

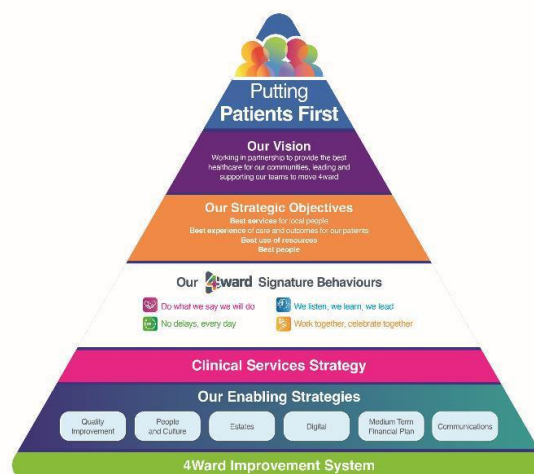
AGENDA

TRUST BOARD

Thursday 8th December 2022

10:00 – 12:30

Crompton Rooms A&B, Charles Hastings
Education Centre,
Worcester Acute Hospitals NHS Trust
Charles Hastings Way
Worcester
WR5 1DD



Anita Day
Chair

Item	Assurance	Action	Enc	Time	
123/22	Welcome and apologies for absence:			10:00	
124/22	Patient Story			10:05	
125/22	Items of Any Other Business To declare any business to be taken under this agenda item			10.30	
126/22	Declarations of Interest To declare any interest members may have in connection with the agenda and any further interest(s) acquired since the previous meeting.				
127/22	Minutes of the previous meeting To approve the Minutes of the meeting held on 10 November 2022	For approval	Enc A Page 4	10:35	
128/22	Action Log	For noting	Enc B Page 14	10:40	
129/22	Chair’s Report	For ratification	Enc C Page 15	10:45	
130/22	Chief Executive’s Report	For noting	Enc D Page 16	10:50	
Best Services for Local People					
131/22	Communications & Engagement Report Director of Communications & Engagement	Level 5	For assurance	Enc E Page 20	11:00

132/22	Board Assurance Framework Company Secretary	Level 5	For assurance	Enc F Page 28	11:10
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Best Experience of Care and Outcomes for our Patients

133/22	Integrated Performance Report Executive Directors	Level 4	For assurance	Enc G Page 34	11:20
134/22	Committee Assurance Reports Committee Chairs		For assurance	Page 128	11:55

Best Use of Resources BAF 7, 8, 11

No matters escalated

Best People BAF 9, 10, 11, 15, 17

135/22	Safest Staffing Report Chief Nursing Officer		For assurance	Enc H	12:00
	a) Adult/Nursing	Level 6		Page 138	
	b) Midwifery	Level 5		Page 144	

Governance

136/22	Responsible Officer Report Chief Medical Officer	Level 6	For assurance	Enc I Page 154	12:10
137/22	Audit & Assurance Report Committee Chair	Level 5	For assurance	Enc J Page 157	12:15
138/22	Any Other Business <i>as previously notified</i>				12:20
139/22	Closing Remarks Chair				

Close

Reading Room:

- BAF
- Responsible Officer appendices

Seven Levels of Assurance

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

Board Assurance Framework

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

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

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

Present:

Chair: Anita Day Chair

**Board members:
(voting)**

Paul Brennan	Chief Operating Officer
Matthew Hopkins	Chief Executive
Paula Gardner	Chief Nursing Officer
Simon Murphy	Non-Executive Director
Neil Cook	Chief Finance Officer
Christine Blanshard	Chief Medical Officer
Richard Oosterom	Associate Non-Executive Director
Dame Julie Moore	Non-Executive Director
Waqar Azmi	Non-Executive Director
Colin Horwath	Non-Executive Director

**Board members:
(non-voting)**

Richard Haynes	Director of Communications and Engagement
Vikki Lewis	Chief Digital Information Officer
Jo Newton	Director of Strategy and Planning
Rebecca O'Connor	Company Secretary
Tina Ricketts	Director of People and Culture
Sue Sinclair	Associate Non-Executive Director

In attendance

Jo Ringshall	Healthwatch
Jo Wells	Deputy Company Secretary
Justine Jeffery	Director of Midwifery
Dr Luke Simonds	LGBTQ+ Staff Network Chair (for item 108/22)
Anna Sterckx	Head of Patient, Carer & Public Engagement (for item 109/22)
Simon Adams	Healthwatch
Emma Mackey	Acute Liaison Nurse (for item 109/22)

Public Via YouTube

Apologies There were no apologies

107/22 **WELCOME**

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

108/22 **LGBTQ+ & STAFF NETWORK**

Ms Ricketts introduced Dr Simonds, the LGBTQ+ Network Chair who shared slides regarding the network's achievements, the barriers experienced and the risks going forward:

- Attitudes towards healthcare inequalities was highlighted. Feedback received outlined that nearly a quarter of patient facing staff had heard homophobic remarks. 1 in 7 LGBTQ+ people avoid hospital attendance for fear of discrimination.
- A new intranet page had been launched which included resources to signpost patients. The Communications team were thanked for their support.

- The NHS Rainbow Badge had been launched and provided the network with training opportunities and education, which is key to development of staff.
- There had been a request from patients to increase visibility to show that the Trust is supportive. New posters will be released to show we are a Trust who values diversity.
- There is room to develop. #CallMe has been helpful with introducing pronouns and this was something patients had requested.
- The limitations of PAS system in including a non-binary selection, which creates a huge barrier in creating a safe, inclusive environment was discussed.
- Inclusive language guidelines were being developed along with a new trans policy.
- A new section on the website had been created for LGBTQ+ patients to access to show that we are thinking of their needs and to provide reassurance.
- Members of the network attended the recent Pride event in Worcester where there was good engagement and was a great opportunity for the network to get together.
- An NHS Rainbow badge assessment had taken place where policies were reviewed along with issuing a staff and patient survey. The Trust received the highest response of the pilot of any other Trust. The Trust had been awarded an initial stage and a number of recommendations were already making progress. The survey indicated that there is a need to ask patients their preferred pronoun. It was disappointing that there were some very homophobic and transphobic comments fed back through the survey, which highlighted the need for a real culture shift.
- A lack of awareness was reflected and it was stressed that understanding is key and achieved through education. Members of the network required protected network time to support this.
- The network required strategic leadership for EDI from the Board. It would be useful to have oversight of ideas to make meaningful change. The Board leading by example and leading change is critical.

Mr Murphy asked what best practice looked like elsewhere and drew attention to the IPR which has a workforce composition slide and records those of a BAME background and queried whether that should include LGBTQ+ and disabilities. Mr Murphy understood that some staff have a fear of discrimination and do not share information. Dr Simonds replied that the Rainbow badge assessment has a gold standard framework to work towards and examples of what has been done elsewhere. Data information capture is important to know who our colleagues are, the problem is in having an environment where people feel safe to divulge that information. More people have come forward upon completing the Rainbow Badge assessment, then are declared on ESR for example.

Mr Adams thanked the Board and Dr Simonds for the reception of the Healthwatch report and asked whether the Trust is carrying out an impact assessment on issues that are internal such as managing restroom areas. Ms Ricketts replied that a meeting had been arranged to develop the impact assessment. There had been some miscommunication about outcomes relating to the theatre build which was due to the pace of the development, however Ms Ricketts clarified that a gender neutral changing room would be included in the development.

Dame Julie thanked Dr Simonds and the team for their leadership and commented that the country appeared to be moving backwards in this area. There were people who are frightened and any discriminatory comments needed to be dealt with firmly. Ms Day advised that she had seen the comments which were shocking and of deep concern.

Mr Azmi reminded that the Trust had adopted the 7 point plan and asked if there had been any analysis of the impact on groups across the Trust. Ms Ricketts replied that there had not at this stage but it could be considered. The team had reviewed current data, workforce race

equality standards, rainbow badge feedback and disabilities. A review of the impact would be reviewed through the People & Culture Committee. Quality impact assessments are undertaken on policies and business case templates included equality impact assessments.

Mr Murphy referred to the Behavioural Charter that was in place and asked all to ensure that it did make a difference.

Ms Day thanked Dr Simonds for the presentation and the progress being made. Ms Day encouraged the consideration of having a specific lead for all of the protected characteristics.

ACTION: Ms Ricketts to explore including LGBTQ+ and disabilities data within the IPR.

109/22

PATIENT STORY

Ms Gardner presented the patient story and welcomed Ms Mackay to present the story which had two parts: one positive visit, one negative visit and the lessons learnt from the patient's experience.

A patient named 'Alan' who had Downs Syndrome recently visited the Trust to have a procedure. Alan was extremely anxious, as was his father, following a previous visit during the covid period. As a result of relatives and carers not being able to visit inpatients at the time, Alan lost weight, his personality changed and he became withdrawn.

The Community Nurse made contact with the Trust regarding Alan's upcoming visit. Ms Mackay contacted Alan's father and offered to them a walkthrough prior to admittance but this was declined as Alan was so anxious. Ms Mackay arranged to meet them on the morning of the procedure at the Alex. The ward staff were made aware of Alan's arrival and had prepared a side room ready for him. Alan would be first on the list for surgery and the Surgeon visited Alan, introduced himself and explained the procedure. You could see Alan's anxiety reducing. Alan had his neck checked for problems, at which point his father advised that Alan had previously had a number of tests on his neck, as he was a diver in the special Olympics. Ms Mackay was present when Alan awoke from his procedure and the feedback received was that he did not feel as anxious as he did during his previous visit. Alan and his father wanted lessons to be learnt and to also share with others the positive experience.

Ms Day gave thanks for the teams going above and beyond in supporting Alan.

Ms Gardner reiterated that the negative side of Alan's story was during the height of the pandemic. Compassionate visiting was in place but it isolated Alan and his father was not allowed to visit. The Trust was now back to open to visiting which is beneficial to patients. It was recognised that when the compassionate visiting was not offered, it did have an impact on patients, however there did seem to be a fear of people coming in on the wards and visiting which was dealt with on a ward by ward basis. Additional training had been introduced and a plan is in place to ensure if Alan has to come back in, the same support process would be used. Ms Mackay reflected that her job was a real privilege and was pleased that she provided reassurance to patients.

Ms Day acknowledged that there were lessons to be learnt, noting that should visiting need to be restricted again, all wards needed to understand the rules, how and when they should be applied.

110/22

ANY OTHER BUSINESS

There was no other business.

111/22 **DECLARATIONS OF INTERESTS**

There were no additional declarations pertinent to the agenda. The full list of declarations of interest is on the Trust's website.

112/22 **MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON 13 OCTOBER 2022**

The minutes were approved subject to the following amendments:

Mr Cook informed that he had an amendment to the finance report element of the minutes and would provide narrative offline to clarify the point which implied an overspend.

Mr Brennan clarified that in the IPR section, 7600 patients could breach if nothing was done.

Ms Jeffrey advised that the new midwives start within the next 12 months, detailed within the midwifery staffing report.

RESOLVED THAT the Minutes of the public meeting held on 13 October 2022, with the above amendments were confirmed as a correct record and signed by the Chair.

113/22 **ACTION SCHEDULE**

A number of actions have been closed. One item remained open and would be closed in December.

114/22 **CHAIR'S REPORT**

Ms Day advised that she had attended the Stepping Forward Event yesterday where the 3 year plan and Clinical Service Strategy were discussed. The event included a number of attendees comprised of Trust staff, Council, Health and Wellbeing Board, HISC, University of Worcester, ICB, Place Executive Committee, Healthwatch, WMAS and the Patient Participation Forum. Fantastic conversations were had, along with good energy and positivity with numerous teams coming together.

A letter had been received from the Bishop of Worcester which talked about the pressures and challenges faced by staff that is not unnoticed and offered their gratitude and admiration for our staff.

There had been a good response to the recruitment process for 2 Non-Executive Directors and 1 Associate Non-Executive Director.

RESOLVED THAT: the Chair's update was noted

115/22 **CHIEF EXECUTIVE'S REPORT**

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

- Pressure on teams and staff continues, particularly in relation to urgent and emergency care.
- There had been a breakthrough in relation to colleagues in community and social care to set clear discharge targets from acute beds.
- Progress had been made with community teams avoiding patients being bought to ED.
- Mr Hopkins had met with the WMAS CEO this week to ensure he was clear on upcoming developments such as the opening of the new Urgent and Emergency

Department and communicating effectively to maintain appropriate and professional relationships given the pressures all are under.

- Waiting times had been featured in the news today. Additional focus had been placed on this area and the Trust were working with the national intensive support team.
- There was continuing focus to deliver against cancer and elective. A self-declaration request had been received.
- The RCN ballot results were received yesterday. Out of those who completed the ballot, the majority agreed that they would support strike action. Planning work was underway with teams to maintain safety in the most appropriate way and a meeting held with senior teams to focus on the next steps. It was noted that other union results have not yet come in but the implications would be reviewed once in receipt.
- The Stepping Forward Event was well received with lots of engagement with local colleagues and teams and we will continue to develop this with a Memorandum of Understanding to articulate relationships and future working.
- Executive team recruitment processes are well underway and dates have been set aside for interviews.

Dr Sinclair reiterated that it was essential to mitigate effects of strike action on patients. It is incredibly difficult for the nurses to make this decision and cautioned to mitigate intimidation and risk against people who have wrestled over what to do in this situation. Mr Hopkins advised that teams would continue close engagement irrelevant of views of industrial action.

Mr Murphy had visited the new UEC and frailty unit and asked whether it would be beneficial to have social workers based there. Mr Hopkins advised that the event yesterday highlighted the challenges of people with frailty. The service needed to be organised in a different way and was under review with the former Lead Nurse of the CCG.

Mr Azmi advised there was opportunity to bring in diversity at a senior level during the recruitment drive and suggested reviewing the track record of the recruitment consultants. Ms Ricketts confirmed diversity had been included as part of the requirement. The company with the best track record of diversity was chosen as the recruitment consultant.

Ms Day reiterated it was understood that our staff are professional people and they will not have taken the decision lightly to support industrial action. Their rights were fully respected.

RESOLVED THAT: the report was noted.

Best Experience of Care and Outcomes for Patients

116/22 INTEGRATED PERFORMANCE REPORT

Ms Lewis presented the report which had an overall assurance level of 4 and had been reviewed at the subcommittees:

- Note the assurance level around cancer performance is 3 given the challenges.
- Elective recovery, urgent and emergency care is outlined within operational performance.
- Fractured neck of femur and IPC feature.
- Improvements in overall fill rates in workforce.

Operational Performance

Mr Brennan highlighted the following key points:

- The elective breaches position has improved and remained on plan to achieve a zero position at the end of March 2023.
- Cancer performance is of concern with a significant number of patients waiting over 62 days, particularly relating to skin. An MRI scanner at Kidderminster is being used predominantly for prostate patients and is reducing the number of patients that will breach in the future.
- A new community diagnostic unit at Kidderminster is undertaking colorectal work and external subcontractors have been bought in to increase activity on the skin pathway.
- Challenges in urgent and emergency care relate to ambulance handovers and congestion in the ED. Teams are looking to reduce the amount of time patients spend in ED and eliminate the 1 hour ambulance handover breaches.
- Discussions have taken place with colleagues across the system and including the ICS, council and Health & Care Trust to get clear discharge targets in place. The agreed targets would be split between Worcester and the Alex and performance monitored. There would be an onsite integrated team based in Worcester from 21st November with the aim of ensuring that the discharge targets are delivered to improve flow and capacity in ED to reduce ambulance handover times.
- Teams would explore further potential enhancement of the ambulance cohort area and are reviewing options to increase the cohort space that did not include corridors. The options report was requested to be complete by the end of the week.
- The North Bristol model continued to progress but there were challenges as the discharge targets were not being met. A session was being hosted tomorrow with the Department of Health about the positives, challenges and risks faced with the model, which would be reported back to the Secretary of State.

Mr Murphy acknowledged the importance of the organisations forming a team on site and commended the negotiations. Mr Brennan stated that it was a really positive development where all parties had to be flexible to make it happen. The Trust was on plan for the first floor of the UEC to be handed over on 9th December and to occupy the Same Day Emergency Care Unit and Acute Medical Unit on 11th December.

Mr Oosterom was pleased to see risks being sharing across the system. Focus at the next Finance & Performance Committee would be on the effect of what we are doing. There was positive development with waiting lists and Mr Oosterom asked for an update on outpatient transformation. Mr Brennan replied that a detailed analysis of outpatient activity based on the day of the week had been undertaken. It had been identified that there was significant difference in the day of the week and the timing of the day. A Tuesday morning would see 11-11500 patients whereas a Friday afternoon would see 5500 patients which was an indicator to make better use of the capacity. Job plans would require adjusting to enable changes to capacity and was therefore not an immediate opportunity.

Dame Julie noted the loss of activity in relation to theatre utilisation and the lack of improvements. Mr Brennan advised there was a theatre group comprising of divisional and clinical directors who had completed a 25 week analysis looking at theatres and individual consultants utilisation. Actions had been agreed which related to ensuring the lists are fully utilised and booked.

Mr Horwath had received feedback that lunch breaks are not synchronised with theatre cleaners and asked whether a review of practical logistics had been completed. Assurance was required that all aspects which prevent utilisation were considered. Mr Brennan replied that this and similar issues had been reviewed and would be discussed during Private Trust Board.

Dr Sinclair queried the intended use of frailty scoring. Mr Brennan advised that scoring is done when a patient is in ED. When the move to the AEC takes place in December, a frailty bay would be created and the assessment done in the AEC rather than ED; Dr Blanshard added that they would be managed more holistically upon arrival.

Ms Day observed a slow creeping up of conversion rate (Decision to admit) and asked if it was a concern and whether any action was being taken. Dr Blanshard replied that the ambulance conveyance to admittance ratio is higher at the Worcester site and related to clinical specialties. The evidence in terms of risk aversion is that the readmission rate following discharge is benchmarked in line with other acute organisations. Mr Brennan advised that there had been a slight increase but between April 2020 and March 2021, the conversion rate was between 29-34%. For April 2021 to March 2022, the range was between 25-29% and for the first 6 months of this year has been 22-25%. Overall, over the last 3 years it has been reducing. When compared with the rest of the region, The Trust is in the lower range of the conversion rate.

Dame Julie asked whether a joint audit had been considered regarding appropriateness of acute beds. Dr Blanshard replied that a point prevalence audit had been completed of patients in bedded care or community supported care across the ICS to consider appropriateness. A meeting was scheduled tomorrow to discuss the findings in more detail.

Quality & Safety

IPC was discussed at Quality Governance Committee. C-diff targets had breached though transmission had declined. There was high instance in the community of c-diff which was likely related to pandemic prescribing of antibiotics at dentistry.

At Worcester, 4 wards were in active outbreak of covid and 8 areas were being monitored. At the Alex there was 1 ward with a covid outbreak and 2 wards in monitoring. There had been no norovirus or flu outbreaks. NHSIE and Professor Wilcox had visited. Actions had been created following feedback which largely related to cleaning and were being worked through.

Dr Blanshard confirmed that actions in relation to fractured neck of femur were progressing and there was an away day planned next week with the wider multi-disciplinary teams to discuss waste and opportunities for improvement. The day would start with a story about a delay in treatment and the effects. Breakout groups had been set up to address different areas in the pathway.

People & Culture

Ms Ricketts informed that the extra resource in central recruitment teams had improved the time to hire. The revised workforce plan had been met and there had been progress with retention.

Finance

Mr Cook advised that the in month position was breakeven to plan in month 6. There was an accumulative variance of £0.2m. The Trust continued to experience high spend with temporary staffing. PEP over performance was reported in the month and the PEP stands at £3.7m year to date.

A forecast deep dive had been undertaken with divisions and came back with a £25m deficit, which was a potential risk of around £5m to achieve plan. There were assumptions that the

Trust may not receive money for PDU from commissioners. Mitigations were being sought and a report would be presented to the Finance & Performance Committee next month.

Mr Azmi noted the increase in expenditure and asked what was causing it and how the PEP could be brought back on track. Mr Cook replied that pay awards and PEP were drivers. In terms of PEP, the non-recurrent benefits and changing the approach were required. The balance sheet was being reviewed.

Mr Oosterom complemented the team for the forecast of the year, however the concern is the under delivery of the PEP and lack of maturity. Spending on business cases had been postponed and the effects of such needed to be understood.

Mr Horwath queried the projected outturn with the system and asked whether the pressure would increase. Ms Day noted that it was assumed that the full ERF will continue, but if it is withdrawn there would be an issue. Mr Cook stated that the Trust were advised by the ICB that we should continue to assume that the ERF would be awarded. A call was planned with the NHSE CFO tomorrow and Mr Cook would seek clarification. The projected outturn is a significant risk for the ICB around continuing healthcare.

Capital was under pressure with the huge programme. £8m had been spent to date. There was challenge around the UEC Scheme in respect of how it will be funded. Teams were looking for an internal solution. There were further potential challenges around timing of schemes such as equipment replacement and maintenance backlog. Mr Hopkins has written to the region for support around timing and funds of larger strategic programmes. If the Trust were to achieve all of the capital programme this year, it would be £13m short at the end of the year. Programmes were being reviewed to ascertain if any could slip to next year.

Cash remained in a healthy position.

Ms Day complimented the structure of the finance report and level 4 assurance was approved.

RESOLVED THAT: The report was noted for assurance.

117/22

COMMITTEE ASSURANCE REPORTS

The following points were highlighted by Committee Chairs:

- Finance & Performance Committee: Highlighted areas of discussion in relation to financial position. Specific risk analysis on capital to be reviewed at the next meeting. – Well-led KLOEs would be presented to the Committee.
- Quality Governance Committee: Covid and c-diff was discussed and solutions being sought for bed washing. The Medicines Optimisation Report was reviewed.
- People & Culture Committee: Committee received a presentation around recruitment and retention.

RESOLVED THAT: The Committee reports were noted for assurance.

Best Use of Resources

118/22

SCHEME OF DELEGATION

A proposal was presented to make improvements to the Authorisation to recruit (ATR) forms. The current process was panel approval which added delays to the recruitment

cycle. It was suggested if someone had been in the post for 6 months and budget was in place, teams could go straight out to recruit.

Those outside of the criteria and/or are above budget is declined at this point. Audit were reviewing high cost agency staff and their report was awaited with regard to any issues around controls.

Mr Horwath has taken a Chair's action as Chair of Audit & Assurance Committee to approve the Scheme of Delegation and recommended the Board to approve. Mr Horwath added that he had asked how many occasions that the panel declined authorisation and had been advised that the majority of them were approved but had caused a delay that did not appear to have a control benefit.

Mr Hopkins advised that senior teams have discussed and rehearsed how we help our divisions to restructure, review skill mix and manage the establishment in the best way. Ms Ricketts confirmed that an establishment control policy was being considered and this was a small part of the review of the value stream of the end to end process.

Mr Oosterom noted that when people deliver, they should be empowered, however when they were not delivering, there should be more scrutiny. Mr Oosterom asked whether this would be allowed for specific divisions if they were not performing. Ms Ricketts replied that there were monthly finance reviews with each of the budget holders and would be scrutinised at PRMS if it was felt there were issues in those areas. It was likely that there would need to be some more guidance supporting this element. Dr Sinclair reflected that scrutinising every role would cause widespread delays needlessly and that very few were rejected.

Ms Day agreed with the comments that changes are being made which would have a financial benefit and encouraged efficiency and working in different ways; however, it was important to also ensure that existing inefficiency did not become entrenched by a lack of scrutiny of like-for-like replacements.

RESOLVED THAT: The Scheme of Delegation was approved.

Best People

119/22 SAFEST STAFFING REPORT

- a) Adult/Nursing
- b) Midwifery

Adult/Nursing

Ms Gardner presented the report with an assurance level of 6 and highlighted the following:

- There was a reduced level of assurance in vacancies.
- Favourable benchmarking with RNs.
- There was still high HCA turnover. Recruitment and retention was under review along with refreshed incentives.
- Appendix 1 detailed an acuity bi-annual review.

Midwifery

Ms Jeffery presented the report with an assurance level of 5 and highlighted the following:

- Increased to level 5 assurance. Though there was a decrease in time of acuity met, there had been a reduction in red flag reporting, a decrease in vacancies, an increase in fill rate and less delays in care reported.
- Sickness did increase slightly but overall the trend was down.
- The final Birthrate+ audit had been received and would be presented next month.

Mr Murphy was pleased to see better staffing levels and that it was evident during a walk about. Ms Jeffrey added that the Trust had been awarded funding to support 6 international recruits.

Ms Day gave thanks to the teams and the level 6 assurance. The assurance levels were approved.

RESOLVED THAT: The report was noted for assurance.

Governance

120/22 TRUST MANAGEMENT EXECUTIVE

Mr Hopkins presented the report, advising that there were additional meetings held to discuss business cases for approval.

There had been a significant amount of discussion on operational pressures and the clinical risk associated to increasing the number of patients the ED and wards are treating.

Mr Horwath attended the Stepping Forward event and asked how the themes discussed would be reported back. Ms Newton replied that the purpose was to come out with an action plan and would be reflected back in a future report. A Board Development session for discussion and reflection would be scheduled before Christmas.

RESOLVED THAT: The report was noted for assurance.

121/22 ANY OTHER BUSINESS

Ms Day informed that the next public Board on 8th December will be a face to face meeting at Worcester. It had been agreed that the Board would meet 4 times per year face to face. Face to face meetings would not be streamed on YouTube, however the public were invited to attend in person.

DATE OF NEXT MEETING

The next Public Trust Board meeting will be held virtually on Thursday 8 December 2022 at 10:00am.

The meeting was closed.

Signed _____
Anita Day, Chair

Date _____

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

PUBLIC TRUST BOARD ACTION SCHEDULE

RAG Rating Key:

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

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

Meeting	Public Trust Board
Date of meeting	8 December 2022
Paper number	Enc C

Chair's Report

For approval:	X	For discussion:		For assurance:		To note:	
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Accountable Director	Anita Day Chair		
Presented by	Anita Day Chair	Author /s	Rebecca O'Connor Company Secretary

Alignment to the Trust's strategic objectives (x)

Best services for local people		Best experience of care and outcomes for our patients		Best use of resources	X	Best people	
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Report previously reviewed by

Committee/Group	Date	Outcome

Recommendations

The Trust Board are requested to ratify the action undertaken on the Chair's behalf since the last Trust Board meeting in November 2022.

Executive summary

The Chair, undertook a Chair's Action on the recommendation of Finance and Performance Committee and in accordance with Section 24.2 of the Trust Standing Orders to:

1. Approve Contract Award Governance Reports 2 and 3 for the AHR Theatre project

The Contract Award Governance reports are enclosed for noting on the Private Trust Board agenda

Risk

Which key red risks does this report address?		What BAF risk does this report address?	BAF 4, 7, 8, 18
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Assurance Level (x)

0	1	2	3	4	5	6	X	7	N/A
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Financial Risk

Action

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

Meeting	Public Trust Board
Date of meeting	8 December 2022
Paper number	Enc D

Chief Executive Officer's Report

For approval:		For discussion:		For assurance:		To note:	X
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Accountable Director	Matthew Hopkins Chief Executive Officer		
Presented by	Matthew Hopkins Chief Executive Officer	Author /s	Rebecca O'Connor Company Secretary

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

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

Recommendations	The Trust Board is requested to <ul style="list-style-type: none"> Note this report.
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Executive Summary	<p>This report is to brief the Board on various local and national issues. Items within this report are as follows:</p> <ul style="list-style-type: none"> Staff Recognition Awards Ceremony Care Quality Commission visit Leadership summit 4Ward Improvement System Strategy Leadership Event Annual Planning System Oversight Framework rating AEC & AMU
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Risk												
Which key red risks does this report address?	N/A			What BAF risk does this report address?			N/A					
Assurance Level (x)	0	1	2	3	4	5	6	7	N/A	X		
Financial Risk	None directly arising as a result of this report.											
Action												
Is there an action plan in place to deliver the desired improvement outcomes?	Y		N		N/A		X					
Are the actions identified starting to or are delivering the desired outcomes?	Y		N									
If no has the action plan been revised/ enhanced	Y		N									
Timescales to achieve next level of assurance												

Meeting	Public Trust Board
Date of meeting	8 December 2022
Paper number	Enc D

Introduction/Background

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

Staff Recognition Awards

As Board members will see from the report and pictures in the Communications Update later in this month's papers, our 2022 Staff Recognition Awards delivered an evening which was moving, inspiring, humbling and entertaining in equal measures.

Ably supported by Paul Sinha, who proved a charming and witty compere, our Chair and I found ourselves 'in the round' in the midst of a lively 300-strong audience of colleagues, sponsors and VIP guests. It was our privilege to hand out a series of awards that recognised some of the wonderful achievements of individual members of staff, teams and volunteers across all our sites and across a wide range of services.

There are many people who deserve a thank you for making the night so special, and we are writing to them all individually to express our gratitude, but special thanks go to our headline sponsors the University of Worcester and to our hosts DRPG, whose venue, staff and event management were excellent. Not content with delivering a memorable awards night, our friends at DRPG are also hosting the Children of Worcestershire Cancer Fund's annual Christmas grotto on Sunday 11 December, providing gifts on the day and planning the event for the Paediatric oncology team.

I would also like to thank our charity and communications teams who I know put in a huge amount of work to plan our first live awards event in several years, and who played a key part in making the evening such a huge success.

Care Quality Commission: Unannounced visits

In late November, we received unannounced visits to the Alexandra and Worcestershire Royal from the Care Quality Commission (CQC). The visits were part of a wider inspection of our local health and care system, and unsurprisingly much of the inspection team's focus while they were with us was on urgent and emergency care pressure, patient flow in and out of our hospitals, patient safety and staff wellbeing.

Once again, colleagues in teams across our sites distinguished themselves by the way they engaged with the CQC, with inspectors praising the warm welcome they received from our staff wherever they went, their focus on patient safety, their continued compassion and commitment despite working in such challenging conditions, our positive culture and our commitment to staff wellbeing.

Other parts of the CQC feedback reflected our shared concerns, including the relentless demand on our services, the difficulties we face in managing patient flow, the resulting pressure on space and the additional strain that places on our people.

They also highlighted a number of specific areas for improvement, including some issues around medicines management, and made a number of recommendations – some of which we dealt with on the day, and others which are being addressed as a matter of urgency.

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I would like to thank everyone who supported our response to the visit. It is likely to be a few months before we see a full written report but from the inspectors' initial verbal feedback and a letter we subsequently received, there is a lot we can be proud of.

Leadership summit 4Ward Improvement System

We held another successful Leading 4Ward event on 1st November at Wharton Park Golf Club in Bewdley, where we engaged the next management tier of the organisation on the 4ward Improvement System. It was another well attended event, with 100 clinical and corporate leaders being introduced the concepts and philosophy of the 4Ward improvement system in their daily management, which includes developing Leaders Standard Work and having greater visibility on the Genba (the place where the work is done). We are planning another event in March 2023 to the next tier of leaders in the organisation as part of the ongoing engagement strategy.

Strategy Leadership Event

The Strategy Leadership Summit took place on 9th November, with the aim to bring our clinicians, senior leaders, patients and partners together to share our Three year plan, look ahead to future opportunities and to shape our approach to delivery. Key to this is keeping the patient voice at the heart of the way our services are planned, developed and delivered. The event was attended by over 100 colleagues and patients who both contributed and responded positively via the event evaluation questionnaire.

The outputs of and feedback on the day have now been collated and reviewed, a summary of which can be found in the slide deck in the Trust Board Reading Room. Key themes have been summarised at Worcestershire, WAHT and division/specialty levels with a focus on those themes which had strong support at the event from patients and their representatives. Retaining the focus on patient/carers involvement is key to our way forward and further conversations will take place with patients/carers to seek their preferences for engagement and involvement. Discussions will start with the Patient Participation Forum in the first instance to understand how we can genuinely involve patients/carers in improvement, co-design and delivery of services and strengthen our approaches to patient engagement.

Follow up conversations with partners have been arranged for week commencing 5th December to prioritise and progress the themes together to secure commitment of all partners (including PCNs). Learning from the event can help inform the ICS Integrated Care Strategy and Five Year Forward Plan. Internally, we plan to ensure that there is a common understanding of how outputs from the event can be prioritised and delivered, including with a system lens. As part of the 4ward Improvement journey we have enlisted support from the Virginia Mason institute to align improvement approaches to delivery. As Dr Julian Berlet assumes his new role as Deputy CMO (clinical strategy) discussions will commence on refreshing our Clinical Services Strategy and a Strategy Steering Group is being convened to develop and oversee the approach.

Annual Planning

Work on annual planning principles including planning assumptions for 2023/24 to 2024/25 was confirmed at a workshop with divisions in September. The ICB have used our assumptions as the basis for the development of those being used by the ICS. We continue to await national planning

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guidance (potentially due mid-December), but nevertheless have progressed with development of our annual plan.

Whilst our approach this year will identify the gap between our capacity and activity required to achieve, the challenge given the wider national political environment and pledges on waiting times, aligned to ICS system level performance targets and financial balance, remains. To this end a new approach to PEP recovery has been discussed at Finance & performance committee acknowledging the need for some investment in capacity which we are confident to receive system support. Forecast financial outturn positions for 22/23 currently being aggregated will provide a Trust level position as a basis from which to develop financial plans for 23/24. Work will continue on these elements of our annual plan, with emphasis on PEP development whilst we continue to await the national guidance. A number of risks to the delivery of annual planning (e.g. industrial action, CQC Well Led Review, operational pressures, Operation Willow and Rapid Process Improvement Workshops) are reviewed regularly and their impact will continue to be monitored to ensure that mitigation is sufficient

System Oversight Framework

Following the publication of the NHS Oversight Framework on the 1 July 2022 we have received confirmation from NHSEI that following the Quarter 2 review at the end of October we remain in segment 3 of the NHS Oversight Framework. Integrated Care Boards (ICB) continue to lead the oversight of their providers with NHSE maintaining statutory accountability for NHS provider organisations. The ICB have been working closely with the trust to address the triggers for segmentation in preparation for the Quarter 3 review.

AEC & AMU

On Sunday the 11 December 2022 the first floor of the new UEC in Aconbury will become operational and the existing AMU will transfer from the 'white space' to the new UEC and the existing AEC will transfer from Mulberry to the new UEC providing a significantly enlarged facility that will incorporate a frailty assessment facility. Following the vacation of the 'white space' this will become a new multi-specialty surgical assessment unit which will incorporate the existing SCU and ESTC as well as creating new capacity for trauma, MaxFax, ENT and additional general surgery.

On completion of these developments we will be transferring Avon 4 from Aconbury to a 21 bed space within a reconfigured SCU/Beech A and B on the afternoon of Tuesday 13th December and following this transfer the ground floor Aconbury corridor will be demolished as part of the UEC works to build our new Emergency Department which is scheduled to open in June 2023.

Issues and options

Recommendations

The Trust Board is requested to

- Note this report.

Appendices – None

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Communications and Engagement Update

For approval:		For discussion:		For assurance:	x	To note:	
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Accountable Director	Richard Haynes, Director of Communications and Engagement		
Presented by	Richard Haynes	Author /s	Richard Haynes

Alignment to the Trust's strategic objectives (x)

Best services for local people	X	Best experience of care and outcomes for our patients	X	Best use of resources	X	Best people	X
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Report previously reviewed by

Committee/Group	Date	Outcome

Recommendations	Board members are asked to note the report for assurance.
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Executive summary	<p>This report provides Board members with examples of significant communications and engagement activities (including charity and fundraising activities where relevant) which have taken place recently as well as looking ahead to key communications events/milestones in coming months.</p> <p>In the spirit of our 4ward behaviour of work together, celebrate together, this report includes recent examples of our more successful proactive media and social media work which help to showcase our commitment to putting patients first, and further improve the profile and reputation of our Trust as well as supporting the wellbeing of our staff.</p> <p>In response to questions raised by Board members during discussions on the previous communications update (September 2022) this report also includes a more detailed look at some of the specific communications support provided recently for recruitment.</p>
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Risk

Which key red risks does this report address?		What BAF risk does this report address?	BAF Risk 12: If we have a poor reputation then we will be unable to recruit or retain staff, resulting in loss of public confidence in the trust, lack of support of key stakeholders and system partners and a negative impact on patient care
Assurance Level (x) 0 1 2 3 4 5 x 6 7 N/A			

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Financial Risk	Related activities carried out within the existing communications budget or covered by the budgets of supported projects or programmes.					
Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y		N	X	N/A	
Are the actions identified starting to or are delivering the desired outcomes?	Y	X	N			
If no has the action plan been revised/ enhanced	Y		N	X		
Timescales to achieve next level of assurance	Communications and engagement priorities for 22/23 are aligned with Trust planning priorities and timelines in ways which are consistent with our Communications Strategy, subject to capacity constraints. Progress and issues will be reflected in future Board updates					

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Introduction/Background

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

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

In response to questions asked by Board members in relation to the previous update (September 2022) this report also includes a more detailed look at some of the specific communications support for recruitment.

Issues and options

Staff Recognition Awards 2022



After several months of hard work by our charity and communications teams, some 300 colleagues from across the Trust, sponsors and VIP guests came together at the end of November for our first live staff awards ceremony in more than five years.

The event was hosted at the Hartlebury headquarters of global creative communications agency DRPG and compered by doctor turned comedian and celebrity quizzer Paul Sinha.



A drinks reception was followed by a two course meal and presentation of the awards, with a disco to bring the evening to a close.

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In the spirit of our 4ward behaviour of work together, celebrate together, the Awards were a welcome opportunity for us to reflect on our many achievements of the past year and showcase some of our successes.

Most importantly, they were also a chance to say a heartfelt thank you to some of the individual colleagues and teams who work so hard every day to put our patients first.

The awards were only made possible by the generosity of our sponsors and thanks are due to them all – including our headline sponsors the University of Worcester and our hosts DRPG.

A big than you also to everyone who came and threw themselves so enthusiastically into the celebrations!

Support for recruitment

Clearly the publicity around our Staff Recognition Awards will also serves to showcase our Trust to potential job applicants, but the communications team also continue to focus a significant amount of time and effort on specific support for recruitment. A few examples are set out below:

Refresh of our recruitment web pages: Working in partnership with colleagues from a number of teams including recruitment, OD and professional development, we carried out an in-depth review of the recruitment section of the Trust website between August and September this year. The review included analysis of the usage figures to improve our understanding of where and how visitors to the site were accessing information.

Following that review we restructured the pages to improve navigation and reduce the number of clicks needed for visitors to access relevant information.

Our overall website usage data reflects high levels of access via mobile devices. We see more than half a million total visits to our website each year, of which approximately two thirds (or c 330,000 visits) are via mobile devices.

With that in mind, it was important to ensure that we offered high quality job opportunity information for desktop users that was also optimised for mobile devices, within the constraints of the current content management system.

Once the structure was developed, the content was completely refreshed and went live in November.

Key improvements to the recruitment section of our website include:

- A new 'landing page' at www.worcsacute.nhs.uk/work-for-us with a strong visual image featuring a clear call to action offering a direct link to all our current vacancies on the NHS jobs website.
- A new 'recruitment news' section highlighting recent recruitment related news items, including short videos, media releases and details of future recruitment events

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- Signposting to more detailed information which showcases our extensive staff support and wellbeing offer (illustrated through the use of in-house produced short videos and bespoke infographics – see for example www.worcsacute.nhs.uk/work-for-us/supporting-our-staff) and specific employment opportunities
- Dedicated areas for apprenticeship and work experience.



The first month of go live saw around 6,000 visits to the landing page and 'child' pages

Future plans include improving direct links to specific roles or vacancies, including an enhanced section for Healthcare Support Workers and a dedicated area for overseas recruitment, as well as expanding the range of recruitment focussed videos and infographics.

Targeted recruitment campaigns: Where additional support for reaching would-be job applicants is required we work more closely with teams to produce bespoke, targeted recruitment campaigns.

One current live example is a campaign aiming to recruit Band 6 Occupational Therapists to fill up to 5 vacant posts that have proved difficult to fill through conventional methods,

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including a dedicated website page, bespoke social media content and highly-targeted social media advertising to show the vacancies to as many relevant people as possible.

This follows previous experiences working with the OT department on successful recruitment campaigns filling a number of roles via this route.

At the time of writing this report, that campaign had only been live for one week with 11 days remaining, but the statistics so far are encouraging.

Facebook = £162 spent, seen 19,984 times, 213 weblink clicks = 76p per click to dedicated OT recruitment webpage on 'work for us' pages.

Twitter = £68 spent, seen 8,565 times, 62 weblink clicks = £1.10 per click to dedicated OT recruitment webpage on 'work for us' pages.

LinkedIn = £129 spent, seen 4,794 times, 59 weblink clicks = £2.19 per click to dedicated OT recruitment webpage on 'work for us' pages.

This is our very first paid-for advertising campaign on Twitter, our research having established that although the cost per click may be marginally higher than on Facebook, the quality of targeting to the relevant potential candidates is higher and more accurately reflecting an interest in the topic.

Bespoke communications materials: Where teams are taking advantage of individual opportunities to reach out to would be employees – through ad hoc recruitment campaigns or recruitment events, we also work with them to produce supporting materials and raise awareness and interest.

Recent examples include an advertorial (words and images) for an ED recruitment campaign in Civvy Street magazine which offers ex-military personnel advice on job vacancies and relocation advice.

We also worked with communications colleagues in our system partners to publicise display materials and social media publicity for a system wide recruitment event which took place in Worcester in November.

Wonders of Worcestershire



This year's Wonders of Worcestershire Fundraising Campaign is now live and aims to build on the success of last year.

There are three main strands to the outward facing campaign:

- A general campaign encouraging monetary donations
- For children – Amazon wishlists set up for our Play Team and Paediatric Oncology

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- For staff – the Support our Staff initiative

Internal elements include posters for wards/teams to put and sign instead of Xmas cards (environmentally sound and time efficient) – the posters are free but have a QR code/Just Giving web link and text link donation options.

There are more details on the appeal at <https://wahcharity.org/>

Positive proactive media and social media



A number of our media releases have generated significant positive media and social media coverage and comment, including: The support we offered for two medical students forced to flee their training at the Dnipro Medical Institute by the war in Ukraine and; our success in securing a £10,000 award from the Workforce Disability Equality Standard Innovation Fund (WDES) to enable and encourage people with a disability or long-term condition to apply for roles within the Trust (pictured is Donna Scarrott, Chair of our Disability Network).

Other issues attracting significant interest

Urgent and Emergency Care: Pressures on our urgent and emergency care services continue to attract significant media and social media coverage and comment, including national media interest (BBC Newsnight and Radio 5 Live). Highlighting the efforts being made to tackle the challenges, and signposting patients to the most appropriate urgent care services remain a priority for communications colleagues at Trust and Place level.

Parking and traffic congestion: Issues around parking on all our sites and traffic congestion (particularly evening rush hour congestion on the Worcestershire Royal Hospital) also continue to generate significant media and social media coverage and comment, as well as concerns expressed by members of staff

And finally: 2023 – a year of opportunity

While 2022 has been a very busy year for the communications and charity teams, 2023 promises to bring even more opportunities.

As well as continuing to support our major transformational programmes (among them our 4ward Improvement System and Electronic Patient Record) we are planning a number of other major pieces of work including:

- The refresh of our 4ward behaviours
- The redevelopment of our Intranet and Internet sites including the migration of both to new content management systems
- An update of our Communications and Engagement Strategy
- NHS 75

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At the same time, we expect ongoing high levels of support required for recruitment, staff wellbeing, several major capital developments, stakeholder engagement, internal and external events, our green initiatives and a lot of 'business as usual.'

Conclusion

Demand for communications and engagement support continues to grow rapidly and with finite capacity we are trying to focus our time and skills on those areas which will provide most value to the Trust's wider strategic and operational priorities.

Recommendations

Board members are asked to note the report for assurance.

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Board Assurance Framework

For approval:	X	For discussion:		For assurance:	X	To note:	
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Accountable Director	Rebecca O'Connor, Company Secretary		
Presented by	Rebecca O'Connor, Company Secretary	Author /s	Rebecca O'Connor, Company Secretary

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

Report previously reviewed by		
Committee/Group	Date	Outcome
TME	16 November 2022	Noted
Quality Governance	24 November 2022	Noted
Finance and Performance	23 November 2022	Noted
People and Culture	29 November 2022	Noted

Recommendations	To review and approve the Board Assurance Framework on a confirm or challenge basis
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Executive summary	<p>This report sets out the full Board Assurance Framework (BAF) following a process of review by Executives and Board Sub-Committees</p> <ul style="list-style-type: none"> The full BAF (at the current point of review) is enclosed within the reading room There has been one change in BAF score since the last high level summary to Trust Board in September 2022. BAF 8 risk score increased from 16 to 20 as a result of the ongoing challenges in the Trust's capital programme A new risk BAF 22 – industrial action has been added as previously agreed by the Board in private session There have been two changes in level of assurance; BAF 19 and 20 have reduced from level 4 to level 3 assurance in light of the current position and ongoing pressures in urgent care Supporting detail and control measures for all risks have been reviewed and updated.
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Risk											
Which key red risks does this report address?		What BAF risk does this report address?	All BAF risks as outlined in this report.								
Assurance Level (x)	0	1	2	3	4	5	X	6	7	N/A	

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Financial Risk	<i>If the Trust does not have a robust BAF and system of monitoring in place there is the risk that the strategic objectives will not be achieved, which could have regulatory, reputation and financial implications and could impact on the quality of care that is provided. Individual risks and associated controls and or mitigating actions may have financial implications.</i>
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Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y	X	N		N/A	
Are the actions identified starting to or are delivering the desired outcomes?	Y		N		As per report	
If no has the action plan been revised/ enhanced	Y		N		As per report	
Timescales to achieve next level of assurance	As outlined for each risk					

Introduction/Background		
<p>The Trust Board is responsible for identifying and monitoring the risks to the achievement of the Trust's strategic objectives. This is achieved through the development of a BAF, which is monitored by the Trust Board and its Committees for areas of their authority.</p> <p>The Audit and Assurance Committee also has oversight of the BAF to inform the annual programme of internal audit activity and to allow the Committee to discharge its duties in terms of providing assurance around the robustness of the overall system of internal control, of which the BAF is an integral component. Strategic risks on the BAF are those which are of such importance, that failure to control the same, may cause the Trust to fail to deliver its strategic objectives.</p> <p>This report provides assurance as to the management of strategic risks which are presented on a confirm or challenge basis.</p>		
Issues and options		
BAF Summary		
A summary of the risk position is as follows:		
	Number	Comment
New Risks opened	1	BAF 22 – industrial actions (agreed at November 22 private Trust Board)
Risks Closed	0	
Risks Escalating	1	BAF 8 – increased from risk score 16 to 20 in light of the challenging capital programme
Risks De-escalating	0	
Total risks identified	18	+1 BAF 22
Level of assurance changes	2 decrease	BAF 19 and 20 - level of assurance reduced from level 4 to level 3 due to the ongoing challenges in urgent and emergency care pressures
<p>A summary of the Trust's risk exposure is below. This shows that whilst the mitigations put in place are slightly reducing the overall risk exposure, this remains very high.</p>		

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	Extreme	High	Moderate	Low
Current risk score	12	6	-	-
Initial risk score	13	5		

BAF Updates

BAF risks have been reviewed and updated, the following changes have been endorsed by Committees as follows:

- Risks Opened/Closed:**

BAF 22 – Industrial action – risk score of 20. New risk opened following discussion at private Trust Board and People & Culture Committee. Full detail and mitigating action is within the appendix.

There is a risk that services will be disrupted by staff shortages due to possible industrial action by the NHS trade unions resulting in delays to patient care and poor patient experience.

- Risk Escalating/ De-escalating:**

None

- Risk Narrative Updates**

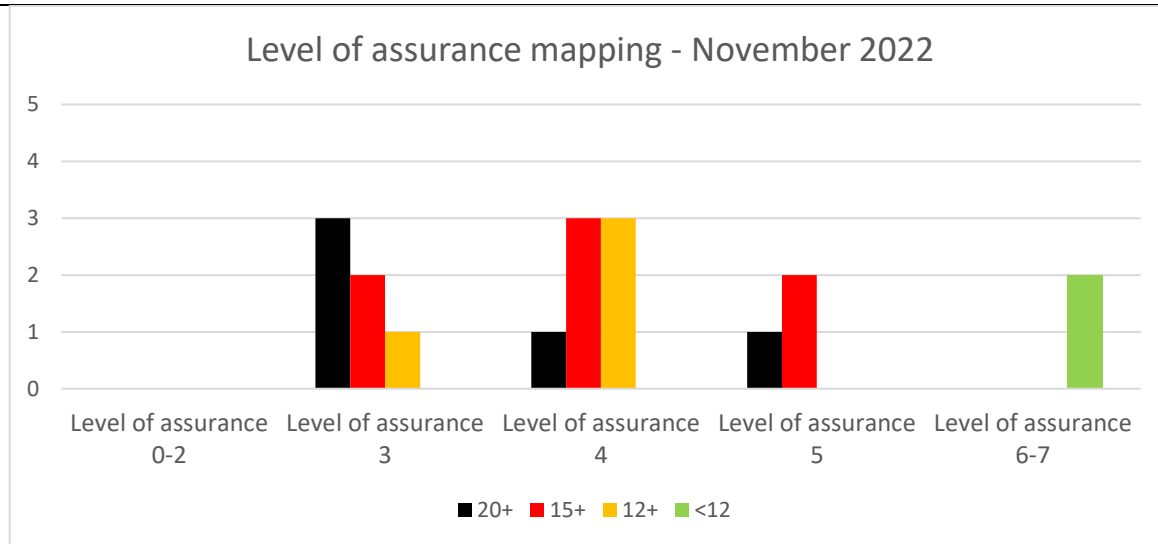
Reviews of all risks have taken place and updates made to all current BAF risks in respect of the actions, controls and mitigations. The latest full BAF is enclosed in the reading room and the high level summary is appended.

Level of Assurance

The level of assurance is mapped as follows. The graph shows the number of risks and their risk score mapped against the level of assurance. The majority of risks (7) have level 4 assurance; however, the number of risks with level 3 assurance is increasing. Of the 18 risks in total, 12 provide level 4 assurance or above.

Tracking of assurance levels demonstrates the improvement made in assurance of the BAF risks, this is shown by movement to the right of the graph.

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The change in levels of assurance can be tracked in the following table which will be added to throughout the year:

	Dec 21	Feb 22	May 22	Sept 22	Nov 22	Change from last Board report
Level of assurance 0-2	-	-	-	-	-	-
Level of assurance 3	4	3	4	4	6	+2
Level of assurance 4	10	10	8	8	7	-1
Level of assurance 5	3	5	5	3	3	-
Level of assurance 6-7	-	-	-	2	2	-

* Note new risk added in November 22

Mapping of Strategic Risks Against Strategic Objectives

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

	BAF 2	BAF 3	BAF 4	BAF 7	BAF 8	BAF 9	BAF 10	BAF 11	BAF 13	BAF 14	BAF 15	BAF 16	BAF 17	BAF 18	BAF 19	BAF 20	BAF 21	BAF 22
Strategic Objective: Best services for local people	X							X	X			X	X	X			X	X
Strategic Objective: Best experience of care & outcomes for our patients		X	X					X							X	X		X

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	Best use of resources				X	X			X									
	Best people						x	x	X		X	X		X				
Goal	Goal – strategy	X							X	X		X	X	X	X			X
	Goal – quality		X	X					X							X	X	X
	Goal - finance				X	X			X									
	Goal – workforce and culture							X	X	x		X	X					X

• Risk Exposure

The Trust's risk exposure overall is increasing and assurance is decreasing. This is due to a number of factors including the ongoing impact of urgent and emergency care pressures, restoration and recovery, a significant capital programme and underlying deficit.

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

• Risk Appetite

The Trust's risk appetite is not necessarily static, but all risks are expected to have controls and mitigations in place, which aim to reduce the risk exposure to a tolerable level.

The Trust Board may vary the amount of risk that it is prepared to tolerate depending on the circumstances at the time. Committees review the BAF and can make recommendations to the Trust Board regarding the adequacy of the outlined mitigations and control measures. If the Trust Board is unwilling to accept the level of risk to which it is currently exposed, it is invited to consider further mitigating actions or challenge those already identified.

Conclusion

The Trust has a Board Assurance Framework in place which is operational and effective. The Trust's risk exposure is increased from the last report and mitigating actions are as outlined in this report.

Recommendations

To review and approve the Board Assurance Framework on a confirm or challenge basis

Appendices

High level BAF risk summary attached
 Full BAF - within the reading room

Risk Number	Theme	Risk Description	Exec Lead	Responsible Committee	Current Risk Score			Change	Previous Risk Score	Initial Risk Score	Target Risk Score	Risk appetite	Level of Assurance	Change
					Likelihood	Consequence	Risk Score							
Sort	Sort	Sort	Sort	Sort	Sort	Sort	Sort	Sort	Sort	Sort	Sort	Sort	Sort	Sort
18	Activity	If we are unable to increase elective activity, remove long waits and reduce waiting list size in a timely and cost effective manner, then patient outcomes will suffer, patient care will be compromised and/or costs will increase	COO	QGC/F&P	4	5	20	→	20	25	8	Low	5	→
7	Finance	If we fail to address the drivers of the underlying deficit and fail to respond effectively to the new financial regime (post COVID-19), then we will not achieve financial sustainability (as measured through achievement of the structural level of deficit [to be fully determined]) resulting in the potential inability to transform the way in which services operate, and putting the Trust at risk of being placed into financial special measures.	Chief Finance Officer	F&P	5	4	20	→	20	15	12	Low	3	→
19	System working	If we do not have effective system wide working to enhance patient flow and to ensure patients are managed in the most appropriate environment, then we will not be able to manage the level of urgent care activity and patient experience for patients who are clinically ready for discharge, but have not been, will suffer	COO	QGC/F&P	5	4	20	→	20	16	8	Low	3	↓
8	Infrastructure	If we are not able to secure financing then we will not be able, to address critical infrastructure risks as well as maintain and modernise our estate, infrastructure, and facilities; equipment and digital technology resulting in a risk of business continuity and delivery of safe, effective and efficient care.	Chief Finance Officer	F&P	4	4	20	↑	16	15	12	Moderate	3	→
22	Industrial Action	There is a risk that services will be disrupted by staff shortages due to possible industrial action by the NHS trade unions resulting in delays to patient care and poor patient experience.	COO/Dir. of People & Culture	P&C	5	4	20		NEW	20	12	Low	4	
13	Cyber	If we do not have assurance on the technology estate lifecycle maintenance and asset management then we could be open to a cybersecurity attack or technology failure resulting in possible loss of service.	Chief Digital Officer	F&P	4	4	16	→	16	20	10	Low	3	→
16	Digital	If we do not make best use of technology and information to support the delivery of patient care and supporting services, then the Trust will not be able to deliver the best possible patient care in the most efficient and effective way	Chief Digital Officer	F&P	4	4	16	→	16	20	15	Low	5	→
20	Urgent care	If we do not ensure that all actions are in place to enable discharge at the point of being ready for clinical discharge then we will adversely impact patient experience and inhibit flow	COO	QGC/F&P	4	4	16	→	16	16	8	Low	3	↓
3	Clinical Services	If we do not implement the Clinical Services Strategy then we will not be able to realise the benefits of the proposed service changes in full, causing reputational damage and impacting on patient experience and patient outcomes.	CMO/Dir of S&P	QGC	4	4	16	→	16	15	5	Low	4	→
17	Engagement with staff	If we fail to effectively involve our staff and learn lessons from the management of change and redesign / transformation of services, then it will adversely affect the success of the implementation of our Clinical Services Strategy resulting in missed opportunity to fully capitalise on the benefits of change and adversely impact staff engagement, morale and performance	COO/Dir P&C	QGC/P&C	4	4	16	→	16	12	8	Low	5	→
11	Reputation	If we have a poor reputation this will result in loss of public confidence in the Trust, lack of support of key stakeholders and system partners and a negative impact on patient care.	Director of C&E	QGC	4	4	16	→	16	12	8	Moderate	4	→
9	Workforce	If we do not have a right sized, sustainable and flexible workforce, we will not be able to provide safe and effective services resulting in poor patient and staff experience and premium staffing costs.	Director of People & Culture	P&C/Trust Board	3	5	15	→	15	15	9	Moderate	4	→
2	Engagement with patients, public and partners	If we fail to effectively engage and involve our patients, the public and other key stakeholders in the redesign and transformation of services then it will adversely affect implementation of our Clinical Services Strategy in full resulting in a detrimental impact on patient experience and a loss of public and regulatory confidence in the Trust.	Director of C&E/CNO	QGC	3	4	12	→	12	12	3	Moderate	4	→
4	Quality	If we do not have in place robust systems and processes to ensure improvement of quality and safety and to meet the national patient safety strategy, then we may fail to deliver high quality safe care resulting in negative impact on patient experience and outcomes.	CMO/CMO	QGC	3	4	12	→	12	20	8	Low	4	→
21	ICS	If the Trust fails to capitalise on the benefits of integrated care at Place, System or intra System level then this will result in missed opportunities to improve quality of care, patient experience, efficiency or financial sustainability	Director of Strategy	Trust Board	3	4	12	→	12	16	8	Low	3	→
15	Leadership	If we do not have a comprehensive leadership model and plan in place then we may not have the right leadership capability and capacity to deliver our strategic objectives and priorities	Director of People & Culture	Trust Board	3	4	12	→	12	12	8	Moderate	4	→
10	Culture	If we fail to sustain the positive change in organisational culture, then we may fail to have the best people which will impede the delivery of safe, effective high quality compassionate treatment and care.	Director of People & Culture	People and Culture/Trust Board	2	5	10	→	10	15	6	Moderate	6	→
14	Health and Wellbeing	If we do not have the capacity and capacity to implement, or staff do not access, health and wellbeing support then we may be unable to maintain safe staffing levels due to higher rates of absence and staff turnover	Director of People & Culture	P&C	2	5	10	→	10	15	10	Moderate	6	→

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Integrated Performance Report – Month 7 2022/23

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

Alignment to the Trust's strategic objectives (x)

Best services for local people	X	Best experience of care and outcomes for our patients	X	Best use of resources	X	Best people	X
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Report previously reviewed by

Committee/Group	Date	Outcome
TME	16 th November 2022	Approved
Finance and Performance Group	23 rd November 2022	Assured
Quality Governance Committee	24 th November 2022	Assured

Recommendations

Trust Board are asked to:

- To note that the assurance level for performance remains unchanged at a level 4.
- To note the addition of site level patient flow diagrams (admission and discharge) and long stay patient benchmarking (slide 6 to 9 and slide 13)
- Note this report for assurance.

Key Issues

Operational Performance

Elective Recovery

Elective Activity			Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	YTD Total
Outpatients	News	Plan	12,488	16,562	18,621	17,547	16,572	18,322	17,713	17,484	15,642	17,837	16,156	17,424	117,826
	(Target 104%)	Actual	13,158	16,084	15,467	15,014	15,629	16,610	17,052						109,014
	Follow-ups	Plan	29,456	24,904	27,523	27,755	25,715	27,713	26,651	25,847	22,988	27,257	24,001	26,156	189,717
Inpatients	(Target 75%)	Actual	30,172	34,009	32,784	31,841	33,248	34,333	32,732						229,119
	Day Case	Plan	5,824	7,293	8,287	8,251	7,650	7,930	7,803	7,902	6,930	7,786	7,248	7,435	53,038
	(Target 104%)	Actual	5,826	6,652	6,282	6,435	7,127	7,077	6,944						46,343
Diagnostics	Elective Spells	Plan	455	584	697	707	646	744	663	824	744	766	808	853	4,496
	(Target 104%)	Actual	450	526	525	449	501	500	528						3,479
	Imaging	Plan	12,565	13,208	12,444	12,711	13,554	14,646	15,215	15,357	14,739	16,584	14,904	16,254	94,343
	(Target 120%)	Actual	11,723	13,515	13,155	13,608	13,540	14,108	14,400						94,049
	Endoscopy	Plan	1,392	1,613	1,596	1,769	1,495	2,390	2,310	1,934	1,338	1,847	1,760	1,966	12,565
	(Target 120%)	Actual	1,022	1,285	1,158	1,278	1,374	1,543	1,583						9,243
	Echocardiography	Plan	806	842	916	684	1,025	982	1,025	1,259	1,001	1,693	1,216	1,151	6,280
	(Target 120%)	Actual	1,001	1,150	1,008	1,072	1,150	1,227	1,360						7,968

Table 1

For Oct-22 we are below the OP New activity target; however, we delivered more appointments in this month than any so far in 22/23; this is in part due to a focus on mitigating activities such as reduction of DNAs

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and cancellations. OP follow-ups continue to be over our plan despite having reduced the number delivered when compared to (year to date) 21/22.

Both day case activity and inpatient (ordinary) are below plan, although we did deliver the most inpatient (ordinary) in Oct-22 for 22/23 to date. Having a dedicated resource focussed on productivity and efficiency improvements in theatres is starting to deliver, with theatre utilisation increasing towards the target of 85%.

Our DM01 Diagnostics waiting list at the end of Oct-22 was 9,603. The number of patients waiting 6+ weeks decreased to 2,218., specifically due to the volume of activity being completed by radiology. For the second time we completed over 18,000 DM01 reportable diagnostic tests during the month. CT and Echocardiography exceeded their annual plan targets and we remain within 2% of achieving our plan.

Elective Performance

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

Table 2.1

		30/10/22	06/11/22	13/11/22	20/11/22	27/11/22	04/12/22	11/12/22	18/12/22	25/12/22	01/01/23	08/01/23	15/01/23	22/01/23	29/01/23	05/02/23	12/02/23	19/02/23	26/02/23	05/03/23	12/03/23	19/03/23	26/03/23	02/04/23
63+ day waiters	Recovery Trajectory	810	819	836	856	868	844	814	770	752	740	695	669	637	606	561	526	493	467	436	393	370	350	328
	Actuals	797	763	730																				

Table 2.2 – Urgent Suspected Referral backlog only

Consultant-led referral to treatment time

The validated number of patients waiting over 104 weeks for Oct-22 is zero. The overall incomplete RTT waiting list continues to increase at a rate of 500 per month. The level of clocks starting continues to be higher than clock stops, there are several lines of enquiry regarding what the root causes are so that mitigations can be put in place and stem the increasing waiting list.

Urgent Care

All performance metrics remain special cause for concern. The 'push/pull' model (North Bristol Model) is in place. The impact during October has been inconsistent, and significant effort has been put in place to ensure staff understand why we need to implement this model and how staff can use the guidance provided to support their decision making.

Following a busy October capacity for the push/pull model in Wards has been maximised.

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Cancer

The number of 2WW referrals in Oct-22 remained above the mean. Overall 2WW performance continues to be a significant concern even though we saw over 3,000 patients in a month for the first time ever. A dedicated resource has commenced and will focus on effective Cancer pathways and updating the rapid improvement plans. Skin and breast remain our most pressured specialties; additional capacity has been sourced for Skin and Breast has predicted a return to the cancer waiting times standard by January. Gynaecology and colorectal achieved the 93% cancer standard.

Following a review of the 2WW process and improvements starting to be realised, the next focus will be on potential delays in accessing diagnostics and identifying mitigations that will support faster diagnosis for patients.

At the end of Oct-22, we recorded 878 patients who have been waiting over 63 days for diagnosis and / or treatment and 326 of those patients have been waiting over 104 days. (November - early sight of the data shows a reduction on the long waiters).

Elective Benchmarking

Elective Benchmarking		Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
2WW Cancer Patients Seen	Trust	2,255	2,261	2,525	2,066	2,653	2,294	2,298	2,335	2,977			
	Peer Average*	1,749	1,906	2,256	2,075	2,184	2,030	2,087	2,323	2,205			
	WAHT Rank**	5	5	5	6	5	6	6	6	4			
2WW Cancer Breast Symptomatic	Trust	116	141	149	66	97	87	70	89	80			
	Peer Average*	88	92	101	79	80	77	72	70	73			
	WAHT Rank**	5	3	3	8	4	4	6	4	6			
28 Day FDS Patients Told Outcome	Trust	2,286	2,110	2,403	1,882	2,376	2,121	2,251	2,169	2,582			
	Peer Average*	1,774	1,832	2,096	1,943	2,038	1,888	1,983	2,151	2,111			
	WAHT Rank**	5	6	6	5	6	6	6	6	4			
62 Day Patients Treated	Trust	151	154	196	152	165	177	182	154	168			
	Peer Average*	111	112	129	118	127	119	113	122	130			
	WAHT Rank**	5	4	3	5	4	4	3	5	5			
Diagnostics Waiting List	Trust	10,719	10,229	10,031	9,609	10,496	10,312	9,683	10,077	9,000			
	Peer Average*	13,760	14,410	15,152	14,933	15,832	16,464	16,400	16,217	16,593			
	WAHT Rank**	6	6	6	6	6	6	6	6	6			
Diagnostics Activity	Trust	17,068	16,048	17,956	15,094	17,572	16,963	17,596	17,696	18,468			
	Peer Average*	14,820	14,557	16,147	14,623	16,024	15,389	16,463	16,772	16,472			
	WAHT Rank**	5	5	5	6	6	6	6	6	5			
RTT 104+ weeks	Trust	489	466	327	253	161	40	31	12	0			
	Peer Average*	314	266	323	243	121	45	28	40	38			
	WAHT Rank**	11	10	6	6 of 9	8 of 9	4 of 6	4 of 6	6 of 8	N/A			
RTT 52+ weeks	Trust	6,025	5,884	5,844	6,481	7,205	7,816	7,683	7,623	7,766			
	Peer Average*	4,359	4,132	4,341	4,467	4,526	4,747	4,992	5,000	5,061			
	WAHT Rank**	12	12	12	12	12	12	12	12	12			

Table 3

- Benchmarking shows that increases in activity from Aug-22 to Sep-22 were not always mirrored by the WM peer Trusts. WAHT's rank improved for 2WW patients seen, 28 Day FDS and Diagnostic tests whilst the peer average decreased for those measures.
- Our Diagnostics waiting list decreased but the peer average waiting list size increased.
- 5 trusts, not including WAHT, recorded having patients breaching 104+ weeks at the end of Sep-22
- The number of patients waiting over 52+ weeks increased for the Trust as did the average of our peers.

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Referrals, Bed Occupancy & Advice & Guidance

Referrals, Bed Occupancy & Advice & Guidance		Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	YTD Total	
Referrals	The total number of referrals made from GPs for first consultant-led outpatient appointments in specific acute treatment functions	Plan	6,011	5,581	5,509	5,842	5,369	6,144	5,893	5,727	6,984	6,264	5,824	4,952	40,349
		Actual	4414	5950	5488	6014	5691	4962	3974						36,493
	The total number of other (non-GP) referral made for first consultant-led outpatient appointments in specific acute treatment functions	Plan	3,183	3,067	2,851	3,203	3,163	3,568	3,275	3,450	3,449	3,095	3,343	2,795	22,310
		Actual	2833	3126	2999	2853	2942	2819	2977						20,549
Bed Occupancy	Average number of overnight G&A beds occupied	Plan	678	678	678	678	678	678	692	692	692	692	692	678	678
		Actual	682	682	682	731	731	731	720						708
	Average number of overnight G&A beds available	Plan	721	721	721	721	721	721	721	721	721	721	721	721	721
		Actual	721	721	721	754	754	754	754						743
A & G	Bed Occupancy - Percentage	Plan	94%	94%	94%	94%	94%	94%	96%	96%	96%	96%	96%	94%	94%
		Actual	95%	96%	95%	97%	97%	97%	95%						95%
	Advice & Guidance - Plan	Plan	2,383	2,314	2,591	2,531	2,512	2,468	2,436	2,542	2,503	2,500	2,493	2,509	12,331
	Advice & Guidance - Actual	Actual	2,306	2,756	2,562	2,617	2,786	2,758	2,730						15,785

Table 4

In Oct-22 we received c8,000 referrals of which 75% went through the referral assessment service and 11% (702) were returned to the referrer. Monitoring up to May-22 shows that approximately 72% of A&G requests do not result in a further request to the same specialty (within 90 days of the initial request).

Urgent and Emergency Care

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

Table 5

The reductions in patients waiting 12+ hours to admission in our emergency departments, long waits on ambulances and spending 12+ hours in department that were observed in Sep-22 have not been continued in Oct-22.

Quality and Safety

Fractured Neck of Femur (#NOF):

There were 87 #NOF admissions in Oct-22 and a total of 44 breaches (29 in Sep-22) with the average time to theatre being 46.2 hours. The whole pathway has been reviewed at a dedicated away day (held on November 18th), with some immediate actions regarding changes for discharge planning (i.e. criteria led discharge). Further more complex improvements were discussed which will take a time to development and come to fruition.

Infection Prevention and Control

We continue to be above the year to date trajectories for CDif, E-coli and MSSA.

The MRSA trajectory target was achieved in Oct-22, and we remain on the year to date trajectory as we have had no attributable cases in 22/23. Infection control remains a key focus with heightened auditing of the cleaning within the hospital; we are also awaiting a report from the system regarding whether we are an outlier, as well as a report from NHSE/I in which we may have some recommendations to work on.

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People and Culture

We are in quartile 3 on model system for staff turnover with a monthly rate of 1.18% compared to the national average of 1.13%. Our turnover of Registered Nurses is very good at 10.2% compared to a national average of 13.6% (July 2022 rates) which means that we have remained in quartile 1 (best). Turnover of medics is high at quartile 3 (31.4% compared to national average of 30.1% (July 2022 rates). However, we have seen slight improvement in our overall turnover rate in the last 3 months and continue to recruit more starters than leavers.

We continue to be an outlier for the use of bank and agency staff (we have moved into the 4th quartile for Medics (worst) and Registered Nursing remain in the 3rd quartile which is a result of:

- Opening of the Acute Medical Unit and Pathway Discharge Unit
- Continued higher levels of sickness absence
- High patient acuity (specialing)
- Continued use of surge areas
- Rollout of the covid and flu vaccination programme which requires additional resource

We have remained in the 2nd quartile (good) in terms of Sickness on Model Hospital with our sickness rate being 5.8% against a National median of 6.2% and a peer median of 6.8%.

Our Financial Position

Month 7

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

In M7 the actual **deficit was £1.9m** against a plan of **£1.5m deficit**, an adverse variance of £0.4m. This brings the year to date M7 actual **deficit to £12.1m** against a plan of **£11.5m deficit**, an adverse variance of £0.6m (5.3%).

Statement of comprehensive income	Plan £'000	Oct-22 Actual £'000	Variance £'000	Plan £'000	Year to Date Actual £'000	Variance £'000
INCOME & EXPENDITURE						
Operating income from patient care activities	47,493	48,545	1,052	332,007	338,558	6,551
Other operating income	2,689	2,973	284	18,016	17,001	(1,015)
Employee expenses	(29,904)	(30,904)	(1,000)	(209,006)	(214,743)	(5,737)
Operating expenses excluding employee expenses	(19,916)	(20,743)	(827)	(139,688)	(140,429)	(741)
OPERATING SURPLUS / (DEFICIT)	362	(129)	(491)	1,329	387	(942)
FINANCE COSTS						
Finance income	0	69	69	0	337	337
Finance expense	(1,165)	(1,149)	16	(8,155)	(8,158)	(3)
PDC dividends payable/refundable	(681)	(681)	0	(4,769)	(4,769)	0
NET FINANCE COSTS	(1,846)	(1,761)	85	(12,924)	(12,590)	334
Other gains/(losses) including disposal of assets	0	0	0	0	251	251
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	(1,484)	(1,890)	(406)	(11,595)	(11,952)	(357)
Add back all I&E impairments/(reversals)	0	0	0	0	0	0
Surplus/(deficit) before impairments and transfers	(1,484)	(1,890)	(406)	(11,595)	(11,952)	(357)
Remove capital donations/grants I&E impact	10	10	0	72	71	(1)
Adjusted financial performance surplus/(deficit)	(1,474)	(1,880)	(406)	(11,523)	(11,881)	(358)
Less gains on disposal of assets	0	0	0	0	(251)	(251)
Adjusted financial performance surplus/(deficit) for the purposes of system achievement	(1,474)	(1,880)	(406)	(11,523)	(12,132)	(609)

The Combined Income (including PbR pass-through drugs & devices and Other Operating Income) was £1.3m (2.7%) above the Trust's Operational Plan in October and £5.5m above year to date (1.6%).

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	<p>The key favourable variances in October relates to the pay award adjustment £0.7m (additional central funding of 1.7% taking the uplift for the pay award from 2.1% to 3.8%), pass through Drugs & Devices £0.6m for ICBs and NHS England and an uplift to the Training & Education tariff £0.5m.</p> <p>The adverse variance of £0.4m (£1.2m year to date) relating to the AMU/PDU funding continues as there is still no resolution with Commissioners to fund this development in 2022/23.</p> <p>The Trust has reported the full value of the Elective Recovery Fund (ERF) income (YTD £9.7m) in the position on the continued assumption that these funds will be passed through. The Trust's actual performance is well below this level and we estimate that had the ERF not been fixed we would have lost c£7.3m (75%) of the available ERF income to date against target.</p> <p>Employee expenses in Month 7 were £1.0m (3.3%) adverse to plan and year to date £5.7m (2.7%) adverse to plan.</p> <p>The adverse variance in month of £1.0m is largely due to the additional cost of the pay award (£0.7m which was not in the plan but is income backed) and £0.5m of undelivered PEP. Favourable variances due to slippage on business cases and reserves held for investment of (£0.4m in month, £2.1m YTD) and ERF (£0.3m in month and £1m YTD) are partially offsetting the adverse position.</p> <p>Operating expenses in Month 7 were £0.8m (4.2%) adverse and £0.7m (0.5%) adverse year to date.</p> <p>The key drivers of the adverse variance in month are Depreciation (£0.5m adverse in month but £1.3m favourable YTD) as a result of a correction of Q1 and Drugs (£0.2m in month, £0.8m YTD) and Non PbR Drugs which are offset by income (£0.4m in month, £2.2m YTD) and linked to higher activity.</p> <p>Adverse variances due to both insufficient identification and slippage in planned PEP (£0.3m in month) continues to be offset by favourable variances due to slippage on business cases and a release of old year accruals no longer required.</p> <p>Full Year Forecast</p> <p>The Finance and Performance Committee was provided with a projection to year end which had been prepared with the support of Divisions and which reflected a potential risk of £5.2m to delivery of the plan. Potential mitigations have been identified which require further work ahead of any consideration to formally revise the forecast.</p> <p>Overall our October deficit of £1.9m is consistent with our forecast.</p> <p>Productivity and Efficiency</p> <p>Our Productivity and Efficiency Programme target for 22/23 is £15.7m (c.3%). In Month 7 we delivered £0.486m of actuals against the plan of £1.159m, a negative variance of £0.673m (58.1%).</p>
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The positive improvement in M6 is due to £1.2m of non-recurrent savings added as a result of a line by line review of all budgets. This has also contributed a further £1.4m of non-recurrent savings to M12 forecast (total saving £2.6m).

The cumulative position at M7 is therefore £4.230m of actuals against a plan of £6.741m, a negative variance of £2.511m (37.2%).

The 22/23 full year forecast at Month 7 is £10.966m which is £4.734m (30.2%) under plan.

Capital

The total capital plan submitted for 2022/23 as £62.1m. The revised forecasted expenditure at M7 is a total of £62.7m as reported externally.

Capital Position	External Plan			Internal Plan	
	22/23 Plan Submitted £'000	M7 Revised Forecasted External Expenditure £'000	Variance £'000	Revised Internal plan £'000	Variance £'000
Property & Works	3,961	3,961	-	3,961	-
Digital	11,648	9,815	(1,833)	9,815	-
Equipment	826	1,006	180	1,006	-
Strategic Developments	34,635	36,782	2,147	15,681	(21,101)
TIF2 Theatres bid (pending approval)	-	-	-	15,000	15,000
Lease Additions	10,785	10,785	-	10,785	-
IFRIC 12 PFI Lifecycle replacement	326	326	-	326	-
Total Capital Expenditure	62,181	62,675	494	56,574	(6,101)

The variance to the original plan of £494k is due to the removal of £1.9m for Levelling up Digital Maturity, the additional PDC of £180k for Digital Diagnostic Capability, plus the award of funding for CDC2.

There are then additional movements from the £62.7m revised external plan to a revised internal plan of £56.6m. This is due to the removal of £6.1m of funding as advised by NHSE as the ASR programme can no longer be a source of funds for the UEC development.

Capital Position	22/23 Plan £'000	Revised Internal plan £'000	Total YTD Valuation £'000	M8 - M12 Spend Forecast £'000	22/23 Full Year Forecast £'000	Unmitigated Variance Against Revised Plan £'000
Property & Works	3,961	3,961	314	1,316	1,629	2,332
Digital	11,648	9,815	2,250	8,337	10,587	(772)
Equipment	826	1,006	518	385	903	103
Strategic Developments	34,635	15,681	8,598	19,466	28,064	(12,383)
TIF2 Theatres bid (pending approval)	-	15,000	-	13,655	13,655	1,345
Lease Additions	10,785	10,785	-	10,785	10,785	-
IFRIC 12 PFI Lifecycle replacement	326	326	63	263	326	-
Total Capital Expenditure	62,181	56,574	11,743	54,206	65,949	(9,375)

Our Capital Position at month 7, being the value of works complete, is £11.7m. This is an increase of £3.6m since month 6.

The Trust Capital forecast against a revised internal plan of £56.7m is estimated to be a potential £9m overspend against our CRL without any mitigations. This overspend has improved since month 6 by circa £3m.

This is due to a revised UEC expenditure forecast reduced by c£2m in 2022/23 which has slipped into 2023/24 and other agreed slippage being identified by workstream leads.

Meeting	Public Trust Board
Date of meeting	8 December 2022
Paper number	Enc G

	<p>Each month, all workstream leads are providing more detailed monthly profiles of expenditure to enable decisions to be made on re-profiling and brokerage of spend into future years.</p> <p>It should be noted that any slippage into 2023/24 will be the first call on any internal capital available in 2023/24 financial year.</p> <p>There remain a number of risks around the strategic capital programmes particularly:</p> <ul style="list-style-type: none"> • Risks remain regarding the financing of the UEC scheme. Discussions are being held regarding brokerage solutions with ICB and Region to try and avoid using a significant proportion of the Trusts own internally generated funds thus delaying a significant proportion of spend on backlog maintenance and equipment replacement in particular. • The timing of the decisions to release funds in support of centrally funded schemes, in particular; ASR Business Case, Frontline Digitisation and the TIF2 Theatres project. The later these notifications are received the greater the risk the Trust carries in managing the spend in the year funds are allocated and could therefore lose the ability to spend altogether if funds were to be subsequently clawed back and not protected over year end. <p>There are ongoing discussions with both ICB and NHSE to support the Trust with capital funding for 22/23 linked to the forecast overspend due to the UEC project and the profiling of the centrally funded schemes over year end.</p> <p>Cash</p> <p>At the end of October 2022 the cash balance was £27.3m against an in month plan of £51.0m. The plan assumed external capital funding of £15.0m which has not been drawn down yet due to the slippage on capital schemes above. The remaining variance is due to higher wage costs and the phasing of creditor payments and income received compared to plan.</p> <p>The relatively high cash balance remains the result of the timing of receipts from the CCG's and NHSE under the continuing COVID era arrangements together with timing of creditor / supplier payments.</p> <p>Requests for PDC in support of revenue funding this year is reviewed based on the amount of cash received in advance under this arrangement, the Trust has not requested any revenue cash support YTD due to the high cash reserves being held.</p> <p>The full year cash flow forecast main assumptions are:</p> <ul style="list-style-type: none"> ▪ £41.9m PDC capital funding to be received in phased amounts this financial year, with nil drawn down to date. The phasing for capital cash drawn down is being reviewed due to possible delays for some strategic business cases. ▪ The plan for capital funding is £61m of which £41.9m is funded via the PDC capital funding, the balance required to support creditor payments is funded by other Trust Income.
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Meeting	Public Trust Board
Date of meeting	8 December 2022
Paper number	Enc G

	The capital and cash flow plan included £10.8m lease funding in 2022-23 to cover the planned lease additions for new lease additions as per IFRS16. To date the Trust has not entered any new leases and therefore the cash/capital implications may be minimal. There has been no guidance to date to confirm how these new leases will be funded in 2022/23. An update will be provided once confirmed.
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Aster

Risk										
Which key red risks does this report address?		What BAF risk does this report address?	2, 3, 4, 5, 7, 8, 9, 10, 11, 13, 14, 15, 16, 17, 18, 19, 20							
Assurance Level (x)	0	1	2	3	4	X	5	6	7	N/A
Financial Risk	N/A									
Action										
Is there an action plan in place to deliver the desired improvement outcomes?	Y		N				N/A		X	
Are the actions identified starting to or are delivering the desired outcomes?	Y		N							
If no has the action plan been revised/ enhanced	Y		N							
Timescales to achieve next level of assurance										
Recommendations										
Trust Board are asked to: <ul style="list-style-type: none"> To note that the assurance level for performance remains unchanged at a level 4. To note the addition of site level patient flow diagrams (admission and discharge) and long stay patient benchmarking (slide 6 to 9 and slide 13) Note this report for assurance. 										
Appendices										
<ul style="list-style-type: none"> Trust Board Integrated Performance Report (up to Oct-22 data) WAHT At A Glance – Oct-22 WAHT October 2022 in Numbers Infographic Committee Assurance Statements – November 2022 meetings 										

TRUST BOARD

8th December 2022

Data: Up to October 2022

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


















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

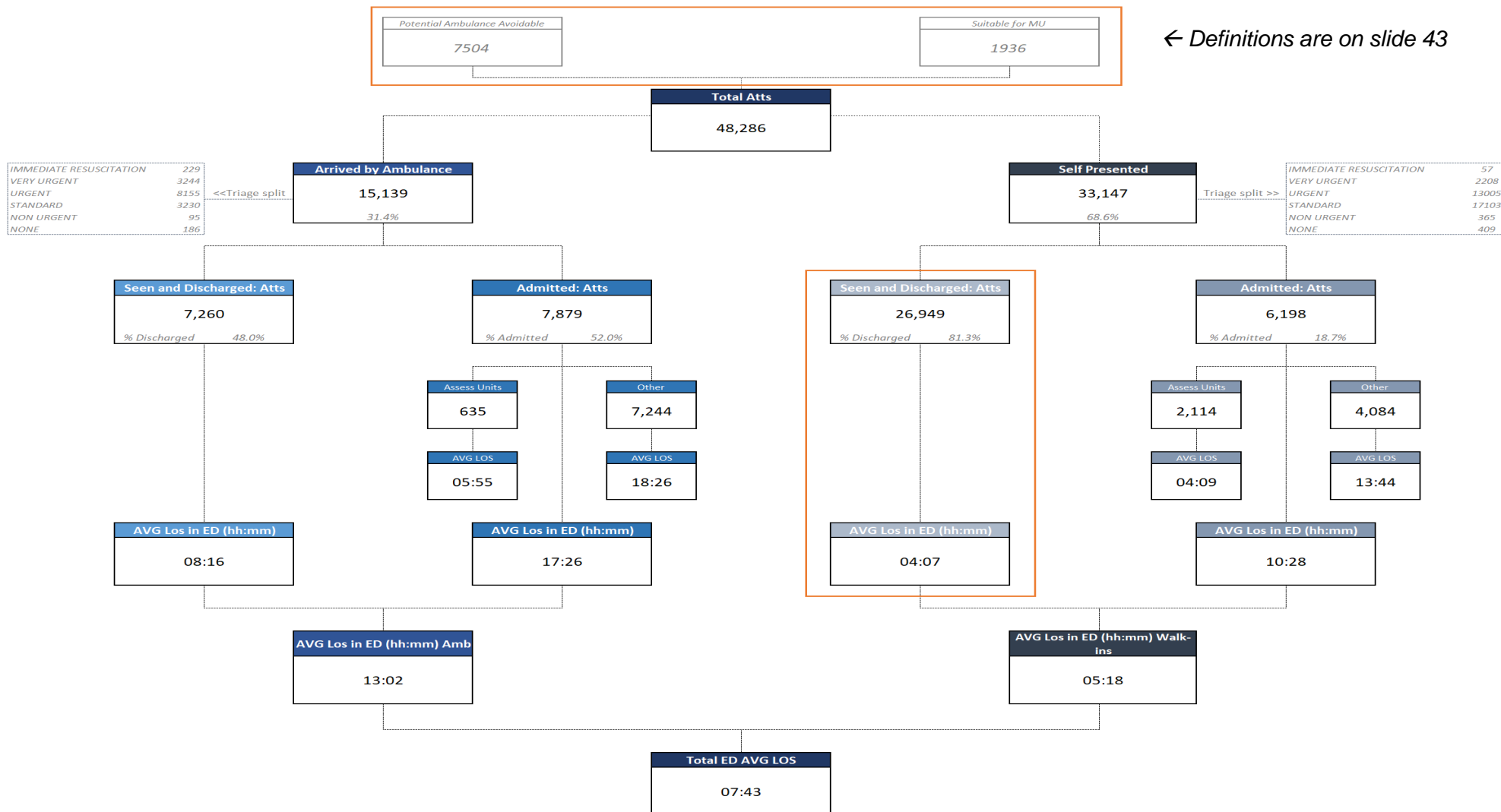
Topic		Page
Successes		2
Operational Performance	Headlines	4
	Patient Flow	5 – 13
	Elective Recovery	14 – 29
	Stroke	30 - 31
Quality & Safety	Headlines	33 – 34
	Infection Prevention and Control Antimicrobial Stewardship	35 – 40
	Fractured Neck of Femur	41 – 42
	Sepsis Six	43 – 44
	VTE Assessments	45 – 46
	Falls	47 – 48
	Pressure Ulcers	49 – 50
	Friends & Family	51 – 52
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Maternity	Headlines and SPCs	56 – 58
People & Culture	Headlines	60
	Getting The Basics Right	61
	Performance Against Plan	62 – 63
	Drivers of Bank and Agency Spend	64 – 65
	Health and Well-being	66
	Strategic Objectives	67
Finance	Key messages	69 - 72
Appendices	Statistical Process Charts (SPC) Guide NHS System Oversight Framework Levels of Assurance Avoidable Admissions Methodology Pathways	74 - 79

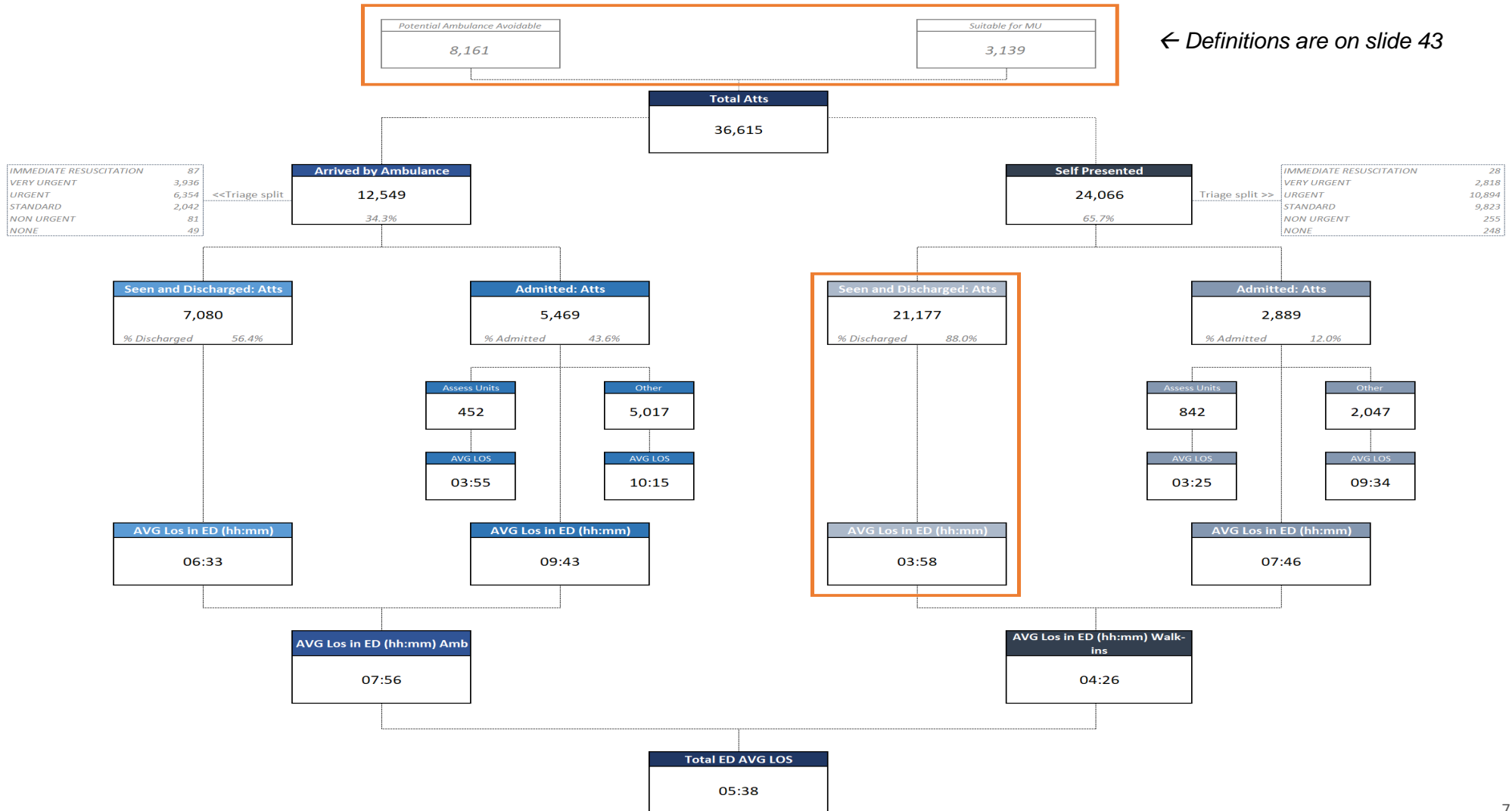
Area	Comments
Cancer	<ul style="list-style-type: none"> Delivering over 3,000 2WW appointments in a month for the first time ever Colorectal, our specialty that receives the most referrals, has achieved the 2WW operational standard for the last 3 months and is at 99% in Oct-22 We are ahead of our weekly trajectory to reduce the 62+ day backlog (submitted to NHS England on 27th October) We are 1 of only 4 West Midlands Trusts who have completed the required submission for best practice cancer pathway data.
Outpatient DNAs	<ul style="list-style-type: none"> Model Hospital - our overall performance for outpatient DNA rates remains in quartile 1 of all Trusts (now up to Sep-22) and is applicable to both first and follow-up appointments
Elective Admissions	<ul style="list-style-type: none"> Model Hospital - the proportion of elective admissions that were day cases was 93% (Aug-22) - this is in quartile 1 of all Trusts Model Hospital - The average length of stay for elective admissions (days – 6 month rolling average) was 2.8 (to Aug-22) – this is in quartile 2 of all Trusts Model Hospital – the proportion of bed days that are due to elective patients staying beyond > 6 days was 31.5% (Aug-22) – this is in quartile 1 of all Trusts Model Hospital - the proportion of all day case admissions that are later converted to inpatient admissions for all BADS procedures was 9.0% (three months to Jul-22) – this is in quartile 2 of all Trusts
RTT Long Waits	<ul style="list-style-type: none"> Submitting zero 104+ breaches at month end for the second consecutive month

Operational Performance

Operational Performance	Comments
Patient Flow	<ul style="list-style-type: none"> The vast majority of headline metrics remain of statistical concern. Slides 6 through 9 show the patient flow into, and out of, WRH and ALX for Apr-22 to Oct-22. Of note are 1) the proportions of attendances which might have been avoided 2) that self-presenting patients who aren't admitted have an average LOS of ~4 hours, and 3) the average length of stay for complex discharges. Slide 13 provides benchmarking on Long Stay patients at Midlands and Trust level. Medically fit and patients who do not have a reason to reside continue to contribute to our bed pressures and impact successful flow from ED to admission and discharge.
Elective Recovery	Cancer (validated) <ul style="list-style-type: none"> Long Waits: The backlog of patients waiting over 62 days is 325 of those waiting 104+ days, with urology and skin contributing the most patients to this cohort of our longest waiters (67%). Although only two weeks into monitoring, we are ahead of the weekly trajectory that was submitted to NHSE. Cancer referrals continue to be significantly high compared to pre-covid referral rates. The cancer waiting time standard for 2WW has not been achieved and only two specialties achieved the 93% standard. The 28 Day Faster Diagnosis standard has not been achieved and remains at risk with referred patients not being seen by a specialist within 14 days. The 62 day standard has not been achieved and the delays are also impacting the 31 day standard of treatment from decision to treat which continues to show special cause concern and below the 96% standard.
	RTT (validated) <ul style="list-style-type: none"> Long Waits: Our 7,957 patients waiting over a year for treatment can be broken down as follows; between 52 and 78 weeks (6,842) and between 78 and 104 weeks (1,115). There were no patients waiting over 104 weeks at the end of Oct-22. The 0-18 weeks cohort has increased following the in-month clock start reduction that occurred in Sep-22. However, the majority of patients have been waiting over 18 weeks. We remain on-track in reducing the number of patients who would be 78+ weeks breaches by the end of Mar-23.
	Outpatients (unvalidated) <ul style="list-style-type: none"> Long Waits: There are almost 34,000 RTT patients waiting for their first appointment and 25% of the total cohort waiting for a first appointment have been dated. Based on our first SUS submission for Oct-22, we have not achieved our submitted plan targets. However, we did deliver fewer follow-up appointments than Oct-19 in-line with annual planning guidance. The validation programme has started and responses from the first cohort of patients have started to arrive and be processed – so far 194 patients have indicated that they wish to be removed from the waiting list.
	Inpatients (unvalidated) <ul style="list-style-type: none"> Based on our second SUS submission, we have not achieved our 22/23 annual plan targets for total elective spells in the month with both elective inpatient and day case falling short.
	Diagnostics (validated) <ul style="list-style-type: none"> Long Waits: 1,843 patients are waiting over 6 weeks for their diagnostic test with 25% waiting for a non-obstetric ultrasound and 24% for a colonoscopy. Total DM01 activity in Oct-22 was 18,995 tests – the highest on record. CT, flexi sigmoidoscopy and echocardiography achieved their annual plan activity targets. MRI, colonoscopy, gastroscopy and echocardiography exceeded our Oct-19 levels of testing. We have delivered sufficient activity to be at 1.7% of the YTD submitted activity plan (to achieve 120% of 19/20).

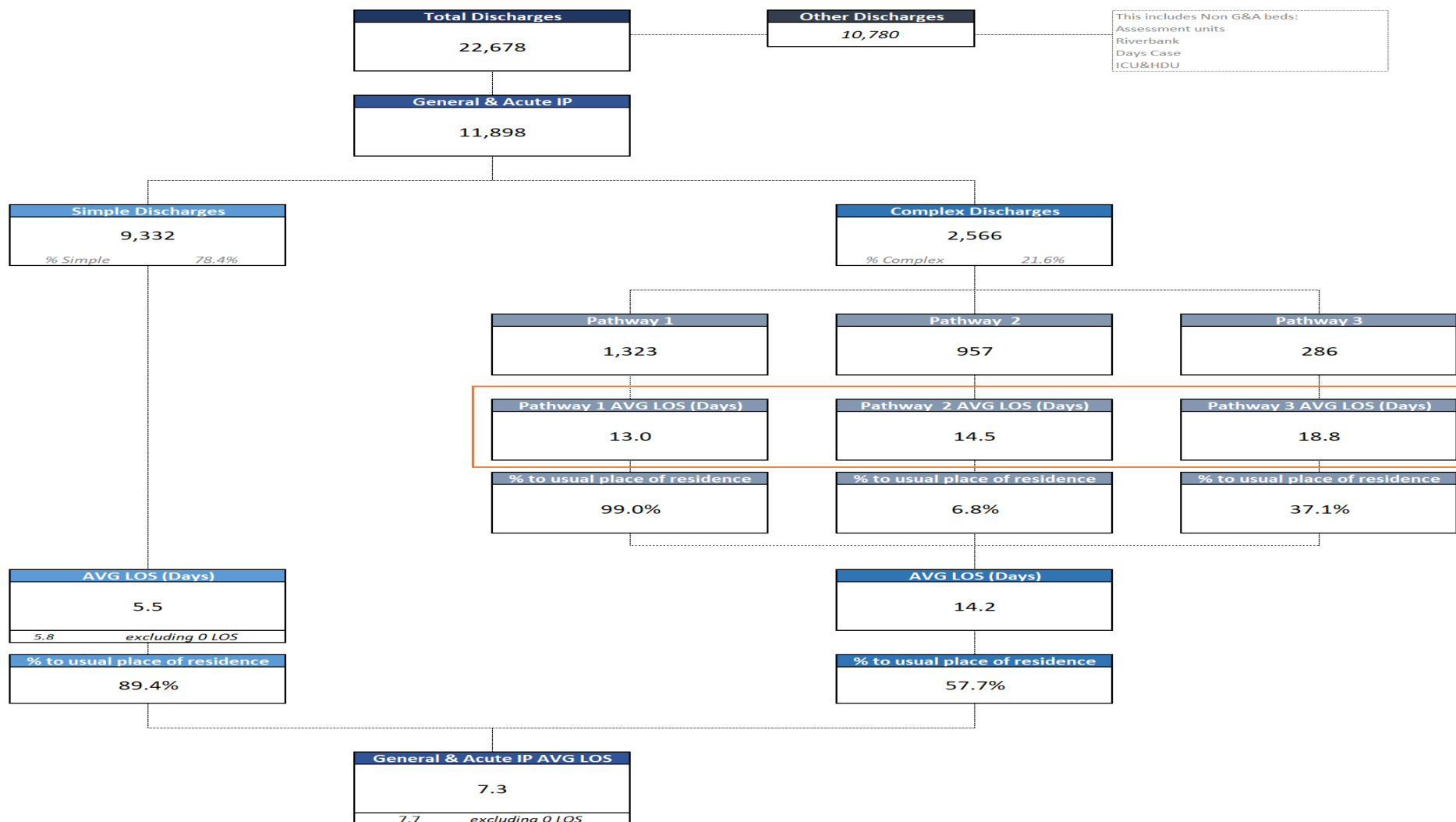
Percentage of Ambulance handover within 15 minutes	60 minute Ambulance Handover Delays	Time to Initial Assessment - % within 15 minutes	Time In Department				12 Hour Trolley Breaches	4 Hour EAS (Type 1)
			Average (mean) time in Dept. for Non Admitted Patients	Average (mean) time in Dept. for Admitted Patients	% Patients spending more than 12 hours in A&E	Number of Patient spending more than 12 hours in A&E 		
								
Aggregated Patient Delay (APD)	Total time spent in A&E (95th Percentile)	Patients discharged to usual place of residence 	NEL Average LOS in Hospital at Discharge (excl. same day discharge)	EL Average LOS in Hospital at Discharge (excl. same day discharge)	% Discharges before midday			
								
What does the data tell us? <ul style="list-style-type: none">Slides 10 and 11 highlight that the patient flow metrics in this report show special cause concern. Any changes, although observable in the charts, are not statistically significant. However, any gains in Sept-22 that <i>might</i> have been attributable to the implementation of the North Bristol model have been reversed in Oct-22. Additional metrics <ul style="list-style-type: none">Slides 6 to 9 show the YTD (Apr-22 to Oct-22) patient flow into and out of our WRH and ALX hospitals.The A&E flow diagrams (slides 6 and 8) show our total attendances, split by ambulance and self-presentation arrival, the high level pathways that were followed and how long on average some of milestone points of a patient’s time in A&E were. The potential ambulance avoidable and suitable for MIU attendances are based on an internal methodology. This would indicate that 20% (WRH) and 31% (ALX) of attendances could have been avoided / seen elsewhere.The discharge flow diagrams (slides 7 and 9) focus on our patients in G&A beds, showing the split between simple and complex discharges, how long on average the milestone events take and the proportions of patients being discharged to their usual place of residence.The conversion rate of attendances to admission was 32% at WRH (2,219 admissions) and 23% at ALX (1,211 admissions). The Midlands 6 week (30th Sep to 10th Nov) average is 28.9%.On the 31st October, there were 104 patients who had a LOS of 21+ days. 52 of those patients had been identified as medically fit for discharge.On average for Oct-22, 10% of patients were classified as not having a reason to reside.			What have we been doing? <ul style="list-style-type: none">Continued refinement of the North Bristol model, including the specialty matrons moving into the site management team.Recruitment progressing for ED Acute physicians.A root cause review of LLOS over 21 days was completed, with the recommendations that a winter patient flow matron is recruited and discharge progress chasers are being recruited. What are we doing next? <ul style="list-style-type: none">The system to consider an increase in the community bed capacity.The Onward Care Team to continue to collaborate with the Acute and the ensure that Patient Tracker is implemented quickly to aid tracking of pathway patients.The recommendations from the LLOS 21 days to be implemented.					
Current Assurance Level: 4 (Oct-22)			When expected to move to next level of assurance: This is dependent on the on-going management of the increased attendances and achieving operational standards.					
Previous assurance level: 4 (Sep-22)			SRO: Paul Brennan					





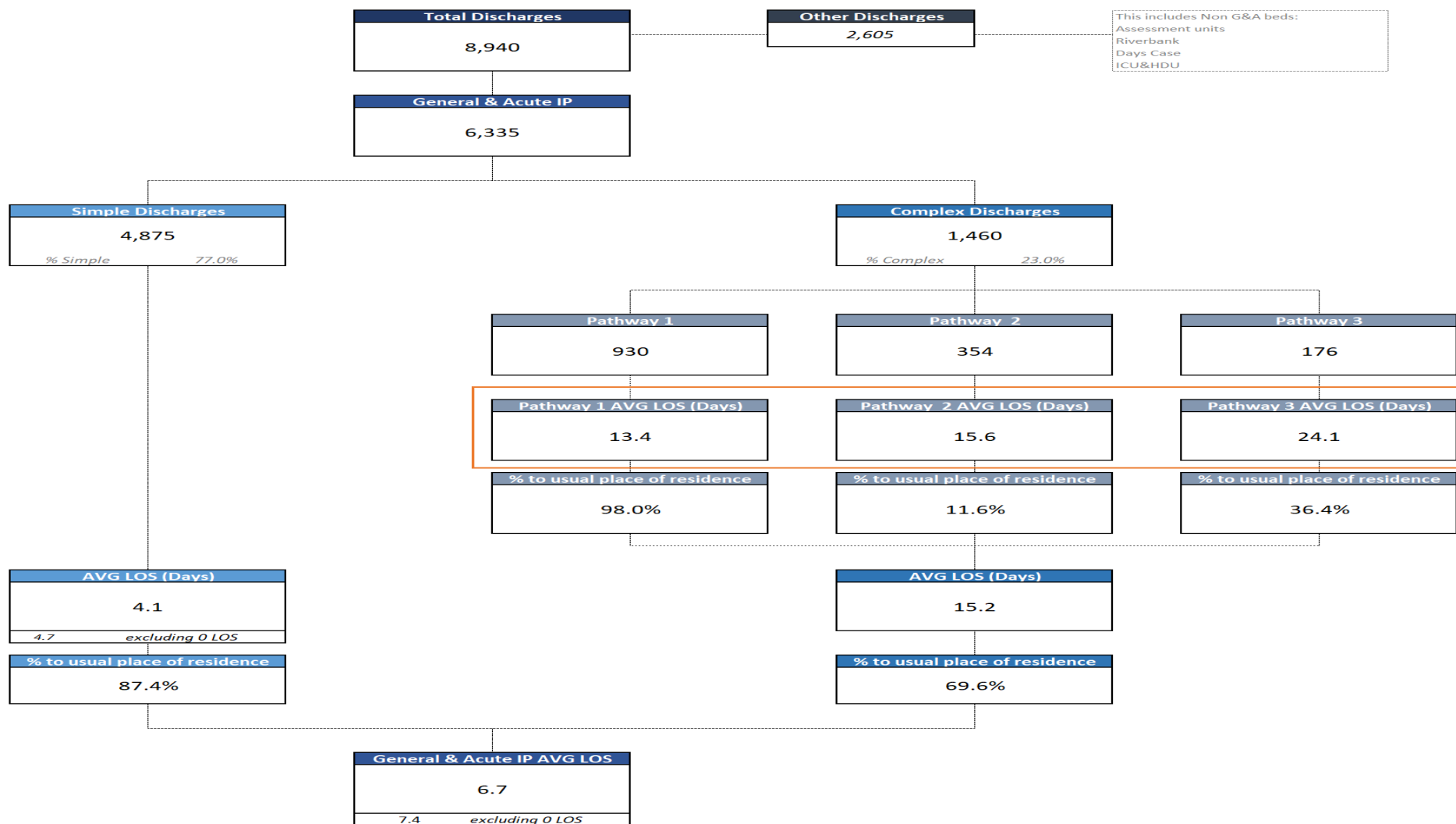
Discharges Flow Chart summary: Worcestershire Royal Hospital

Apr-22 to Oct-22



Discharges Flow Chart summary: Alexandra Hospital

Apr-22 to Oct-22

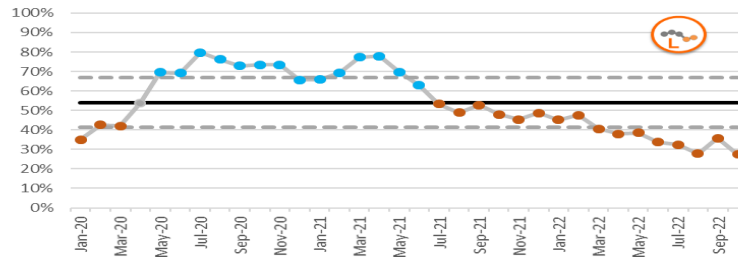


9

Percentage of Ambulance handover within 15 minutes

27%

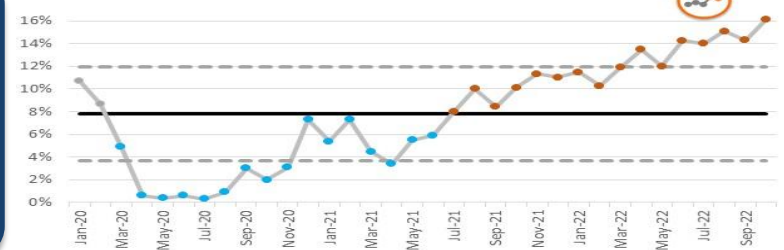
Ambulance handovers within 15 minutes



Patients spending more than 12 hours in ED

16%
1,923 patients

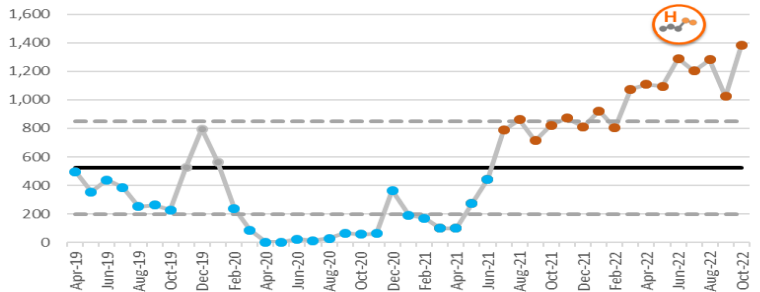
Patients spending 12+ hours in ED



60 minute Ambulance Handover Delays

1,380

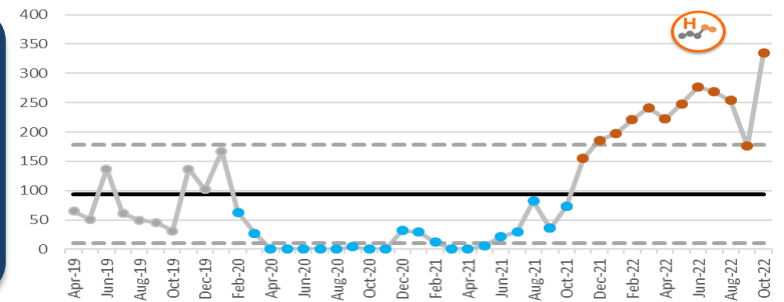
60 minute ambulance handover delays



12 Hour Trolley Breaches

335

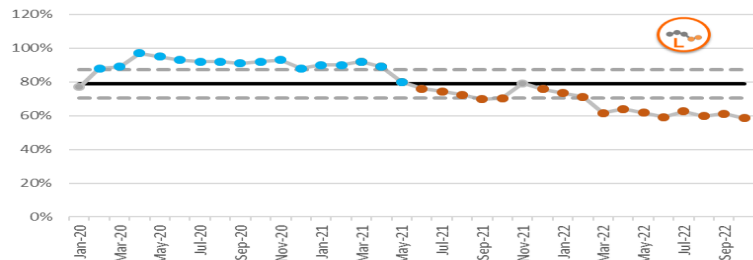
12 hour breaches



Time to Initial Assessment - % within 15 minutes

59%

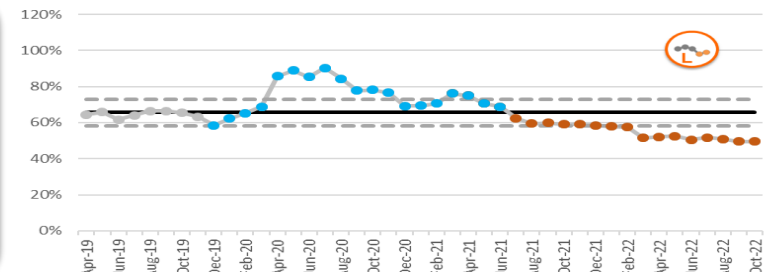
Time to initial assessment within 15 minutes



4 Hour EAS (Type 1)

49.6%
6,061 of 12,207

EAS Type 1 - 4 hour performance

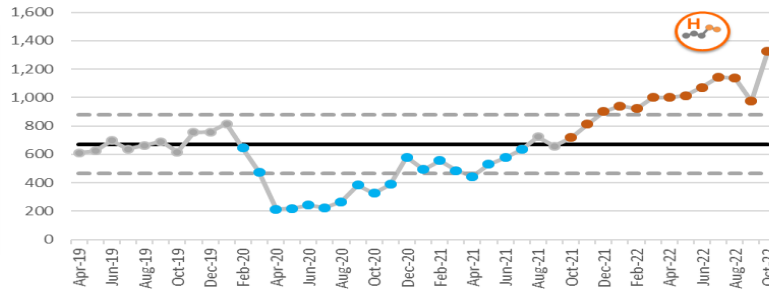


All graphs include Oct-22 data

Aggregated Patient Delay (APD)

1,324

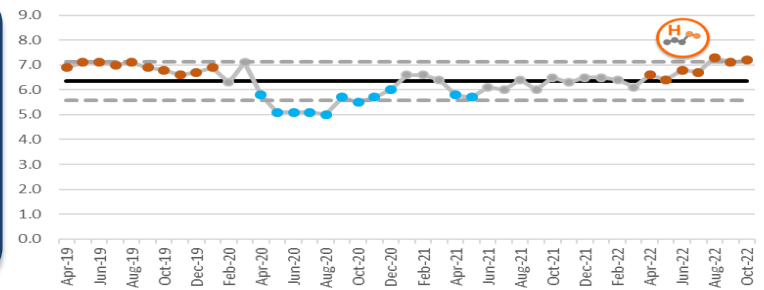
Aggregated Patient Delay (APD)



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

7.2 days

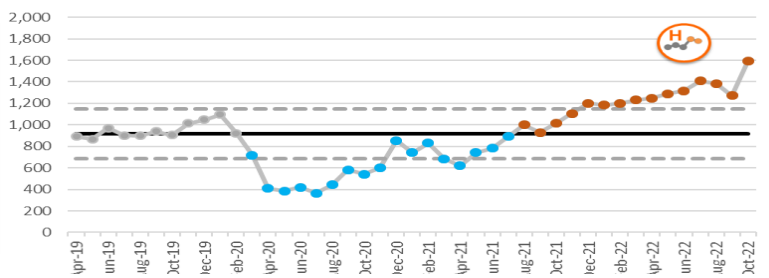
AVG LOS - NEL



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

1,591

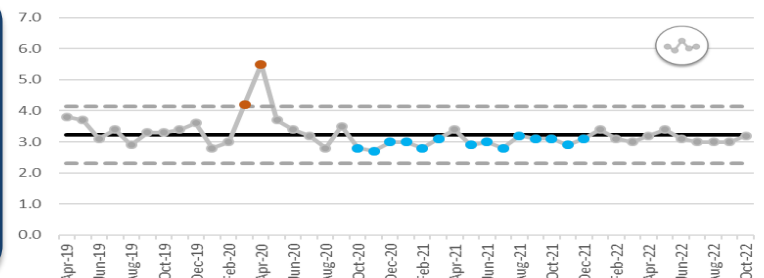
Total Time in A&E



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

3.2 days

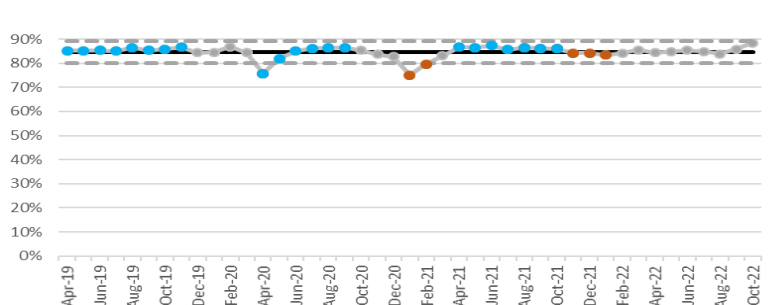
AVG LOS - EL



Patients discharged to usual place of residence

88%

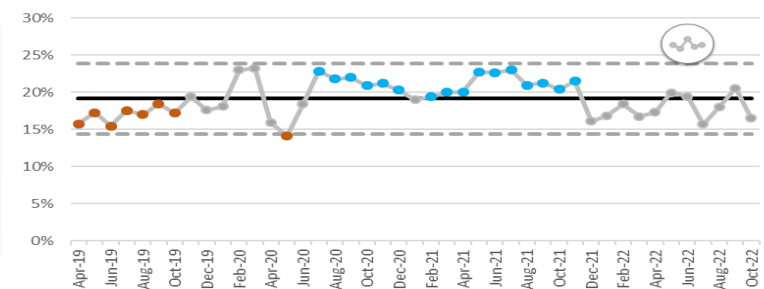
Usual Place of Residence



% Discharges before midday

17%

Discharges before midday



All graphs include Oct-22 data

National Benchmarking (October 2022)

EAS (All) – The Trust was one of 2 of 13 West Midlands Trusts which saw an increase in performance between Sep-22 and Oct-22. This Trust was ranked 6 out of 13; we were ranked 8 the previous month. The peer group performance ranged from 49.5% to 79.7% with a peer group average of 65.0%; declining from 66.2% the previous month. The England average for Oct-22 was 69.3%; a 1.7% decrease from 71.0% in Sep-22.

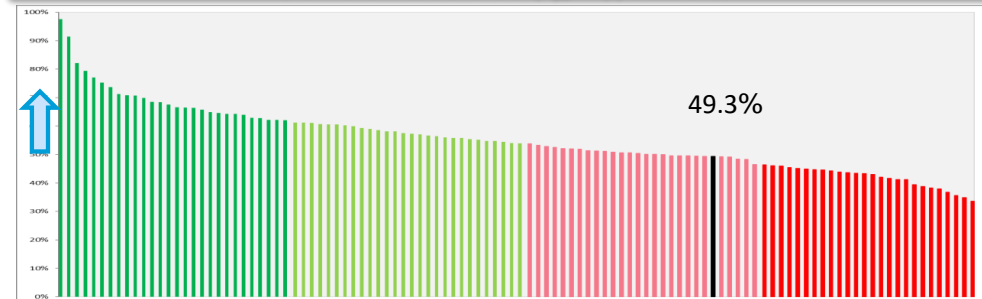
EAS (Type 1) – The Trust was one of 2 of 13 West Midlands Trusts which saw an increase in performance between Sep-22 and Oct-22. This Trust was ranked 10 out of 13; no change from the previous month. The peer group performance ranged from 37.95% to 71.30% with a peer group average of 53.12%; improving from 54.81% the previous month. The England average for Oct-22 was 54.8%; a 2.1% decrease from 56.9% in Sep-22.

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

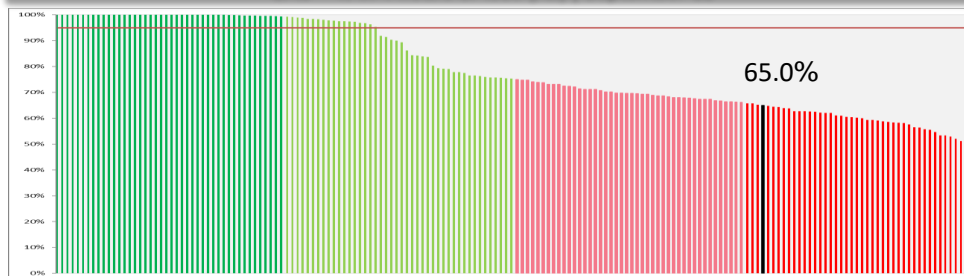
EAS – % in 4 hours or less (All) | October-22



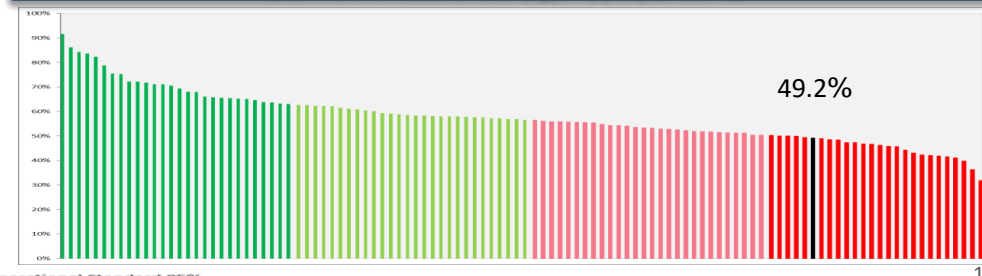
EAS – % in 4 hours or less (Type 1) | October-22



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

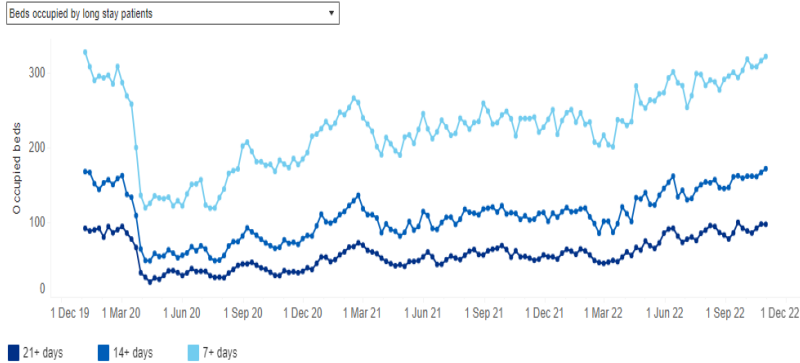


EAS – % in 4 hours or less (Type 1) | September-22

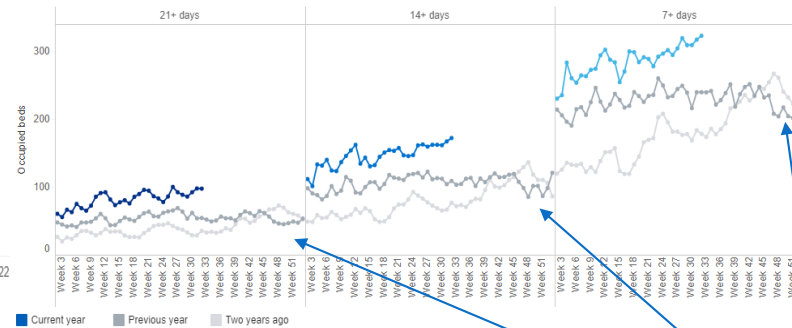


Bed Occupied by Long Stay Patients Benchmarking (to week commencing 31st October)

WAHT

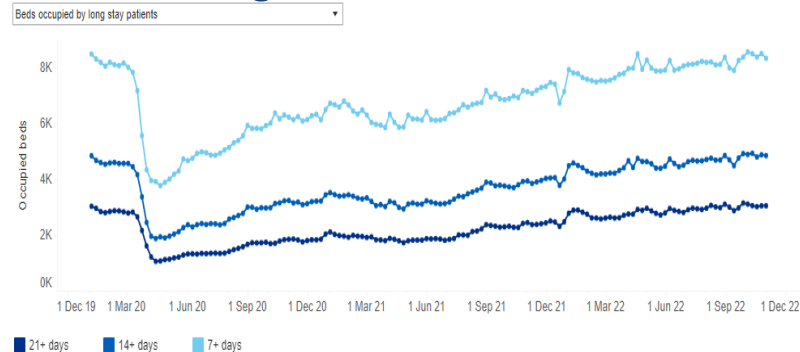


Beds occupied by long stay patients
Year on year comparison

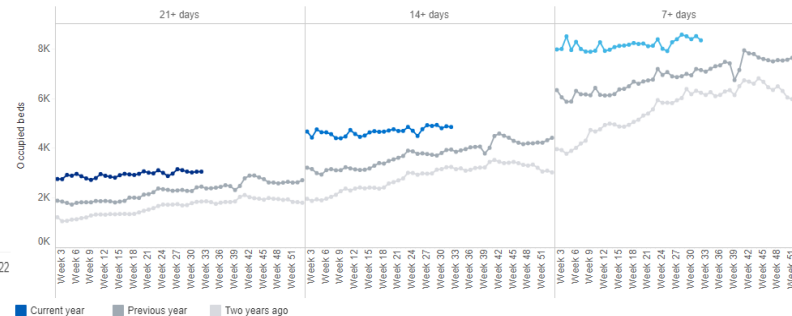


These graphs show, by week, and by year on year same week comparison, the increasing number of patients who have lengths of stays of 7+, 14+ and 21+ days (based on a weekly average).

Midlands Region



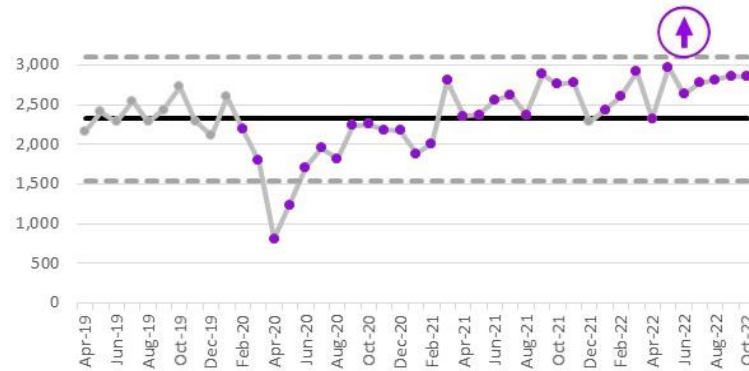
Beds occupied by long stay patients
Year on year comparison



With the exception of the long stay reductions we achieved last year, the increasing number of long stay patients we are experiencing at WHAT now is mirrored at the Midlands region level.

2WW Cancer Referrals	Patients seen within 14 days (All Cancers)	Patients seen within 14 days (Breast Symptoms)	Patients told cancer diagnosis outcome within 28 days (FDS)	Patients treated within 31 days	Patients treated within 62 days	Total Cancer PTL	Patients waiting 63 days or more	Of which, patients waiting 104 days
What does the data tells us? <ul style="list-style-type: none">2WW referrals are showing a statistically significant variation as there has been a continued upward trend and shift above the mean since Mar-21.2WW: This metric is deteriorating and the target will not be achieved without intervention.28 Faster Diagnosis: This metric is deteriorating and the target is unlikely be achieved without intervention.31 Day: This metric is deteriorating and the target is unlikely be achieved without intervention.62 Day: This metric is deteriorating and the target will not be achieved without intervention.Cancer PTL is showing a statistically significant variation as there has been a continued upward trend and shift above the mean. Although a reduction from September, as at the 31st October there were 3,938 patients on our PTL. 347 patients having been diagnosed and 3,586 are classified as suspected.Backlog: This metric is deteriorating and the target lies below the current process limits so the target will not be achieved without change. The number of patients waiting 63+ days is 878 and the number of patients waiting 104+ days has increased to 326. Urology (139) and skin (107) have the largest number of patients waiting over 104 days. 111 of the 326 patients waiting over 104 days are diagnosed and the remaining 212 are suspected.Reducing our backlog to the annual plan target of 160 by the end of Mar-23 will require intervention.				What have we been doing? <ul style="list-style-type: none">Breast are now reporting a return to performance for 2ww in the New Year due to further instances where capacity has been adverse to demand, with the other performance metrics to follow in the months afterwards.Skin are now booking at approximately 3 weeks with two Independent Sector companies contracted to provide the capacity shortfall, with Pertemps here until mid December 2022 and 18 Week Support contracted to the end of March 2023. In addition a small amount of mutual aid has been secured from Wye Valley Trust for GP practices in the Malvern area. This allows for the recovery of the 2ww standards and in turn others in the months that follow, with further plans required from April 2023 onwards.Supported and attended the NSHE IST 2 day review visit on 2nd and 3rd November 2022.New start of Urology Prostate pathway commenced trial period on 10th November 2022 and so far results have been very encouraging.				
				What are we doing next? <ul style="list-style-type: none">With support from NHS EC-IST, produce detailed capacity and demand analysis across key elements of all suspected cancer pathways.Next focus for Prostate pathway is biopsy booking and capacity.Recruitment to 2WW Booking Team in recognition of the ‘new normal’ levels of demand, particularly in relation to 2ww Colorectal.Setting up a new fortnightly Cancer PTL meeting which focuses on diagnostic demand vs capacity, pathway bottlenecks / delays etc.Continued refinement of and holding action owners to account for the Remedial Action Plans (RAPs).				
Current Assurance Levels (Oct-22)		Previous Assurance Levels (Sep-22)		When expected to move to next levels of assurance: when we are consistently meeting the operational standards of cancer waiting times and the backlog of patients waiting for diagnosis / treatment starts to decrease.				
2WW – Level 4		2WW - Level 4						
31 Day Treatment - Level 5		31 Day Treatment - Level 5						
62 Day Referral to Treatment – Level 3 (F&P 28-9-22)		62 Day Referral to Treatment - Level 4		SRO: Paul Brennan				

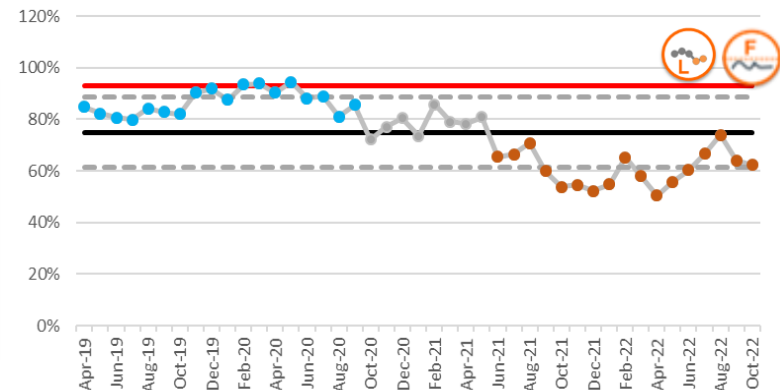
2WW Cancer Referrals



2WW Referrals

2,850

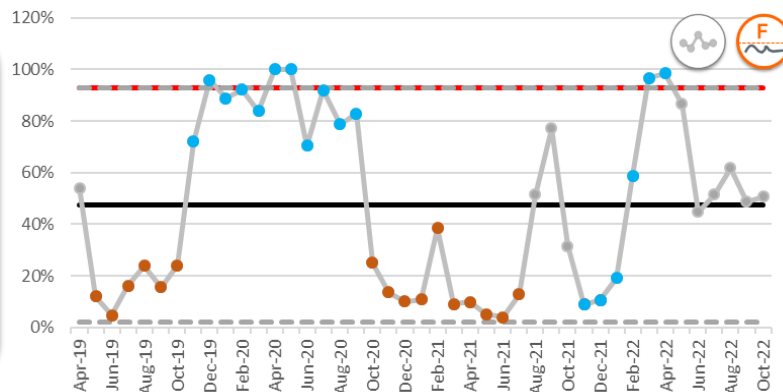
2WW Cancer (All)



2WW Cancer

63%
3,007
patients seen

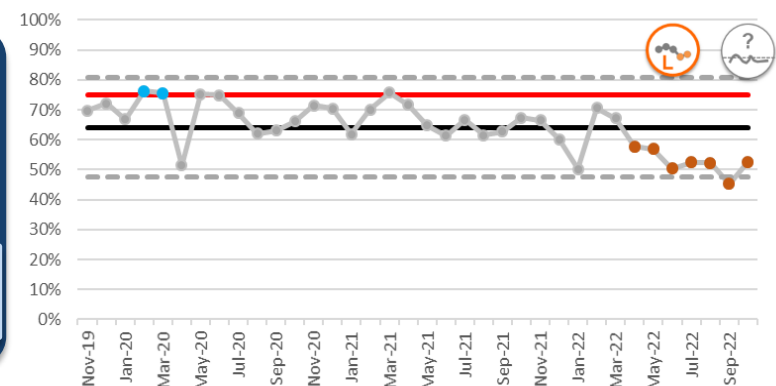
2WW Cancer Breast Symptomatic



2WW Breast Symptomatic

51%
82 patients
seen

28 Day Faster Diagnosis



28 Day Faster Diagnosis

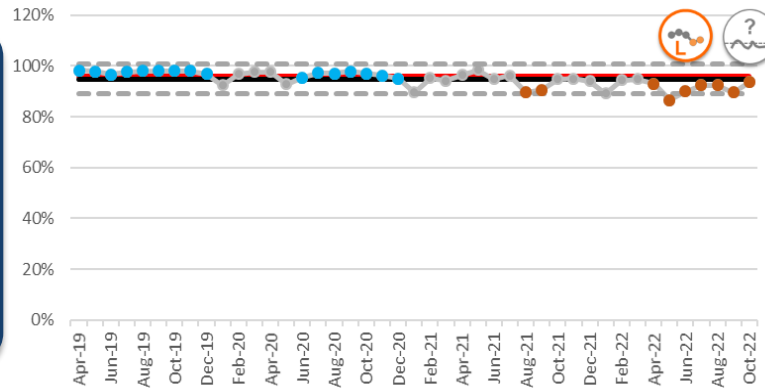
54%
2,870
patients told



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

All graphs include Oct-22 data

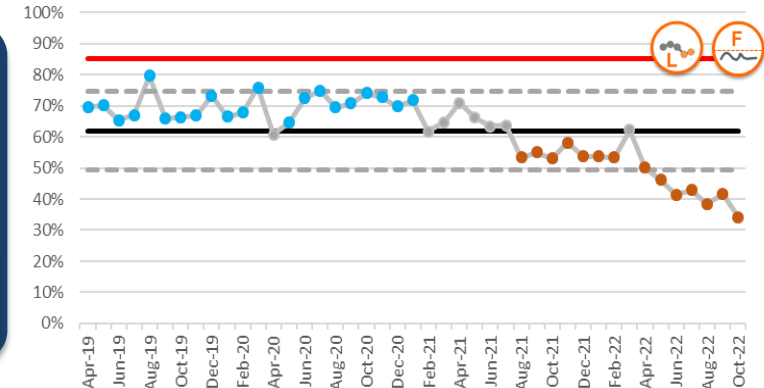
31 Day Cancer (All)



31 Day
Cancer

94%
285 patients
treated

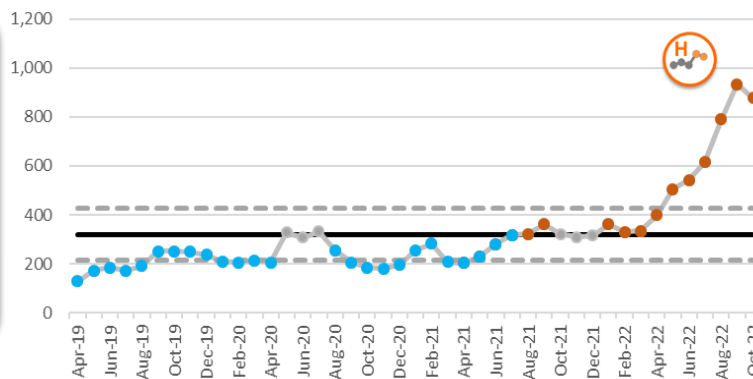
62 Day Cancer (All)



62 Day
Cancer

33%
200 patients
treated

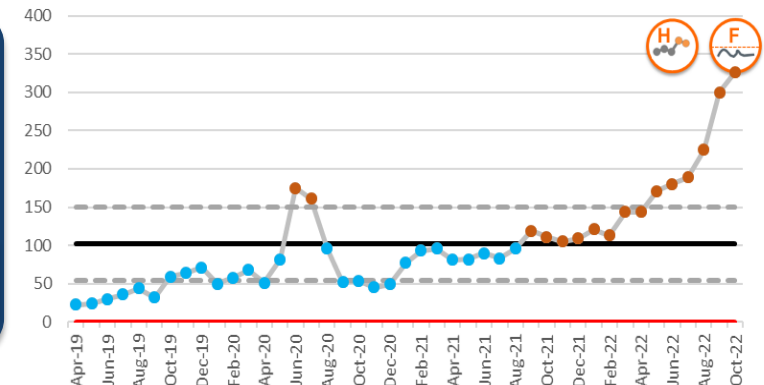
62+ Day Backlog



Backlog
Patients
waiting 63
days or
more*

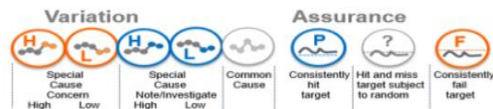
878

104+ Day Backlog



Backlog
Patients
waiting 104
day or more*

326

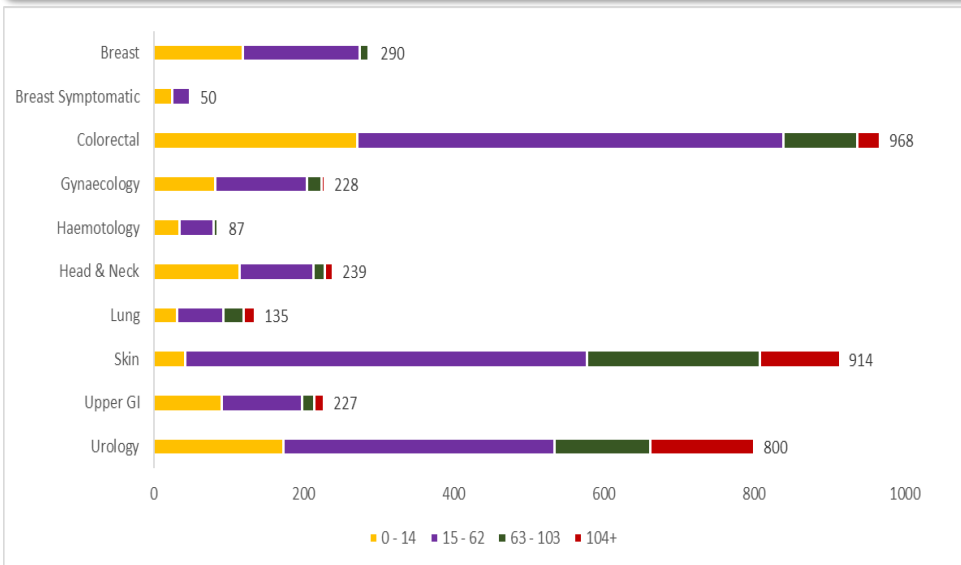


Key

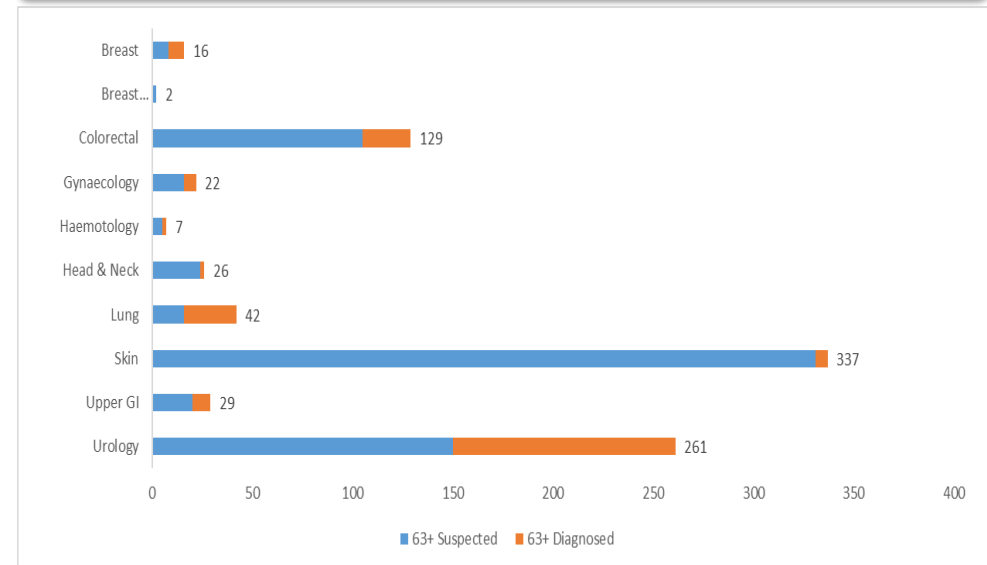
- Internal target
- Operational standard

All graphs include Oct-22 data

Cancer PTL by Specialty and Days Wait



Cancer Long Waiter Backlog by Specialty and Status



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

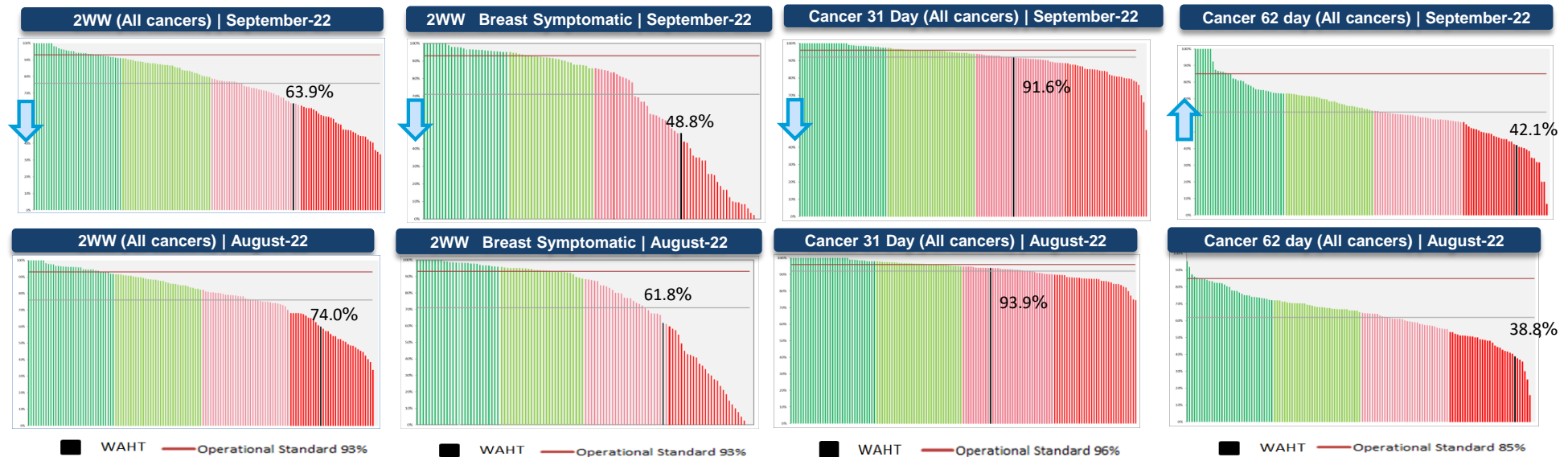
National Benchmarking (September 2022)

2WW: The Trust was one of 10 of 13 West Midlands Trusts which saw a decrease in performance between Aug-22 and Sep-22. This Trust was ranked 10 out of 13; we were ranked 10 the previous month. The peer group performance ranged from 46.1% to 95.2% with a peer group average of 69.8%; declining from 75.5% the previous month. The England average for Sep-22 was 72.6%; a 3.0% decrease from 75.6% in Aug-22.

2WW BS: The Trust was one of 8 of 13 West Midlands Trusts which saw a decrease in performance between Aug-22 and Sep-22. This Trust was ranked 10 out of 13; we were ranked 10 the previous month. The peer group performance ranged from 9.4% to 100.0% with a peer group average of 74.8%; declining from 83.3% the previous month. The England average for Sep-22 was 67.7%; a 3.2% decrease from 70.9% in Aug-22.

31 days: The Trust was one of 8 of 13 West Midlands Trusts which saw a decrease in performance between Aug-22 and Sep-22. This Trust was ranked 4 out of 13; we were ranked 4 the previous month. The peer group performance ranged from 70.1% to 100.0% with a peer group average of 86.9%; declining from 87.9% the previous month. The England average for Sep-22 was 91.1%; a 1.0% decrease from 92.1% in Aug-22.

62 Days: The Trust was one of 5 of 13 West Midlands Trusts which saw an increase in performance between Aug-22 and Sep-22. This Trust was ranked 11 out of 13; no change from the previous month. The peer group performance ranged from 38.4% to 67.6% with a peer group average of 49.2%; declining from 50.9% the previous month. The England average for Sep-22 was 60.5%; a 1.4% decrease from 61.9% in Aug-22.



Elective Recovery – Referral to Treatment

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

Electronic Referral Service (ERS) Referrals		Referrals to Referral Assessment Service (RAS)	Advice & Guidance (A&G) *unvalidated / ERS only		Total RTT Waiting List	Patients on a consultant led pathway waiting less than 18 weeks for their first definitive treatment		Number of patients waiting 52+ weeks	Of whom, waiting 78+ weeks	Of whom, waiting 104+ weeks
Total	8,344	7,751	1,376	84% responses within 2 working days						
Non-2WW	5,319									

What does the data tells us?

Referrals (unvalidated)

- **Non-2WW ERS Referrals** are showing special cause variation indicating a sustained increase.
- **Referral Assessment Service:** a total of 7,751 referrals to RAS were made in Oct-22. Only 71% of the 2WW RAS referrals have been outcomed within 2 working days – normally we achieve over 90%.
- **A&G Requests** are within normal variation and above the performance threshold.

Referral To Treatment Time (unvalidated)

- The RTT Incomplete waiting list is unvalidated at 66,647. This is not a significant change from previous months, however, it remains the case that the 0-18 cohort is below 30,000 due to a reduction in processed clock starts and patients moving into the 18+ weeks category.
- The consequence of this is that RTT performance for Oct-22 is unvalidated at 44.8% compared to 45.5% in Sep-22 and the operational standard target of 92% will not be achieved without change.
- The number of patients waiting over 52 weeks for their first definitive treatment is 8,091, a 319 patient increase from the previous month. Of that cohort, 1,153 patients have been waiting over 78 weeks, increased from 979 the previous month, and there are 0 patients over 104 weeks.

What have we been doing?

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

What are we doing next?

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

Current Assurance Level: 3 (Oct-22)

When expected to move to next level of assurance: When the RTT incomplete waiting list growth starts to reverse, as system plans start to impact on the reduction of referrals and internal plans start to increase the clock stop to start ratio.

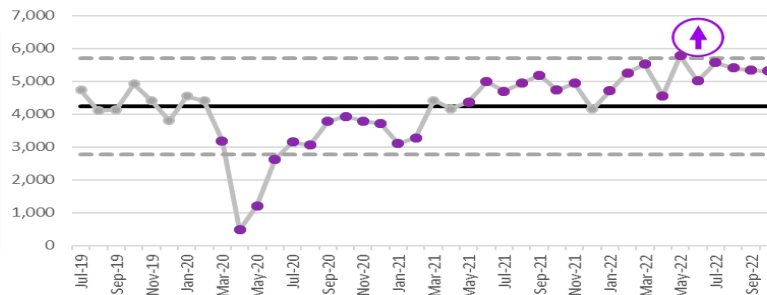
Previous Assurance Level: 3 (Sep-22)

SRO: Paul Brennan

Electronic Referrals Profile (non-2WW)

5,319

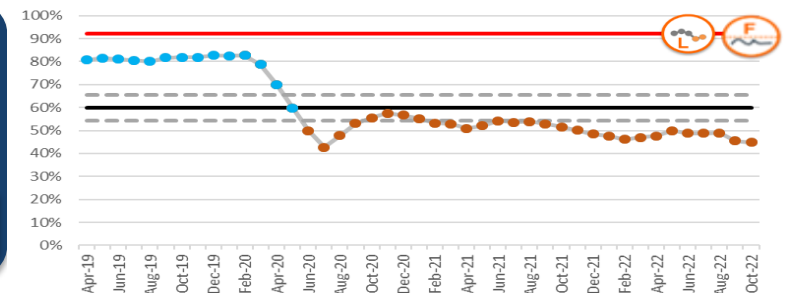
Non-2WW Electronic Referrals



RTT % within 18 weeks

45.4%

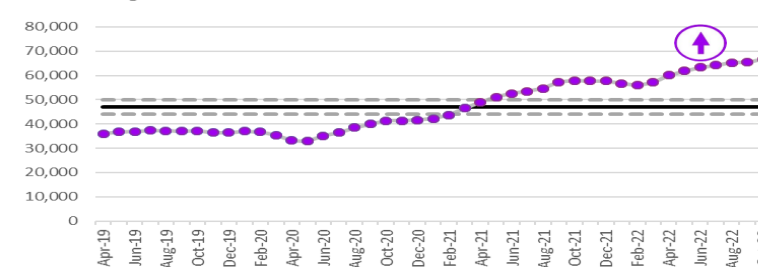
RTT - % Incomplete



RTT Incomplete PTL

66,703

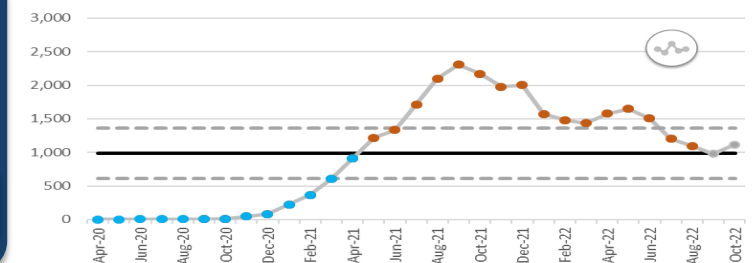
RTT Waiting List



78+ week waits

1,115

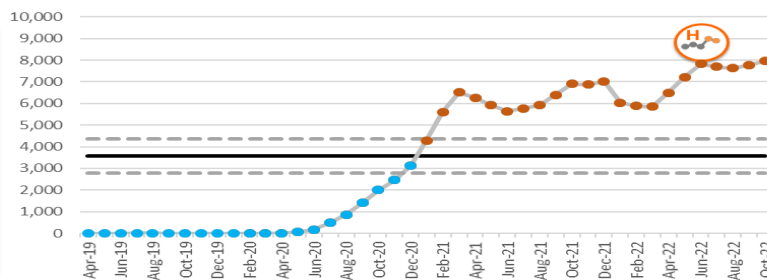
78+ Week Waits



52+ week waits

7,957

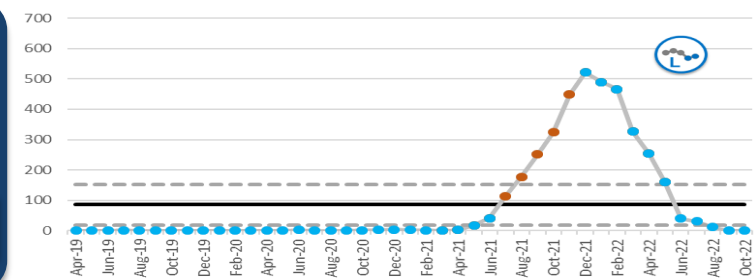
52+ Week Waits



104+ week waits

0

104+ Week Waits



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

All graphs include Oct-22 data

Patients
Waiting
80,000

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

Split by weeks waiting

