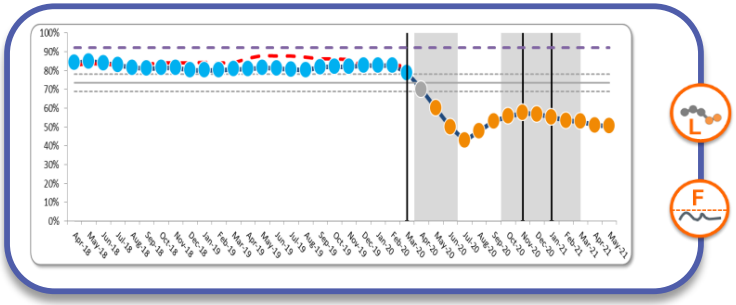
Month 2 [May] | 2021-22 | Operational Performance: RTT

Responsible Director: Chief Operating Officer | Validated May-21 as 17th June 2021

NHS Worcestershire Acute Hospitals NHS Trust

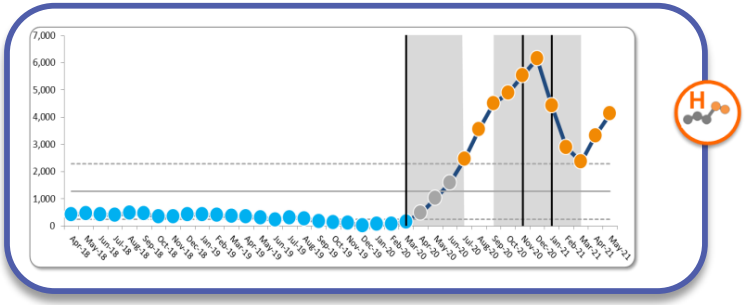
RTT % within 18 weeks

52.01%



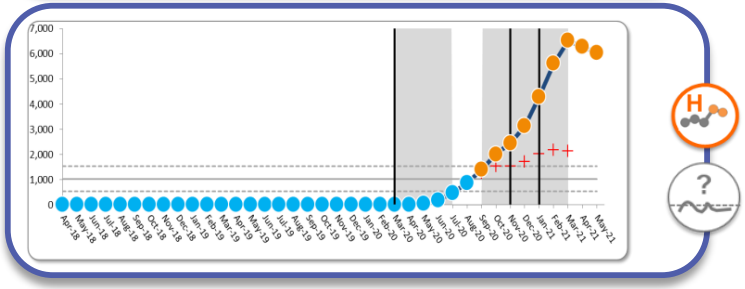
40-52 week waits

4,072



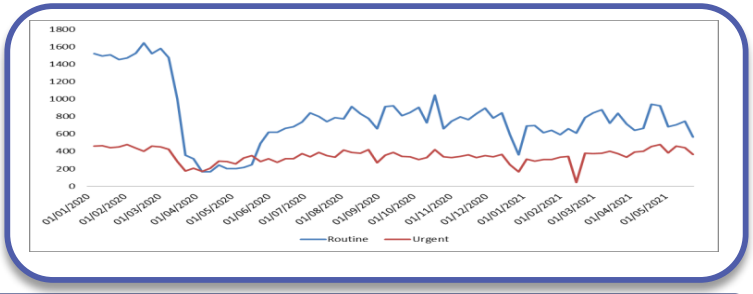
52+ week waits

5,920

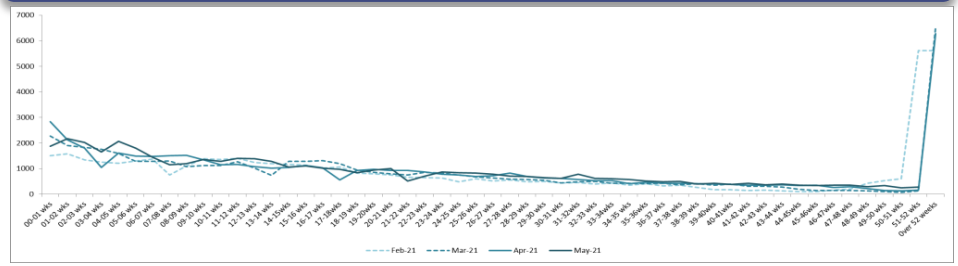


RTT Referrals Profile

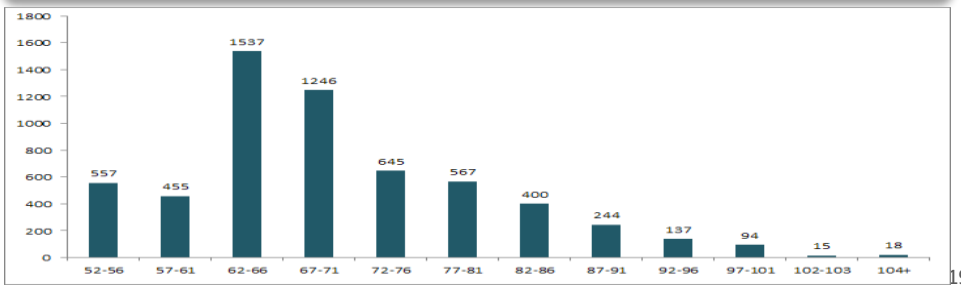
4,940



RTT waiting list profile (Jan-21 to Mayl-21) by weeks waiting



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



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

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

Key

+ phase 3 target
- Internal target
- Operational standard

Operational Performance: RTT Benchmarking

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

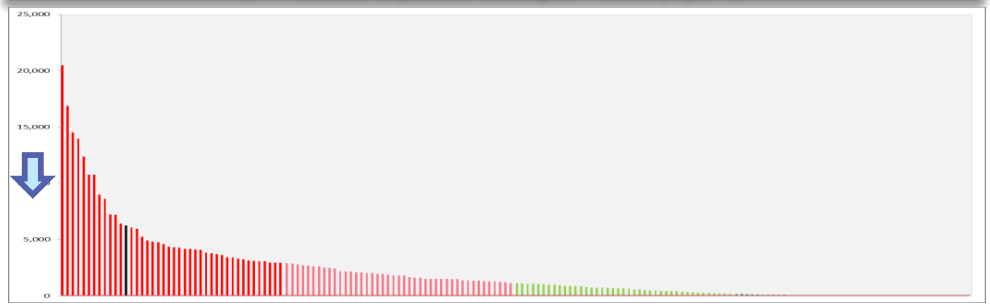
National Benchmarking (April 2021) | The Trust was one of 10 of 12 West Midlands Trust which saw a decrease in performance between Mar-21 and Apr-21 This Trust was ranked 11 out of 13; where we were 12 previous month. The peer group performance ranged from 50.85% to 77.19% with a peer group average of 54.06%; declining from 55.53% the previous month. The England average for Apr-21 was 64.60% a 0.2% increase from 64.40% in Mar-21.

Nationally, there were 385,490 patients waiting 52+ weeks, 6,249 (1.62%) of that cohort were our patients.

Nationally, there were 124,691 patients waiting 70+ weeks, 1,922 (1.54%) of that cohort were our patients.

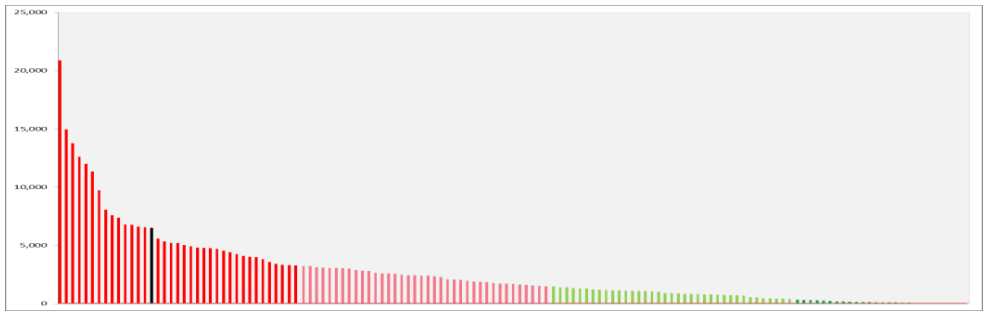
RTT - % patients within 18 weeks | April-21

RTT – number of patients waiting 52+ weeks | April -21



RTT - % patients within 18 weeks | March-21

RTT – number of patients waiting 52+ weeks | March-21



WAHT — Operational Standard 92%

20

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

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

News Face to Face (excl OP+ – all other activity)	News Non Face to Face (excl OP+ – all other activity)	News % Non Face to Face	Follow ups Face to Face (excl OP+ – all other activity)	Follow ups Non Face to Face (excl OP+ – all other activity)	Follow ups % Non Face to Face	Total % Non Face to Face
10,003	2,226	18.16%	13,991	9,954	41.57%	32.5%

Outpatients - what does the data tell us?

- The graphs on slide 23 compare our May-21 consultant led outpatient appointments to May-19 and our H1 activity target. Although we are not undertaking the same volume of appointments in May-21 compared to May-19, we achieved or were marginally under the targets. Non-face-to-face appointments were our area of weakest performance – a contributing factor is ensuring outcomes are entered on our PAS as without them, we cannot count this activity in our totals.
- The Trust undertook 36,482 outpatient appointments in May-21 (consultant and non-consultant led). For context, this is 13,300 fewer appointments than May-19 and -1,122 fewer appointments when compared to the H1 activity target (unvalidated).
- In May-19, 48,385 face-to-face appointments took place compared to 24,594 in May-21; however, the H1 target is exceeded by +2,047. As would be expected with non-face-to-face was not the norm in May-19, May-21 is considerably higher than May-19 with 11,888 appointments taking place compared to 1,264. However, we are -3,170 appointments below the H1 target.
- Of all appointments in the month, 32.5% (both new and follow-up) were non-face-to-face.

Planned Admissions - what does the data tell us?

- On the day cancellations shows no significant change since Jun-20.
- Theatre utilisation has remained above the mean, at 74%.
- In Apr-21, we achieved the day case and elective inpatient H1 targets and although activity has increased between Apr-21 and May-21 for both, we are marginally below plan by -96 (DC) and -48 (EL) but above the ERF target for both April and May.
- The % of patients rebooked within 28 days for their cancelled operation shows a lot of variance from month to month as it currently more difficult to rebook patients. It should be noted that in comparison to pre-pandemic performance (between Jun-18 and Apr-20, the denominator average was 55 patients being cancelled), the number of patients being cancelled has reduced so the variance seen month to month is being influenced by small numbers (between Aug-20 and May-21, the denominator average was 12 patients being cancelled).
- The Independent Sector undertook 39 day cases and 4 electives; this was –95 less compared to Apr-21.

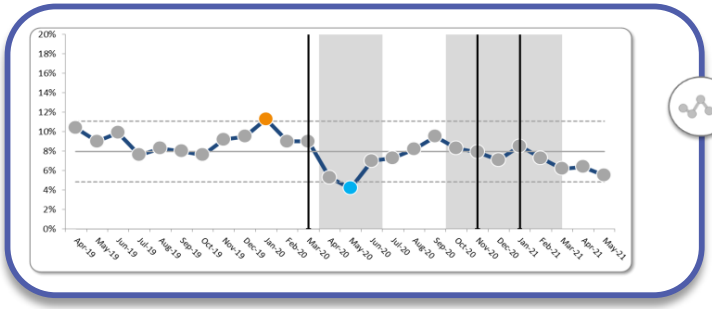
Current Assurance Level: 4 (May-21)	**When expected to move to next level of assurance: :** This is dependent on the success of the programme of restoration for increasing outpatient appointments and planned admissions for surgery being maintained
Previous Assurance Level: 4 (Apr-21)	**SRO: Paul Brennan**

Month 2 [May] 2020-21 | Operational Performance: Theatre Utilisation & Outpatients

Responsible Director: Chief Operating Officer | Validated May-21 as 17th June 2021

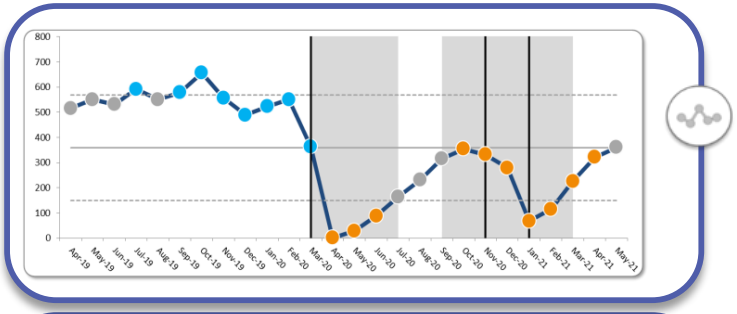
On the day cancellation as a percentage of scheduled procedures (%)

5.50%



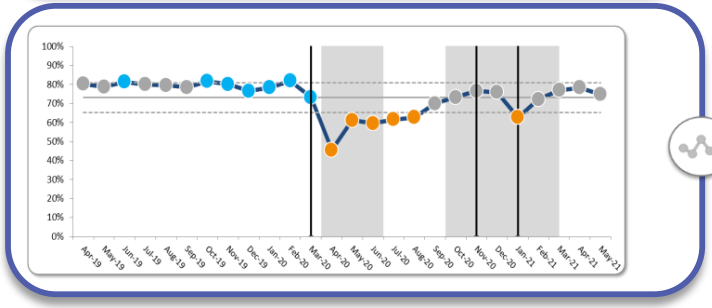
Electives on elective theatre sessions (n)

360



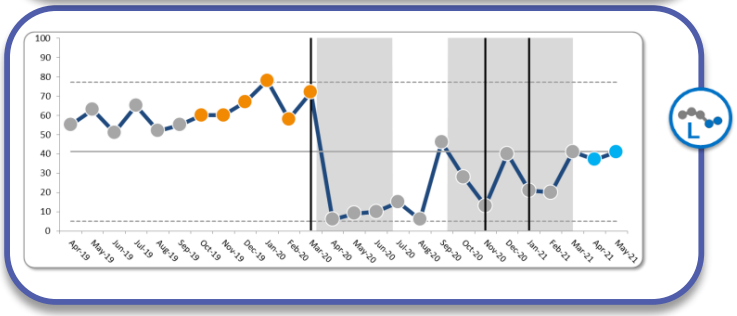
Actual Theatre session utilisation (%)

74.90%



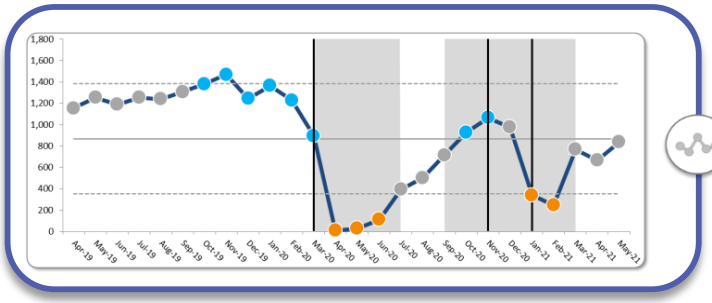
Non-electives & emergencies on elective theatre sessions (n)

41



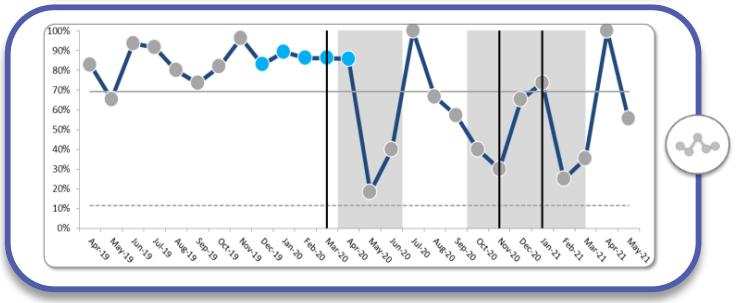
Day cases on elective theatre sessions (n)

839



% patients rebooked with 28 days of cancellation

55.56



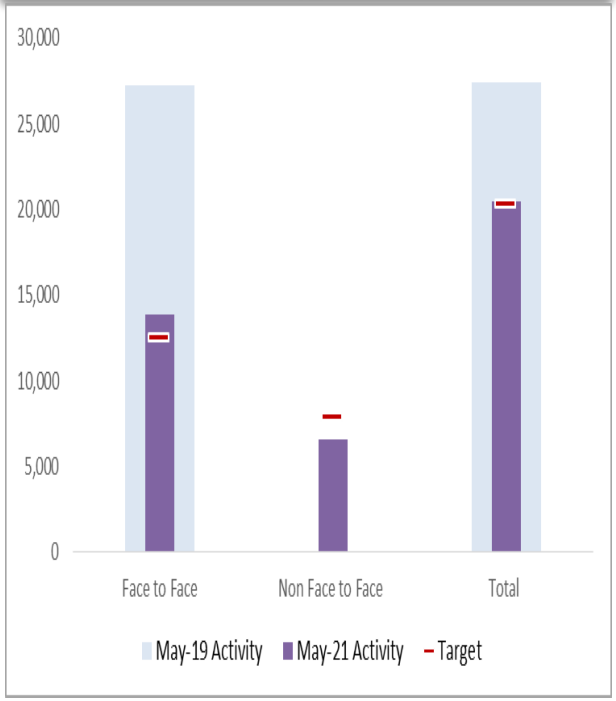
*Phase 3 restoration is based on consultant-led activity only that has been submitted via SUS. This graph is reflective of **all** the Outpatient activity that has been delivered by the Trust.

Month 2 [May] | 2021-22 | Operational Performance: Outpatients

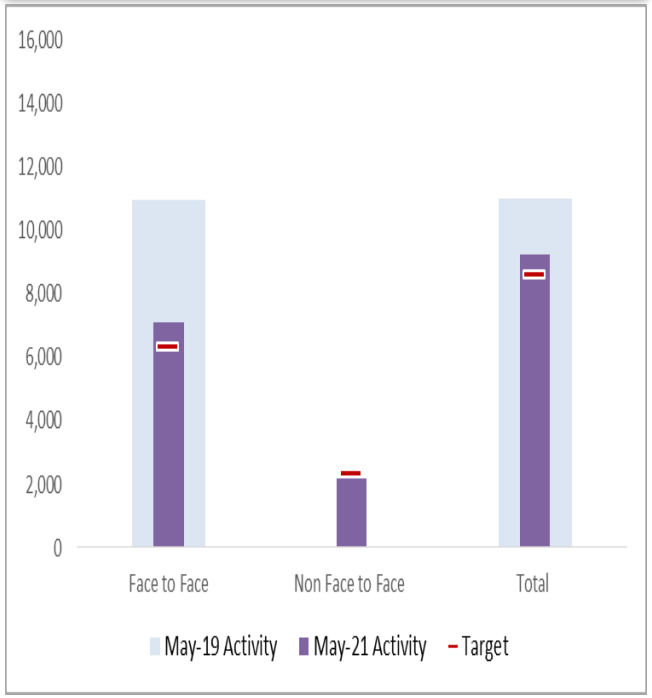
Responsible Director: Chief Operating Officer | Unvalidated for May-21 as 16th June 2021

Comparing Consultant-Led Outpatients Activity between 2019, 2021 and the H1 activity target

Total



New



Follow up

Operational Performance: DM01 Diagnostics

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

NHS Worcestershire Acute Hospitals NHS Trust

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

Trust Total			Radiology			Physiology			Endoscopy		
11,586	4,952	57.26%	6,515	2,357	63.80%	3,238	1,640	49.40%	1,833	955	47.70%

What does the data tell us?

- The DM01 performance is validated at 57.26% of patients waiting less than 6 weeks for their diagnostic test, the third consecutive month this has improved, but still consistent with the sustained underperformance since the cessation of elective diagnostic tests due to COVID-19 created a backlog of patients.
- The diagnostic waiting list has increased with the total waiting list currently at 11,586 patients, an increase of 324 patients from the previous month.
- The total number of patients waiting 6+ weeks has decreased by 514 patients (5,466 in April-21) and there are now 2,366 patients waiting over 13 weeks (2,609 in April-21) and Radiology has the largest number of patients waiting at 6,515 and has the largest number of patient waiting over 6 weeks at 2,357; a decrease of 423 in May-21 compared to April-21.
- Over 15,000 diagnostic tests were undertaken in May-21 in-line with the peak of phase 3 recovery recorded in Oct-20 and Nov-20. A subset of the DM01 modalities are monitored in the H1 activity plan.
- For radiology, CT and non-obstetric ultrasound achieved their H1 targets and showed an increase between Apr-21 and May-21, whereas MRI showed no change in activity and didn't achieve the activity targets.
- For endoscopy, all three modalities showed an increase in activity but only gastroscopy achieved an H1 target which was in Apr-21.
- Echocardiography is a new addition to our monitoring having not been part of phase 3; this modality has a decrease in activity between Apr-21 and May-21 and didn't achieve the activity targets (see slide 26).

RADIOLOGY

What have we been doing?

- Continued utilisation of mobile CT at KTC site
- Continued WLI sessions countywide, staff permitting.
- Continued discussion with CCG re DEXA referral review- continued to provide DEXA appointments. CCG have confirmed process, Informatics team have now re-run data.
- Commenced discussions with WVT on support with Nuc Med ARSAC license
- Commenced CDH bid
- Liaising with Cobalt to obtain capacity following removal of CT mobiles unit
- Commenced discussion with Medneo re CT scanner

Issues

- Removal of CT mobile reduces capacity by 650 patients per month
- Significant increase in MRI 2ww referrals, resulting in cancellation of routine appointments
- Reduced number of WLI as staff not offering additional sessions

What are we going to do next?

- Agree contract for continued mobile on KTC site, awaiting dates from Cobalt or contract with Medneo to be confirmed
- Continue WLI session in CT, MRI and US.
- Send GP practices list of DEXA patients for review
- Commence discussions internally on managing DEXA back log
- Plan KTC CT replacement schedule
- Obtain CT1/CT3 staffing business case approval
- Explore contract with Medicare for US capacity

ENDOSCOPY (inc. Gynaecology & Urology)

What have we been doing?

- Continuing the use of IS at BMI for SPOT patients
- Regular fortnightly GA lists being offered to endoscopy through weekly theatre 6-4-2 meetings
- Maintained use of 18 week at Evesham
- Exploring ways to increase ERCP capacity with Radiology; securing some ad-hoc sessions
- Commenced additional Urology activity through UIC, ALX with support from endoscopy decontamination. Further capacity now being used through Wye Valley

What are we going to do next?

- Increasing validation of Surveillance WL against 2019 BSG guidelines
- Looking to increase numbers through BMI; proposed 100-120 pts per month

Issues

- Total of 50 lists were lost throughout May; Bank Holidays, decontamination equipment failure, infrastructure works, sickness, and unable to backfill
- Decontamination issues a concern at ECH, with a number of lists dropped at short notice. Paper being drafted for equipment replacement
- Unisoft issues still being reported; not as frequent since IT upgrade at ECH. Solus upgrade benefits realisation complete; business case awaiting server upgrade timeline . Digital PMO meeting 14/06/21 to discuss.

Operational Performance: DM01 Diagnostics

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

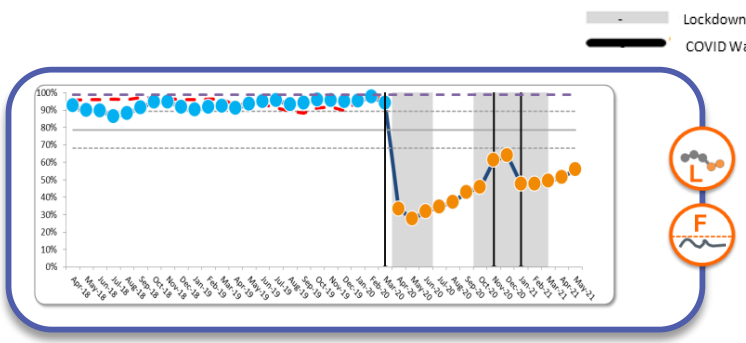
NHS Worcestershire Acute Hospitals NHS Trust

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

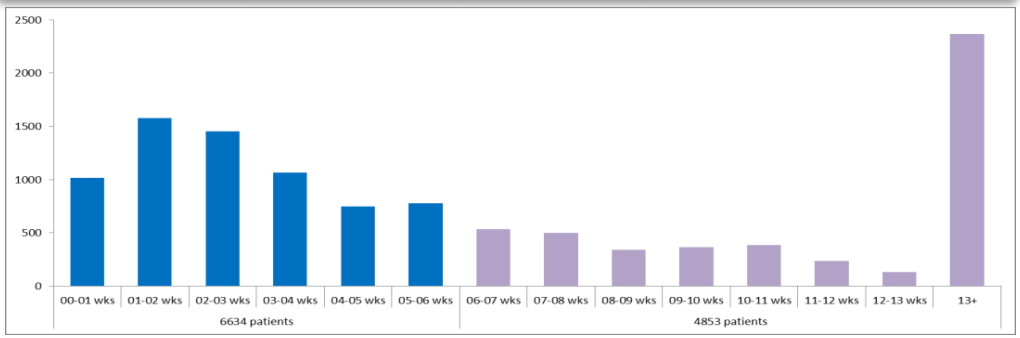
Trust Total			Radiology			Physiology			Endoscopy		
11,586	4,952	57.26%	6,515	2,357	63.80%	3,238	1,640	49.40%	1,833	955	47.70%

DM01 Diagnostics % patients within 6 weeks

57.26%



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



NEUROPHYSIOLOGY

What have we been doing?

- Clinics have now restarted since 22/3/2021 – over 1000 patients are on the Waiting list.
- Clinical urgency is being reviewed
- Clinics are being booked at KGH once a week.
- Additional clinics starting at Redditch from 27/5

What are we going to do next?

- Awaiting to see if there is approval for WLI clinics to recover some of the backlog.

CARDIOLOGY – ECHO

What have we been doing?

- Approval was given to reopen services
- Service currently open to all patients
- Workloads for all sites are prioritised based on urgency
- Backlog is still increasing due to reduced capacity
- WLI clinics are continuing back on referring site
- Have been given agreement to perform Pacing clinics and holter monitors in the assessment PODs which will allow for increased department activity

What are we going to do next?

- WLI clinics to continue where possible
- Trial POD activity before increasing Echo levels

Current Assurance Level: 4 (May-21)

When expected to move to next level of assurance: This is dependent on the on-going management resulting in increasing our capacity for routine diagnostic activity

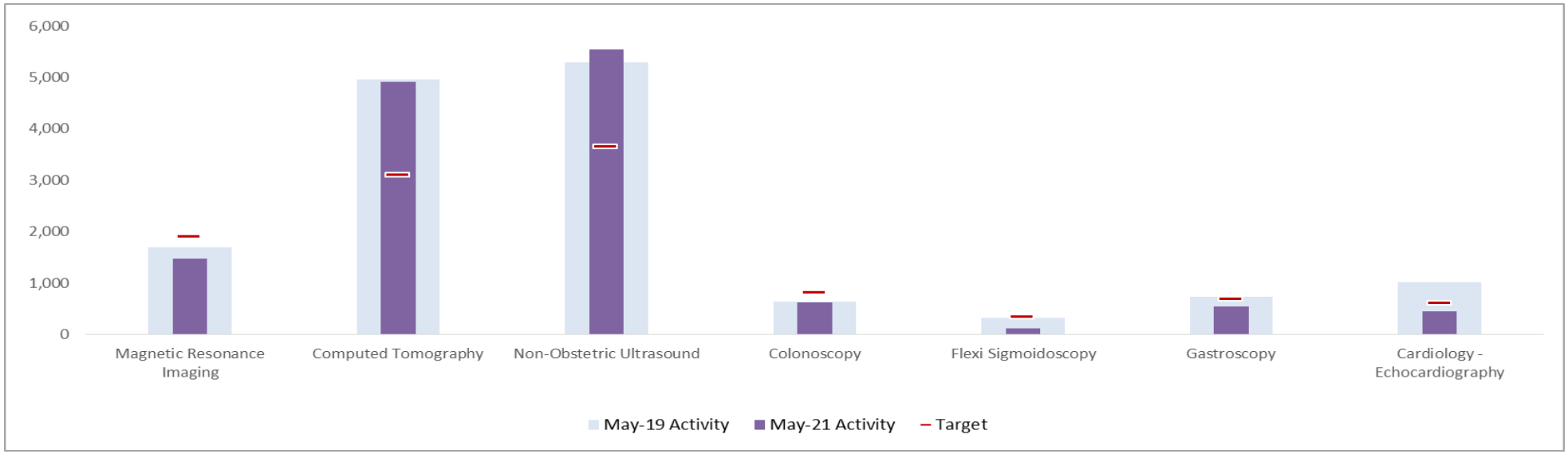
Previous assurance level: 4 (Apr-21)

SRO: Paul Brennan

Month 2 [May] 2021-22 | Operational Performance: DM01 Diagnostics

Responsible Director: Chief Operating Officer | Validated for May-21 as 16th June 2021

DM01 Diagnostics Activity | May -21 Diagnostic activity compared to H1 restoration plan

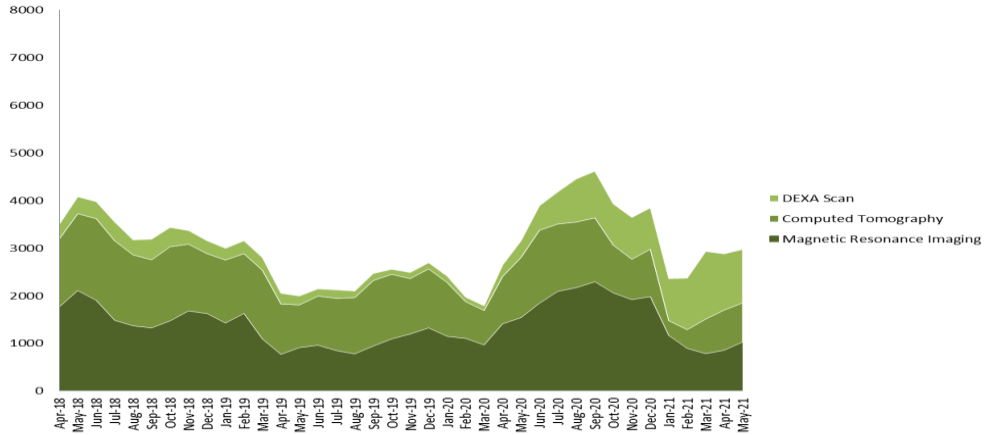


These graphs represent H1 annual planning restoration only, as submitted in the plan. All other physiology tests, DEXA and cystoscopy were not included in the request from NHSEI.

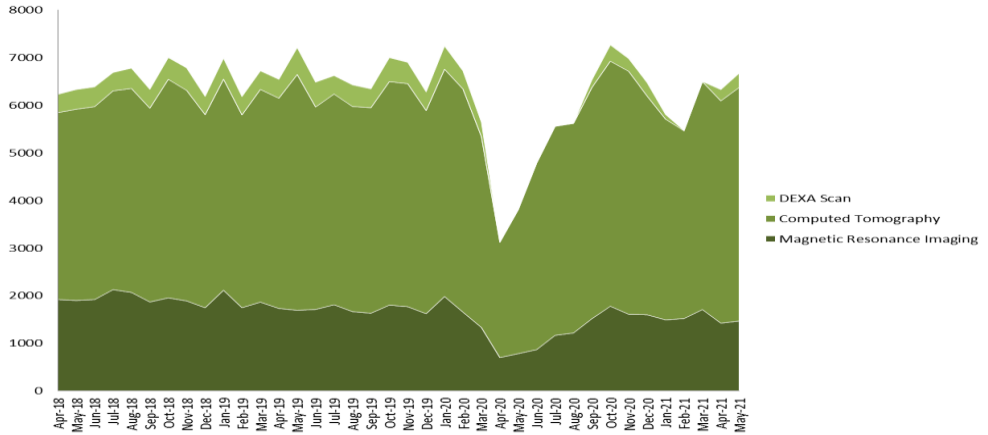
Month 2 [May] 2021-22 | Operational Performance: DM01 Diagnostics

Responsible Director: Chief Operating Officer | Validated May-21 as 16th June 2021

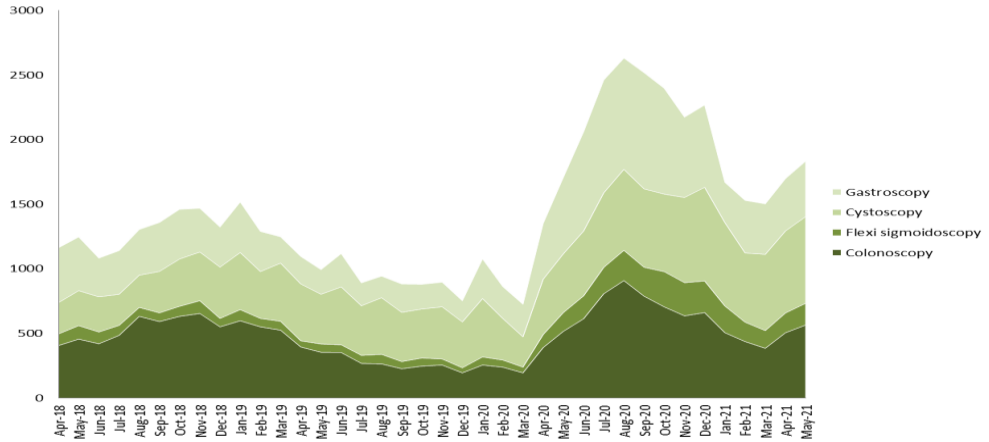
Radiology DM01 waiting list size - Monthly snapshot



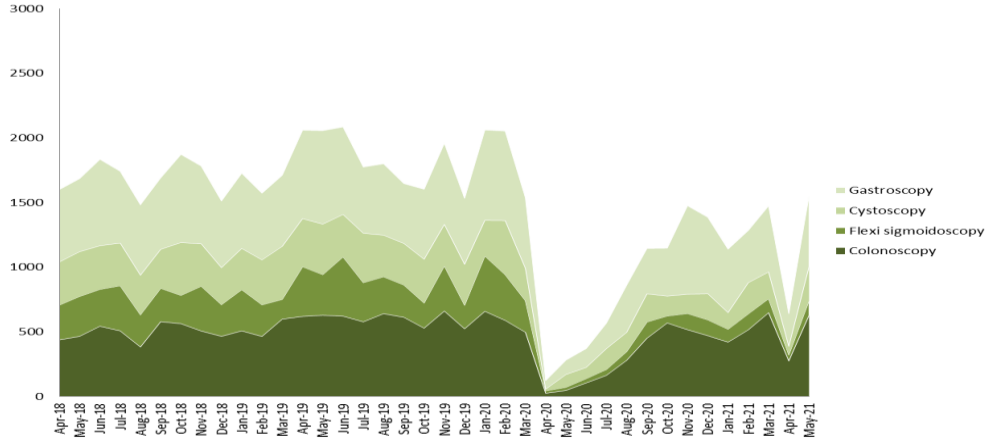
Radiology DM01 Activity - Monthly snapshot



Endoscopy DM01 waiting list size - Monthly snapshot



Endoscopy DM01 Activity - Monthly snapshot



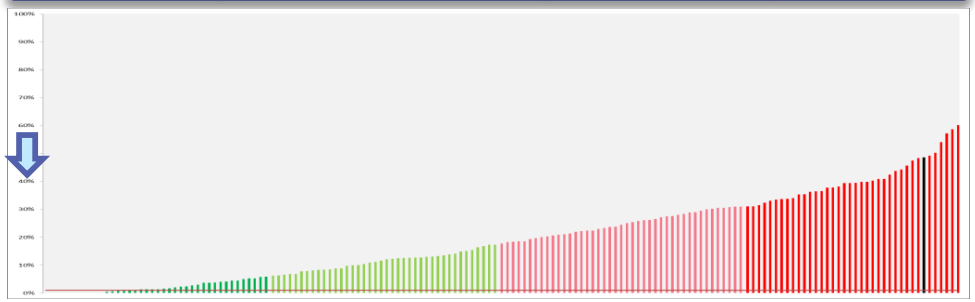
Note the different scaled axis on the graphs when comparing them

Operational Performance: Diagnostics (DM01) Benchmarking

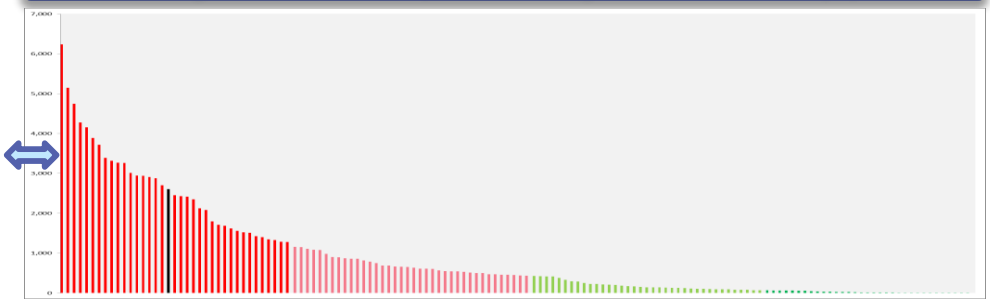
National Benchmarking (April 2021) | The Trust was one of 7 of 13 West Midlands Trust which saw a increase in performance between Mar-21 and Apr-21 This Trust was ranked 13 out of 13; where we were 13 previous month. The peer group performance ranged from 0.78% to 48.56% with a peer group average of 22.39%; 0.243 from 22.10% the previous month. The England average for Apr-21 was 24.00% a -0.3% increase from 24.30% in Mar-21.

In April, there were 136,208 patients recorded as waiting 13+ weeks for their diagnostic test; 2,603 (1.91%) of these patients were from WHAT

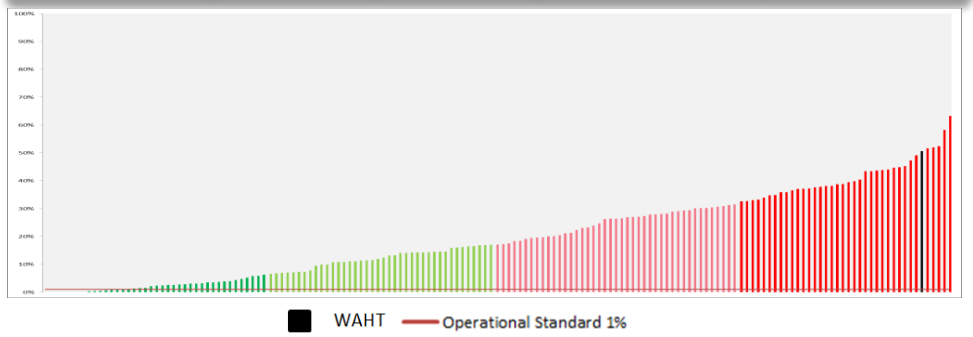
DM01 Diagnostics - % of patients waiting more than 6 weeks | April-21



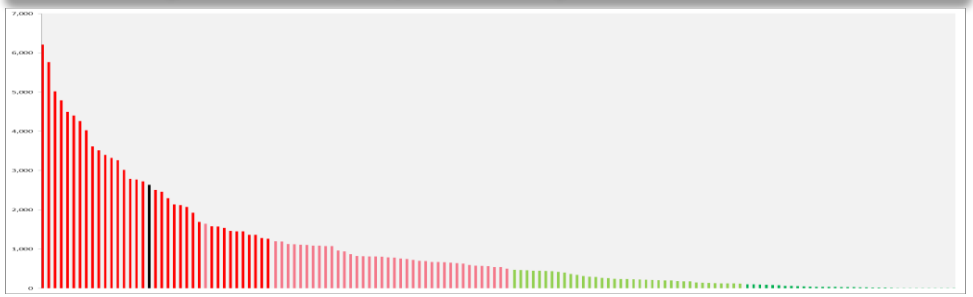
DM01 Diagnostics - number of patients waiting more than 13 weeks | April-21



DM01 Diagnostics - % of patients waiting more than 6 weeks | March-21



DM01 Diagnostics - number of patients waiting more than 13 weeks | March -21



28

Operational Performance: Stroke

% of patients spending 90% of time on a Stroke Ward	% of patients who had Direct Admission (via A&E) to a Stroke Ward	% patients seen in TIA clinic within 24 hours	% of patients who had a CT within 60 minutes of arrival	SSNAP Q4 Jan-21 to Mar-21			
75.00%	37.50%	91.30%	35.71%	Score	66.6	Grade	C

What does the data tell us?

SSNAP

- Quarter 4 SSNAP results were published on the 2nd June and we have improved to a grade C from a grade D.
- Overall, clinically, we achieved a grade B and 74 points. This was an 8 point improvement on the previous quarter.
- Unfortunately we achieved a level C on audit compliance which resulted in a 10% reduction in the overall score which reduced to 66.6 and a grade C.
- This was still an improvement on the grade D achieved in Q3 and clinically the majority of metrics have shown improvement and examples of the positive improvements in key metrics were:
  - Percentage of patients who were thrombolysed within 1 hour of clock start – improved from a grade E to A
  - Median time between clock start and being assessed by stroke consultant - reduced from 6hrs 30 to 4 hrs 55 and a grade B to an A.
  - Percentage of applicable patients who have a continence plan drawn up within 3 weeks of clock start - improved from 44% and grade E to 93% and a grade B
  - Percentage of applicable patients in atrial fibrillation on discharge who are discharged on anticoagulants or with a plan to start anticoagulation -improved from 66% and a grade D to 100% and a grade A.
- The areas for improvement are :
  - Percentage of applicable patients who were given a swallow screen within 4hrs of clock start – this has reduced from a grade D and 74% to a grade E and 64%.
  - Median time between clock start and being assessed by occupational therapist/SLT/Physio – these are still grade D although the Overall Domain 8 of MDT working is a level B.

- TIA SOP – Draft TIA specific SOP was developed and was presented in the Stroke Directorate meeting in May and to be discussed again in June. The expectation is that this would be used as a recommended guide and ensure consultants and other colleagues supporting the service provide an equitable service to all TIA patients.
- TIA education session for GPs – The clinical lead for Stroke to meet with GP's across Worcestershire to discuss current challenges the team experiencing with regards to inappropriate referrals and aim to set a clear guidance in term of expectation, criteria and access to alternative pathways including Advice & Guidance to reduce inappropriate demand on the service.
- Thrombolysis Training – All on-call Registrars are given the opportunity to receive F2F training with Stroke consultant and this would be arranged for end of June or beginning of July. This should improve care of patients receiving thrombolysis treatment and support performance improvement against this indicator.
- Stroke patient transfer pathway – This has been reviewed and revised to make it clearer for patients presenting at Alex/Worcester and now reflects the current SOP in place. In addition, this was approved by the division and has now been shared across the Trust and envisage this would considerably improve patients experience going forward.
- Initial Stroke assessment paperwork has been updated and discussed in the directorate meeting, subsequently this has been recirculated for further feedback.
- Stroke Registrar & Consultant Vacancy – Stroke Registrar appointed end of March has now started and have been successful in recruiting to the 2nd post. Furthermore, a joint Stroke/Neurology consultant appointed on a 12 month fix term is scheduled to start end of June and have agreed in principle for a further consultant to join in July on banks for 12 months. Currently, re-advertising for a 12 months fix term consultants post and discussions are on-going with QE in relation to a joint consultant post.
- SSNAP Performance – Quarter 4 performance has improved from overall grade of D in Q3 to C in Q4, however, points were deducted due to audit compliance and meeting has been arranged for next week to review Q4 performance in detail to establish the reason and identify key lessons to be learnt. As part of this exercise and renewed focus on data, the team aim to reconcile data uploaded on SSNAP against all missed target on each key indicators by individual patients on a monthly/quarterly basis. This would provide a comprehensive audit trail and consequential assurance on data quality.
- 24/7 CNS Cover – Change in working hours to cover 7 days a week including night has been discussed in the JNCC meeting and has been circulated for feedback. As a result comments have been received and these are to be answered to progress the process of changing the current contract.
- Limited flow to Rehab Beds – Infection control at Evesham Community Hospital requires patients being transferred from acute Trust to be admitted into a side-room, which causes significant delay in flow.

Operational Performance: Stroke

% of patients spending 90% of time on a Stroke Ward	% of patients who had Direct Admission (via A&E) to a Stroke Ward	% patients seen in TIA clinic within 24 hours	% of patients who had a CT within 60 minutes of arrival	SSNAP Q4 Jan-21 to Mar-21			
75.00%	37.50%	91.30%	35.71%	Score	65.7	Grade	C

What does the data tell us?

Stroke Metrics

- All four main stroke metrics show performance that is within common cause variation.
- Patients spending 90% of their time on a stroke ward shows no significant change in performance since Apr-18. The process is unlikely to achieve the target of 80% consistently but may be expected to vary between 63% and 91%.
- Patients who had Direct Admission (via A&E) to a stroke ward shows no significant change in performance since Oct-19. The process will not achieve the target of 90% but may be expected to vary between 17% and 78%.
- Patients seen in TIA clinic within 24 hours showed a step change in Mar-20. The process will currently consistently achieve the target of 70%.
- Patients who had a CT scan within 60 minutes of arrival shows no change since Sept-18. The process will not achieve the target of 80% but may be expected to vary between 21% and 78%.

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

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

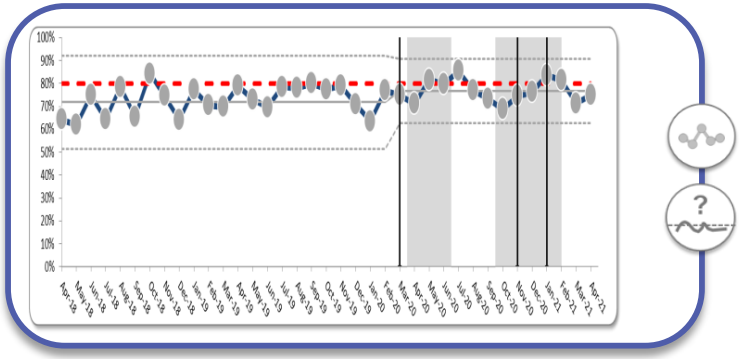
Current Assurance Level: 5 (May-21)	**When expected to move to next level of assurance:** This is dependent on the ring-fencing of stroke beds and increased availability of MRI scanning.
Previous Assurance Level: 5 (Apr-21)	**SRO: Paul Brennan**

Month 2 [May] | 2021-22 | Operational Performance: Stroke

Responsible Director: Chief Operating Officer | Validated for April-21 as 05th June 2021

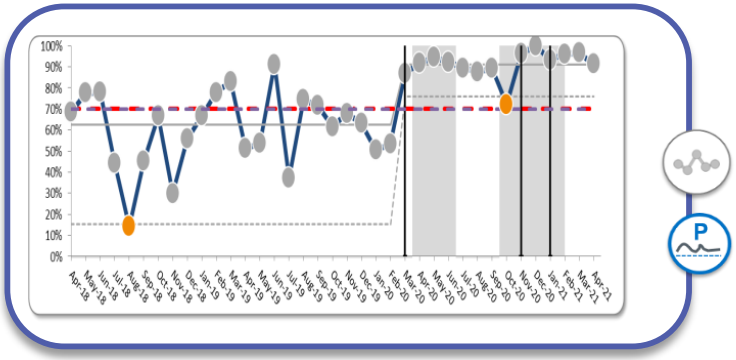
Stroke: % patients spending 90% of time on stroke unit

75.00%



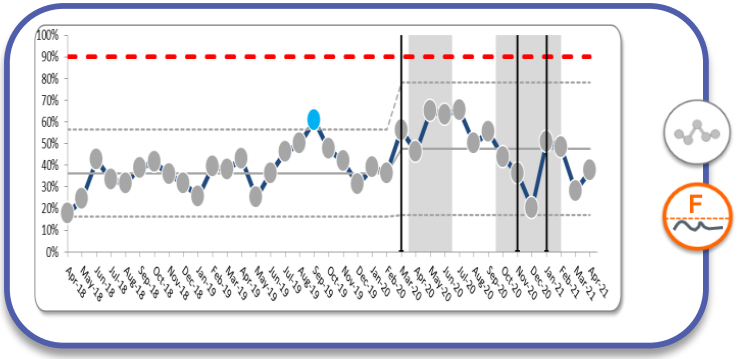
Stroke: % seen in TIA clinic within 24 hours

91.30%



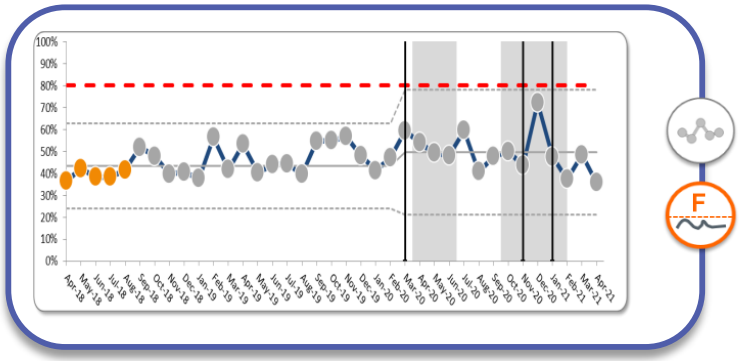
Stroke : % Direct Admission to Stroke ward

37.50%



Stroke : % CT scan within 60 minutes

35.71%



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

Lockdown Period

COVID Wave

Quality and Safety

Data Quality Risk Matrix – Quality & Safety

Data Set	Includes	Likelihood	Impact	Total Score	Context
Infection prevention and Control	C-Diff	1	3	3	This data is scrutinised at patient level regularly. There are no known issues with this data known at present.
	E-Coli	1	3	3	
	MSSA	1	3	3	
	MRSA	1	3	3	
Hand Hygiene	Hand Hygiene Participation Hand Hygiene Compliance	Unknown	Unknown	N/A	Not yet reviewed. Plan to review the completion of these audits from a data quality perspective (Q2 2021/22)
Sepsis	Sepsis 6 bundle Compliance Sepsis Screening Compliance Sepsis Screening Antibiotics	Unknown	Unknown	N/A	Not yet reviewed. Plan to audit the completion of these audits from a data quality perspective. (Q3 2021/22)
VTE	VTE Assessment 24 Hours VTE Assessment	2	2	4	This metric has had a lot of scrutiny and is reviewed fortnightly in a meeting so no concerns.
ICE Reporting	ICE reports viewed radiology	3	2	6	The data quality issue is in relation are in relation to filing and management of reporting by consultants and allocation of report to correct consultant. There are some small technical issues for which there is currently no resolution. **Mitigation:** There are reports available on WREN at consultant level to provide focus on which reports require viewing and filing.
	ICE reports viewed Pathology	3	2	6	

Data Quality Risk Matrix – Quality & Safety

Data Set	Includes	Likelihood	Impact	Total Score	Context
Fractured Neck of Femur	NOF time to theatre	2	3	6	Data is captured robustly in a FNOF national database, the data quality between the clinical PAS and the database can be different, however we routinely audit this.
Falls	Falls per 1,000 bed days causing harm	1	1	2	No data quality issues due to the in depth patient level scrutiny.
Pressure Ulcers	All Acquired Pressure Ulcers Serious Incident Pressure Ulcers	1	1	2	No data quality issues due to the in depth patient level scrutiny.
Medicine Incidents	Total medicine Incidents reports Medicine incidents causing harm	Unknown	Unknown		Not yet reviewed. Plan to audit the completion of these audits from a data quality perspective (Q2 2021/22)
Complaints	Complaints Reponses </= 25 days	Unknown	Unknown		

Data Quality Risk Matrix – Quality & Safety

Data Set	Includes	Likelihood	Impact	Total Score	Context
Mortality	HSMR 12 month rolling	2	2	4	On occasion issues are identified but these are investigated as they arise. No current known issues.
	Mortally review completed </= 30 days	2	3	6	There are still some investigations regarding the accuracy of data in the new bereavement app. Issues may be related to interpretation of how the app should be used and interpretation of which data to record where. **Mitigation:** Detailed review of the app – mortality working group is systematically working through a review of the app.
Friends and Family	A&E Responses Rates Inpatient Responses Rates Maternity Responses Rates Outpatients Responses Rates A&E Recommended Rate Inpatient Recommended Rate Maternity Recommended Rate Outpatients Recommended Rate	No score	No score		

Integrated Quality Performance Report – Headline Performance

Area	Metric	Last 3 Months*		
		Mar-21	Apr-21	May-21
Infection Control	C.difficile	🔴	🟢	🔴
	E-Coli	🟢	🔴	🔴
	MSSA	🟢	🟢	🟢
	MRSA	🔴	🟢	🟢
	Hand Hygiene Audit Participation	🟡	🟡	🟡
	Hand Hygiene Compliance	🟢	🟢	🟢
SEPSIS 6	Bundle Completed Within 1 Hour	🔴	🔴	-
	Screening Compliance	🔴	🔴	-
	% Antibiotics Provided Within 1 Hour	🟢	🟢	-
VTE	Assessment on Admission	🟢	🟢	🟢
	24 Hour Reassessment	🔴	🔴	🔴
ICE Reporting	Radiology Reports Viewed	🟡	🟡	-
	Pathology Reports Viewed	🟢	🟢	-
Friends & Family	Recommended Rate - Inpatients	🟢	🟢	🟢
	Recommended Rate - Maternity	🟡	🟡	🟢
	Recommended Rate - Outpatients	🟡	🟡	🟡
	Recommended Rate - A&E	🔴	🔴	🔴
Complaints	Responded Within 25 Days	🔴	🟢	🟢
Hospital Acquired Pressure Ulcers (HAPU)	Serious Incident HAPUs	🟢	🟢	🟢
	Total HAPUs	🟢	🟢	🟢
Falls	Serious Incident Falls	🟢	🔴	🟢
	Total Number of Falls (Inpatients)	🟢	🟢	🟢
Fractured Neck of Femur	Time to Theatre <= 36 Hours	🔴	🔴	🔴

** Source: SQUID*

Integrated Quality Performance Report - Headlines

Quality Performance	Comments (All metrics on this slide have additional Improvement Statements later in this report)
Infection Control	• *C.difficile* infections failed to achieve the in-month target for May-21, but is achieving the year to date trajectory. • E-Coli BSI failed to achieve the in-month target for May-21, and is also failing to meet the year to date trajectory. • MSSA and MRSA achieved the in-month targets for May-21, and are both achieving their year to date trajectories. • Hand Hygiene Practice Compliance rate continues to perform above the 98% target, with 99% being exceeded for the last 16 months • Hand hygiene audit participation dropped slightly in May-21 following 4 consecutive months improvement.
Never Events	• One Never Event was recorded in May-21 • There have now been 3 Never Events in 2021/22
SEPSIS 6	• The sepsis 6 bundle completed within one hour compliance dropped in Apr-21 following 3 consecutive months of improvement. • Sepsis 6 screening performance rose in Apr-21, but has not met the target since May 2019. • Sepsis 6 antibiotics provided within one hour compliance dropped slightly in Apr-21, but it has hit the target for the 4th consecutive month.
VTE Assessments	• There has been a sustained significant improvement in VTE assessments, with the target begin attained every month since April 2019. • There is concern about VTE 24 hour VTE re-assessment rates, which although achieving its highest performance level in May-21is still below target. • Data being recorded on Badgernet by W&C is now being reviewed and will be incorporated into VTE reporting.
ICE Reporting	• The Target of 95% for viewing Radiology Reports on ICE has not been achieved in the past 13 months (range 80.56% to 84.03%). • The Target of 95% for viewing Pathology Reports on ICE has been achieved for 10 consecutive months.
Fractured Neck of Femur	• The #NOF target of 85% has not been achieved since the start of the pandemic in March 2020 (87.30%). • Performance has been over 80% for 3 of the 13 months since the start of the Pandemic, peaking in Jan 2021(80.72%) with a trough in Jun 2020 (64.79%).

Integrated Quality Performance Report - Headlines

Quality Performance	Comments
Friends & Family Test	• The recommended rate exceeded the 95% target for Inpatients for the 11th month out of the last 12 (the remaining month was only just under at 94.87%) • The recommended rate for Maternity was above the target at 96.51%, and improved for the 4th month in a row. • The recommended rate for Outpatients dropped to 93.47% in May-21, which is the 1st time the figure has been below 94% in the past 7 months. • The recommended rate for A&E dropped to 79.79%, however it has been above 83% for the previous 12 months.
Complaints	• The % of complaints responded to within 25 days increased and was above target at 89.74% in May-21.
Hospital Acquired Pressure Ulcers (HAPU)	• There were zero Serious Incident HAPU's in May-21 for the 9th time in the last 12 months. • There were zero Category 4 HAPU's in May-21 for the 10th consecutive month. • There were a total of 6 HAPUs in May-21, which is below the in-month target of 22. • The total of 20 HAPUs year to date is just under 50% of the year to date trajectory of 41.
Falls	• The number of falls per 1000 bed days rose slightly in May-21 to 4.88 (remains below the national benchmark of 6.63) • This followed 5 months in a row this figure has fallen. • There were 4 falls reported as SIs on DATIX in May-21, all of these have been requested for downgrade as no omissions in care were identified. • At the moment, 1 case remains on the WREN reports so is included. • SI falls trajectory 21/22: no more than 6 cases in the year • Falls trajectory 21/22: no more than 1,235 cases (no more than 103 falls per month apart from Apr-20 which is 102)

2.1 Care that is Safe - Infection Prevention and Control

Embed our current infection prevention and control policies and practices | Full compliance with our Key Standards to Prevent Infection, specifically Hand Hygiene above 97%, Cleanliness in line with national standards, ongoing care of invasive devices

C-Diff		E-Coli		MSSA		MRSA	
May actual vs target	Year to date actual / year to date target	May actual vs target	Year to date actual / year to date target	May actual vs target	Year to date actual / year to date target	May actual vs target	Year to date actual / year to date target
5/4	7/9	4/2	7/4	0/1	1/3	0/0	0/0

What does the data tell us?

- *C.difficile* infections failed the in-month target for May-21, but is achieving the year to date trajectory.
- E-Coli BSI exceeded the in-month target for May-21, and is above the year to date trajectory.
- MSSA achieved the in-month target for May-21, and is achieving the year to date trajectory.
- MRSA achieved the in-month target for May-21, and is achieving the year to date trajectory.

*Note all HCAI targets and trajectories have been set internally for 21-22. National targets are expected to be issued by July 21 and will supersede local targets.

- The Hand Hygiene audit participation rate dropped slightly in May-21 to 91.82% following 4 consecutive months improvement.
- Hand Hygiene Practice Compliance rate continues to perform above the 98% target, with 99% being exceeded for the last 16 months. This metric will reliably achieve the target.

- The latest revision of the COVID BAF (Version 1.5) was published by NHSEI on 12th Feb 2021, and a repeat self-assessment was reviewed at the CGG, TME and QGC meetings in May 21. Level 6 assurance was supported and approved.

What improvements will we make?

- Monthly scrutiny of divisional progress with AMS plans will continue via ASSG, and COO Performance Review Meetings.
- Revised Neutropenic sepsis guidance will be issued within the next month supporting reduced use of carbapenem antibiotics.
- Work is in progress within each division on specific issues as set out in divisional AMS plans.

- The *Staphylococcus aureus* BSI Quality Improvement Steering Group met on 24-05-21, and made progress with re-establishing work streams, and pulling back together the various elements of work identified as part of this project.
- The new theme identified at the TIPCC Scrutiny & Learning Meeting, relating to the management of chronic wounds and chronic skin conditions infected or colonised with *Staph aureus*, has been fed into the QI project. A work stream has been identified to progress this as part of the project.
- E coli BSI is often related to factors outside acute healthcare, and it should be noted that we achieved a 38% reduction in 20-21, performing significantly better that the target of 50. The locally-set target for 21-22 has set an ambitious further 10% reduction on 20-21 performance. Review is underway of all E coli BSI reported in 20-21 to identify issues which can be targeted within the trust to achieve this further reduction in these infections.

Assurance level – Level 6 COVID-19 / Level 4 for non-Covid (May-21) Reason: Non Covid - Antimicrobial Stewardship is a key concern.	**When expected to move to next level of assurance for non Covid**: This will be next reviewed in July 21, when quarter 1 performance can be assessed.
Previous assurance level (Apr-21) –Level 6 COVID-19 / Level 4 for non-Covid	SRO: Paula Gardner(CNO)

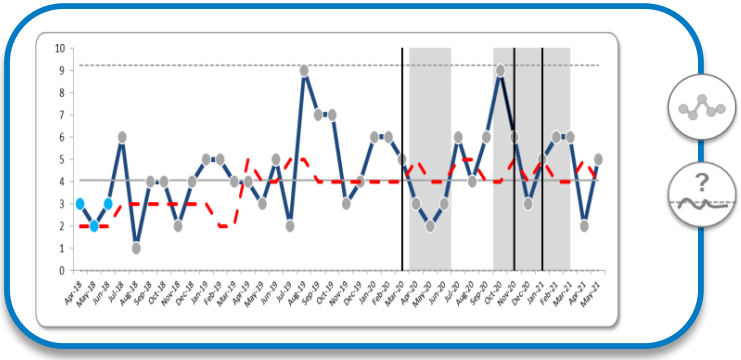
Month 2 [May] | 2021-22 Quality & Safety - Care that is Safe

Responsible Director: Chief Nursing Officer, Chief Medical Officer | Validated May 21 as at 10th June 2021

NHS Worcestershire Acute Hospitals NHS Trust

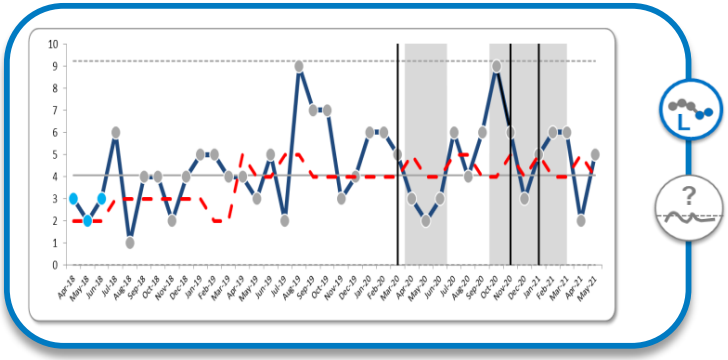
C-Diff

5



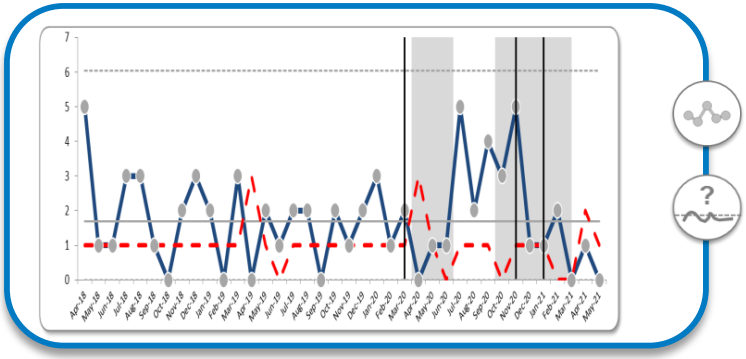
E-Coli

4



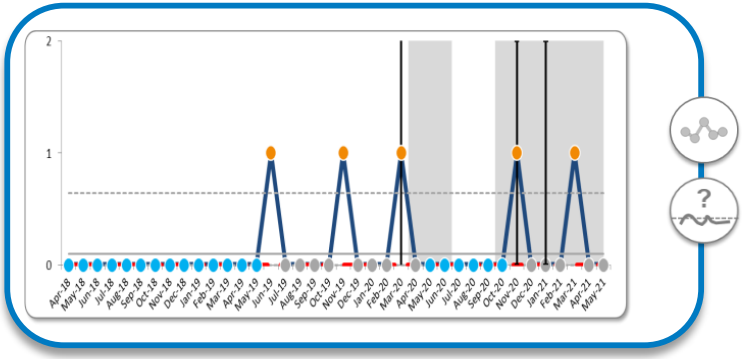
MSSA

0



MRSA

0



Lockdown Period

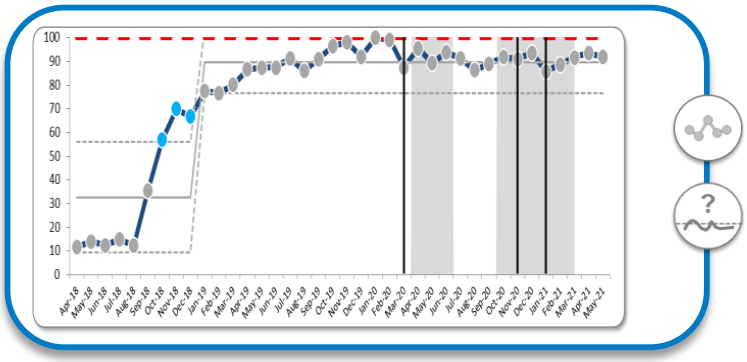
COVID Wave

Month 2 [May] | 2021-22 Quality & Safety - Care that is Safe

Responsible Director: Chief Nursing Officer, Chief Medical Officer | Validated May 21 as at 10th June 2021

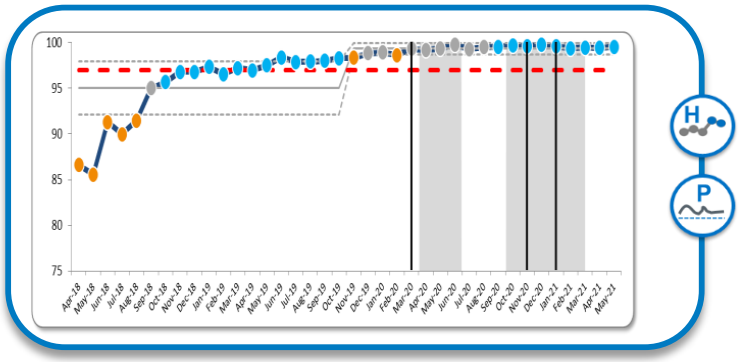
Hand Hygiene Audit Participation (%)

91.82



Hand Hygiene Compliance (%)

99.53



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

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

Lockdown Period

COVID Wave

2.1 Care that is Safe – Never Events

Number of Never Events	
May 2021: One	
What does the data tell us? • A Never Event was reported during May 2021, in addition to the two reported in April • There are no trends in the Never Events reported other than the April incidents occurring in the same location • The latest incident involved an incorrectly inserted NG tube which resulted in feed delivery into the lungs • One incident involved a retained guidewire during the insertion of a chest drain • One incident involved the biopsy of the incorrect area of the chest	**What will we be doing?** • All incidents are being investigated in line with Trust policy for Serious Incidents • The findings will be discussed with the teams involved and a report will be produced on behalf of the Trust • The actions will be agreed with the specialty and monitored via the Divisional Governance meetings • The report will be shared for learning purposes and presented to Quality Governance Committee • The report will be shared with Commissioners and CQC in line with current reporting arrangements
Assurance level – N/A	**When expected to move to next level of assurance**: **N/A**
Previous assurance level: N/A	SRO: Mike Hallissey (CMO)

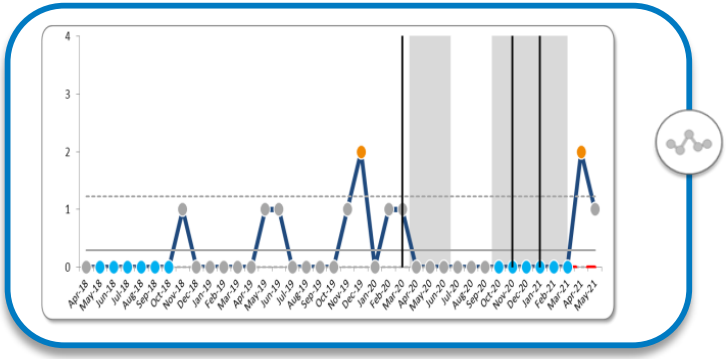
Month 2 [May] | 2021-22 Quality & Safety - Care that is Safe

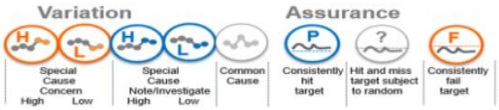
Responsible Director: Chief Nursing Officer, Chief Medical Officer | Validated May 21 as at 10th June 2021

Worcestershire Acute Hospitals NHS Trust

Never Events

1





Lockdown Period

COVID Wave

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

Sepsis six bundle completed in one hour (Target 90%)	Sepsis screening Compliance Audit (Target 90%)	% Antibiotics provided within one hour (Target 90%)	Urine	Oxygen	IV Fluid Bolus	Lactate	Blood Cultures
Apr 21: 50.00% (Mar 64.06%)	**83.52% (72.17%)**	**90.71% (93.75%)**	72.86% (84.38%)	86.43% (96.09%)	90.71% (93.75%)	75.71% (78.13%)	78.57% (80.47%)

What does the data tell us?

- The sepsis 6 bundle completed within one hour compliance dropped in Apr-21 following 3 consecutive months of improvement. The performance is still below the target.
- Sepsis 6 screening performance rose in Apr-21, but has not met the target since May 2019.
- Sepsis 6 antibiotics provided within one hour compliance dropped slightly in Apr-21, but it has hit the target for the 4th consecutive month.
- Compliance for all five of the remaining elements of the Sepsis 6 bundle dropped in Apr-21, although IV Fluid Bolus still achieved the target.
- Neutropenic Sepsis antibiotics given with 1 hour achieved 100% compliance in May-21. This is the 4th time in the last 6 months 100% has been achieved.

What improvements will we make?

- The Divisions each presented their current position, and outlined their action plans to improve overall performance reporting as part of a deep dive with the Quality Governance Committee.
- The committee welcomed both the work undertaken by the Divisions and the Sepsis 6 working group.
- The QGC approved an assurance level of 6 following the deep dive.
- Revised documentation will be introduced shortly which should make the process of identification easier and an update will be provided in September

Assurance level – Level 6 (May-21)

When expected to move to next level of assurance for non Covid:
Q2 following full implementation of the Divisional plans.

Previous assurance level (Apr-21) – Level 6
As approved by QGC

SRO: Mike Hallissey (CMO)

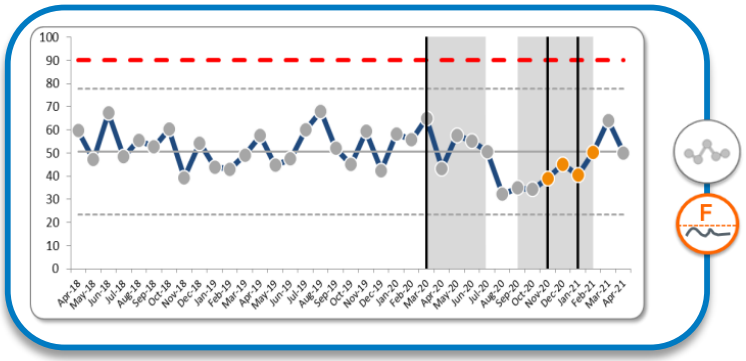
Month 2 [May] | 2021-22 Quality & Safety - Care that is Effective

Responsible Director: Chief Nursing Officer, Chief Medical Officer | Validated May 21 as at 10th June 2021

Worcestershire Acute Hospitals NHS Trust

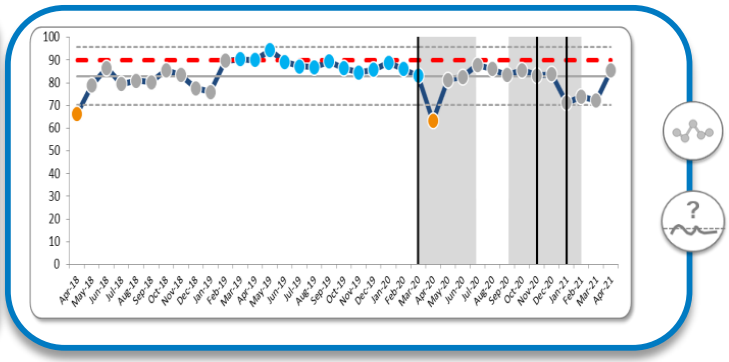
Sepsis 6 Bundle Compliance (audit)

50.00%



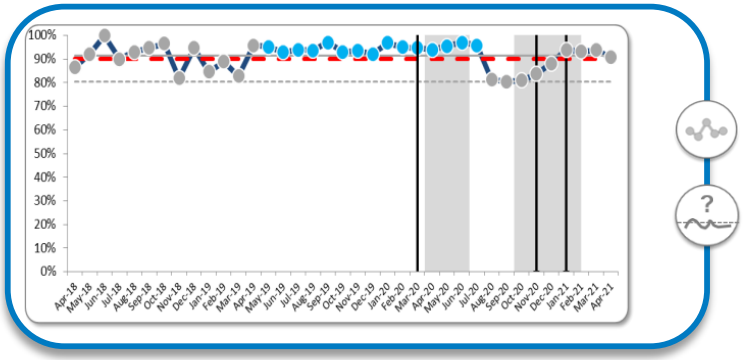
Sepsis Screening Compliance (audit)

85.52%



Sepsis Screening Antibiotics Compliance (audit)

90.71%



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

VTE assessment on admission to hospital		24 hour VTE re-assessment rates	
May 2021	Target	May 2021	Target
96.67%	95%	**66.26%**	95%

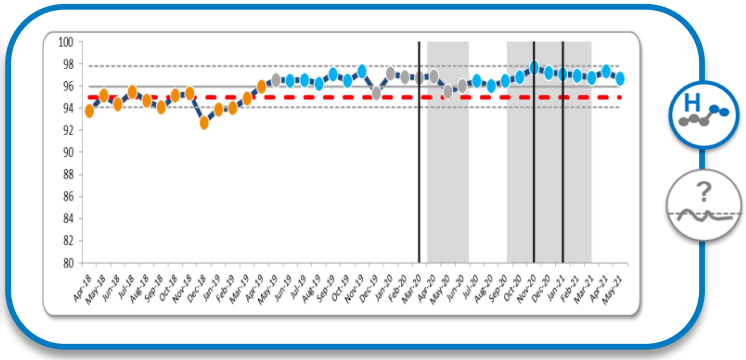
What does the data tell us?	What improvements will we make?
• We have achieved the initial VTE assessment on admission target every month since April 2019, including throughout the Pandemic. • The same level of performance has not been mirrored for compliance with 24 hour VTE re-assessment, which is still to achieve the target. Although the trend is generally upward, and in May achieved it's best performance to date.	• The monthly Trust Thrombosis (VTE) Group meetings have recommenced following de-escalation. Capacity to undertake more detailed work on 24 hour review will follow. • HAT reviews have demonstrated good compliance with 24 hour reviews • Identification of the issues over recording are being established to improve accuracy of recording. This includes reviewing and then incorporating the VTE data now recorded by the Women & Children Division in Badgernet.
Assurance level – Level 4 (May-21) Reason: Sustained compliance for VTE on assessment, but requires improvement for the 24 re-assessments	**When expected to move to next level of assurance** : Q2 21/22 – following embedding change made as a result of the audit.
Previous assurance Level - 4 (Apr-21)	SRO: Mike Hallissey (CMO)

Month 2 [May] | 2021-22 Quality & Safety - Care that is Effective

Responsible Director: Chief Nursing Officer, Chief Medical Officer | Validated May 21 as at 10th June 2021

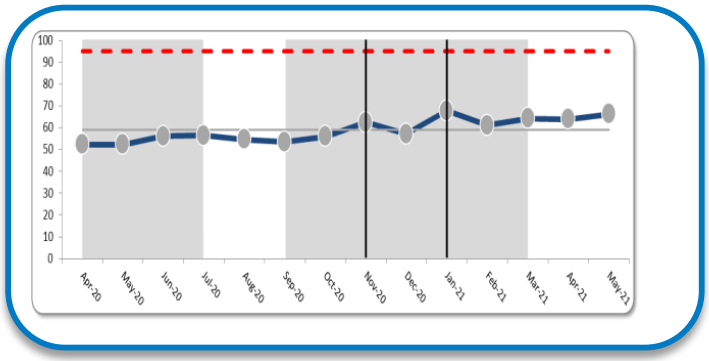
VTE Assessment Compliance (%)

96.67



24 hours VTE Assessment Compliance (%)

66.26



Lockdown Period

COVID Wave

2.2 Care that is effective - ICE Reporting

% Radiology reports viewed - ICE	% Radiology reports filed - ICE	% Pathology reports viewed - ICE	% Pathology reports filed - ICE
82.89% - Apr 2021 (84.03% - Mar 2021)	60.41% (62.72%)	95.79% (96.48%)	73.07% (74.21%)

What does the data tell us?

- The Target of 95% for viewing Radiology Reports on ICE has not been achieved in the past 13 months (range 80.56% to 84.03%).
- The Target of 95% for viewing Pathology Reports on ICE has been achieved for 10 consecutive months.

What have we been doing?

- The data reported on WREN is now included within the governance reports to each directorate meeting.
- It has been agreed and is being actioned for negative MRSA and COVID swabs and T&O trauma plain radiographs to be auto-filed and retrospectively batch filed
- Confirmed that inpatient blood results cannot be auto-filed or batch filed as the ICE system cannot separate out the inpatient group

What will we be doing?

- Going live with auto-filing and batch filing of negative MRSA and COVID swabs and T&O trauma plain radiographs
- Simplifying the process for filing by providing a filing pop up window when the results are viewed and not allowing the viewer of the results to close the window without making a decision to file or not.
- A comprehensive report will be prepared for the next cycle of Committee / Board meetings.

Assurance level – Level 4 (May-21)

When expected to move to next level of assurance:
When review of criteria for inclusion is complete – August 2021.

Previous assurance level: Level 4 (Apr 2020)

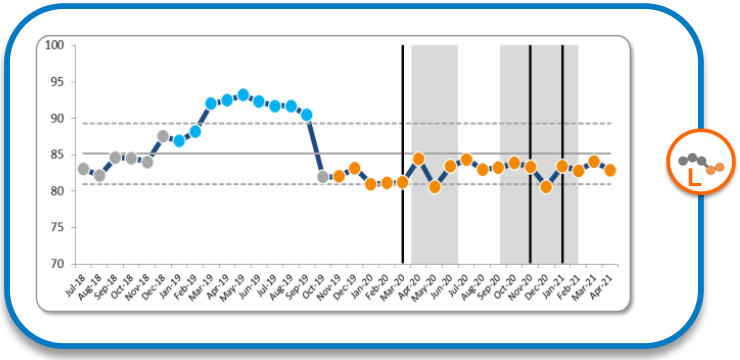
Month 2 [May] | 2021-22 Quality & Safety - Care that is Effective

Responsible Director: Chief Nursing Officer, Chief Medical Officer | Validated May 21 as at 10th June 2021

Worcestershire Acute Hospitals NHS Trust

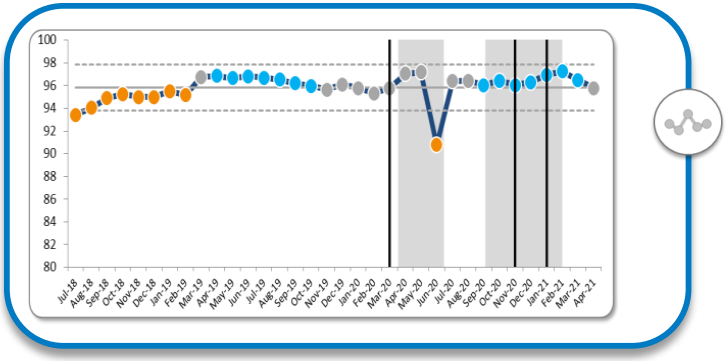
ICE reports viewed radiology (%)

82.89



ICE reports viewed pathology (%)

95.79



Lockdown Period

COVID Wave

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

#NOF – Time to Theatre <= 36 Hours	#NOF – Time to Theatre <= 36 Hours Excluding Unfit Patients
77.19% (May 2021) 67.14% (Apr 2021)	91.67% (May 2021) 77.19% (Apr 2021)

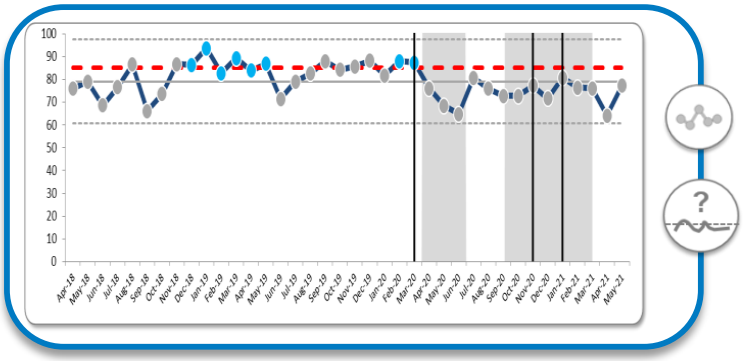
What does the data tell us?	What will we be doing?
• The #NOF target of 85% has not been achieved since the start of the pandemic in March 2020 (87.30%). • Performance has been over 80% for 3 of the 13 months since the start of the Pandemic, peaking in Jan 2021(80.72%) with a trough in Jun 2020 (64.79%). • In the 13 months pre-pandemic, performance was over 80% for 12 months, and achieved target on 6 occasions. • The causes for breaches in May were 7 patients treated non operatively, requiring further imaging or delayed presentation which caused a delay to theatre and 6 patients not being medically fit.	• Utilising Kidderminster Treatment Centre for speciality ambulatory trauma lists 3 days per week. • 2 sessions per day dedicated to Inpatient Trauma with #NoF's prioritised. • Utilise afternoon CEPOD list on ALX site (where emergency cases allow) for Trauma • Work is being undertaken with Theatres/anaesthetics and ED to put a more streamlined process in place for Covid swabbing out of hours to ensure the swab is back in a timely manner for those patients requiring urgent surgery.
Current assurance level – 4 (May-21)	**When expected to move to next level of assurance**: June 2021
Previous assurance level: 4 (Apr-21)	

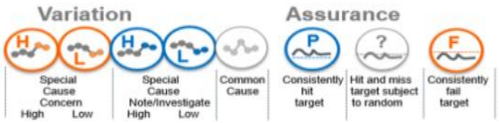
Month 2 [May] | 2021-22 Quality & Safety - Care that is Effective

Responsible Director: Chief Nursing Officer, Chief Medical Officer | Validated May 21 as at 10th June 2021

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

77.19%





Lockdown Period

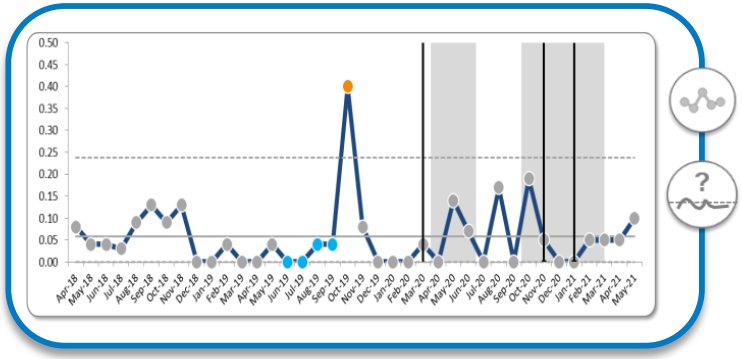
COVID Wave

Month 2 [May] | 2021-22 Quality & Safety - Care that is Safe

Responsible Director: Chief Nursing Officer, Chief Medical Officer | Validated May 21 as at 10th June 2021

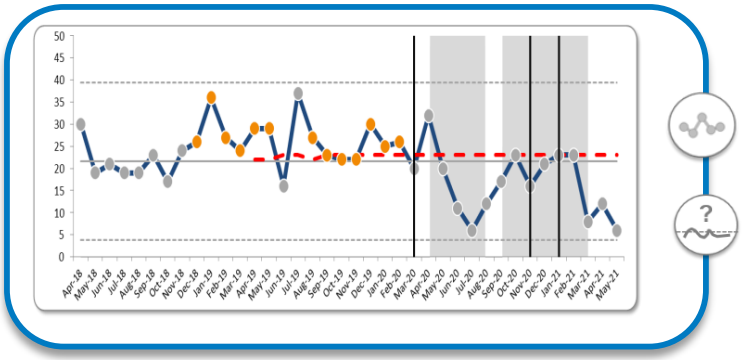
Falls per 1,000 bed days causing harm

0.1



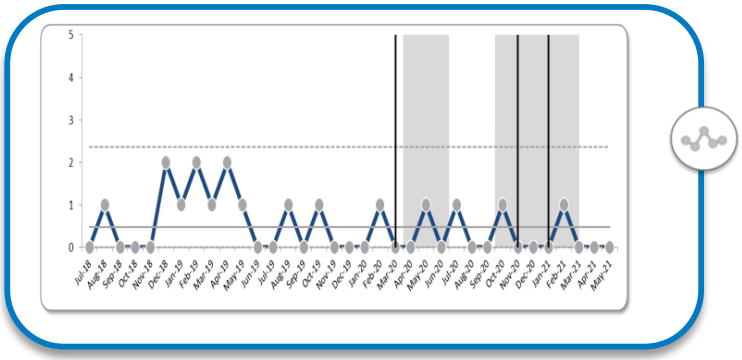
All Hospital Acquired Pressure Ulcers

6



Serious Incident Pressure Ulcers

0



Lockdown Period

COVID Wave

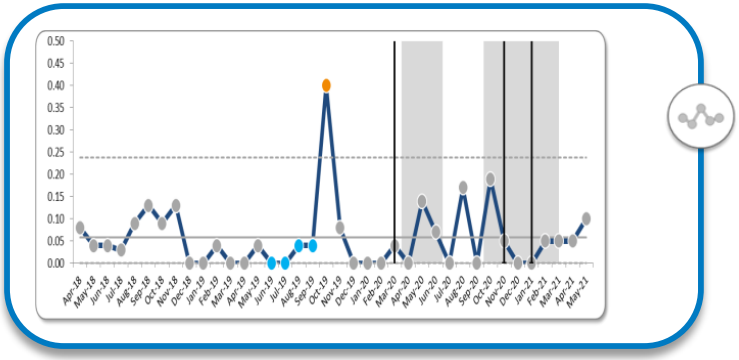
Month 2 [May] | 2021-22 Quality & Safety - Care that is Effective

Responsible Director: Chief Nursing Officer, Chief Medical Officer | Validated May 21 as at 10th June 2021

Worcestershire Acute Hospitals NHS Trust

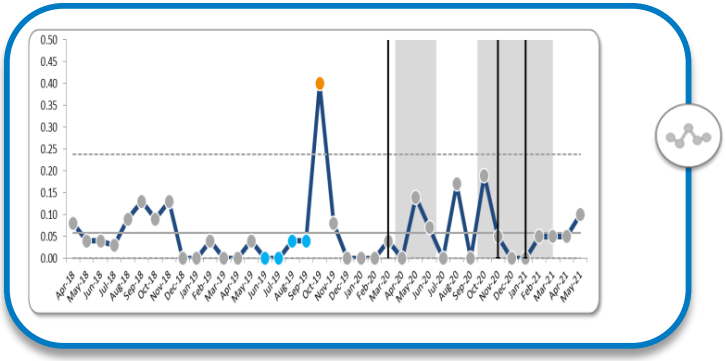
Discharges before midday (%)

16.34



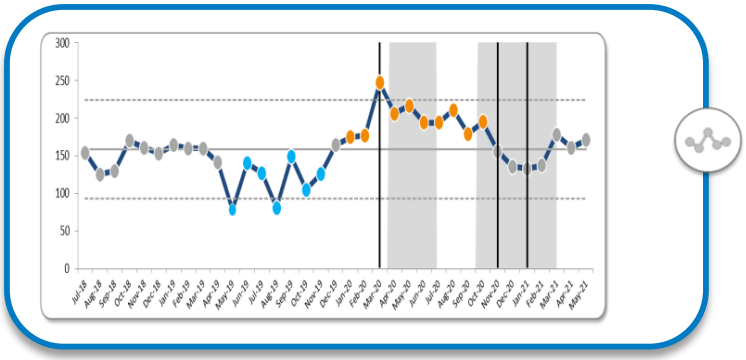
Risks overdue review

133



Risks with overdue actions

171



Lockdown Period

COVID Wave

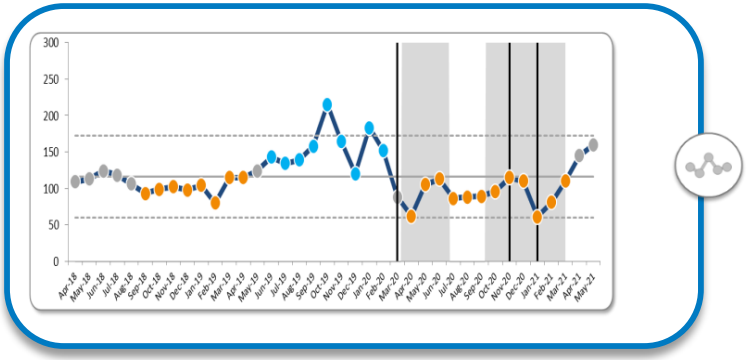
Month 2 [May] | 2021-22 Quality & Safety - Care that is Effective

Responsible Director: Chief Nursing Officer, Chief Medical Officer | Validated May 21 as at 10th June 2021

Worcestershire Acute Hospitals NHS Trust

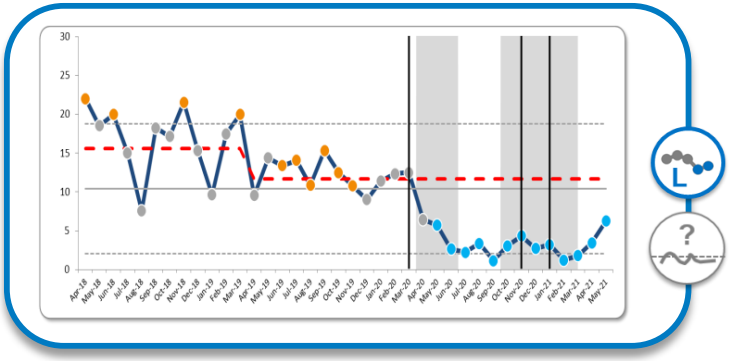
Total Medicine incidents reported

160



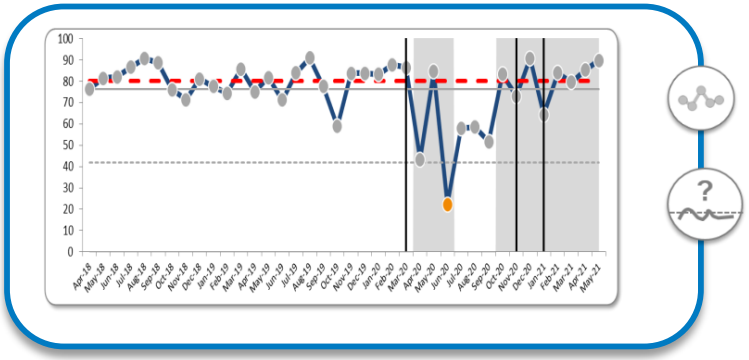
Medicine incidents causing harm (%)

6.25



Complaints Responses </= 25 days (%)

89.74



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

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

Lockdown Period

COVID Wave

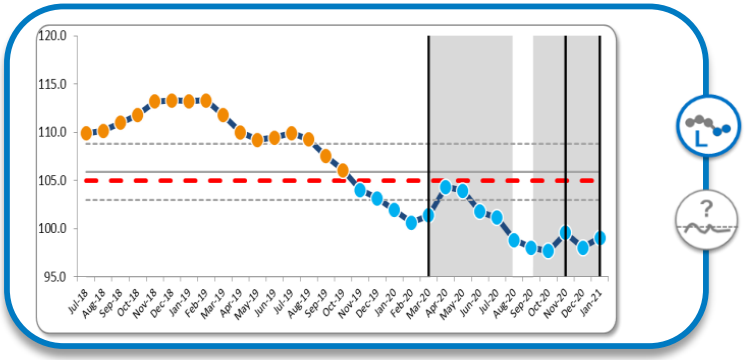
Month 2 [May] | 2021-22 Quality & Safety - Care that is Effective

Responsible Director: Chief Nursing Officer, Chief Medical Officer | Validated May 21 as at 10th June 2021

HSMR 12 month rolling average

Jan – 21

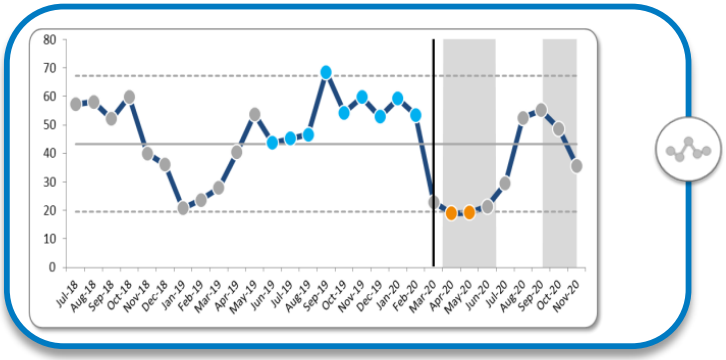
99.08



Mortality Reviews completed </=30 days (%)

Nov 20

33.50



Lockdown Period

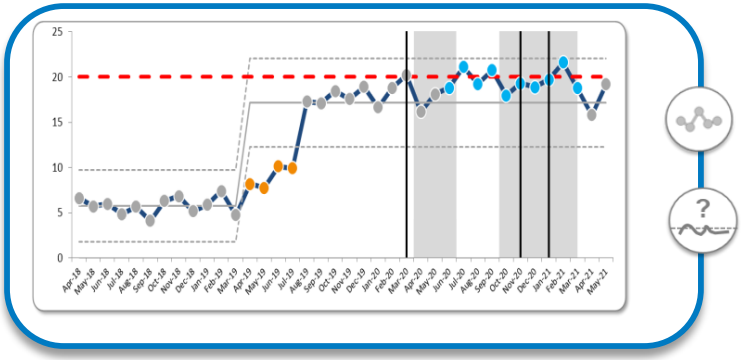
COVID Wave

Month 2 [May] | 2021-22 Quality & Safety - Care that is Positive Experience

Responsible Director: Chief Nursing Officer, Chief Medical Officer | Validated May 21 as at 10th June 2021

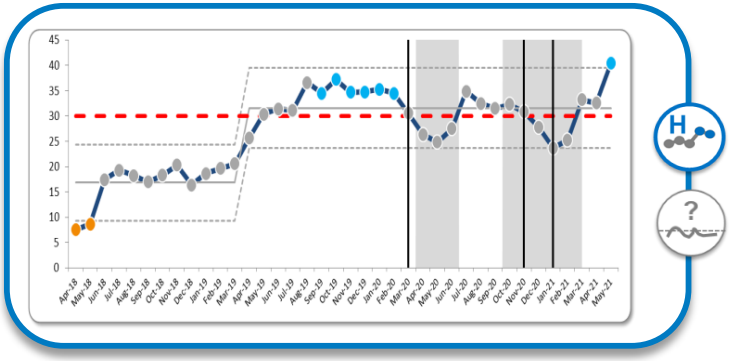
Accident & Emergency Response Rate Friends & Family Test (%)

19.19



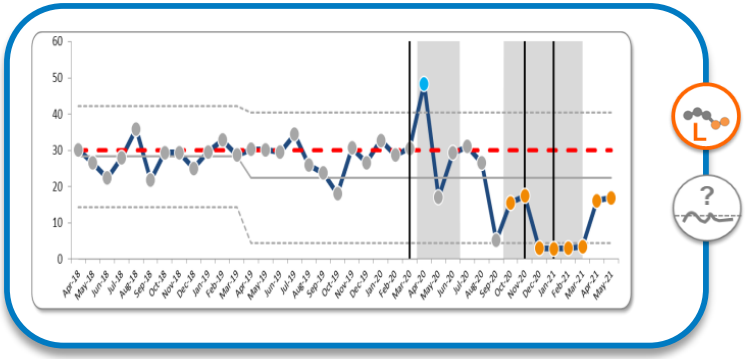
Inpatient Response Rate Friends & Family Test (%)

40.39



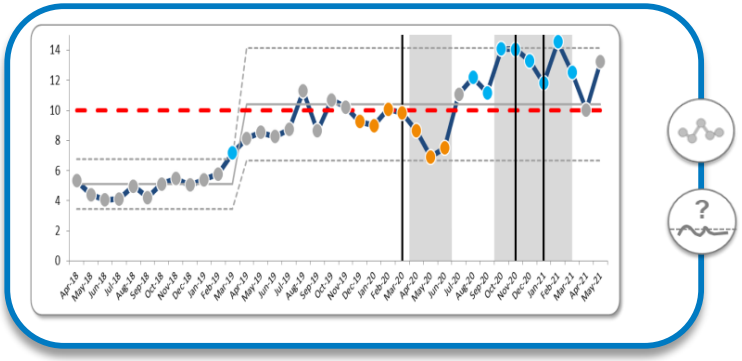
Maternity Response Rate Friends & Family Test (%)

16.91



Outpatients Response Rate Friends & Family Test (%)

13.23



Lockdown Period

COVID Wave

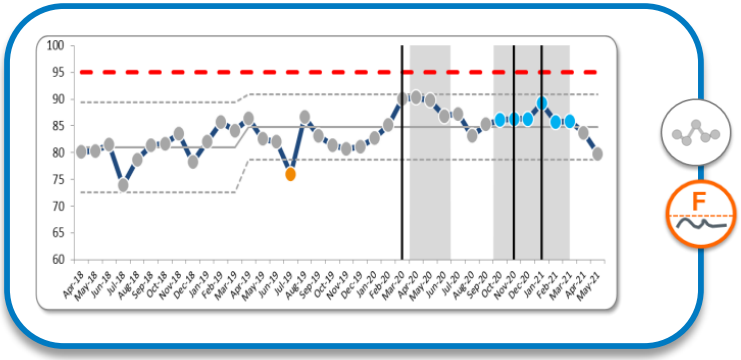
Month 2 [May] | 2021-22 Quality & Safety - Care that is Positive Experience

Responsible Director: Chief Nursing Officer, Chief Medical Officer | Validated May 21 as at 10th June 2021

Worcestershire Acute Hospitals NHS Trust

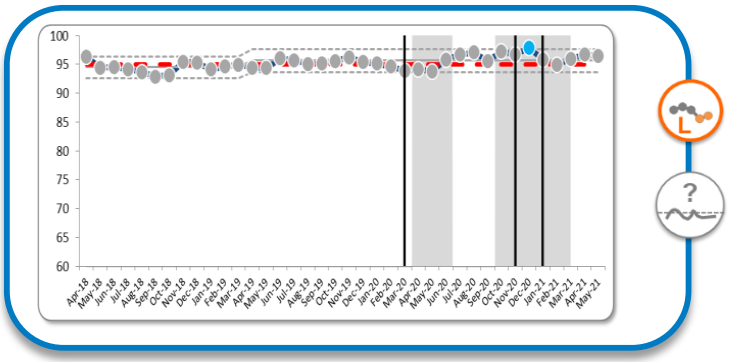
Accident & Emergency Recommended Rate Friends & Family Test (%)

79.79



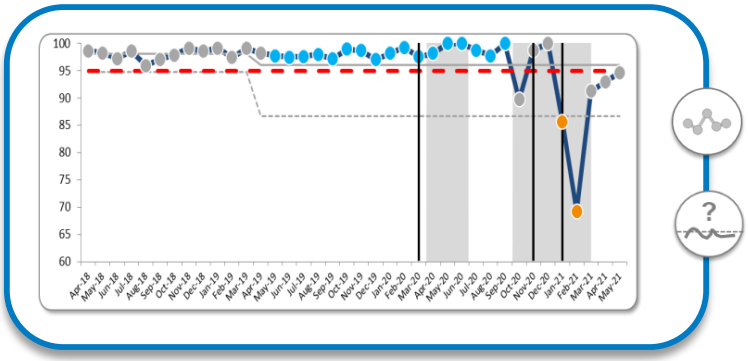
Inpatient Recommended Rate Friends & Family Test (%)

96.48



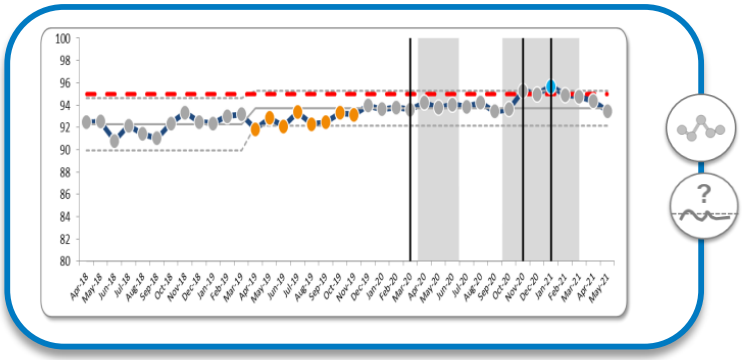
Maternity Recommended Rate Friends & Family Test (%)

94.68



Outpatients Recommended Rate Friends & Family Test (%)

93.47



Maternity

Data Quality Risk Matrix – Maternity

Data Set	Includes	Likelihood	Impact	Total Score	Context
Pregnancy bookings	• Trust bookings • Bookings before made before 12wks + 6days gestation	4	3	12	Paper pregnancy notes weren't migrated to Badgernet so when those women deliver and are 'booked' onto the system, our booking figures are being inflated. The recording of women booked to deliver at the Trust, those receiving antenatal care only and transfers of care is under review. Incorrect booking figures have an impact on service delivery and planning. **Mitigation:** Figures have been adjusted by referencing previous maternity system data. The pregnancies of the green notes cohort have concluded and this is now a historic issue. It is recommended that the Service updates the date of entry to the backdated/correct booking date. An audit of booking classifications will be undertaken across the next 3 months.
Deliveries	• Total deliveries • Home deliveries • Vaginal deliveries • Instrumental (Ventouse & Forceps) deliveries • Total Caesareans • Elective Caesareans • Emergency Caesareans • Induced deliveries	3	3	9	The recording of women delivering at the Trust and those receiving postnatal care only having delivered elsewhere is under review. Some caesareans are missing classification (emergency / elective) details. There are discrepancies in the data on inductions due to the multiple ways of recording this in the BadgerNet system. Higher delivery figures on Badgernet will impact the coding process by making it appear that there are deliveries that haven't been created as admissions on OASIS and the Trust delivery activity as being higher than actually occurred. **Mitigation:** Figures have been adjusted by applying business logic to back-end data. Further refinement of logic is on-going and will be reviewed and signed off by the Service in July. Advice and guidance on the key fields used to identify Trust and non-Trust activity in BadgerNet has been fed back to the maternity service by the information department.

Data Quality Risk Matrix – Maternity

Data Set	Includes	Likelihood	Impact	Total Score	Context
Births	• Total births • Stillbirths • Pre-term births • Admission of term babies to Neonatal care	3	2	6	The correct recording of babies not born at the Trust, where postnatal care is being provided by the Trust, is under review. This affects the total births denominator used in the reporting of safety related ratios for stillbirths, pre-terms and term admissions to neonatal care **Mitigation:** Figures have been adjusted by applying business logic to back-end data. Further refinement of logic is ongoing and will be reviewed and signed-off by the Service in July. Advice and guidance on the key fields used to identify Trust and non-Trust activity in BadgerNet has been fed back to the maternity service by the information department.
Governance & Safety	• Maternal deaths • Neonatal Deaths	3	5	15	Maternal deaths' cannot easily be identified in either the BadgerNet system front-end reports nor back-end data but are fully documented in Datix. The last maternal death (December 2020) has no critical incident declared in BadgerNet, hence reliance is on the established Datix notification and Divisional governance process. Neonatal deaths data has also been a concern with there being 3 different data sources by which to identify a neonatal death within 28 days of delivery (BadgerNet Maternity, BadgerNet Neonatal and OASIS). **Mitigation:** A thorough joint review of neonatal deaths data and processes has been undertaken between the maternity service and information department. Monthly meetings will be held to review and compare the data held by the Divisional governance and bereavement team with the neonatal deaths identified by the information department. The information department are liaising with the supplier and maternity service regarding improving processes around maternal death data capture and identification to ensure time series data accuracy.

Month 2 [May] 2021-22 Maternity

% admission of full-tern babies to neonatal care	Neonatal Deaths (>24+0 weeks gestation)	Stillbirths	Maternal Deaths	% Pre-term births	% Home births	Booked before 12+6 weeks	Births
3.4%	0	2	0	9.2%	4.2%	84.1%	405

What does the data tell us?

- Following the approved hiatus to allow for a review of the data reporting processes and logic the SPC charts on the following slides now include April and May 2021.
- With the exception of home births which remains significantly high, indicating that women are choosing, and being supported to deliver at home, all other metrics show no significant change.
- The neonatal deaths have been an area of scrutiny and the numbers reported have been validated by clinical review; in this section we are reporting on liveborn babies whose gestation was reported as 24^{+0} weeks or older but sadly passed away. There were no recorded neonatal deaths in Apr-21 or May-21.
- Births in May-21 are showing no significant change, just below the mean for the period Apr-18 to May-21, and shows an increase from Feb-21 when only 320 babies were born.
- Modes of birth are all within normal variation, showing no significant change.
- There is, following two months of significant variation, an improved rate of women booked by 12+6 weeks of pregnancy. This is following feedback and action on ensuring data is captured accurately at the point of entry.

What have we been doing?

- Progress made against CQC/Staff engagement action plan
- Continue to prepare evidence for Ockenden
- Completed NHSEI bid for workforce monies
- Improving incident reporting culture
- Ongoing review of IOL pathway & CoC SoP.
- Continue to engage with NHSEI support programme
- Active recruitment
- Targeted work with CMWs to improve booking KPI as still below expected requirement
- Obtained midwifery workforce data

What are we doing next?

- Work with NHSEI support programme
- Continue to progress overarching improvement action plan
- Recruit further midwives to cover planned leavers and maternity leave.
- Submit evidence to meet CNST requirements
- Submit Ockenden evidence.
- Manging historic high levels of sickness absence

Current Assurance Level: 5 (May-21)

When expected to move to next level of assurance:
Following evidence submission to NHSEI for Ockenden and position confirmed
Review of IOL pathway complete
Review of SoP for CoC complete
No midwifery vacancies/reduce sickness absence levels
Complete improvement plan

Previous Assurance Level: 6 (Mar-21)

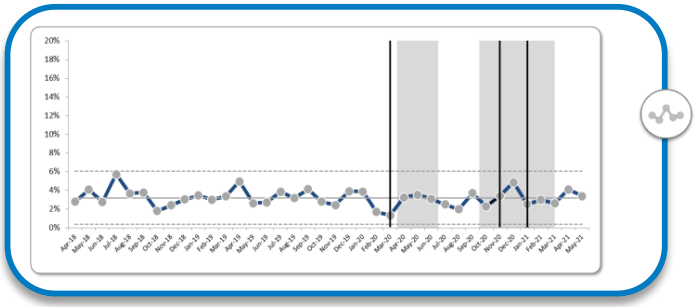
SRO: Paula Gardner (CNO)

Month 2 [May] 2021-22 Maternity Summary

Responsible Director: Chief Nursing Officer| Validated for May-21 as 15th June 2021

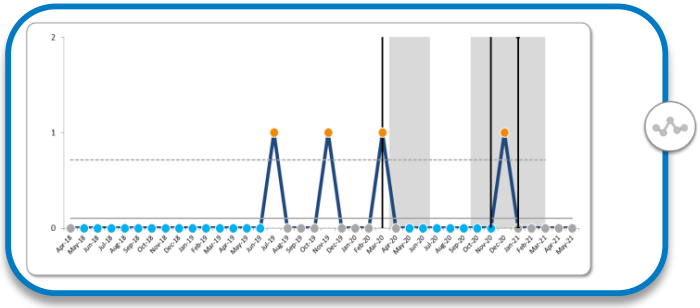
% admission of full-tern babies to neonatal care

3.4%



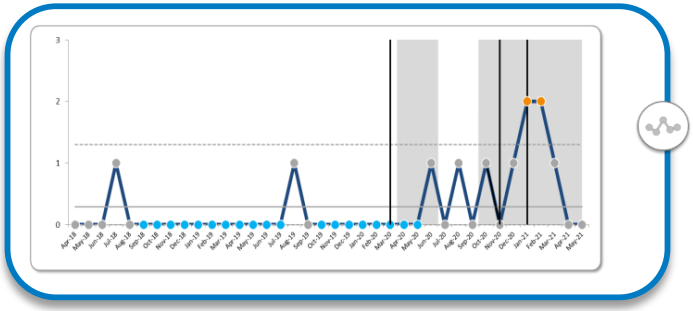
Maternal Deaths

0



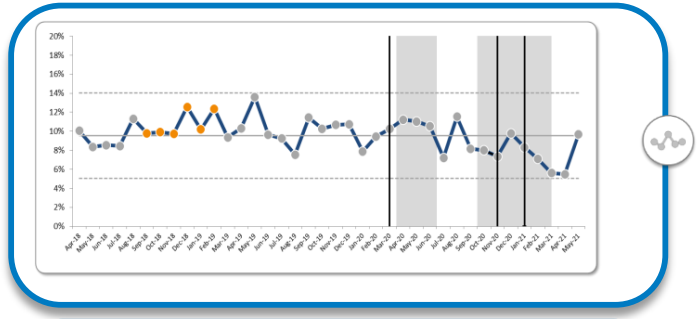
Neonatal Deaths (>24+0 weeks gestation)

0



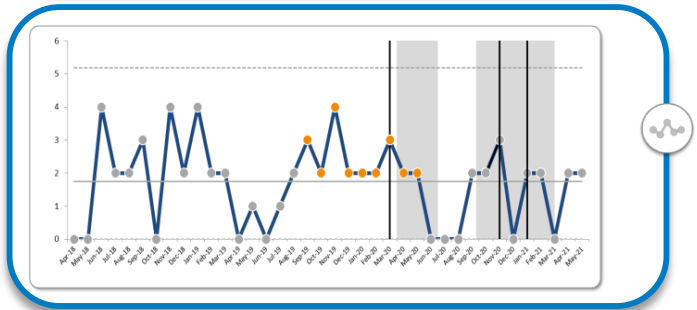
% Pre term births

9.7%



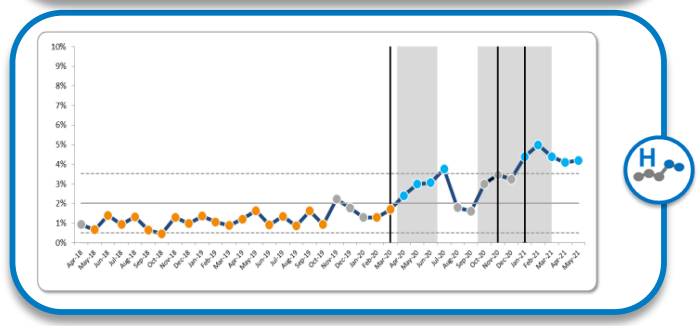
Stillbirths

2



% Home births

4.2%



Lockdown Period

COVID Wave

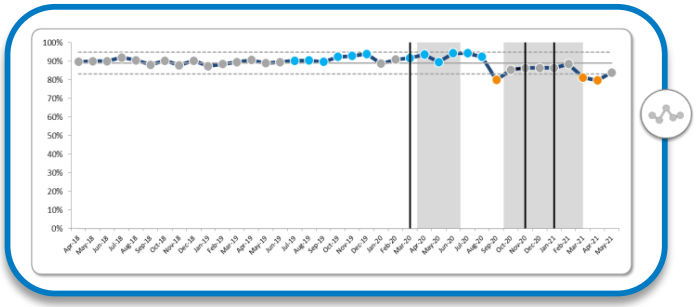
Month 02 [May] 2021-22 Maternity Summary

Responsible Director: Chief Nursing Officer| Validated for May-21 as 15th June 2021

NHS Worcestershire Acute Hospitals NHS Trust

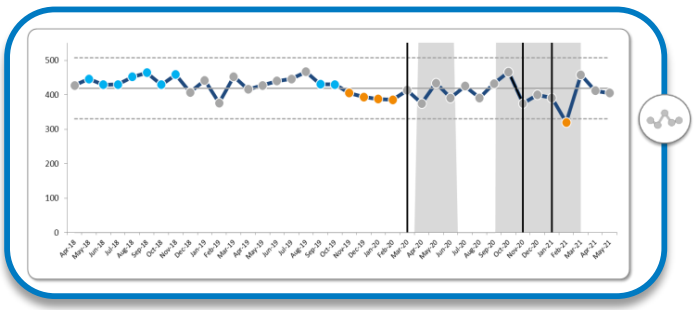
Booked before 12+6 weeks

84.1%



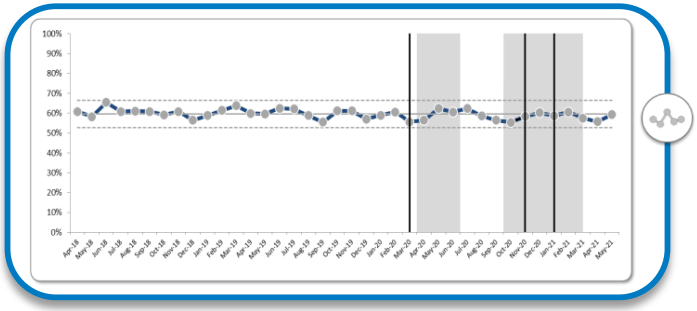
Births

405



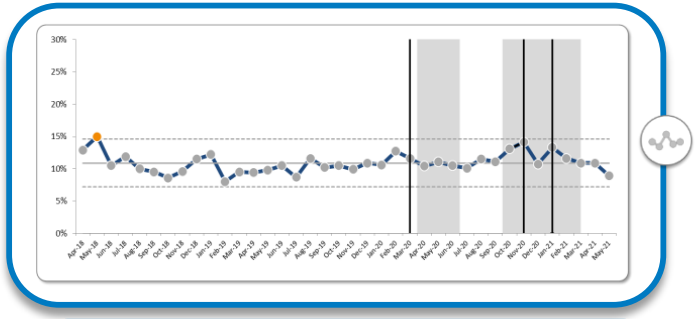
Vaginal Births

59.3%



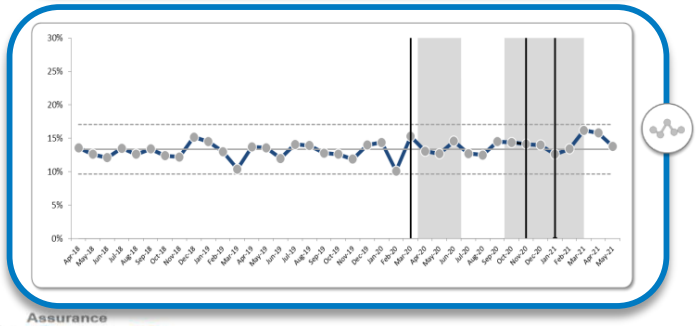
Instrumental rate

8.9%



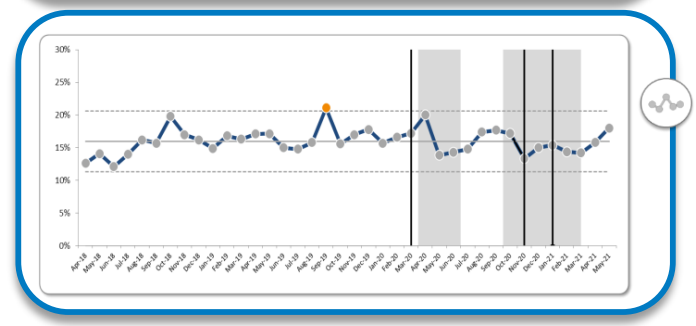
Elective Caesarean

13.8%



Emergency Caesarean

18.0%



Lockdown Period

COVID Wave

Workforce

Data Quality Risk Matrix - Workforce

Data Set	Includes	Likelihood	Impact	Total Score	Context
Workforce Compliance	Appraisal (Non-Medical)	3	1	3	We are confident in the reporting which is from nationally created ESR BI reports. However, there have been issues with accuracy of recording by Managers on Self Service. This is addressed by training/screenshots and a supplementary IT link for sending appraisal through for inputting in L&D. Monthly reports are sent to Managers and both Managers and Staff can validate on ESR Self Service.
	Medical Appraisal	1	1	1	There is manual intervention to remove doctors in training but no current issues identified.
	Mandatory Training	3	1	3	We are confident in reporting which is from Competencies set up on OLM and pulled through nationally created BI reports from ESR. However, there are periodic issues reported where staff cannot access training due to IT issues which are resolved individually. Mitigation is for L&D to validate Monthly data and provide commentary on any IT/operational issues.
	Consultant job plans	2	1	2	We are confident in reporting from Allocate e-Job Plan. However, compliance is low due to lack of job planning, or late reporting. Dedicated Job Planning Officer role now in post to review/audit and improve compliance.
	Staff turnover	3	1	3	We are confident in reporting via nationally created BI report. Delays in managers submitting Starter and Leaver forms do result in retrospective adjustment which has been addressed by changing timescale to require forms 8 weeks before start/leave. Annual Payroll audit by CW Audit takes place of Starter and Leaver forms. Monthly Payroll meeting reviews late forms which affect pay.
	Covid risk assessment compliance	4	2	6	There have been issues with the recording of Risk Assessments due to forms not being received, or actioned in a timely manner in Occupational Health due to increased workload. Weekly reports were sent to Divisions for validation. These currently appear to be resolved. There are remaining issues with timeliness of forms for New Starters which is escalated with Divisions.

Data Quality Risk Matrix - Workforce

Data Set	Includes	Likelihood	Impact	Total Score	Context
Workforce Performance	• Substantive Vacancy Rate • Total Vacancies Rate (including Bank and Agency) [Source: Finance ADI]	Unknown	Unknown	N/A	Not yet reviewed Plan to review collaboratively across Finance and Workforce in Jul-21
	• Growth in Establishment [Source: Finance ADI]	Unknown	Unknown	N/A	Not yet reviewed Plan to review collaboratively across Finance and Workforce in Jul-21
	• Total hours worked [Source: Finance ADI]	Unknown	Unknown	N/A	Not yet reviewed Plan to review collaboratively across Finance and Workforce in Jul-21
	• Monthly staff sickness absence • % Staff absent due to stress and Anxiety [Source: ESR/Allocate HealthRoster]	3	3	9	Sickness (and all absence) from 1st April 2021 are recorded through HealthRoster by Managers. An Absence interface to ESR pulls through once per month on payroll upload. Weekly meetings to review project progress and testing of data pulled through interface. There have been issues identified historically of late or non-reporting of absence which are investigated individually. The full rollout of Rostering to all staff should help to address this. However, this is reliant on Managers inputting roster changes in a timely manner so will require regular review by e-Rostering team.
	• Number of Covid sickness • Number Self Isolating [Source: WREN/Allocate HealthRoster]	3	3	9	These absences have been recorded on HealthRoster since Wave 1 of Covid Pandemic, initially via a Covid Absence Line, and latterly by Managers with rollout of HealthRoster to all staff groups. There were issues initially of late and non-reporting which are being addressed through full rollout of Rostering. Intermittent issues of incorrect categorisation of absence is picked up individually with managers by e-Rostering Team.
	• Bank Spend as % of Gross Cost • Agency Spend as a % of Gross Cost [Source: Finance]	Unknown	Unknown	N/A	Not yet reviewed Plan to review collaboratively across Finance and Workforce in Jul-21
	• Maternity/Adoption Leave [Source: ESR]	3	3	9	We are confident of the report which is from a nationally created ESR BI report. However, there is intermittent late reporting of both the commencement and end of maternity leave which is reviewed through Payroll meeting monthly as they impact on Maternity Pay.

People and Culture Performance Report Month 2 - Headlines

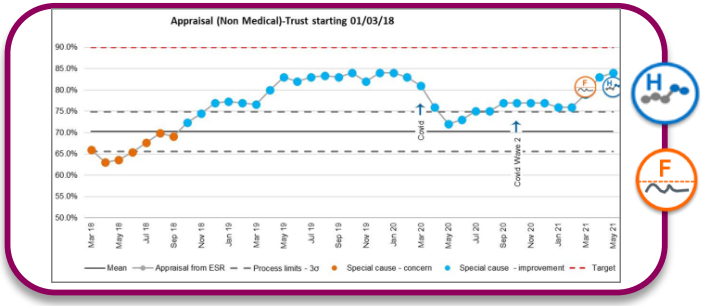
People & Culture	Comments
Getting the basics right (appraisal, mandatory training, job plans)	• Mandatory training compliance has exceeded Trust target at 91% • Medical appraisal compliance has improved by 5% to 93% which is better than Model Hospital • Non-medical appraisal rate has improved by 1% to 84% • There has been an 8% improvement in Consultant Job Planning with improvement across all divisions. However we are still performing below Model Hospital average
Drivers of Bank & Agency spend	• Our vacancy rate of 10.1% is above the ONS national average of 8.1% and the Model Hospital average of 7.37%. The increase has been driven by an increase in establishment of 16 wte in May • There are an additional 160 staff on maternity leave in May (an additional 2.39% absence on top of the substantive vacancy rate) compared to 130 staff for the same period last year • Monthly Sickness is 4.68% which is 0.88% lower than the same period last year • Staff turnover has reduced by 0.14% this month to 8.94% which is 2.51% better than the same period last year. We perform well at Quartile 2 on Model Hospital with 0.86% monthly turnover against a national average of 0.93% (January 2021 data)
Staff Health & Wellbeing	• Cumulative sickness has reduced to 4.67%. Covid absence rates were broadly unchanged • Sickness due to S10 (stress and anxiety) increased by 0.21% to 1.30% • Our staff health and wellbeing offer continues to be communicated to staff at every opportunity through Worcestershire Weekly and intranet as well as Leadership Briefing • Location by Vocation pilot has commenced facilitating eligible staff to work from home for at least 40% of their working week

Month 2 [May] 2020-21 Workforce "Getting the Basics Right" Summary

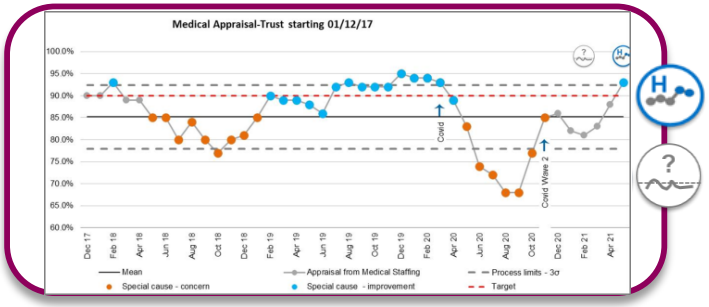
Responsible Director: Director of People and Culture | Validated for May -21 as 10th June 2021

NHS Worcestershire Acute Hospitals NHS Trust

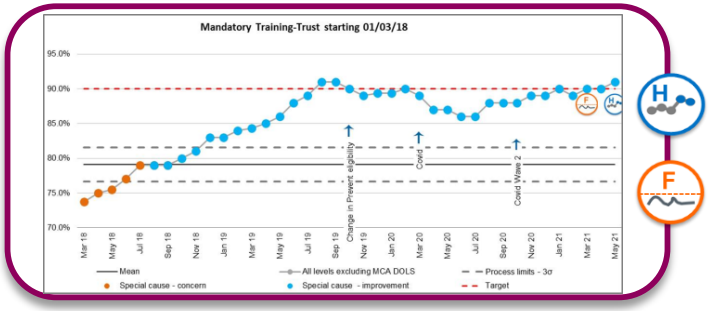
Appraisal (Non-Medical) — 84%



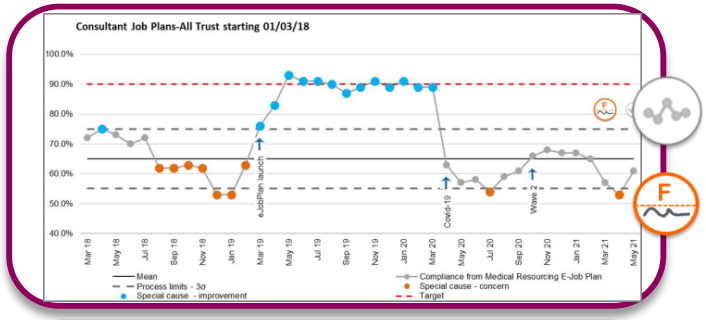
Medical Appraisal — 93%



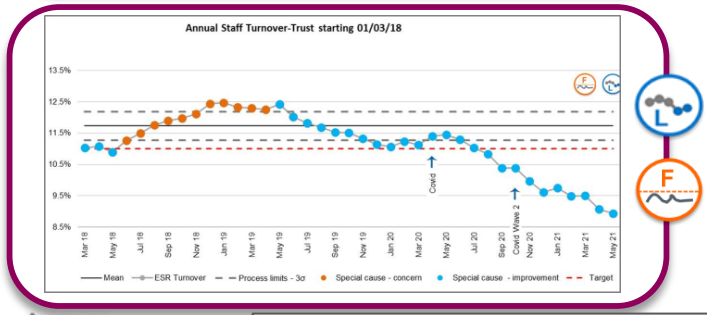
Mandatory Training — 91%



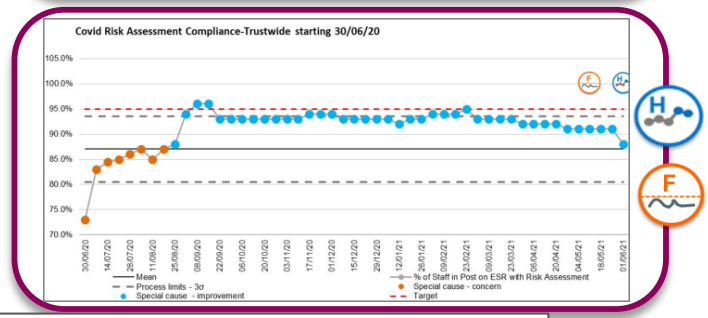
Consultant Job Plans — 61%



Staff Turnover — 8.94%



Covid Risk Assessment Compliance — 88%



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

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

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

Workforce Compliance Month 2: - What does the data tell us?

Appraisal and Medical Appraisal	Mandatory Training and Core Essential to Role Training	Consultant Job Planning	Annual Staff Turnover	Covid Risk Assessment Compliance
84% and 93%	91% and 78%	61%	8.94%	88%

What does the data tell us?

- **Appraisal** – Compliance has improved by 1% to 83% which is 12% higher than the same period last year.
- **Medical Appraisal –** Medical appraisal has improved by 5% to 93 % this month and is now 10% higher than the same period last year
- **Mandatory Training** – Mandatory Training compliance has exceeded the 90% to 91% this month which is 4% better than the same period last year despite Covid Wave 2. Prevent Basic Awareness has dropped by 9% due to an issue with the module which has been escalated to the national provider.
- **Essential to Role Training** – Essential to Role training has improved by 8% to 78%. All topics have improved except MCA and DOLS Level 4 which relates to a change in lead. The eligibility for End of Life Care has been reviewed by the lead due to concerns about the relevance for non-clinical staff.
- **Consultant Job Plans** – Consultant job planning compliance has improved this month by 8%. All divisions have seen an improvement this month. Surgery continues to be an outlier at 35% despite a 11% improvement. Appointment to the dedicated Job Planning Officer role has helped to push compliance with divisions with training planned to fully utilise the e-job plan functionality.
- **Staff Turnover** – Staff annual turnover has improved by 0.14% this month despite the reduction in contracted staff in post. This is due to turnover being based on a rolling 12 month period with May 2020 being higher. The current annual turnover rate is 8.94% which is well within target and 2.51% better than the same period last year. Our performance on Model Hospital is favourable in Quartile 2.
- **Covid Risk Assessment Compliance –** Compliance dropped by 3% to 88% due to turnover of staff and staff returning from sick leave or maternity leave who were previously excluded

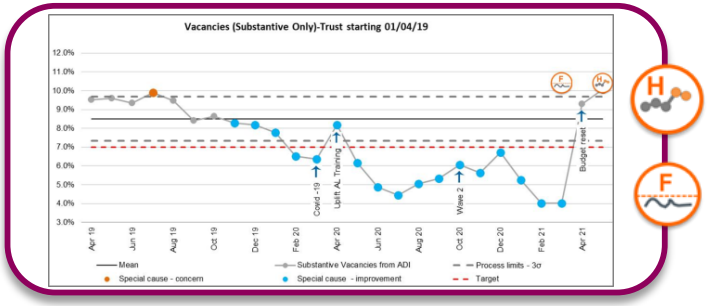
National Benchmarking (June 2021)
Model Hospital Benchmark for Mandatory Training compliance is 90% and a peer group average of 88% so the Trust is better than average. Performance is better than Model Hospital average of 85% for Medical Appraisal and only 1% short for Non-Medical appraisal. We remain an outlier for job planning but this an improving position.

Month 2 [May] 2020-21 Workforce "Drivers of Bank & Agency Spend" Summary

Responsible Director: Director of People and Culture | Validated for May -21 as 10th June 2021

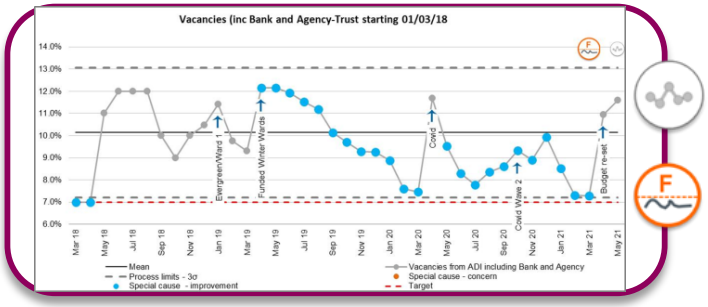
Substantive Vacancy Rate

10.1%



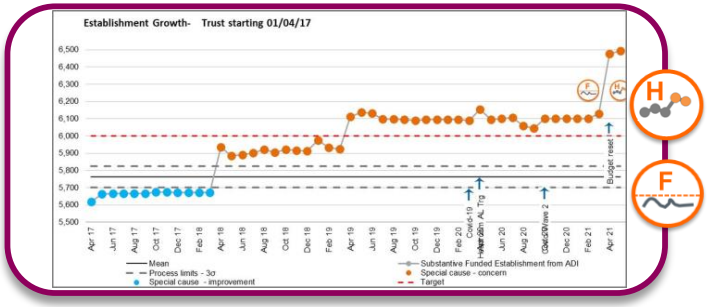
Vacancy Rate including Bank/Agency

11.6%



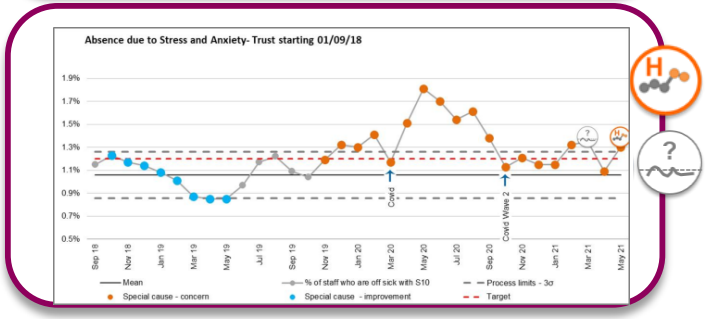
Growth in Establish-ment

6494 wte



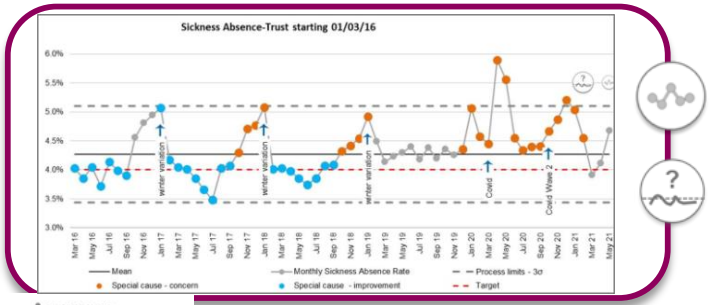
% Staff absent due to Stress and Anxiety (S10)

1.30%



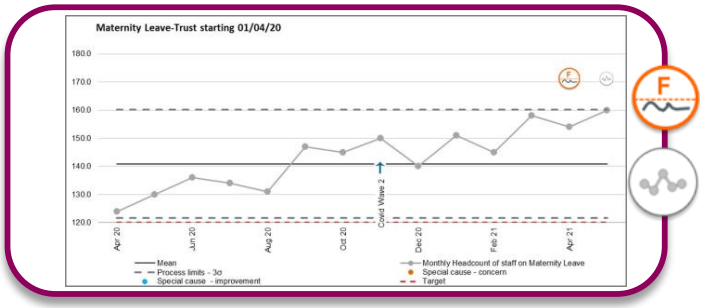
Monthly Staff Sickness Absence

4.68%



Maternity/ Adoption Leave

160



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

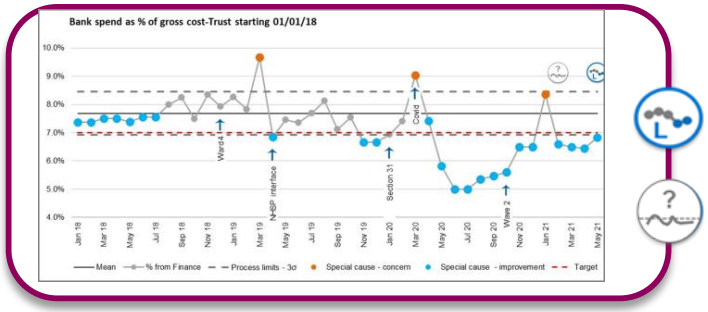
Month 2 [May] 2020-21 Workforce Performance Summary

Responsible Director: Director of People and Culture | Validated for May -21 as 10th June 2021

NHS Worcestershire Acute Hospitals NHS Trust

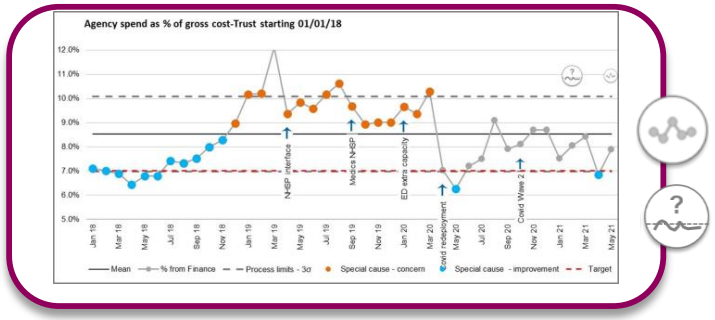
Bank Spend as a % of Gross Cost

6.83%



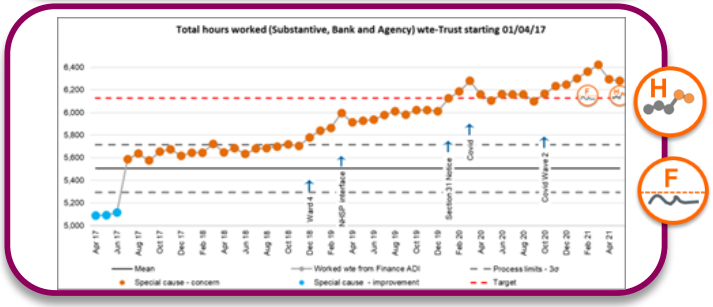
Agency Spend as a % of Gross Cost

6.85%



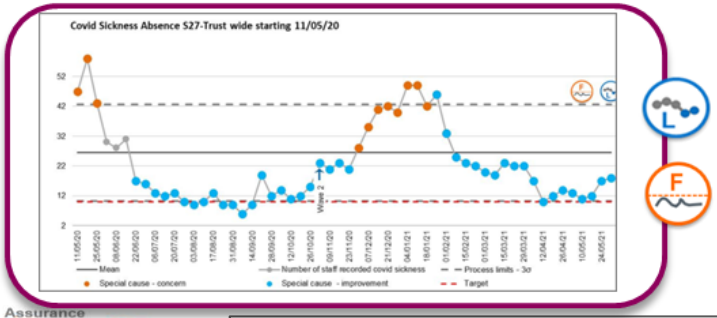
Total Hours Worked

6281 wte



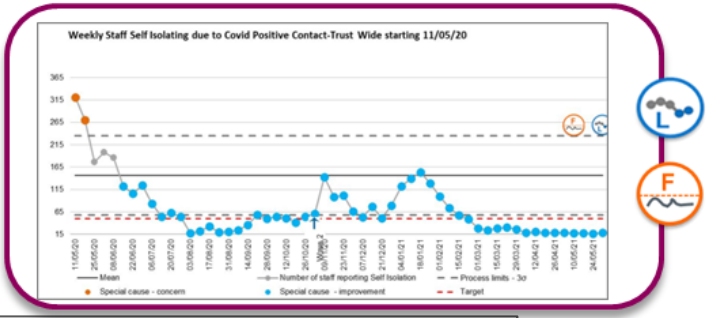
Number Covid Sickness (S27)

18



Number Self Isolating

19



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

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

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

Workforce Performance Month 2 - What does the data tell us?

Substantive Vacancy Rate	Total Hours worked (including substantive bank and agency)	Monthly Sickness Absence Rate and cumulative sickness rate for 12 months	% Staff absent due to Stress and Anxiety (S10)	Number of staff off with Covid Sickness (S27) on the last Monday of month	Number of Staff self isolating due to Covid+ contact on the last Monday	Number of Staff on Maternity Leave	Bank and Agency Spend as a % of Gross Cost
10.1%	6,281 wte	4.68% and 4.67%	1.30%	18	19	160	6.83% and 6.85%

What does the data tell us?

- **Vacancy Rate** – Substantive vacancy rates have increased by 0.77% to 10.1% this month due to increase of 16 wte in establishment, and a reduction of 36 contracted staff in post.
- **Vacancy Rate including Bank and Agency** In April 2021 funding for new wards was moved from Bank and Agency to the Substantive establishment line
- **Total Hours Worked** – The total hours worked for substantive, bank and agency staff reduced by 15 wte from 6,296 wte to 6281 wte This is against a revised increased funded establishment of 6,494 wte. Bank has increased by 31 wte and Agency increased by 21 wte.
- **Monthly Sickness Absence Rate** – Sickness has increased this month by 0.47% but this is still 0.88% better than the same period last year. Cumulative sickness has reduced to 4.67% from 4.72%.
- **Absence due to Stress and Anxiety (S10)** – Absence due to stress and anxiety has increased by 0.21% to 1.30% this month which is 0.54% better than the same period last year at the beginning of the pandemic.
- **Absence due to Covid Sickness (S27) –** 18 staff were absent due to Covid at the end of May. This figure includes those staff who have reported sick due to effects of the Covid vaccine. Absence due to self isolation (including shielding, and Test and Trace) was 19 at the end of May compared to the peak of 244 in mid January. The Trust has had no positive staff PCR swabs during May.
- **Maternity/Adoption Leave** – We have seen a steady increase in the number of staff on maternity or adoption leave since the start of the pandemic with 160 currently off, compared to around 120 previously.
- **Bank and Agency Spend as a % of Gross Cost** – has increased to 6.83% this month

National Benchmarking (June 2021)
We remained at Quartile 2 on Model Hospital for sickness with 3.91% compared to 3.92% national average (March 2021) data). Monthly turnover is also good at Quartile 2 with 0.86% compared to 0.93% national average (January 2021 data)

Annual Plan Strategic Objectives: Workforce

Strategic Workforce Plan		BAME Workforce	Organisational Development
Introduce new roles and staffing models to support the delivery of our clinical services strategy	Accelerate new ways of working from the Covid-19 experience	Undertake Covid-19 Risk Assessments for all BAME staff	Implement new operational management structure

Annual Plan: Strategic Objectives | Best people

Ensure all our staff have annual appraisal and are suitably trained with up to date job plans. Ensure we have adequate staff to meet patient needs within financial envelope, and that this is a good place to work so that we can retain our substantive staff and reduce reliance on bank and agency staff.

How have we been doing?

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

- Non-medical appraisal (1% lower)
- Job Planning (>20% lower)
- Vacancy rates (2% higher than ONS)

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

- An increase in sickness absence
- 160 staff on maternity leave
- Reduction of 36 wte staff in post

What improvements will we make?

- Vacancies will only be reported for substantive establishment going forward as funding for new wards has now moved from the bank and agency line
- We will continue to work with divisions to ensure 95% of patient facing staff are encouraged to take up the Covid vaccine
- We will continue with the implementation of the Best People Programme to reduce premium staffing costs
- We will further embed SafeCare on all wards to provide accurate staffing position linked to patient acuity.
- Continue to work with divisions to ensure that OH risk assessments are kept up to date and compliance maintained for new starters and that Version 4 forms are completed for all CEV staff.
- Add reporting on Location by Vocation Pilot

Overarching Workforce Performance Level – 5 – May 2021 **Previous Assurance Level - 5 – April 2021**	**To work towards improvement to next assurance level**

Finance

Finance | Headlines

COVID-19 Financial Regime

Due to the continuing COVID-19 pandemic, a revised COVID-19 financial framework will be in place for H1 21/22. System funding envelope, comprising adjusted CCG allocations, system top-up and COVID-19 fixed allocation, based on the H2 2020/21 envelopes adjusted for known pressures and policy priorities. Block payment arrangements will remain in place and signed contracts between NHS commissioners and NHS providers are not required for the H1 2021/22 period. NHS England and NHS Improvement have nationally calculated CCG and NHS provider organisational plans for the H1 period as a default position for systems and organisations to adopt.

H1 2021/22 Financial Plan £(2.9)m

The 2021/22 operational financial plan for H1 has been developed from a roll forward of the recurrent cost and non patient income budget from 2019/20 adjusting for an assessment of PEP delivery in 2020/21 and the recurrent impact, identification of cost pressures and an assessment of legacy and approved business cases in 2020/21. We have then overlaid the impacts of additional Covid expenditure (and additional Covid income) and PEP schemes developed by the Divisions. The final step has been to adjust for vacancy factors, activity levels lower than 2019/20 and any slippage in Business cases. **Our submission to the system for H1 shows a deficit position of £(2.9)m reassessed to £(1.1)m deficit (excluding ERF). Including ERF is a £1.1m surplus. A revised plan will be submitted on 22nd June.**

Delivery of the H1 Internal Financial Plan £(2.9)m

Month 2 May Position

Statement of Comprehensive Income	May 21 (Month 2)			Year to Date			H1 Plan
	H1 Plan £000s	Actual £000s	Var to Plan £000s	H1 Plan £000s	Actual £000s	Var to Plan £000s	£000s
Operating Revenue & Income							
Operating income from patient care activities	43,989	45,412	1,423	87,978	89,778	1,800	263,805
Other operating income	1,882	1,800	(82)	3,764	3,645	(119)	11,415
Operating Expenses							
Employee expenses	(27,069)	(27,324)	(255)	(54,148)	(54,222)	(74)	(161,338)
Operating expenses excluding employee expenses	(17,975)	(17,592)	383	(35,951)	(34,961)	990	(107,249)
OPERATING SURPLUS / (DEFICIT)	**827**	**2,296**	**1,469**	**1,643**	**4,240**	**2,597**	**6,633**
Finance Costs							
Finance income	1	0	(1)	2	0	(2)	6
Finance expense	(1,025)	(1,025)	(0)	(2,050)	(2,049)	1	(6,148)
Movement in provisions	0	0	0	0	0	0	0
PDC dividends payable/refundable	(571)	(571)	0	(1,142)	(1,142)	0	(3,426)
Net Finance Costs	**(1,595)**	**(1,596)**	**(1)**	**(3,190)**	**(3,191)**	**(1)**	**(9,568)**
Other gains/(losses) including disposal of assets	0	0	0	0	1	1	0
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**(768)**	**700**	**1,468**	**(1,547)**	**1,050**	**2,597**	**(2,935)**
Less impact of Donated Asset Accounting (depreciation only)	5	14	9	10	28	18	30
Adjusted financial performance surplus/(deficit) inc PSF, FRF, MRET & Top-Up	**(763)**	**713**	**1,476**	**(1,537)**	**1,077**	**2,614**	**(2,905)**

Against the H1 operational plan £(2.9)m, in month 2 (May 2021) we report an **actual surplus of £0.7m** against the plan £(0.8)m deficit. **Positive variance of £1.5m**.

The combined income position was **£1.3m** favourable to plan of which **£1m was Elective Recovery Fund** income recognised in month.

Favourable variances against operating expenses (£0.4m) largely driven by activity and slippage to the overseas nurse recruitment programme.

Adverse variances against employee expenses (£0.3m) of which £0.2m relates to retrospective shifts added to the Medics booking system. This has been escalated to HR.

While we are currently reporting £0.2m favourable Covid variance in month, we are reviewing Divisional spend to ensure all costs are being appropriately classified as Covid. £0.2m relating to Business Case slippage is being offset by increased expenditure elsewhere.

Given the positive variance in YTD across the system (£3.1m), system CFOs have agreed to offset beneficial variances position to the unmitigated system risk in H1 (£6.4m). A further assessment of ERF achievement has been performed following the recent activity submissions. Our H1 revised plan, inclusive of ERF is a £1.1m surplus. Excluding ERF this would be a £(1.1)m deficit.

I&E Delivery Assurance Level: **Level 4**

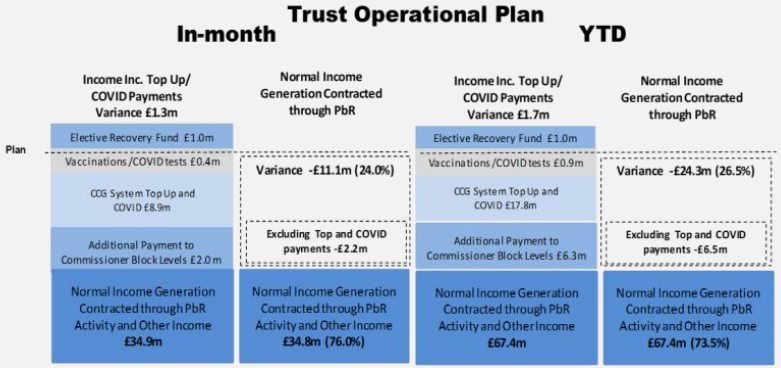
Reason: H1 plan deficit of c.£(2.9)m reassessed to £1.1m surplus, however risks remains over costs of delivering additional activity and plan assumption that bank and agency will decrease following increased absenteeism reported in month . Controls remain. POSITIVE Financial variance in month. PEP & Temp Staffing remain challenged. Underlying deficit consistent.

Finance | Headlines

PERFORMANCE AGAINST Operational Trust plan

Income

The Combined Income (including PbR pass-through drugs & devices and Other Operating Income) was **£1.3m** above the Trust's Internal operational plan in May.



£8.9m additional System COVID/top up payment was received from Commissioners to cover additional costs of COVID and to fulfil the STP breakeven requirement. This arrangement will be in place April to September **(H1**) with the continuation of block payments for the first half of 2021/22. As with 2020/21 there will be no contracts in place for first 6 months of 2021/22.

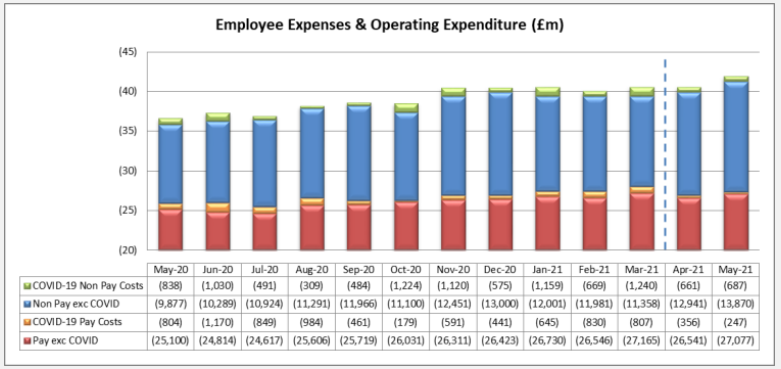
In addition to the block payments and System COVID & Top up payment in **H1** the Trust can qualify for further funding should the STP achieve above targets set by NHS England & Improvement under the **Elective Recovery Fund.** The Trust's estimated YTD achievement is **£1.0m.** The final value will be validated by NHSE/I in the coming weeks for each month.

Expenditure

In M2 the **combined expenditure** variance is **£0.1m favourable** against the operational plan for H1 (deficit of £(2.9)m).

Employee expenses were **£27.3m** in May, £0.4m higher than April, of which £0.2m relates to retrospective shifts added to the Medics booking system that related to April. £0.1m increase in additional session payments supporting restoration and a further £0.1m increase due to premium costs of covering increased vacancies and absenteeism.

Operating expenses excluding employee expenses were £17.6m in May, £0.2m higher than April of which £0.1m due to 5 week month for stock and £0.1m for Covid related catering costs which post month end close down we have determined that they relate to 20/21 and therefore will be written off against prior year provision in M3.



	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
COVID-19 Non Pay Costs	(838)	(1,030)	(491)	(309)	(484)	(1,224)	(1,120)	(575)	(1,159)	(669)	(1,240)	(661)	(687)
Non Pay exc COVID	(9,877)	(10,289)	(10,924)	(11,291)	(11,966)	(11,100)	(12,451)	(13,000)	(12,001)	(11,981)	(11,358)	(12,941)	(13,870)
COVID-19 Pay Costs	(804)	(1,170)	(849)	(984)	(461)	(179)	(591)	(441)	(645)	(830)	(807)	(356)	(247)
Pay exc COVID	(25,100)	(24,814)	(24,617)	(25,606)	(25,719)	(26,031)	(26,311)	(26,423)	(26,730)	(26,546)	(27,165)	(26,541)	(27,077)

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

Finance | Headlines

Capital

Capital expenditure for month 2 of financial year 2021/22 is £3.4m, with the majority relating to spend on projects carried over from the previous financial year. The 2021/22 Capital Plan is £51.69m for the financial year, including IFRIC 12. This is inclusive of the in-year works on the new Urgent and Emergency Care scheme, plus the ASR project subject to Full Business Case national approval. The share of the remaining capital envelope is being prioritised across the work streams to ensure we address regulatory risks, infrastructure backlog and to replace end of life equipment.

Capital Assurance Level: **Level 5**

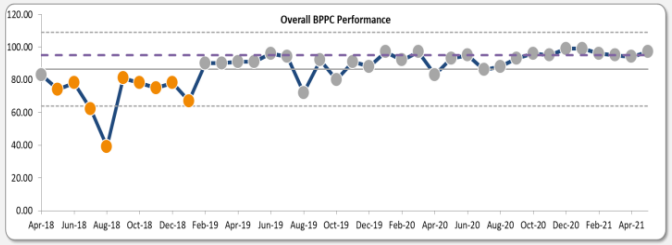
Reason: Reason: Significant capital schemes continue into 2021/22 and will require robust programme management to ensure delivery. Commitment monitoring remains in place and prioritisation of schemes nearing completion. Risk remains in medium term.

Cash Balance

At the end of May 2021 the cash balance was £33.5m. The high cash balance is the result of the timing of receipts from the CCG's and NHSE under the current payment arrangement as well as the timing of supplier invoices.

Cash Assurance Level: **Level 6**

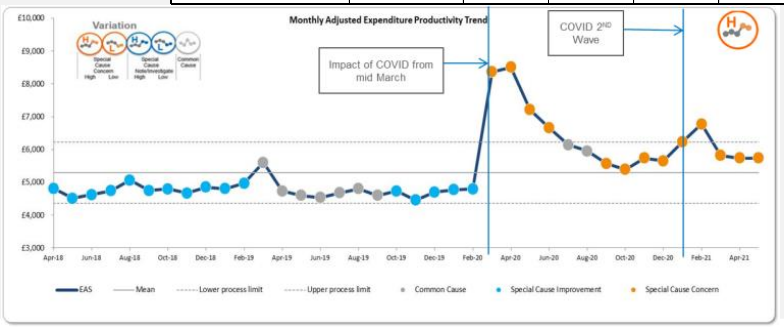
Reason: Good cash balances, rolling CF forecasting well established, achieving BPPC target, positive SPC trends on aged debtors and cash. Risks remain around sustainability given evolving regime for H2 2021/22 and beyond.



Productivity & Efficiency

Our internal operational plan for H1 is inclusive of **£5.4m** of annual Productivity and Efficiency plans. Plans for the H1 period (M1 – M6) total £2m. International Nurses scheme was due to commence delivering savings in M3. Our current forecast is that there is likely to be a reduction to the savings delivered in 21/22 of £0.7m of which £0.1m is in H1.

	Apr-21 M1	May-21 M2	Jun-21 M3	Jul-21 M4	Aug-21 M5	Sep-21 M6	Oct-21 M7	Nov-21 M8	Dec-21 M9	Jan-22 M10	Feb-22 M11	Mar-22 M12	FY TOTAL
PEP Profile £000's	158	169	328	400	443	460	556	554	565	571	578	581	5,362



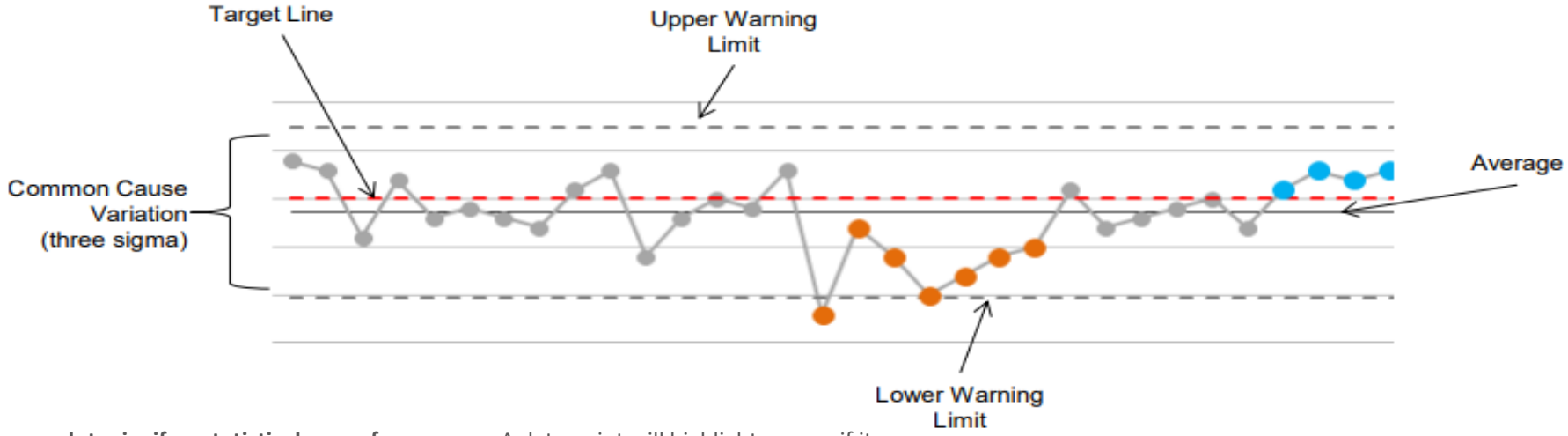
Adjusted Expenditure Productivity Trend:

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

May has seen the trend remain static, the mix in the WAU has increased Emergency and ED but reduced Outpatient on April.

Appendices

Statistical Process Charts (SPC) Guidance



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

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

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

Levels of Assurance

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

MAY 2021 IN NUMBERS

Worcestershire Acute Hospitals NHS Trust

7,849
Walk-in patients (A&E)

5,122
Patients arriving by ambulance

11,272
Inpatients

24,237
Face to Face outpatients

12,421
Telephone consultations

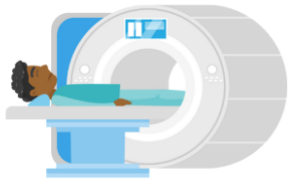
412
Babies

1,246
Elective operations

171
Trauma Operations

302
Emergency Operations

5.4
Average length of stay



15,027
Diagnostics