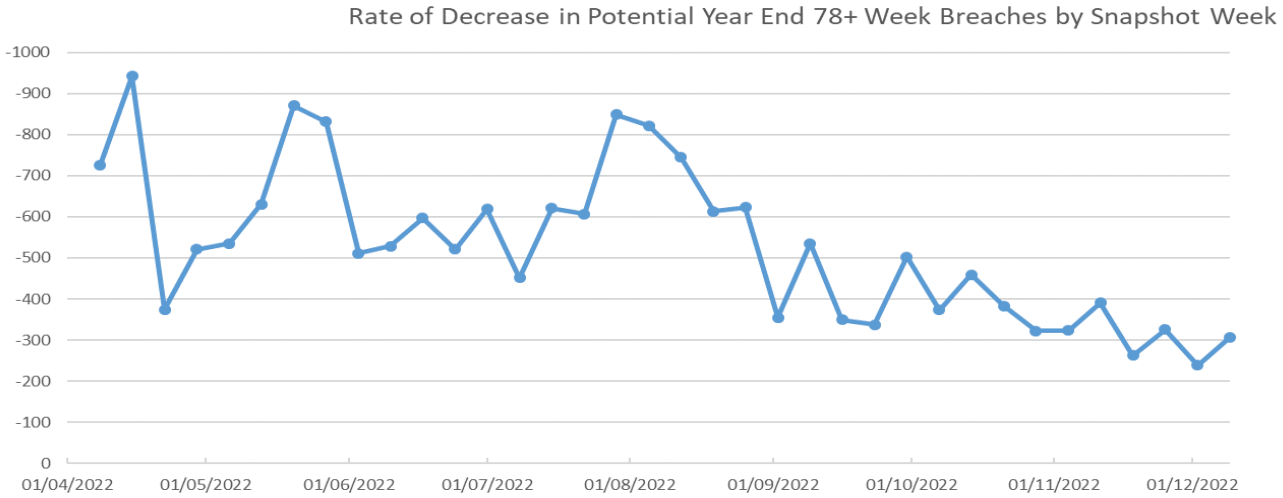


17

Elective Recovery - RTT Incomplete Waiting List | Potential 78+ Week Breaches

Responsible Director: Chief Operating Officer | Validated to 9th December 2022





The first graph shows our weekly progress to date in reducing the potential number of 78+ week breaches, followed by a linear trajectory. This is based on ~305 clock stops a week for 16 weeks which would result in zero breaches at month end Mar-23.

The second graph shows the numerical rate of decrease. The average of the last 4 weeks is 284, 305 for 5 weeks and 308 for 6 weeks; hence demonstrating the impact of 300 clock stops.

Referral To Treatment Benchmarking

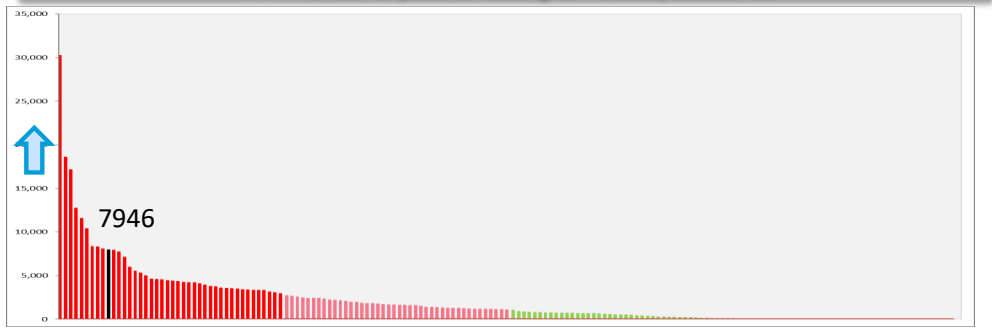
STRATEGIC OBJECTIVE TWO: BEST EXPERIENCE OF CARE AND BEST OUTCOMES FOR OUR PATIENTS | BEC1: elective recovery and reset

National Benchmarking (September 2022) | The Trust was one of 6 of 12 West Midlands Trusts which saw a decrease in performance between Sep-22 and Oct-22. This Trust was ranked 12 out of 13; no change from the previous month. The peer group performance ranged from 40.35% to 70.64% with a peer group average of 53.39%; improving from 53.26% the previous month. The England average for Oct-22 was 60.10%; a 0.7% increase from 59.40% in Sep-22.

- Nationally, there were 410,983 patients waiting 52+ weeks, 7,946 (1.93%) of that cohort were our patients.
- Nationally, there were 50,124 patients waiting 78+ weeks, 1,118 (2.23%) of that cohort were our patients.

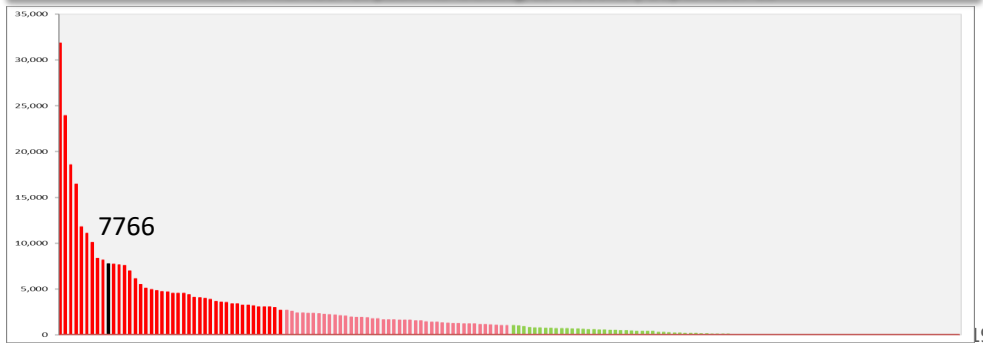
RTT - % patients within 18 weeks | October-22

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



RTT - % patients within 18 weeks | September-22

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



19

Elective Recovery | Outpatients and Elective Inpatients

Annual Plan Activity	Total Outpatient Attendances	Total OP Attendances First	Total OP Attendances Follow-Up	Elective IP Day Case	Elective IP Ordinary	Elective Inpatients	Theatre Utilisation	Cases per list	Lost Utilisation (early starts / late finishes)	On the day cancellations
Target achieved?	✓	✓	×	×	×					

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

- The OP data on slide 19 compares our second SUS submission for Nov22 outpatient attendances to Nov-19 and our annual plan activity targets. As noted in the top row of this table we achieved our OP New target for the first time this year.
- Model Hospital benchmarking **for Sep-22** shows that our outpatient **DNA rate is in quartile 1 of all Trusts.**
- In the RTT OP cohort, there are over 34,000 patients waiting for their first appointment. 29% of the total cohort waiting for a first appointment have been dated. Of those not dated 2,578 patients have been waiting over 52 weeks.
- The top five specialties with the most 52+ week waiters in the outpatient new cohort remains unchanged and are General Surgery, Gynaecology, ENT, Urology and Oral Surgery.

Planned Admissions - what does the data tell us?

- In Nov-22, the total number of day cases and EL IP increased from Oct-22. Although Day case (-264) was under plan, we did delivery the most spells in a month to date in 22/23 and was more than Nov-19. EL IP (-298) was below the annual plan target for the month.
- Theatre utilisation continues to showing positive improvement.
- The cases per list is showing deteriorating performance; an increase will be required in order to get closer to achieving the annual plan activity targets.
- As we have been treating a higher proportion of urgent and cancer patients in 2022 (37.3% in 2019 v 51.5% in 2022), this has increased the average time per procedure and consequently reduced the number of cases per list.
- Lost utilisation due to late start / early finish continues to shows significant improvement. However, this does equate to 517 hours lost in Nov-22 and is made up of 227 hours that are due to late starts and 290 hours that are early finishes. On average, 77 minutes were lost per 4 hour session, noting this includes time lost to cancellation.
- On the day cancellations are still showing normal variation.
- 83.3% of eligible patients were rebooked within 28 days for their cancelled operation in Nov-22; this is 25 of 30 patients being rebooked within the required timeframe but no significant change from the mean outcome.

What have we been doing?

- Continuation of developments within the personalised patient portal that will provide higher visibility and self-management for patients.
- Continuing review of GIRFT recommendation to identify opportunities for improvement specifically in T&O, Gynaecology and General Surgery e.g. the transfer of a simple pessary service to primary care
- The 6-4-2 meeting has been restructured to ensure appropriate oversight and challenge is in place to make further productivity and efficiency gains

What are we doing next?

- Engage with the ICS to work through the interim guidance that are updating the RTT rules.
- Awaiting recommendations from NHSEI IST that will bolster our existing recovery plans.
- Evaluating whether acuity is impacting the cases per session for inpatients, as utilisation has increased, but activity remains below expected levels.
- Reviewing the variances within specialities for the times taken by individuals for the same procedures.
- Reviewing the job plans against the activity levels.
- Preparing for a third party organisation who are coming in January to independently review our pre operative processes.

Current Assurance Level: 4 (Nov-22)

When expected to move to next level of assurance: : This is dependent on the success of the programme of restoration for increasing outpatient appointments and planned admissions for surgery being maintained and in-line with annual planning expectations from NSHE for 2022/23.

Previous Assurance Level: 4 (Oct-22)

SRO: Paul Brennan

Elective Recovery – Outpatient and Elective Activity | Month 8 [November] | 2022-23

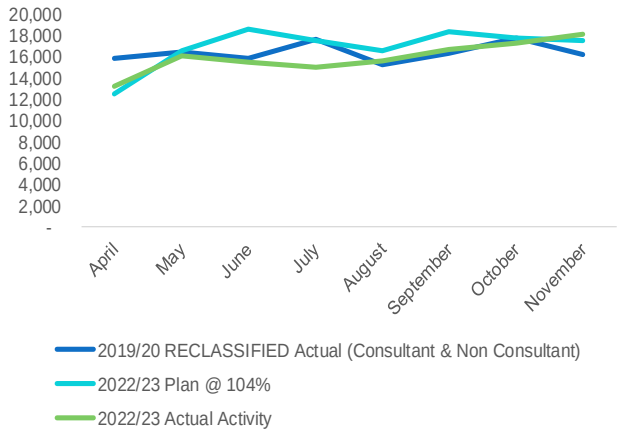
Responsible Director: Chief Operating Officer | Unvalidated for November 2022 (Second SUS Submission)

NHS Worcestershire Acute Hospitals NHS Trust

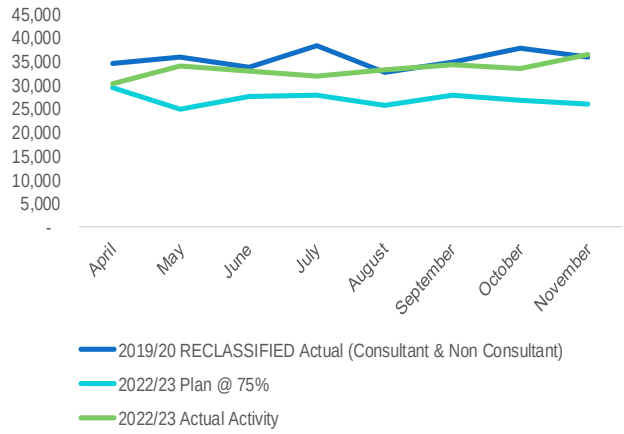
Elective Activity comparing Nov-19 to submitted Annual Plan 22/23 and Nov-22

Activity		Nov-19	Submitted Plan	Nov-22
Outpatient (reclassified)	New	16,124	17,484	18,087
	Follow-up NHS	35,895	25,847	36,449
	Total	**52,019**	**43,331**	**54,536**
Elective	Day Case	7,621	7,902	7,660
	Inpatient	709	824	522
	Total	**8,330**	**8,726**	**8,182**

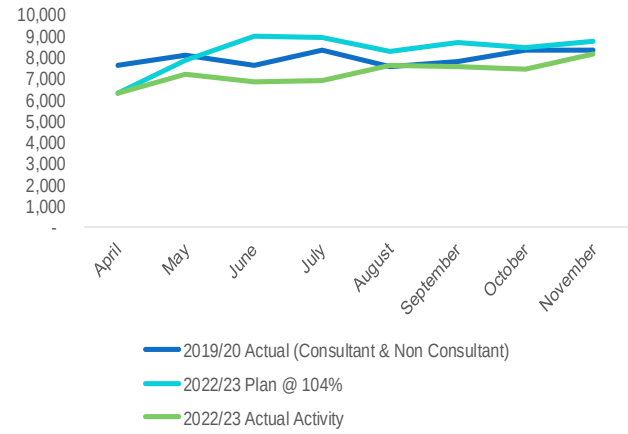
Outpatient New Activity Trend



Outpatient Follow-up Activity Trend



Day Case and Inpatient Activity Trend



Elective Recovery - Theatre Utilisation | Month 8 [November] | 2022-23

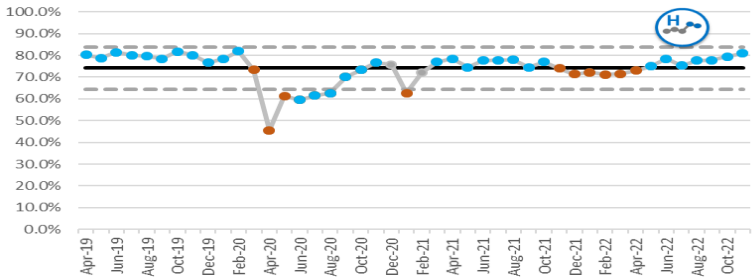
Responsible Director: Chief Operating Officer | Validated for Nov-22 as at 5th January 2023

NHS Worcestershire Acute Hospitals NHS Trust

Actual Theatre session utilisation (%)

80.9%

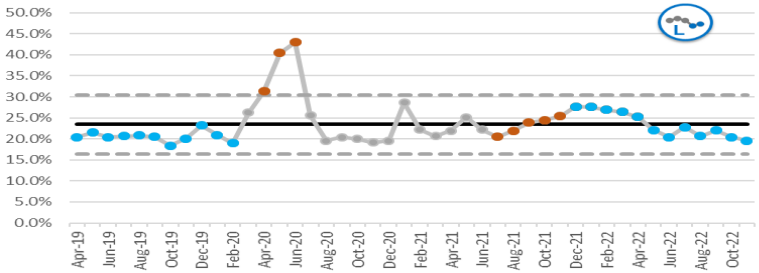
Theatre Utilisation



Lost utilisation to late starts and early finishes

19.6% (517 hours)

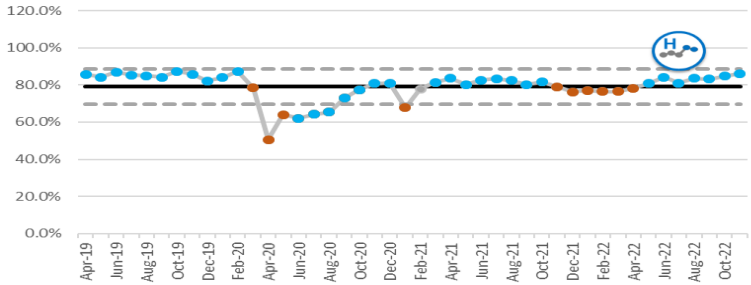
Lost utilisation



Actual Theatre session utilisation incl. allowed downtime (%)

86.1%

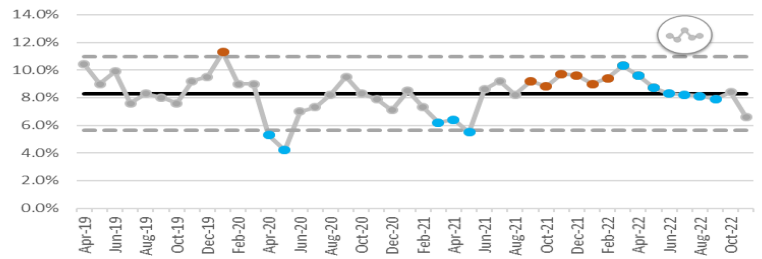
Theatre Utilisation (incl. downtime)



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

6.6% (115 patients)

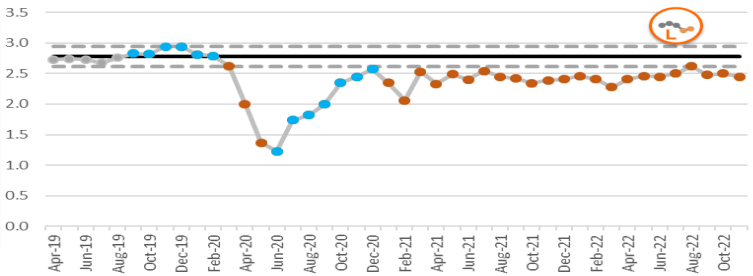
On the day cancellations



Completed procedures per 4 hour session

2.45

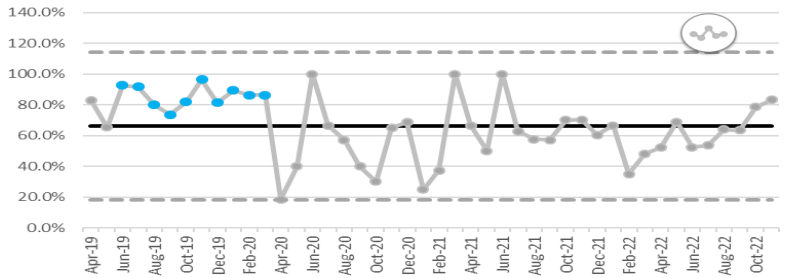
Cases per list



% patients rebooked with 28 days of cancellation

83.3% (25 of 30 rebooked)

% rebooked within 28 days



All graphs include Nov-22 data

Elective Recovery: DM01 Diagnostics | Waiting List and Activity

STRATEGIC OBJECTIVE TWO: BEST EXPERIENCE OF CARE AND BEST OUTCOMES FOR OUR PATIENTS | BEC1: elective recovery and reset

NHS Worcestershire Acute Hospitals NHS Trust

Annual Plan Activity	MRI	CT	Non-obstetric ultrasound	Colonoscopy	Flexi Sigmoidoscopy	Gastroscopy	Echocardiography	DM01	% patients waiting 6+ weeks
Target achieved?	×	✓	×	×	✓	×	✓		

What does the data tell us?

DM01 Waiting List

- The DM01 performance is validated at 81.2% of patients waiting less than 6 weeks for their diagnostic test remaining special cause improvement.
- The diagnostic waiting list has decreased by 932 patients (11%) and the total number of patients waiting 6+ weeks has decreased by 214 patients to 1,629. There are 696 patients waiting over 13 weeks (815 in Nov-22).
- Radiology has the largest number of patients waiting, at 4,744 but the number of patients 6+ weeks has decreased to 489 from 731 at the end of Oct-22.
- The total number of patients waiting for an endoscopy decreased and the number of patients waiting over 6+ weeks has stayed the same. Of note is the further increase in patients waiting for a cystoscopy.
- Physiological science modalities saw a decrease in their total PTL and in increase in breaching patients.

Activity

- 19,765 DM01 diagnostic tests were undertaken in Nov-22. This is the third month in a row setting the highest activity level on record.
- 23% (4,579 tests) of our total DM01 activity was classified as unscheduled / emergency. 68% were waiting list tests and 9% were planned tests.
- Of all the modalities, CT, echocardiography and flexi sigmoidoscopy achieved the H2 plan for Nov-22.
- Overall we have delivered 93.2% of this months diagnostics plan and YTD, 8 completed months, we have delivered 97.6% of the plan.

RADIOLOGY

What have we been doing?

- Commenced improvements in 2ww prostate pathway
- Submitted CAG for CT mobile extension until Mar-23 and utilisation of Pertemps on KTC until Dec-23
- Obtained Cancer Alliance funding for MRI mobile until Mar-23
- Increased CT Colon 2ww capacity countywide, slots at KTC and ALX, plus WLIs
- Increased CT biopsy slots by 2 per week in support of 28 day diagnostic pathway
- Offered 6 Radiographer posts

What are we going to do next?

- Continue WLI sessions in US.
- Continue WLIs in DEXA to address backlog
- Work with BI and Cancer team to identify and deliver further improvements on 28 day faster diagnosis, commenced weekly PTL meeting
- Review vetting resource requirements - improving faster vetting, will support improving time to an appointment being allocated
- Obtain financial approval to continue mobiles and US WLIs
- Identify external support for Proctograms
- Improve capacity/demand modelling using Pythia
- Complete NHSE/I deep dive capacity model

Issues

- Increase in 2ww CT Colon referrals, specialised Radiographers perform these which minimises capacity
- Concern on delay approving CT mobile extension, TIC will commence plans to remove on 10th December

ENDOSCOPY (inc. Gynaecology & Urology)

What have we been doing?

- Booking 2ww patients by day 10 of the pathway which has improved overall performance in best practice pathway.
- Maintained weekend waiting list activity
- Continued with 18 week supporting 18 sessions across ECH and KTC sites
- Ceased the contract with InHealth for their mobile endoscopy unit.

What are we going to do next?

- Re-introduce telephone pre-assessment for all patients having a colonoscopy – in order to improve efficacy of bowel prep and reduce need for repeat procedures.
- Use Pythia to improve capacity and demand modelling
- Commence retire and return contracts for 2 Gastroenterologists who will be joining endoscopy service as pure endoscopists.

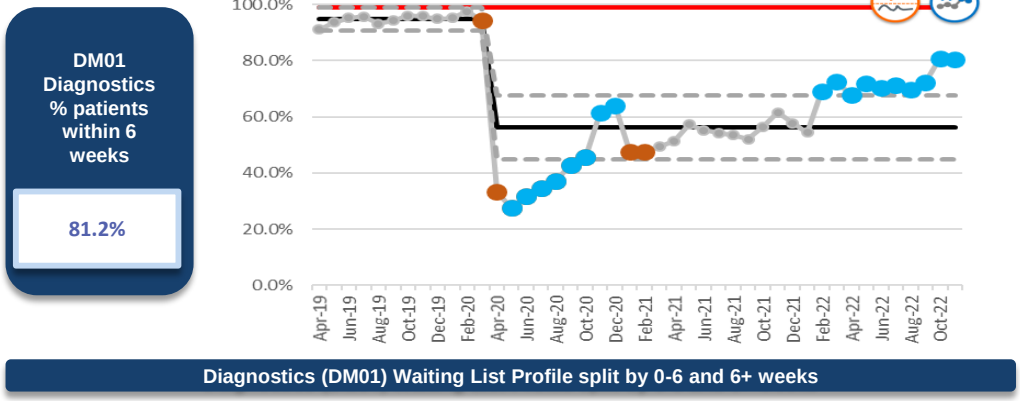
Issues

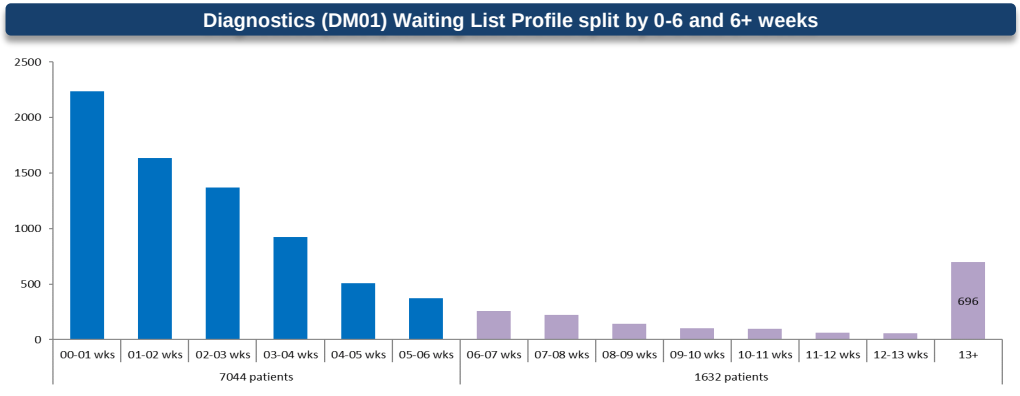
- Ongoing postal strikes continues to be challenging.
- Planned nursing strikes
- 2 members of booking team have confirmed they will be resigning

23

Elective Recovery: DM01 Diagnostics | Waiting List and Activity

STRATEGIC OBJECTIVE TWO: BEST EXPERIENCE OF CARE AND BEST OUTCOMES FOR OUR PATIENTS | BEC1: elective recovery and reset





CARDIOLOGY – ECHO

What have we been doing?
- Improved 6 week breach position
- Ceased Insourcing 27/11/22

What are we going to do next?
- Monitor numbers and add WLIs if required

Issues
- Limited equipment which affects our capacity to manage increasing demands.

RESPIRATORY (Sleep studies)

Issues
- Number of patients that can be diagnosed is limited by available equipment
- Numbers are being increased from 14/11 to 10 patients per day
- Not able to increase capacity further due to staffing and equipment issues
- Only able to offer Monday – Friday service

Current Assurance Level: 5 (Nov-22)

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

Previous assurance level: 5 (Oct-22)

SRO: Paul Brennan

Elective Recovery DM01 Diagnostics | Month 8 [November] 2022-23

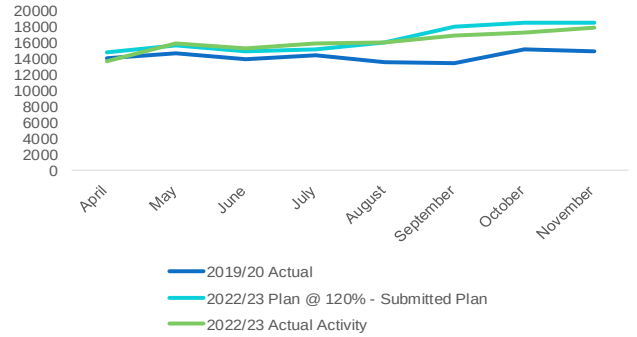
Responsible Director: Chief Operating Officer | Validated for Nov-22 as 16th December 2022

NHS Worcestershire Acute Hospitals NHS Trust

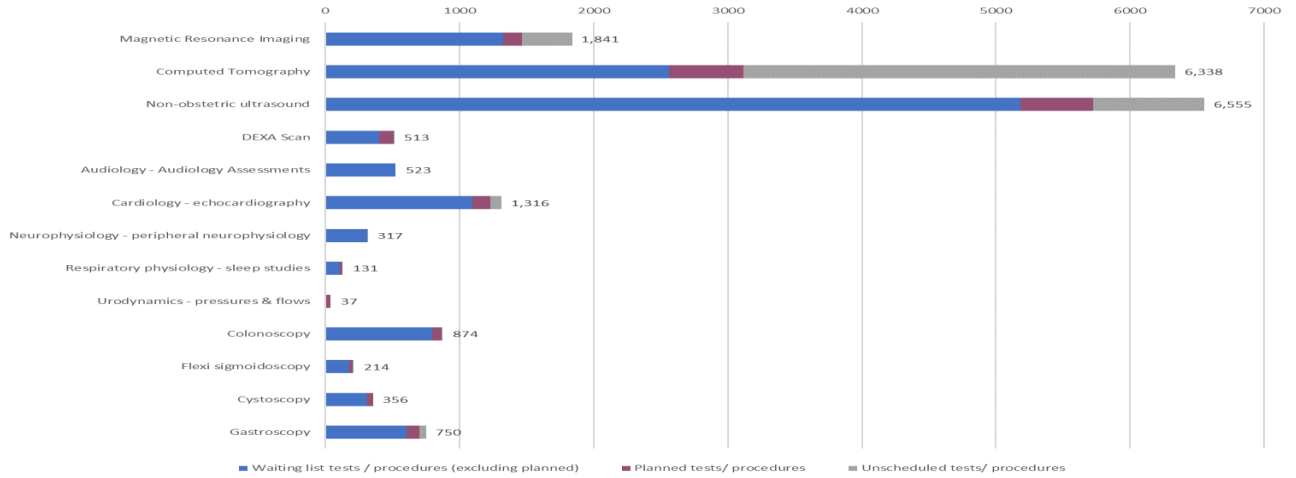
Diagnostic Activity | Annual Plan Monitoring

Annual Plan Activity Modalities		Nov-19	Submitted Plan	Nov-22
Imaging	MRI	1,757	2,862	1,841
	CT	4,651	5,809	6,338
	Non-obstetric ultrasound	6,015	6,686	6,555
Endoscopy	Colonoscopy	659	945	874
	Flexi Sigmoidoscopy	349	160	214
	Gastroscopy	626	826	750
Echocardiography		838	1,259	1,316
Diagnostics Total		14,895	18,550	17,888

Annual Plan Diagnostics Activity Trend



Total DM01 Activity split by modality and type



MRI, CT, non-obstetric ultrasound colonoscopy and gastroscopy exceeded the activity delivered in Nov-19.

CT and flexi sigmoidoscopy achieved the activity levels in our submitted plan.

23% of all unscheduled activity in Nov-22 were CT tests.

Operational Performance: Diagnostics (DM01) Benchmarking

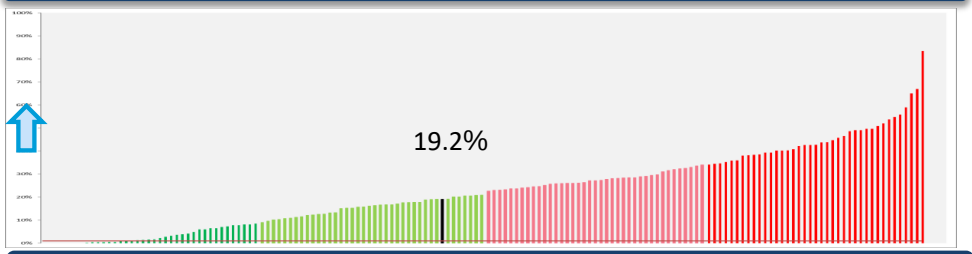
STRATEGIC OBJECTIVE TWO: BEST EXPERIENCE OF CARE AND BEST OUTCOMES FOR OUR PATIENTS | BEC1: elective recovery and reset

National Benchmarking (September 2022)

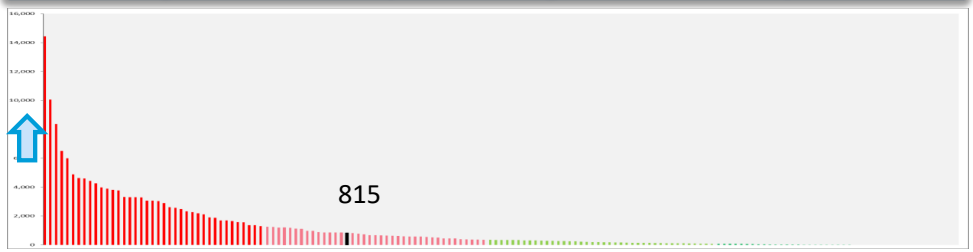
The Trust was one of 11 of 13 West Midlands Trusts which saw an improvement in performance between Sep-22 and Oct-22. This Trust was ranked 5 out of 13; we were ranked 6 the previous month. The peer group performance ranged from 2.8% to 49.6% with a peer group average of 34.4%; improving from 36.9% the previous month. The England average for Oct-22 was 27.5%; a 2.3% decrease from 29.8% in Sep-22.Nationally, there were 463,930 patients recorded as waiting 6+ weeks for their diagnostic test; 2,497 (0.54%) of these patients were from WAHT.

- Nationally, there were 426,003 patients recorded as waiting 6+ weeks for their diagnostic test; 1,843 (0.43%) of these patients were from WAHT.
- Nationally, there were 184,187 patients recorded as waiting 13+ weeks for their diagnostic test; 815 (0.44%) of these patients were from WAHT.

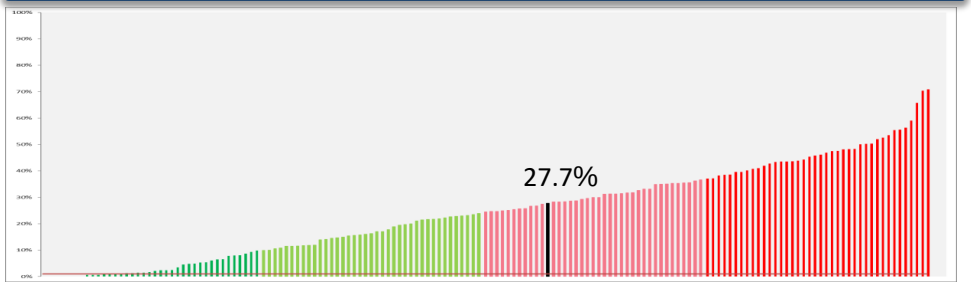
DM01 Diagnostics - % of patients waiting more than 6 weeks | October-22



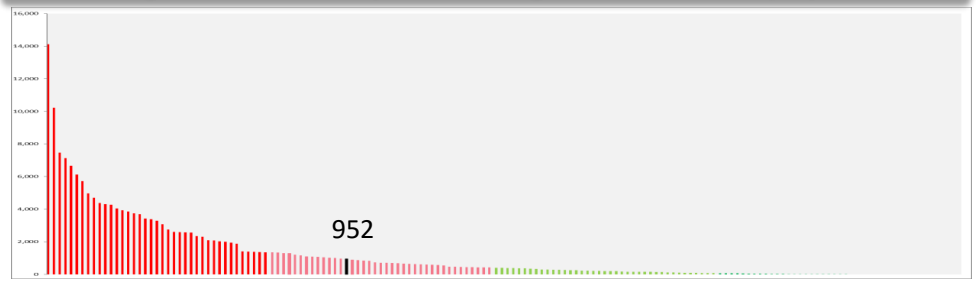
DM01 Diagnostics - number of patients waiting more than 13 weeks | October-22



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



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



WAHT — Operational Standard 1%

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

26

Stroke

STRATEGIC OBJECTIVE ONE: BEST SERVICES FOR LOCAL PEOPLE | BS1 Work with partners to deliver high quality seamless care

Patients spending 90% of time on a Stroke Ward		Patients who had Direct Admission (via A&E) to a Stroke Ward within 4 hours		Patients who had a CT within 60 minutes of arrival		Patients seen in TIA clinic within 24 hours		SSNAP Q2 22-23 Jul-22 to Sep-22 (validated)			
	E		E		B		N/A	Score	82.0	Grade	A

What does the data tell us?

- Validated SSNAP scores have been published and we have achieved a grade A for Q2 22/23 with a score of 82.0.

	Q1 22/23		Q2 22/23	
Domain	Score	Grade	Score	Grade
1) Scanning	88	B	83	C
2) Stroke unit	29	E	34	E
3) Thrombolysis	50	D	48	D
4) Specialist Assessments	96	A	90	A
5) Occupational therapy	94	A	88	A
6) Physiotherapy	88	A	90	A
7) Speech and Language therapy	85	A	79	A
8) MDT working	85	B	85	A
9) Standards by discharge	96	A	98	A
10) Discharge processes	99	A	100	A
Combined Total Key Indicator score	82	A	82	A
Case ascertainment band	80-89%	B	90%+	A
Audit compliance band	89.6%	B	88.10%	B
SSNAP score	77.9	B	82.0	A

- No metric is showing special cause concern although we cannot achieve the Direct Admission target without change.
- Patients seen in the TIA clinic within 24 hours continues to show special cause improvement with a run above the mean.

What are we doing to improve?

Patients Admitted Within 4 Hours / 90% Stay on Stroke Ward / Specialty Review Within 30 Minutes

- In order to promote flow throughout the stroke pathway, the on-call Stroke team will assess patients alongside the therapy teams, if appropriate, to prioritise discharging patients directly home from ED/AMU. Ongoing investigations are then requested on an out-patient basis. This ensures that ASU beds are only used for those patients who are not medically fit for discharge.
- The stroke unit continues to ring fence one "boarding" area for Thrombolysis whereby one patient from the unit will be reverse boarded to accommodate a Thrombolysis patient ensuring a seamless transfer to the unit.
- Countywide therapy meetings which include the Health and Care Trust are ongoing– this includes the therapists in the county meeting regularly with the Acute Trust consultant. This encourages communication throughout the stroke pathway to discuss any concerns/issues with patients on the stroke pathway being admitted and discharge which is improving communications and thus helping to support flow. This improved communication allows a shared understanding of Trust issues with regards to flow and allows our community partners to support patient flow.
- When accepting referrals from AGH, patient demographics are now checked prior to accepting patients to ensure that ASU do not accept out of area patients, thereby impacting on flow through the unit.
- Early conversations with families of patients on the end of life pathway alongside earlier involvement of the OCT to support decision making in terms of final destinations, not only will support flow but also improve patient experience throughout their stroke journey.

Thrombolysis:

- The positive impact of ongoing face-to-face stroke simulation training alongside in-house consultant cover for advice and guidance after 5pm are reflected in the Thrombolysis scores on SSNAP showing an improvement from an E to a D.
- We are still consistently achieving a Level B in the SNNAP score results which is demonstrating all of the improvements we are putting into place as mentioned above.

Current Assurance Level: 5 (Nov-22)

When expected to move to next level of assurance: Moving to assurance level 6 is dependent on achieving the main stroke metrics and demonstrable **sustained** improvements in the SSNAP score / grade.

Previous Assurance Level: 5 (Oct-22)

SRO: Paul Brennan

27

Stroke | Month 7 [October] | 2022-23

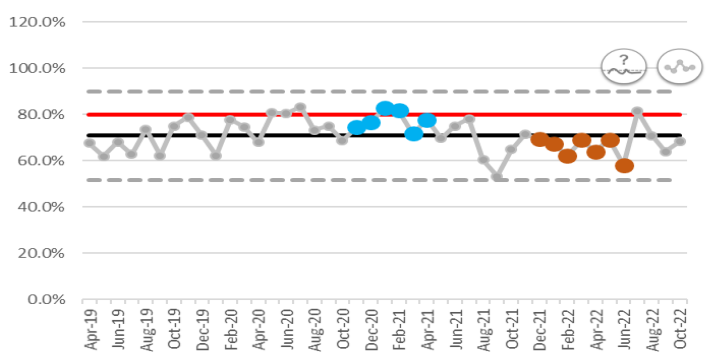
Responsible Director: Chief Operating Officer | Validated for Oct-22 as 5th January 2023

NHS Worcestershire Acute Hospitals NHS Trust

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

68%

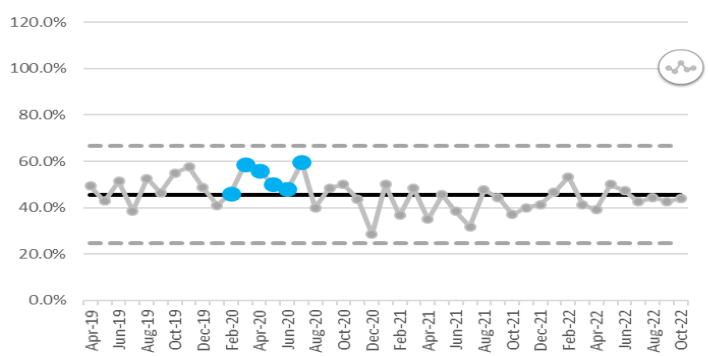
Time spent on Stroke Unit



Stroke : % CT scan within 60 minutes

44%

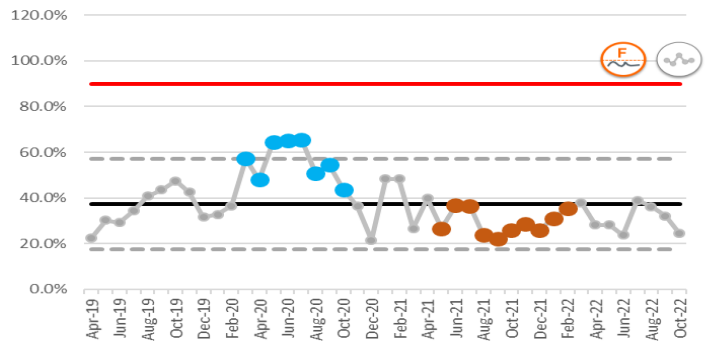
CT within 60 minutes



Stroke : % Direct Admission to Stroke ward

24%

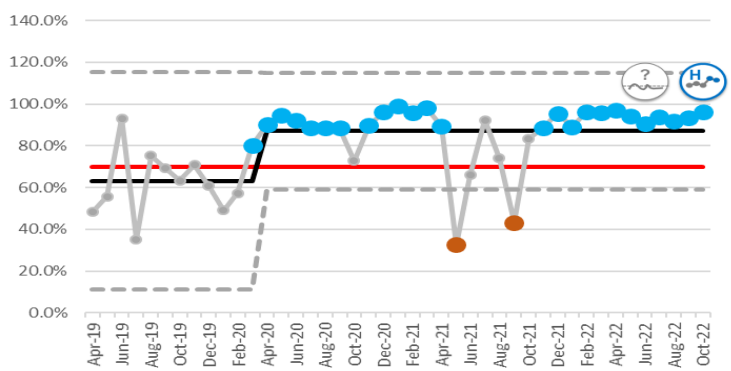
Direct Admission to Stroke Ward



Stroke: % seen in TIA clinic within 24 hours

96%

TIA within 24 hr



All graphs include Oct-22 data