NHS
Worcestershire Acute Hospitals
NHS Trust

A G E N D A

TRUST BOARD

Thursday 13th April 2023

10:00 – 12:00

Alexandra Hospital Board Room, Woodrow Drive, Redditch, B98 7UB and streamed on YouTube

As we understand, industrial action will be taking place on this day, therefore papers will be taken as read and the meeting will be a truncated as possible. Executives may need to step out during the course of the meeting.

Anita Day
Chair

Item		Assurance	Action	Enc	Time
001/23	**Welcome and apologies for absence:**				**10:00**
002/23	**Items of Any Other Business** To declare any business to be taken under this agenda item				
003/23	**Declarations of Interest** To declare any interest members may have in connection with the agenda and any further interest(s) acquired since the previous meeting.				
004/23	**Minutes of the previous meeting** *To approve the Minutes of the meeting held on 9th March 2023*		*For approval*	**Enc A** **Page 5**	**10:05**
005/23	**Action Log**		*For noting*	**Enc B** **Page 13**	**10:10**
006/23	**Chair's Report**		*For noting*	**Verbal**	**10:15**
007/23	**Chief Executive's Report**		*For noting*	**Enc C** **Page 14**	**10:20**
	Best Services for Local People *BAF 2, 11, 13, 14, 16, 17, 18, 21*				
008/23	**Provider Collaborative** Director of Strategy & Planning	Level 4	*For noting*	**Enc D** **Page 17**	**10:30**
009/23	**CQC Inspection Report** Chief Nursing Officer	Level 4	*For assurance*	**Enc E** **Page 43**	**10:40**
	Best Experience of Care and Outcomes for our Patients				

		BAF 3, 4, 11, 19, 20			
010/23	**Integrated Performance Report** Executive Directors	Level 4	*For assurance*	**Enc F** **Page 47**	**10:50**
011/23	**Committee Assurance Reports** Committee Chairs		*For assurance*	**Page 137**	**11.05**
	Best Use of Resources *BAF 7, 8, 11*				
012/23	**Going Concern** Chief Finance Officer	Level 7	*For approval*	**Enc G** **Page 149**	**11:10**
	Best People *BAF 9, 10, 11, 15, 17*				
013/23	**Staff Survey 2022** Director of People & Culture	Level 4	*For discussion*	**Enc H** **Page 156**	**11:15**
014/23	**Safest Staffing Report** Chief Nursing Officer **a) Adult/Nursing** **b) Midwifery**	 Level 6 Level 6	*For assurance*	**Enc I** **Page 193** **Page 201**	**11:30**
	Governance				
015/23	**Provider Licence Conditions FT4 and G6 review** Director of Corporate Governance	Level 5	*For approval*	**Enc J** **Page 209**	**11.40**
016/23	**Audit & Assurance Report** *Committee Chair*	Level 5	*For assurance*	**Enc K** **Page 218**	**11.45**
017/23	**Trust Management Executive Report** *Chief Executive*		*For assurance*	**Enc L** **Page 228**	**11.50**
018/23	**Remuneration Committee Terms of Reference** *Committee Chair*	Level 6	*For approval*	**Enc M** **Page 232**	**11.55**
019/23	**Any Other Business** *as previously notified*				**12:00**
	Close				

Reading Room:

- Value for Money Assurance
- Staff survey appendices
- CQC Report

Seven Levels of Assurance

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

Board Assurance Framework

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

	BAF 10 – Culture BAF 11 – Reputation BAF 15 – Leadership BAF 17 – Staff engagement

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

MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON THURSDAY 9 MARCH 2023 AT 10:00 AM VIA MS TEAMS AND STREAMED ON YOUTUBE

Present:		
Chair:	Anita Day	Chair
Board members: (voting)	Paul Brennan	Chief Operating Officer
	Matthew Hopkins	Chief Executive
	Simon Murphy	Non-Executive Director
	Neil Cook	Chief Finance Officer
	Christine Blanshard	Chief Medical Officer
	Colin Horwath	Non-Executive Director
	Jackie Edwards	Interim Chief Nursing Officer
	Tony Bramley	Non-Executive Director
Board members: (non-voting)	Richard Haynes	Director of Communications and Engagement
	Jo Newton	Director of Strategy and Planning
	Rebecca O'Connor	Director of Corporate Governance
	Tina Ricketts	Director of People and Culture
	Sue Sinclair	Associate Non-Executive Director
	Vikki Lewis	Chief Digital Information Officer
	Michelle Lynch	NExT Director
In attendance	Jo Wells	Deputy Company Secretary
	Justine Jeffery	Director of Midwifery
	Mark Chivers	Patient's son (Patient story)
	Anna Sterckx	Patient Engagement (Patient story)
Public		Via YouTube
Apologies	Richard Oosterom	Associate Non-Executive Director
	Dame Julie Moore	Non-Executive Director
	Karen Martin	Non-Executive Director
	Jo Ringshall	Healthwatch

173/22 **WELCOME**

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

Ms Day referred to the strategic pyramid and despite the challenges, it was important not to forget the signature behaviours and giving our patients the care they need and deserve. Colleagues were urged to reflect on the patient story, think about the signature behaviours and what actions we can take after the event to minimise the elements of care that could have been better.

174/22 **PATIENT STORY**

Ms Edwards introduced Mr Chivers who was presenting a story regarding his father's care.

The Trust was under a lot of pressure during the time when Mr Chivers' 80 year old father was admitted to the Alex via ambulance following a fall on 30th December 2022. Mr Chivers' father spent 14 hours on a trolley in a corridor in A&E. There were ambulances queuing

outside and A&E was under pressure but the department was run with very good grace and calmness. Eventually a bed was available and the patient was housed in a cubicle and settled well for the night.

Mr Chivers' father had been moved to AMU during the night and the Health Care Assistant built a rapport with their patients and was managing the 6 bed ward brilliantly. His father was content and feeling well cared for. It transpired that his father required a pacemaker. Whilst awaiting the procedure, Mr Chivers left his father to go to fetch a hearing aid charger but upon his return, his father had been moved to cardiology. His father felt confused due to a miscommunication. Once Mr Chivers' father was moved to Worcester, the charger was left at the Alex.

The pacemaker procedure went well and his father was due to be discharged on 5th January but unfortunately whilst waiting for transport, he had a further fall and sustained a minor injury to his head. He was discharged on 7th January. Mr Chivers described how his father had suffered with mental and physical deterioration whilst in hospital and it has taken him some since to build up some strength.

Mr Murphy observed that the learning from the story was communication and deconditioning and welcomed comments on how to address them.

Mr Hopkins apologised for the lack of care and communication during Mr Chivers' father's stay. The risk of patient decline was well known. There had been an increase in length of stay at both sites which increased the risk of functional decline. An independent review of treatment plans was underway to obtain a better understanding of the factors behind length of stay. Multiple ward moves also increased length of stay.

Ms Edwards thanked Mr Chivers for sharing the story. There was still more to do to improve functional decline. A holistic approach was favoured but wards are not the most healing environment with light, noise and proximity to the facilities. It was recognised that functional decline also had had a wider impact on carers and loved ones who look after patients outside of the hospital. Involving the Carers Association was encouraged to address the issue across the pathway pre and post hospital care.

Mr Chivers reiterated that overall, it was a positive story. The fall whilst awaiting discharge increased the length of stay and deterioration. The Trust was dealing with staff shortages with good grace and managing to their best ability. The Trust should be proud of the services and the care provided.

Ms Day asked whether it was the move from AMU to the cardiology ward that his father found disorientating. Mr Chivers replied that it was and his father was confused as he did not expect to be moved so quickly and was concerned Mr Chivers may not be able to locate him upon his return.

Mr Murphy asked Mr Chivers how his father was recovering. Mr Chivers advised that his father was now in his own flat with live in nursing following a couple of months in a care home to build strength. He is generally deteriorating and in decline but physically he is stronger than when he came out of hospital.

Ms Day thanked Mr Chivers for sharing the story and was pleased to hear so many aspects of care were good. The highlighted issues were well known but it was helpful to hear how they impacted upon the patient.

175/22 **ANY OTHER BUSINESS**
There was no other business.

176/22 **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.

177/22 **MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON 12 FEBRUARY 2023**
The minutes were approved

Ms Edwards advised that there was a minor amendment to item 168/22 to read 'a rise of vacancies **at** 8%'.

RESOLVED THAT: The Minutes of the public meeting held on 12 February 2023 were confirmed as a correct record with the above amendment.

178/22 **ACTION SCHEDULE**
There were no actions due for this meeting.

Mr Murphy congratulated Ms Ricketts and team with the work relating to the behavioural charter and the new strap line was welcomed.

179/22 **CHAIR'S REPORT**
Ms Day advised that Board that she had taken a Chair's action to approve the managed print service contract extension.

RESOLVED THAT: The Chair's Action was approved.

180/22 **CHIEF EXECUTIVE'S REPORT**
Mr Hopkins presented his report and the following key points were highlighted:

- Planning for next financial year is continuing at pace.
- There was a bottom up plan to deliver on the 65 week zero wait target. The 63 day cancer standard has changed since the last discussion and now reduced to 190.
- Work was progressing on the diagnostic standard.
- The increase in demand was above anticipated.
- The emergency care standard target of 76% had been set, however the Trust would be unable to deliver this without the help of its partners. Work is continuing to set out a plan to move from 60% to 76% by the end of March 2024.
- Teams were developing the operational and financial plans that are realistic.
- The Garden Suite move had been completed and thanks were passed on to all of the clinical operational teams, estates and communications teams for the move.
- Thanks were passed on to the Electronic Patient Record (EPR) team for successful implementation.
- Ambulance handover delays continued to be a priority and work continued with regional colleagues to reduce them.
- Industrial action remains a concern. There was most concern about the 72 hour strike by junior doctors. Teams continued to work to support our juniors and consultants were stepping in to provide care. The impact on patients will be huge and there needed to be a swift resolution to resolve the pay dispute. Patient safety risks for the upcoming industrial action were untenable and a resolve is crucial.
- This was Mr Brennan's final Board meeting and his massive contribution to the Trust was recognised. Thanks were extended for his personal support and focus on putting

patients first and it was hoped that Mr Brennan enjoyed a long, healthy and enjoyable retirement.

Mr Horwath echoed the comments regarding Mr Brennan and wished him well. Mr Horwath referred to the patient story and advised that he had recently visited the Alex Emergency Department and found there to be an inspirational leadership team and teams were relaxed and calm. It was noted that the EPR rollout had not yet been introduced and asked when it would be progressed. Ms Lewis advised that the ED deployment is planned at a phase later in the year and would coincide with the Urgent & Emergency Care move at Worcester. Ms Lewis added the hybrid risk was recognised and was being managed during the implementation period.

Mr Murphy thanked colleagues for the work done to deescalate priorities from national to regional level.

Ms Day highlighted the real positives included within the report. The Garden Suite had moved ahead of schedule, good implementation of EPR phase 1, ambulance de-escalation and the comments regarding Mr Brennan. Operational performance improvements are credited to Mr Brennan and his team and he has been instrumental in leading it. In regard to industrial action, it is a really difficult time for the Trust and our staff. There was a risk of harm to patients and government support was required to resolve it.

RESOLVED THAT: The report was noted.

181/22 **COMMUNICATIONS & ENGAGEMENT REPORT**

Mr Haynes reflected on the real challenges and the pride in staff working so hard to put our patients first.

There were ongoing improvements to strategies and ways of working to make the Trust both a good place to work and to be cared for. A leadership conference was held last week and there was much discussion around the 4ward improvement system to deliver real improvements in managing the organisation. There is a growing confidence within clinical and corporate teams in sharing good news stories.

Mr Murphy thanked the team for promoting the rainbow badge and encouraged staff to complete the rainbow badge training. Mr Haynes stated that it was a great example of the work the network is doing.

Ms Day was pleased to see the good news stories being shared.

RESOLVED THAT: The report was noted.

Best Experience of Care and Outcomes for Patients

182/22 **INTEGRATED PERFORMANCE REPORT**

Ms Lewis presented the report with an assurance level of 4. No patient flow data was included within the report and this will be addressed for the next meeting. Issues across elective and cancer had been identified and there were improvements being seen in cancer performance times.

Operational Performance

Elective

Mr Brennan highlighted the following key points:

- The table on page 2 of the report outlined both the submitted plan and bottom up plan.
- The work done by the divisional teams was recognised.
- It was reported that the 78 week position today, based on trajectory should reduce to 814. The data was constantly under review. 460 of the 814 are already dated. There was a risk that the Trust would not achieve the zero waiting target due to the number of new outpatients being seen.

Cancer

- Cancer performance continued to improve. There had been a reduction week on week since the beginning of January.
- The number of patients waiting over 62 days was reported as 302 against a trajectory of 436.

Ms Day acknowledged the good progress made and passed on her thanks to the teams.

Emergency Care

Challenges with flow and ambulance handovers remained. Over the last three weeks, ambulance handover time lost had reduced from over 1400 to 274. Improvement appeared to be sustained but the target was 0 hours. The main challenge is the quantum and timing of discharges. A driving factor of success was achieving at least 40% of the 740 discharge target per week before midday.

Mr Murphy queried whether there was any data regarding the numbers of patients who did not need to attend ED. Mr Brennan replied that the analysis could indicate 16% of patients presenting at ED could be managed at an alternate setting. It was highlighted however that it is possible that the patient presenting could have additional complications that is not picked up from the presenting condition. The next step is to have a broader system discussion and agreement regarding these patients.

Quality & Safety

Ms Edwards advised that there were capacity and acuity pressures but the review of patient experience is demonstrating a positive experience overall. Targets had consistently been achieved throughout January and February. The key priority is infection prevention and control.

There continued to be challenges with outbreaks of norovirus however there had been a decline with covid and flu. Covid numbers were slightly increasing and it was reported that there was a national wave in the community during March.

Following a visit by NHSE in October, an action list had been created and colleagues were working through them. NHSE would revisit the Trust in May and a training package would be rolled out collectively and in partnership with them.

Dr Blanshard highlighted that there had been a sustained improvement with fractured neck of femur performance. It was reported that antimicrobial stewardship was achieved with 95% of patients receiving appropriate antibiotics. In regard to sepsis, more than 90% of patients commenced treatment within an hour of presentation. There was good performance regarding length of stay and mortality, though there had been pressures in the Emergency Department.

Mr Bramley referred to the neck of femur pathway and queried if there was a solution to the issues or timescale for resolve. Dr Blanshard replied that the data represented an improved

position. Challenges with the pathway were discussed at an away day held in November with all staff involved in the pathway. A comprehensive improvement plan was created which the teams were working to. Ms Sinclair added that it was a complex problem but teams were responding well and the trajectory looked promising.

Ms Day observed that progress was being made in terms of getting people home as quickly as possible and asked if there was any assurance this could be sustained. Mr Brennan replied that there had not been any increase in the readmission rate of simple discharges. The last 6 weeks had been compared to the same week last year and the length of stay largely remained the same, though overall length of stay has increased over the last 12 months. The increase is predominantly related to patients going home on a pathway discharge. Readmission rates for pathway discharges had not yet been reviewed.

People & Culture

Ms Ricketts highlighted the following:

- The workforce plans were on track to achieve the number of staff in posts by the end of March.
- There had been no reduction in agency and bank staffing due to turnover, sickness and the opening of surge areas in urgent and emergency care. Focus was on recruitment and retention to tackle bank and agency.
- The staff survey results were being issued nationally today and would be circulated to members for review prior to presenting to committees and Trust Board in April.

Finance

Mr Cook drew attention to the following key points:

- The Trust was reporting £0.4m favourable variance in month 10 and there was £0.9m adverse variance to date.
- Expenditure related to the pay award and winter funding to support the backlog of activity and was in line with the forecast.
- £1.4m had been invested in month from the balance sheet. Funds had been brokered into next year.
- It was expected the £19.9m plan would be achieved with support from the balance sheet.
- Productivity and Efficiency Programmes projected £10.4m however there was a £5m shortfall on plan.
- Capital is challenged at £24.6m. It was forecast that £26m would be achieved with spend in months 11/12. Regular meetings with estates took place.
- There had been movement in TIF2 forecasts with an underspend of £800k and work was underway to pull schemes forward to ensure there is no underspend.
- The cash balance remains high.

Mr Murphy queried whether the weather could be an issue to construction. Mr Cook replied that meetings were taking place with the team regularly and that there may need to be some mitigation.

Ms Day noted a lot of good progress and encouraged keeping focus on the items that haven't had much movement.

Level 4 assurance was approved.

RESOLVED THAT: The report was noted for assurance.

183/22 **COMMITTEE ASSURANCE REPORT**

QGC: Ms Sinclair highlighted that following the elective care visit, an action plan had been created to address the issues and progress was now being seen. Committee have discussed the feedback from the IPC visit and receive updates regarding the actions put in place.

RESOLVED THAT: The Committee report was noted for assurance.

Best Use of Resources

184/22 **AMENDMENT TO SCHEME OF DELEGATION**

Mr Cook advised that recruitment had been reviewed and a rapid process improvement workshop was held with 4ward improvement. The first stage had been presented with the divisional proposal to progress to recruit. The second element related to budget and concerns had been raised due to the approval through finance and workforce for assurance. An app had now been developed and divisions were leading the process. The Scheme of Delegation was presented for approval of the secondary process.

12a outlined the current process and 12.b is the proposal. Assurance is in place with the app which is being trialled before rollout. Changes had been made as a result and approval was sought for the secondary process.

Ms Day agreed with the approach and was satisfied with the controls and safeguards in place. Ms Day queried how steps were taken to ensure that productivity, efficiency and ways of working regarding leavers was considered. Mr Cook replied that divisions have a PEP to deliver and are aware of the expectation. The secondary component would still need to be signed off and HR business partners are involved. There were levels of scrutiny for challenge to take place. Mr Hopkins encouraged removing barriers to build confidence and trust with leadership.

Mr Bramley referred to the 5 bullet point criteria on page 2 of the report and queried whether the fifth point should read establishment budget. Mr Cook confirmed that it is budget rather than establishment.

Level 6 assurance was approved.

RESOLVED THAT: The Scheme of Delegation was approved.

Best People

185/22 **SAFEST STAFFING REPORT**

a) Adult/Nursing

Ms Edwards provided the following update:

- Staffing was maintained safely.
- Patient needs required the use of bank and agency staffing. A number of temporary staff were utilised to cover sickness.
- Vacancies were benchmarked in line with other Trusts.
- The Trust remained an outlier with Health Care Assistants with a vacancy factor of 12.3%. This was a key workstream area being focused on.
- There was targeted recruitment in place in Radiology. This was a challenged area and bank and agency were being used to provide cover.
- Wellbeing work is key; there were still staff reporting real challenges with the cost of living. Teams were working with HR reviewing packages of care to support staff.

- The Trust had been subject to a number of strikes which were having an impact on staff in terms of supporting those taking action and the volume of work involved on a ward based level.

The assurance level of 6 was approved.

b) Midwifery

Ms Jeffrey reported the following:

- There was an increased assurance level of the report.
- There had been a reduction in vacancies, sickness, turnover and red flag reporting.
- Times to escalate other staff groups had reduced.
- The fill rates and times met acuity has improved.
- Issues with recruiting maternity support workers is slowly improving.

The assurance level of 6 was approved.

RESOLVED THAT: The reports were noted for assurance.

Governance

186/22 **BOARD ASSURANCE FRAMEWORK**

Ms O'Connor presented the report with an increased level of assurance. The BAF has been effective in managing the industrial action risk. There was evidence that the committee structures are well engaged and good embedding of the BAF across the organisation.

There had been an increase in the industrial action risk and a decrease in the level of assurance which was reflective of the changing environment. An amendment had been made to the summary in engagement with staff. Overall, mitigating actions were in place against the risks and the assurance framework was reflective of the risks being faced by the Trust.

Ms Day was pleased to see an increased level of assurance. Dr Blanshard noted that the risks are changing all the time. The upcoming junior doctor strike is the most difficult to predict and the Trust was reliant on others doing extra duties.

Level 6 assurance was approved.

RESOLVED THAT: The report was noted for assurance.

187/22 **ANY OTHER BUSINESS**

There was no other business

DATE OF NEXT MEETING

The next Public Trust Board meeting will be held in person on Thursday 13 April 2023 at 10:00am.

The meeting was closed.

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

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST

PUBLIC TRUST BOARD ACTION SCHEDULE

RAG Rating Key:

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

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

Worcestershire Acute Hospitals NHS Trust

Meeting	Public Trust Board
Date of meeting	13 April 2023
Paper number	Enc C

Chief Executive Officer's Report

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

Accountable Director	Matthew Hopkins Chief Executive Officer		
Presented by	Matthew Hopkins Chief Executive Officer	**Author /s**	Rebecca O'Connor Director of Corporate Governance

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

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

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

Executive Summary	This report is to brief the Board on various local and national issues. Items within this report are as follows: • Matthew Hopkins leaving • Industrial Action • CQC • Annual Plan 23/24 • Interpreting Machines • Ramadan, Easter & Sikh festivities

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						

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Introduction/Background

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

Matthew Hopkins leaving

After over four hugely rewarding years as a member of Team Worcestershire Acute, the time has come for me to move on.

I have been offered, and accepted, the position of Chief Executive at Mid and South Essex NHS Foundation Trust, a large, multi-hospital Trust (16,000 staff, turnover of £1.4 billion) which provides a wide range of clinical services and cares for a population of over 1.2 million people in central and south Essex.

I am also getting married in the summer and this move will mean my wife and I can spend more time together, as well as greatly reducing my commuting journey and (as much as any job of this kind will allow) give me a better work/life balance.

I take up my new post later this year. In the meantime, while we progress the succession arrangements I will remain absolutely focussed on supporting the Trust as we continue to build on the amazing progress we have made together in Putting Patients First.

Industrial Action

Trade union members on agenda for change terms and conditions are currently voting on whether they will accept the pay offer put forward by the Government on 16th March 2023. It consists of a one-off payment for the financial year 2022/23 worth between £1,655 and £3,789 and a 5% consolidated (permanent) pay increase for 2023/24, which is in addition to the pay rise NHS staff have already received for 2022/23.

Of concern is the 96 hour industrial action planned by Junior Doctors from 11th to 14th April 2023. Daily planning meetings are in place to mitigate the risk to patient safety and experience as the strike action will follow a 4 day bank holiday weekend. A key action is the rescheduling of planned care to allow a focus on urgent and emergency care and the care of patients within our wards. A verbal update will be provided at the Board meeting as this takes place on the 3rd day of industrial action.

CQC

CQC released their final inspection report to the Trust on the 30th March which was published on the CQC website on the 6th April 2023. There has been no change to the overall Trust or individual WRH and ALX site ratings which all remain as “Requires Improvement”. The outcome has resulted in the “Inadequate” ratings being removed and upgraded to “Requires Improvement” at both Emergency Departments, meaning that we are no longer rated inadequate in any area across any of our hospitals.

Annual Plan 23/24

Regular updates on our annual plan have been received by Trust Board since November 2022. Our plan was submitted to Herefordshire and Worcestershire Integrated Care Board (ICB) on 24th March following which the submission was approved by Finance and Performance Committee (delegated by Trust Board) on 29th March. The ICB submitted the system plan to NHSE on 30th March. Our 2023/24 plan has been developed to meet the extremely challenging targets set by NHSE and includes a significant investment in workforce to deliver those targets. Significant work

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continues to be undertaken at both trust and system level to make the plans as robust and affordable as possible to ensure they stand the test of external scrutiny by NHSE. Delivery of activity, performance standards and financial targets including PEP will be closely monitored through PRMs (supported by an accountability framework), TME and F&P, as well as at ICS level. Continued focus on reducing waste and harnessing divisional PEPs and the wider PEP programme will be essential to support the financial position. Despite the challenges, we continue to invest in our workforce and infrastructure, underpinned by the 4ward improvement system, to deliver our strategic objectives and vision to put patients first.

Interpreting Machines

Two new interpreting machines are now being used in the Alexandra Hospital and Worcestershire Royal Hospital to provide a better experience for patients from the d/Deaf community.

A **WoW Machine** (Wordskii on Wheels) was delivered to each Emergency Department (ED) in March, enabling "on demand" interpreting by connecting staff to British Sign Language interpreters within minutes.

The devices can connect a patient to an interpreter 24/7 who can interpret the conversation with the clinical member of staff. The WoWs can also invite additional consultants or family members into the conversation if required.

We've supported a series of measures as a Trust which have been developed with the local d/Deaf community, including posters, cards, training, and a new provider to facilitate British Sign Language interpreting in our hospitals.

The two brand new machines are currently on loan for a trial period of three months. If successful we plan to put together a bid to purchase some permanent WoWs.

Ramadan, Easter & Sikh festivities

Warmest wishes to all of our colleagues celebrating Ramadan, Easter, Passover, or Vaisakhi in the coming month.

Issues and options

Recommendations

The Trust Board is requested to

- Note this report.

Appendices – None

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

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Worcestershire Acute Hospitals NHS Trust - Provider Collaboratives

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

Accountable Director	Jo Newton, Director of Strategy & Planning		
Presented by	Lisa Peaty, Deputy Director of Strategy & Planning	**Author /s**	Jo Newton, Director of Strategy, Improvement & Planning Lisa Peaty, Deputy Director of Strategy & Planning Sarah Speck, Strategy and Partnership Manager

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

Report previously reviewed by		
Committee/Group	Date	Outcome

Recommendations	The Trust Board are asked to: • Note the context in which provider collaboratives are being developed • Note the work to date which highlights the potential for provider collaborative development

Executive summary	Provider collaboratives are part of national policy to: • improve service resilience, • reduce unwarranted variation in outcomes and access, • reduce population health inequalities and • support workforce recruitment and retention between providers. This paper revisits the provider collaborative journey to date and provides information about principles for future provider collaborations.

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

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

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

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

Introduction

Our Three Year Plan and Clinical Services Strategy recognise the importance and interdependence of working in partnership with system partners to deliver both our strategic objectives and as a leading provider within the Herefordshire & Worcestershire Integrated Care system. Partnership working can take many forms at both operational and strategic level, with NHS colleagues across England having demonstrated the benefits to patients of provider collaborative working where this has been done successfully together.

The NHS Long Term Plan describes collaborative arrangements as drivers of integration. This translated into a significant step forward in Integrating care: next steps to building strong and effective integrated care systems across England, which introduced formal provider collaboratives and outlined them as one of the four interlocking elements, alongside place, integrated care systems (ICSs) and the national and regional bodies that would make up the future landscape of the NHS.

The formalisation of provider collaboration in this form was then confirmed in the Integration and innovation White Paper and NHS England guidance, which cited the Covid-19 pandemic as bringing fresh impetus to this type of collaboration as existing collaborative arrangements often played a role in co-ordinating parts of the pandemic response.

Issues and options

Why form a Provider collaborative?

A provider collaborative can be defined as a partnership that brings together two or more NHS trusts to work together at scale to benefit their populations. NHS England published their report '[Working together at scale, guidance on Provider Collaboratives]' in August 2021 which mandated that all providers join a provider collaborative. Worcestershire Acute Hospitals NHS Trust joined the SWFT Foundation group, as an associate member of their improvement collaborative in early 2022.

Any collaborative arrangement is intended to align with national and local expectations to provide mutual aid and sustainability. The policy emphasis is on networked, collaborative service provision.

The aims of provider collaboratives are specifically to:

- Improve service resilience

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- Reduce unwarranted variation in outcomes and access
- Reduce population health inequalities
- Improve workforce capability, easier recruitment, more options to improve staff retention
-

Benefits of working in collaboration

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

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

Stocktake of collaborative working arrangements

In January 2020, the board reviewed Strategic Partnership Development to sustain local access to high quality specialised cancer care in Worcestershire. Implementation of the recommendations were superceded by the COVID pandemic. As part of the post pandemic recovery the role of clinical networks, use of mutual aid and sustainability of services has led to a change of collaborative arrangements outlined below:

We are currently participating in the following provider collaboratives:

- WAHT and Herefordshire & Worcestershire Health and Care NHS Trust – Memorandum of Understanding signed by both Trust Boards in January 2023. Current work areas include International nursing recruitment, workforce wellbeing and vaccination, stroke pathway and urgent care

- WAHT and University Hospitals Birmingham NHS Foundation Trust – Maintain cancer network access and outcomes, other tertiary referrals

- WAHT and University Hospitals Coventry and Warwickshire NHS Trust – MDT working on clinical services in head & neck cancer, cardiac electrophysiology, urology cancer. Work progressing on full membership of urology network. Improvement partner for 4Ward improvement methodology.

- Associate member South Warwickshire Foundation Trust Improvement collaborative 'Foundation Group' (2021)

- WAHT and Wye Valley NHS Trust – Memorandum of understanding proposed for May board. Extensive work operationally to sustain vulnerable clinical services (haematology,urology, dermatology) supported by strategic review of specialities.

We are currently participating in the following network arrangements:

- West Midlands Cardiology network chaired by WAHT

Meeting	Trust Board
Date of meeting	13 April 2023
Paper number	Enc D

- South Midlands Pathology Network (2022)- board approvals received for LIMs outline business case and membership of the South Midlands Pathology Network.
- West Midlands Cancer Alliance - ongoing membership

Further details of the profiles of the neighbouring trusts are shown in Appendix 1

Areas for further consideration

The Kings Fund (2022) recognised the need for flexibility in development of provider collaborations developed to meet local need and circumstances. Some models are outlined below. An underlying assumption is to determine which provider collaborative model(s) best support our patients' needs and individual services/pathways.

Models of collaborative working:

Mutual Aid *Time-limited targeted support*	**Shared Pathway** *Collaboration across two Trusts*	**Shared Delivery** *Collaboration across two Trusts*	**Single Service** *Leadership and delivery by one Trust on behalf of the other*
• Transfer of a specific cohort of the PTL, e.g. procedure/ test	• Standardisation of referral criteria and protocols	• Single PTL across system	• Centralisation (delivery maybe at various local clinics across system)
	• Sharing clinical leadership	• Sharing clinical leadership	• Single point of access / single PTL
		• Sharing / rotation of middle grades	• Single team
		• Single training & development plan	
		• Joint recruitment	

Short-term ← → *Long-term*

The NHS at national and local level has identified working collaboratively as being beneficial to service delivery. However, success is dependent on three key dimensions: the quality of relationships; the identification of the scope and agreement of areas of work; and the approach to how participants choose to work together.

Consistent with our Three Year Plan and Clinical Services Strategy, our approach to working with partners is driven by what will deliver the best outcome for patients. Together, these dimensions are central to our developing collaborations.

NHS England Provider Collaborative Innovator Scheme

In early 2023, the SWFT 'Foundation Group' (of which WAHT is an Associate Member) was chosen by NHS England to be one of the two member groups from the Midlands region to take part in the Provider Collaborative Innovator Scheme.

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	13 April 2023
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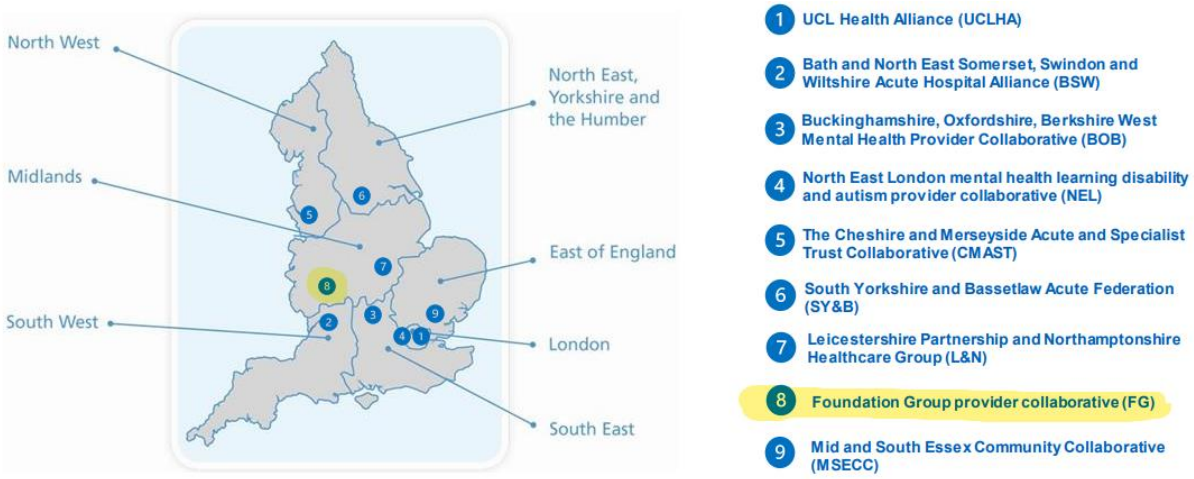

This national scheme is working with 9 Provider Collaboratives across England to:

- build on progress already achieved and go further and faster
- inform future national policy
- share learning over the year to help provider collaboratives improve care across the country.

Risks

Four key risks have been identified in achieving success in provider collaboration in this context:

	Risk	Mitigation
1	Operational pressures undermining the ability to build a collaborative way of working and transformational change.	Prioritise key areas to focus on collaboration and ensure adequate project management/administrative support is in place.
2	Lack of engagement by individual services, clinicians or managers who wish to protect the status quo.	Communicate WAHT Board endorsement for provider collaborative approach and cascade through the directorates/teams.
3	A lack of risk appetite or creativity to design and deliver new transformational ways of working	Develop clear system and organisation narrative and communicate through the organisation, also share case studies of current examples of successful provider collaborative work taking place elsewhere.
4	Risk of capacity to support the full range of potential collaboratives	Prioritise according to strategic priority need.

Conclusion

Consistent with national and local policy and our strategic plan, the opportunity exists to develop provider collaboratives across, and beyond, our Integrated Care System to improve the outcomes for patients and our communities in a planned and sustainable way.

Meeting	Trust Board
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The work to date provides a basis from which further development can take place to select clinical and non-clinical services which would benefit from a collaborative service model.

Recommendations

The Trust Board are asked to:

- Note the context in which provider collaboratives are being developed
- Note the work to date which highlights the potential for provider collaborative development

Appendices

Appendix1

The Local NHS Acute Trust Landscape

Information and definitions of neighbouring NHS acute trust organisations can be found in the table below:

Name of Trust	Operating Income 21/22 (£,000)	NHSE Definition	Acute Services
University Hospitals Birmingham NHS Foundation Trust	2,066,179	Supra Large Acute NHS Foundation Trust	Tertiary
University Hospitals Coventry and Warwickshire NHS Trust	877,683	Supra Large Acute NHS Trust	Tertiary
Gloucestershire Hospitals NHS Foundation Trust	667,438	Extra Large Acute NHS Foundation Trust	Secondary
South Warwickshire University NHS Foundation Trust	396,400	Medium Acute NHS Foundation Trust	Secondary
Wye Valley Trust	299,167	Medium Acute NHS Trust	Secondary
Worcestershire Acute Hospitals NHS Trust	577,210	Extra Large Acute Trust	Secondary

Definitions of acute trusts taken from NHSE information

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4ward

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Worcestershire Acute Hospitals NHS Trust

Developing Provider Collaboratives

Briefing Paper

13th April 2023

Putting Patients First 4ward

NHS Worcestershire Acute Hospitals NHS Trust

The purpose of this presentation is to:

- Revisit the provider collaborative journey to date
- Review current case studies and current collaborative working
- Consider principles for future collaborations

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Provider Collaborative Development

Evolution of Provider Collaboratives

Provider collaboratives are defined as: '*a partnership that brings together two or more NHS trusts to work together at scale to benefit their populations*'

The aims of provider collaboratives are to:

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

Collaborative arrangements to align with national and local expectations to provide mutual aid and sustainability

NHSE paper 2021: B0754-working-together-at-scale-guidance-on-provider-collaboratives.pdf (england.nhs.uk) mandated that all trusts providing acute & mental health services must be part of a provider collaborative by April 2022

WAHT joined the SWFT Foundation Group as an associate member of their improvement collaborative in 2021

Latest information

NHS Providers March 2023: the-evolution-of-provider-collaboration_fnl.pdf (nhsproviders.org)

1. Many provider collaborations are still focusing on set up such as governance arrangements, leadership models and decision-making processes as well as relationships with ICBs.

2. Two thirds of provider collaborations intend to focus on clinical pathway redesign or the consolidation of clinical services.

3. Many provider collaborations are taking their first steps by focusing on improving the quality of care by reducing out-of-area placements, strengthening community services, tackling backlogs and making services more efficient.

4. Collaboratives vary by sector and in maturity. The varied nature highlights that providers are using the deliberately open statutory framework to take approaches that make sense in their local areas.

5. As well as time, collaborations need staffing, resource and leadership capacity.

NHSE underpinning principles for Provider Collaboratives

- A shared vision and commitment to collaborate
- Strong accountability mechanisms for members
- Building on existing successful governance arrangements
- Efficient decision-making
- Embedding clinical and community voices
- Streamlining ways of working

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Service Model Options

Mutual Aid *Time-limited targeted support*	**Shared Pathway** *Collaboration across two Trusts*	**Shared Delivery** *Collaboration across two Trusts*	**Single Service** *Leadership and delivery by one Trust on behalf of the other*
• Transfer of a specific cohort of the PTL, e.g. procedure/ test	• Standardisation of referral criteria and protocols	• Single PTL across system	• Centralisation (delivery maybe at various local clinics across system)
	• Sharing clinical leadership	• Sharing clinical leadership	• Single point of access / single PTL
		• Sharing / rotation of middle grades	• Single team
		• Single training & development plan	
		• Joint recruitment	

Short-term ← → *Long-term*

Putting Patients First

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Worcestershire Acute Hospitals NHS Trust

Case studies and current collaborative working

Case study 1

The Black Country Provider Collaborative (Sandwell & West B'ham, The Dudley Group, Royal Wolverhampton & Walsall Healthcare) was formed in late 2020. Clinically led with 9 system clinical leads appointed in the first 18 months.
The Clinical Improvement Programme identified services under the greatest pressure and developed a network approach for each service, appointing clinical leads and project support teams for each specialist network.

The form of the provider collaborative is yet to be decided, although the four providers have started conversations about the potential of introducing a shared chair.

Examples of the clinical network approach include:

- Critical care – appointed a critical care lead and brought together the critical care units across the 4 providers
- Orthopaedics – a lead surgeon was appointed and has successfully brought together the orthopaedic teams from each provider to consider how to structure teams
- Skin cancer and skin services – 2 skin cancer leads have been appointed who are planning to introduce 'tele dermatology'
- Breast cancer – there are long waiting lists for breast cancer services across the Black Country. The newly appointed clinical lead is developing a model with one centre providing more specialised services and two other sites providing more routine services.

Case study 2

South Warwickshire NHS FT (SWFT) began by buddying support to Wye Valley Trust (WVT). Subsequently the SWFT chair and CEO were appointed to corresponding roles at WVT through an MoU.

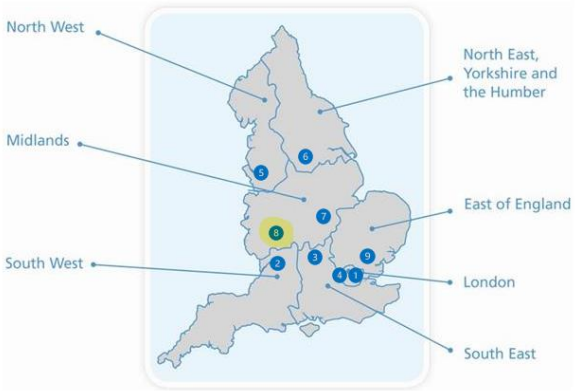
- 2017 - Foundation Group created in partnership with SWFT and WVT
- 2018 – George Eliot Hospital NHS Trust (GEH) joined the Foundation Group.
- All 3 trusts have common strategic vision: To support more rapid health and social care integration in both settings with local partners.

List of priorities:

- Involve primary care in leadership roles and change structures to focus more on place
- Alongside local commissioners, delivery of the mental health investment standard to invest more in mental health care
- Prioritise business cases which deliver activity reductions or public health benefits
- Incentivise primary care to reduce acute demand
- Draw on the skills of LA commissioners to reduce the cost of continuing healthcare
- Support the voluntary sector and local hospices including developing integrated IT and records
- Turn data into intelligence to improve public health outcomes with key partners
- Facilitate the development of skills and roles in the wider health and care workforce
- Be a trusted source of evidence to our communities to support healthy lifestyle choices
- Take decisive action to reduce carbon emissions and act as an anchor institution at place.

NHSE Provider Collaborative Innovators Scheme

In early 2023, the SWFT Foundation Group's 'shared leadership' model was chosen to be one of the two Midlands members of the NHSE Provider Collaborative Innovator Scheme.



1. UCL Health Alliance (UCLHA)
2. Bath and North East Somerset, Swindon and Wiltshire Acute Hospital Alliance (BSW)
3. Buckinghamshire, Oxfordshire, Berkshire West Mental Health Provider Collaborative (BOB)
4. North East London mental health learning disability and autism provider collaborative (NEL)
5. The Cheshire and Merseyside Acute and Specialist Trust Collaborative (CMAST)
6. South Yorkshire and Bassetlaw Acute Federation (SY&B)
7. Leicestershire Partnership and Northamptonshire Healthcare Group (L&N)
8. Foundation Group provider collaborative (FG)
9. Mid and South Essex Community Collaborative (MSECC)

The Provider Collaborative Innovators Scheme aims to:

- Build on the progress already achieve and go further and faster
- Inform future national policy
- Share what we learn together over the coming year to help provider collaboratives improve care across the country.

Stocktake - WAHT and provider collaborative working

- **WAHT and H&W HCT** – Memorandum of Understanding (MoU) signed by both Trust Boards in January 2023 and work programme agreed. Current work areas include international nurse recruitment, workforce wellbeing and vaccination, stroke pathway and urgent care.

- **WAHT and UHB** – Maintain cancer network access and outcomes, other tertiary referrals.

- **WAHT and UHC&W** – MDT working on clinical services in head & neck cancer, cardiac electrophysiology, urology cancer. Work progressing on full membership of urology network. Improvement partner for Virginia Mason methodology.

- **WAHT and SWFT Improvement Collaborative** – WAHT is an associate member

- **WAHT and WVT** – Service sustainability analysis completed and being developed into a work plan. Agreement to form collaborative arrangement and MoU being developed. Continued joined working on sustainability of vulnerable services with joint workshop WVT/WAHT on pathology and maxfax.

Stocktake – WAHT and networks

- **West Midlands Cardiology network** chaired by our Divisional Director in Specialist Medicine
- **SW Midlands Pathology Network** - board approvals received for LIMs outline business case and SM Pathology network collaborative.
- **West Midlands Cancer Alliance -** ongoing membership

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Future collaborations

Acute Trust Information and Definitions

Name of Trust	Operating Income 21/22 (£,000)	NHSE Definition	Acute Services
University Hospitals Birmingham NHS Foundation Trust	2,066,179	Supra Large Acute NHS Foundation Trust	Tertiary
University Hospitals Coventry and Warwickshire NHS Trust	877,683	Supra Large Acute NHS Trust	Tertiary
Gloucestershire Hospitals NHS Foundation Trust	667,438	Extra Large Acute NHS Foundation Trust	Secondary
South Warwickshire University NHS Foundation Trust	396,400	Medium Acute NHS Foundation Trust	Secondary
Wye Valley Trust	299,167	Medium Acute NHS Trust	Secondary
Worcestershire Acute Hospitals NHS Trust	577,210	Extra Large Acute Trust	Secondary

Definitions of acute hospitals (NHSE)

Small Acute	£0-200m turnover
Medium Acute	£200-400m turnover
Large Acute	£400-500m turnover
Extra Large Acute	£500-750m turnover
Supra Large Acute	£750m+ turnover

Points for consideration: potential benefits

1. Collaborative working offers the opportunity for NHS Trusts to do things at scale and potentially benefit from more efficient working processes

2. Standardisation of pathways, protocols and policies can improve patient outcomes and experience

3. Sharing between providers presents the opportunity for capacity to be viewed in a combined sense rather than an organisational footprint

4. There is little evidence that one model of provider collaboration is more effective than another

5. Flexibility is important to allow arrangements to fit with the specific local context

Points for Consideration: potential challenges

1. The development of collaborative working, shared purpose and changes in working practices (such as flexible working) takes time, which is limited.

2. Some collaborative working may span across multiple places within an ICS, and across ICS boundaries, which adds to complexity.

3. Against a stretched health and care landscape, finding resources (time and people) to progress provider collaboratives work may be difficult.

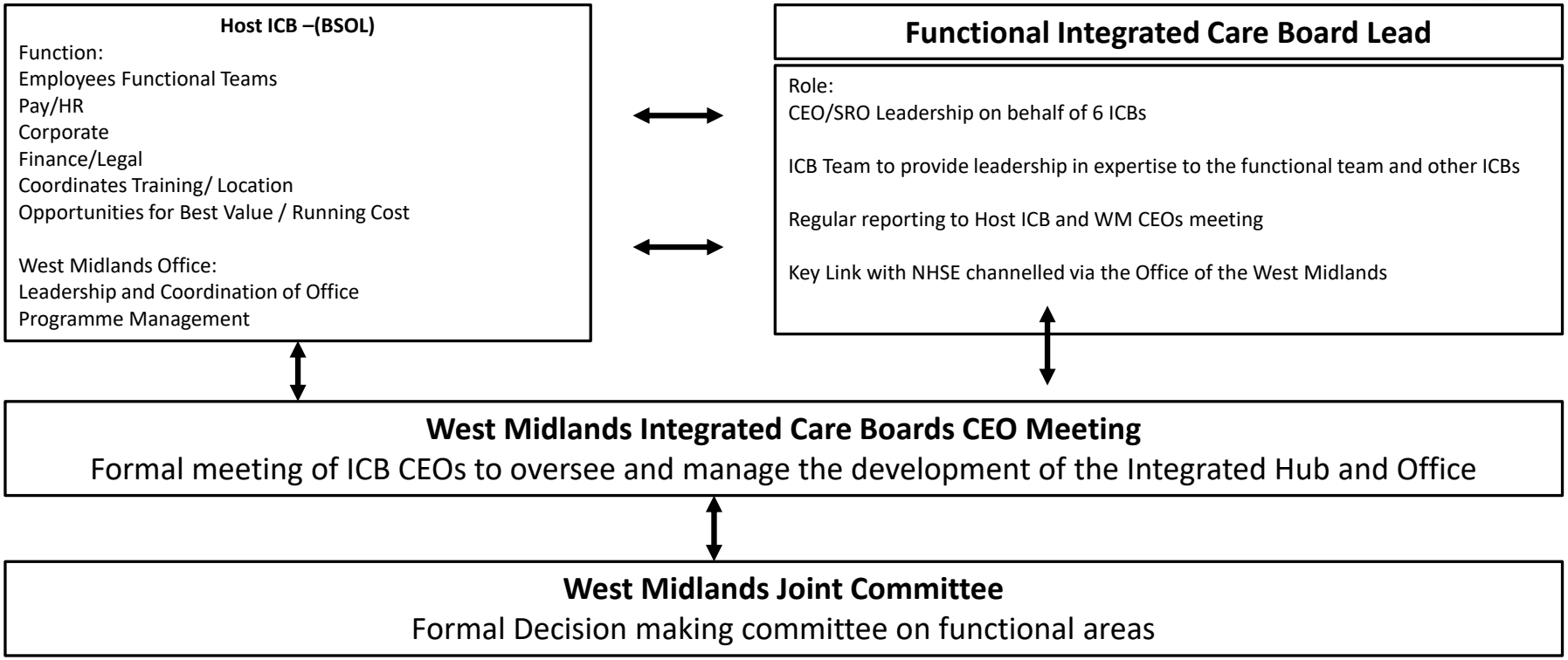
4. Cultural changes - creating a shared vision across leaders and gaining buy-in from staff is essential to develop a culture of collaboration and common purpose.

5. The specific issues being addressed by provider collaboratives should be clearly defined as this may be challenging.

APPENDIX 1 – Information from Office of West Midlands, Partnership of Integrated Care Boards

Office of the West Midlands Integrated Hub.

Office of the West Midlands
Partnership of Integrated Care Boards



The agreed 2023/2024 Joint Work Programme

The Office of the West Midlands will be a servant of the 6 ICBs working to a distributed leadership model with each ICB taking a lead on defined annual programme of joint work: there are currently 9 agreed Programmes of work as follows:

(1) POD / GMaST / Complaints/ Secondary Dental:	Simon Trickett, Hereford and Worcester ICB
(2) Operating Model Development; (3) Collaboratives:	Phil Johns, Coventry and Warwickshire ICB
(4) Integrated Staff Hub & OWM hosting (5) Spec Comm:	David Melbourne, Birmingham and Solihull ICB
(6) Commissioning Support Unit review:	Simon Whitehouse, Shropshire, Telford and Wrekin ICB
(7) 111/999; (8)WM Combined Authority:	Mark Axcell, Black Country ICB
(9) Immunisations and Vaccinations:	Peter Axon, Staffordshire and Stoke on Trent ICB

Other delegations / functional transfers to be agreed

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	13 April 2023
Paper number	Enc E

CQC Inspection Report – November 2022

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

Accountable Director	Matthew Hopkins, Chief Executive Officer		
Presented by	Sue Smith, Deputy Chief Nursing Officer	**Author /s**	Amy Gray, Healthcare Standards Lead

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		Best people	

Report previously reviewed by		
Committee/Group	Date	Outcome

Recommendations	Trust Board is requested to receive the Care Quality Commission (CQC) report published on 6th April 2023 and to note that an action plan will be collated and shared with the CQC by 19th May 2023.

Executive summary	The CQC carried out an unannounced inspection of the Trust's Emergency Departments, Speciality Medicine Wards, Discharge Lounges, Laurel 2 & 3 and Endoscopy services at Worcestershire Royal Hospital (WRH) and the Alexandra Hospital (ALX) on 21st - 23rd November 2022. At the time of the inspection, both departments were under adverse pressure from increased patient attendance and delayed ambulance offloads. CQC released their final inspection report to the Trust on the 30th March which was published on the CQC website on the 6th April 2023 (Appendix 1). There has been no change to the overall Trust or individual WRH and ALX site ratings which all remain as "Requires Improvement". The outcome has resulted in the "Inadequate" ratings being removed and upgraded to "Requires Improvement" at both Emergency Departments, meaning that we are no longer rated inadequate in any area across any of our hospitals. A handful of domains within Medical Care and across both Emergency Departments resulted in a change and ratings have been revised as follows: **Worcestershire Royal Hospital** See table below.

	Safe	Effective	Caring	Responsive	Well-Led
Urgent and Emergency Services	Requires Improvement Mar 2023 ↑	Good Mar 2023 ↔	Good Mar 2023 ↑	Requires Improvement Mar 2023 ↑	Requires Improvement Mar 2023 ↑
Medical Care (including older people's care)	Requires Improvement Mar 2023 ↔	Good Mar 2023 ↑	Good Mar 2023 ↔	Requires Improvement Mar 2023 ↔	Requires Improvement Mar 2023 ↓

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

Meeting	Trust Board
Date of meeting	13 April 2023
Paper number	Enc E

Alexandra Hospital

	Safe	Effective	Caring	Responsive	Well-Led
Urgent and Emergency Services	Requires Improvement Mar 2023 ↑	Good Mar 2023 ↑	Good Mar 2023 ↔	Requires Improvement Mar 2023 ↑	Requires Improvement Mar 2023 ↑
Medical Care (including older people's care)	Requires Improvement Mar 2023 ↔	Good Mar 2023 ↑	Good Mar 2023 ↔	Requires Improvement Mar 2023 ↓	Requires Improvement Mar 2023 ↓

The Well-Led inspection was initially scheduled to be undertaken in January 2023. However, in response to the winter pressures and ongoing industrial action, the CQC adjusted regulatory activity to focus on high risk areas until April 2023. No further dates have been confirmed for this. Therefore, Well-Led has been rated from the inspection in November and is based on trust management and leadership in individual services.

The following positive findings were identified:

- Staff understood how to protect patients from abuse and worked well with other agencies to do so.
- Infection risks were controlled well and equipment and premises were visibly clean.
- Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank, agency and locum staff a full induction.
- Patient safety incidents were managed well and when things went wrong, staff apologised and gave patients honest information and suitable support.
- Care and treatment provided is based on national guidance and evidence-based practice.
- Staff gave patients enough food and drink to meet their needs.
- Doctors, nurses and other healthcare professionals worked together as a team and supported each other to benefit patients and provide good care.
- Key services were available seven days a week.
- The pleural effusion service that is ran by a Clinical Nurse Specialist was recognised as Outstanding Practice.
- Staff supported patients to make informed decisions about their care and treatment and followed national guidance to gain patients' consent.
- Staff treated patients with compassion and kindness and provided emotional support to patients, families and carers. An episode of care between a healthcare assistant and a patient living with dementia was observed and recognised as Outstanding Practice.
- Staff made reasonable adjustments to help patients access services and coordinated care with other services and providers.
- It was easy for people to give feedback and raise concerns about care received and these were taken seriously.

- Leaders understood and managed the priorities and issues services faced and supported staff to develop their skills and take on more senior roles.
- The proactive approach to staff welfare, particularly focusing on supporting staff who have suffered violence or aggression within the Emergency Departments was recognised as Outstanding Practice.
- Staff were committed to continually learning and improving services and had a good understanding of quality improvement methods and skills to use them.

The CQC identified that further improvements were required within the following areas:

- Patients were often admitted to the Discharge Lounges and PDU against criteria within the standard operating procedure and the units did not have adequate facilities or medical cover.
- Risk assessments were not always completed in a timely way for each person on arrival.
- Discharges at times were delayed and there were handover delays for patients arriving by ambulance, which delayed assessment and treatment.
- Corridor care within the Emergency Departments should be made more dignified for patients.
- Medicines were not always stored safely and appropriately.
- Staff were not meeting the 90% mandatory training target, particularly medical staff.
- The Trust should consider using signage to encourage the community to attend an appropriate paediatric department and ensure staff within the Emergency Department at the ALX have completed paediatric competencies.

The report identified a total of 6 Must Do's and 32 Should Do's (Appendix 2). The CQC have requested an action plan by 19th May 2023 outlining actions the Trust will take to ensure the following regulated activities are met:

- Regulation 12 Safe Care and Treatment
- Regulation 17 Good governance

All new Must and Should Do's will be progressed via the Trust's Regulated Activity Improvement Tool (RAIT) and process, which will involve the Divisions having ownership and reporting actions to the Healthcare Standards Team. Progress updates and escalations will be reported through Clinical Governance Group (CGG).

Worcestershire Acute Hospitals NHS Trust

Assurance levels Nov 2020

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	On a final note, the CQC are progressing their Maternity focused inspection programme and the Trust are awaiting an inspection. The CQC have confirmed they will give 48 hours' notice for this. The full report can be found on the CQC website: https://www.cqc.org.uk/location/RWP50

Risk			
Which key red risks does this report address?		**What BAF risk does this report address?**	*19, 20, 11, 4*

Assurance Level (x)	0		1		2		3		4	X	5	6		7		N/A	
Financial Risk	*State the full year revenue cost/saving/capital cost, whether a budget already exists, or how it is proposed that the resources will be managed.*																

Action						
Is there an action plan in place to deliver the desired improvement outcomes?	Y	X	N		N/A	
Are the actions identified starting to or are delivering the desired outcomes?	Y	X	N			
If no has the action plan been revised/ enhanced	Y		N			
Timescales to achieve next level of assurance						
Appendices						
Appendix 1 – CQC Inspection Report	Final Report INS2-12829014491 R					
Appendix 2 – Must Do's & Should Do's	Must Do's & Should Do's.docx					

NHS
Worcestershire Acute Hospitals NHS Trust

Meeting	Trust Board
Date of meeting	13 April 2023
Paper number	Enc F

Integrated Performance Report – Month 11 2022/23

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

Accountable Directors	Tracy Pearson – Interim Chief Operating Officer, Jackie Edwards – 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**	Nikki O'Brien - Associate Director – Business Intelligence, Performance and Digital Steven Price – Senior Performance Manager

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

Report previously reviewed by		
Committee/Group	Date	Outcome
TME	22nd March 2023	Approved
Finance and Performance	29th March 2023	Assured
Quality Governance	30th March 2023	Assured
People and Culture	4th April 2023	Assured

Recommendations	Trust Board are asked to: ▪ note this report for assurance
Key Issues	**1. Operational Performance** **Elective Recovery - Activity** We did not achieve the OP New or the OP follow-ups submitted activity plan in Feb-23. We did exceed the bottom-up plan (BUP) for OP New and we did deliver 2,800 fewer follow-up appointments than Feb-20 but this was still above BUP. Both day case activity and inpatient (ordinary) were below submitted plan but day case was above the BUP. In-line with the Feb-23 unvalidated outcomes, we have not achieved the year to date submitted plan totals but have exceeded the BUPs for OP New and Day Case. As per the 22/23 annual planning requirement, we have delivered fewer OP follow-up appointments than YTD 19/20 but not at submitted plan volumes. Our validated DM01 Diagnostics waiting list at the end of Feb-23 remained stable and the number of patients waiting 6+ weeks decreased with 83% of the cohort were waiting less than 6 weeks. However, the number of patients waiting over 13 weeks increased for the 3rd consecutive month. Although a reduction in activity was to be expected in February, we delivered fewer test than our submitted plan noting however that 1) we

delivered more tests than Feb-20 and 2) our total DM01 activity was over 17,000 tests.

Elective Recovery - Industrial Action
Nurses represented by the Royal College of Nursing (RCN) took part in a second round of action on the 6th and 7th February. Across the two days, ~1,000 outpatient appointments and ~200 elective inpatient treatments were cancelled. Over 85% of those cancellations have been rescheduled

Elective Recovery - Performance
Consultant-led referral to treatment time
The validated number of patients waiting over 104 weeks for Feb-23 is zero. The overall incomplete RTT waiting list has decreased for the second consecutive month. Although significant effort has been made to have no patients waiting over 78 weeks by the end of March, our validated Feb-23 position is 713 and we are projecting carrying forward just over 400 patients into Apr-23. This cohort will need to be managed alongside additional patients at risk of breaching at the end of April to meet NHSE's ambition of zero.

Cancer
The number of 2WW referrals in Feb-23 increased in-line with seasonal variation and over is 2,800 for the 6th time in 22/23. We have achieved the 2WW waiting time standard for the third consecutive month indicating we currently have the correct capacity to meet current demand. Best practice pathway improvements continue to support progress towards achieving the 28-day faster diagnosis standard which was above 70% this month but further work is required to ensure more patients are informed of their diagnosis by day 28.

At the end of Feb-23, we recorded 418 patients who have been waiting over 63 days for diagnosis and / or treatment and 182 of those patients have been waiting over 104 days. We remain ahead of the weekly recovery trajectory for the urgent suspected cohort and w/e 5th March were at 302, 57% of whom are under the care of urology.

Patient Flow
All urgent care performance metrics remain special cause for concern. The number of ambulance handover delays over 60 minutes did increase but remained below 1,000 for only the second time this year. However, regional benchmarking does show WRH as the second highest contributor to ambulance handover delays. Bed occupancy averaged at 98% again this month but was higher on individual days and does not include boarding; this means occupancy has been over 100% when taken into consideration. COVID and D&V had a significant impact on patient flow through February where at its peak nearly 160 beds were closed due to IPC related illnesses.

2,770 patients were discharged in Feb-23, 80% of which were classified as 'simple'. The overall length of stay of was 6.9 days although this does increase to 7.5 when the zero-day cohort is removed. 19% of patients

were discharged before midday. On the last day of the month 94 patients had a length of stay greater than 21 days, equating to 1,188 bed days.

Stroke

Quarter 3 SSNAP outcomes have been published. Our final score has seen a reduction from 82.0 in Q2 to 70.3 meaning the grade has changed from an A to a B. Six domains remained the same as the previous quarter and four domains saw a score / grade reduction. The combined score of all the domains was 74 but a 5% reduction was imposed as our audit compliance was graded as a B.

Small changes in domain scores have also contributed to the overall position however, the areas of focus still need to be direct admission to the stroke ward and patients spending 90% of their stay on the unit; this is the section we are scored the lowest on.

The assurance level remains at 5 given the majority of actions are being delivered to delivery care that is safe and effective for our patients.

2. Quality and Safety

Despite another highly pressurised month, there is no new significant cause for concern in relation to patient safety or harm.

However, there remains ongoing concern in relation to Infection Prevention and Control management specifically whilst the hospitals have Covid, Influenza and Norovirus patients, and in particular CDiff patients. As a precautionary measure where risk is low to patients, clinicians are waiting for results of tests before administering antibiotics which has a negative impact on the Sepsis six bundle; however, no patients have come to harm as a result of delaying prescribing.

The number of hospital acquired pressure ulcers was above the monthly target and there was one fall with serious harm but both metrics remain within common cause variation, so are not required for further escalation at this point, just close monitoring.

Fractured NOF performance (78%) remains below the target (85%) for patients receiving surgery within 36 hours with theatre capacity being one of the main reasons. It remains essential that we as a Trust and the wider integrated care system remain focused on improving patient flow to enable us to maximise the physical footprint that we have and improve outcomes for patients. Ensuring fractured NOF patients have a bed for recovery so they can access theatre quickly and that they move onto the most suitable healthcare provider for their recovery as quickly as possible.

The Friends and Family test for Inpatients and Outpatients remained above the targets for recommended rates, but the A&E target is above the upper control limit for ‘common cause variation’ indicating that it is unrealistic to achieve it without a focused and radical intervention.

We are not consistently replying to complaints within 25 working days and have not achieved the target for 8 consecutive months. 75% of breached

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complaints are with the Surgery Division who have working to clear their backlog by the end of March.

3. People and Culture

As at month 11 and from a trend perspective we have remained consistent in getting the basics right (mandatory training, appraisals, essential to role development) with the exception of job planning compliance which has seen a downward trend to 60%. The Divisional Directors have been asked to focus on job planning compliance as a priority.

We will meet our workforce plan this year and have seen improvement in our vacancy rate due to successful recruitment in the second half of the year. However, challenges remain with our time to hire due to insufficient recruitment and medical resourcing capacity. A business case is being considered by Trust Management Executive this month for additional resource which will see financial benefit.

Staff turnover has been on a downward trend since January 2022. However, bank and agency usage has been on an upward trend due to the increase in sickness absence, higher staff turnover than forecast, the opening of new services at short notice and the continued use of surge areas.

Based on the above exit position we have refreshed our priorities for year 2 of the 3-year plan (2023/24) and these have been shared with Trust Management Executive for approval. Last month the Trust Management Executive approved the new governance structure for the People & Culture agenda and this has been designed to support the delivery of the priorities.

4. Our Financial Position

Month 11

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.

The M11 **deficit is £(2.0)m** against a plan of **£(1.2)m deficit**, an adverse variance of £0.8m. This brings the year to date M11 actual **deficit to £(19.3)m** against a plan of **£(17.5)m deficit,** an adverse variance of £1.8m (10.1%).

Statement of comprehensive income	Feb-23 Plan £'000	Feb-23 Actual £'000	Feb-23 Variance £'000	Year to Date Plan £'000	Year to Date Actual £'000	Year to Date Variance £'000
INCOME & EXPENDITURE						
Operating income from patient care activities	47,307	48,448	1,141	521,373	534,443	13,070
Other operating income	2,689	3,134	445	28,772	28,360	(412)
Employee expenses	(29,713)	(30,863)	(1,150)	(328,768)	(341,067)	(12,299)
Operating expenses excluding employee expenses	(19,637)	(20,943)	(1,306)	(218,718)	(220,964)	(2,246)
OPERATING SURPLUS / (DEFICIT)	**646**	**(224)**	**(870)**	**2,659**	**772**	**(1,887)**
FINANCE COSTS						
Finance income	0	80	80	0	660	660
Finance expense	(1,166)	(1,182)	(16)	(12,816)	(13,148)	(332)
PDC dividends payable/refundable	(681)	(712)	(31)	(7,494)	(7,833)	(339)
NET FINANCE COSTS	**(1,847)**	**(1,814)**	**33**	**(20,310)**	**(20,321)**	**(11)**
Other gains/(losses) including disposal of assets	0	0	0	0	117	117
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**(1,201)**	**(2,038)**	**(837)**	**(17,651)**	**(19,432)**	**(1,781)**
Add back all I&E impairments/(reversals)	0	0	0	0	0	0
Surplus/(deficit) before impairments and transfers	**(1,201)**	**(2,038)**	**(837)**	**(17,651)**	**(19,432)**	**(1,781)**
Remove capital donations/grants I&E impact	10	10	0	114	115	1
Adjusted financial performance surplus/(deficit)	**(1,191)**	**(2,028)**	**(837)**	**(17,537)**	**(19,317)**	**(1,780)**

The Combined Income (including PbR pass-through drugs & devices and Other Operating Income) was £1.6m (3.2%) above the Trust's Operational Plan in February and £12.7m above year to date (2.3%)

The key favourable variances in February relate to the pay award adjustment £0.7m (additional central funding of 1.7% taking the uplift to 3.8%) reduced by £0.2m as a result of the NI reduction, pass through Drugs & Devices £0.2m, additional investments £0.3m including the Robot, KGH MRI scanner, Dermatology & Urology insourcing and £0.4m winter pressure funding.

The Trust has now had confirmation that the Elective Recovery Fund (ERF) will not be withdrawn in 2022/23. The Trust's actual performance is well below the planned level and we estimate that had the ERF not been fixed we would have lost c.£10.4m (75%) of the available ERF income to date against target.

Employee expenses in Month 11 were £1.2m (3.9%) adverse to plan and year to date £12.3m (3.7%) adverse to plan.

Of the adverse variance £0.5m in month (£7.1m YTD) is due to the pay award which was not in the plan but is income backed and £0.6m underachieved PEP (£2.9m YTD) net of the £1.2m YTD Business Case pay underspend declared to date. Winter pressures which are externally funded account for £0.1m in month (£1.1m YTD), however an additional £0.3m has been identified against winter in excess of our allocation and £0.1m in month (£0.3m YTD) due to the re-banding of international nurses. The remainder of the adverse variance is due to vacancy fill, patient acuity and premium costs of temporary staff. This is partially offset by £1.1m balance sheet release and £0.2m favourable COVID expenditure.

Operating expenses in Month 11 were £1.3m (6.7%) adverse to plan and are £2.2m (1.0%) adverse year to date.

Adverse variances in month include £0.3m relating to drug costs (£5.4m YTD) of which £0.2m in month is Non PbR and offset by income, £0.4m Non PbR Devices (partly due to timing of usage and partly due to a stock correction), underachieved PEP of (£0.3m in month and £3.6m YTD), impact of seasonal utility costs (£0.2m), additional supplies and services and outsourcing spend linked to activity (including ERF mobile scanner costs of £0.3m in month). The adverse variances are partially offset by £5m of year to date balance sheet releases.

Full Year Forecast

The Finance and Performance Committee was provided with a projection to year end which had been prepared with the support of Divisions and which reflected a potential risk of £5.2m to delivery of the plan. Potential risks and mitigations were identified at the time that held the likely out turn at a £25m deficit before further mitigation. Forecast scenarios incorporating recent months' financial performance continue to be presented. It remains that further non recurrent measures including

balance sheet support (following review of remaining risk) will be required in order to return the deficit position to plan levels.

In month 11 our reported position was favourable to the bottom built operational forecast largely due to releasing £1.4m of non-recurrent funds following review of the balance sheet.

Productivity and Efficiency

Our Productivity and Efficiency Programme target for 22/23 is £15.7m. In Month 11 we delivered £0.767m of actuals against the plan as submitted to NHSE in April 2022 of £1.090m, an adverse variance of £0.323m (29.6%).

The cumulative position at M11 is therefore £8.065m of actuals against a plan of £11.121m, a negative variance of £3.056m. (27.5%).

The 22/23 full year forecast at Month 11 is £10.304m which is £5.396m (34.4%) under the £15.7m plan as submitted to NHSE.

Capital

The Trust Capital Position at month 11, being the value of works complete, is £25.9m. This is an increase of £1,326k since month 10.

The Finance and Procurement teams are working closely with the Capital team to ensure the forecast spend for 2022/23 of £50.962m is achieved.

The Trust has recently agreed with the Regional NHSE team to return £800k PDC for the RAAC (roofing) scheme, however the Trust has an additional £500k allocation which will be dealt with either via an allowable system over commitment which will be managed regionally, or an uplift to our CRL allocations. This reduces our forecast to £50.662m. The RAAC £800k will be submitted for PDC funding in 23/24 to complete the works.

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

- The Trust does not meet its agreed CRL target. Weekly monitoring of the strategic schemes and P&W internal schemes to ensure the schemes are as expected to the FOT. Continue to work with procurement to ensure equipment and suppliers order are placed following the appropriate VFM and governance.
- Risks remain regarding the financing of the UEC scheme. The Capital plan provides a mechanism to broker a solution into 23/24 to accommodate the over spend in this year. However, funds brokered from nationally funded schemes will need to be replenished as a 1st call on the Trusts 23/24 internally generated programme.
- The UEC build has been complex and has still to be completely fitted out and there is therefore risk of further unforeseen costs being identified that require funding.
- The Trust is in the process of requesting a retrospective vat reclaim in respect of the UEC build and the timing of the ruling

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could present accounting challenges leading to the loss of capital resource or non-achievement of CRL.

Capital Position	22/23 Plan £'000	Revised Internal plan £'000	Total YTD Valuation £'000	M12 Spend Forecast £'000	22/23 Full Year Forecast £'000
Property & Works	3,961	3,961	539	3,422	3,961
Digital	11,648	10,282	4,534	5,748	10,282
Equipment	826	1,116	289	827	1,116
Strategic Developments	34,635	21,782	13,731	8,051	21,782
TIF2 Theatres bid	-	11,330	4,776	6,554	11,330
Lease Additions	10,785	1,500	1,325	175	1,500
IFRIC 12 PFI Lifecycle replacement	326	991	761	230	991
Total Capital Expenditure	**62,181**	**50,962**	**25,955**	**25,007**	**50,962**

It should also be noted that any further slippage into 2023/24 will be the first call on any internal capital available next year adding further pressure to an already over-subscribed programme.

The full year forecast position does not include any costs associated with the land sale/car-parking solutions.

Cash

At the end of February 2023 the cash balance was £20.0m against an in month plan of £30.6m. The plan assumed external capital funding of £34.5m of which £12.7m has been drawn to date due to the slippage on capital schemes. However, further notifications have now been received and the capital cash is being paid in Mar 23. The remaining cash variance is mainly due to the timing of supplier payments and deferred income. The Trust has not requested any revenue cash support this financial year due to the high cash reserves being held.

Aster

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

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

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

Recommendations
Trust Board are asked to: ▪ note this report for assurance
Appendices
▪ Integrated Performance Report (up to Feb-23 data) ▪ WAHT At A Glance – Feb-23 ▪ WAHT February 2023 in Numbers Infographic ▪ Committee Assurance Statements – March / April 2023 meetings

Integrated Performance Report

NHS Worcestershire Acute Hospitals NHS Trust

Trust Board

13th April 2023

Data: Up to February 2023

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

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

Operational Performance

HEADLINES AND SUCCESSES

Area	Comments
Cancer	• Our 2WW performance exceeded the cancer waiting times standard of 93% for the third consecutive month. • 5 specialties have achieved the 2ww operational standard this month. • 3 specialties have achieved the 28 Day Faster Diagnosis Standard this month. • Our 63+ day backlog, and those waiting over 104 days, has continued to reduce. The number of urgent suspected referral patients breaching 62 days is at it's lowest point since w/e 29th May (slide 12).
Recovery	• There were zero patients breaching 104+ weeks at the end of Feb-23. • The number of patients breaching 78+ weeks has decreased from 1,135 to 713. • The potential number of 78+ week breaches at Mar-23 end has now decreased below 1,000 (as at 3rd March– slide 17). • Even with Industrial Action related rescheduling we delivered 48,205 outpatient appointments in Feb-23; 456 more than Feb-20. • Although higher than submitted plan, we delivered fewer OP follow-ups than in Feb-20. • Even with Industrial Action related rescheduling we delivered 7,300 Day Case and Inpatient combined in Feb-23, only 357 fewer than Feb-20
Diagnostics	• YTD we have delivered 95% of a plan that was set at 120% of 19/20 levels. • In Feb-23 we delivered 17,757 DM01 reportable tests.

Patient Flow

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

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

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

What does the data tell us?

- Slides 4 and 5 highlight that the patient flow metrics in this report continue to show special cause concern.
- Slide 7 indicates the impact that Covid, D&V and other IPC cases had on patient flow – at it's peak almost 160 beds occupied by adults with IPC related conditions.
- Although ambulance handover breaches were below 1,000, latest regional benchmarking (Chart 1 rolling 30-day trend) shows that WRH is the second highest contributor at site level.

Chart 1

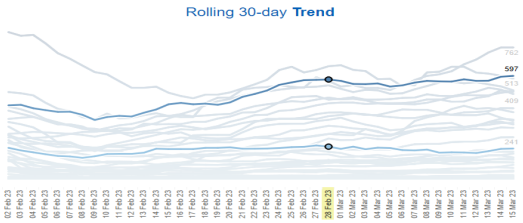
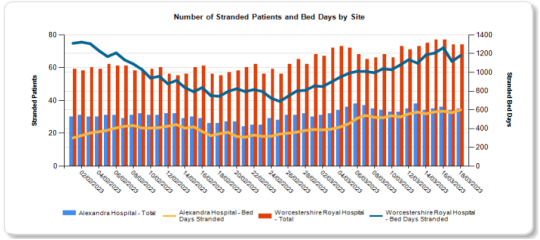


Chart 2



Addi

- The conversion rate of attendances to admission was 33% at WRH (2,045 admissions) and 23% at ALX (1,051 admissions). The Midlands 6 week (5th Feb to 18th Mar) average is 28.8%.
- On the 28th February, there were 94 patients who had a LOS of 21+ days. 27 of those patients had been identified as medically fit for discharge. Chart 2 above shows the trend of stranded patients for both WRH and ALX and slide 8 shows how long stay patients are contributing to patient flow pressures across the Midlands.

What have we been doing?

- Primary Care Streaming - redirection tool pilot areas agreed and updated SOP written
- SDEC - Discharge task force situated on site and working closely with Urgent Care team, relationship working well and collaborating successfully
- Medical SDEC has expanded the pull criteria at risk. This has resulted in more conversions to inpatients, however it is a known risk to mitigate ED crowding
- Gynae operating escalation model when full, resulting in swifter pull and streaming and enabling availability of space
- Recruitment – successful B5/6 for ALX ED, B7 ED and Paeds HCA approved and advertised. 4 applications for substantive consultant in ED and Bank Consultant appointed for Acute Medicine

What are we doing next?

- SDEC Critical Friend visit agreed for 13th March
- Planning for winter 23/24 to ensure agreed supporting processes are agreed, established and funded ASAP
- Chasing updates on bids for national monies to support patient safety and flow
- Reduce reliance on Bank & Agency to include stopping use of premium agencies and initiatives to enhance substantive staff provision.
- Contribute to discussions with system partners to facilitate direct admissions to community beds and therefore reduce inappropriate admissions to acute beds

Current Assurance Level: 4 (Feb-23)	**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 (Jan-23)	**SRO: Chief Operating Officer**

Patient Flow | Month 11 [February] | 2022-23

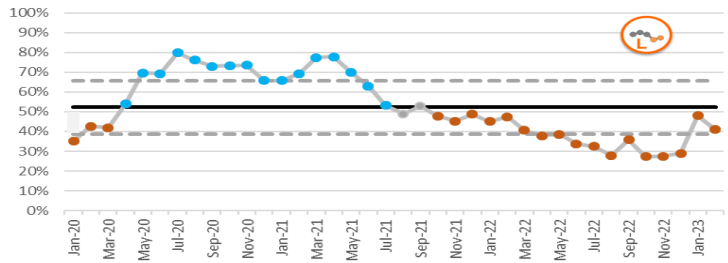
Responsible Director: Chief Operating Officer | Validated for Feb-23 as at 17th February 2023

NHS Worcestershire Acute Hospitals NHS Trust

Percentage of Ambulance handover within 15 minutes

41%

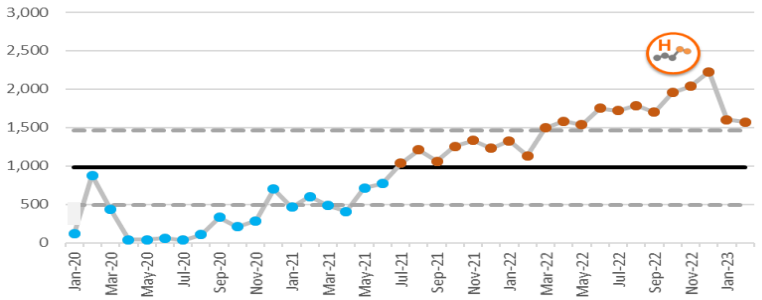
Ambulance handovers within 15 minutes



Patients spending more than 12 hours in ED

15%
1570 patients

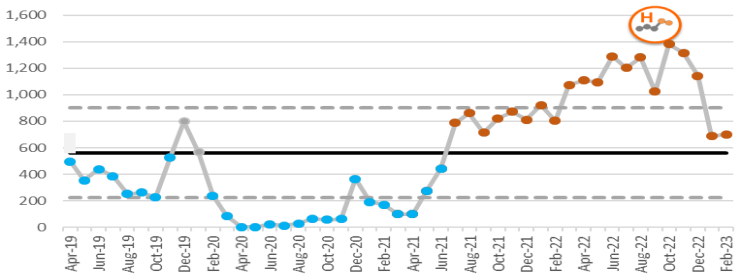
Patients spending 12+ hours in ED



60 minute Ambulance Handover Delays

700

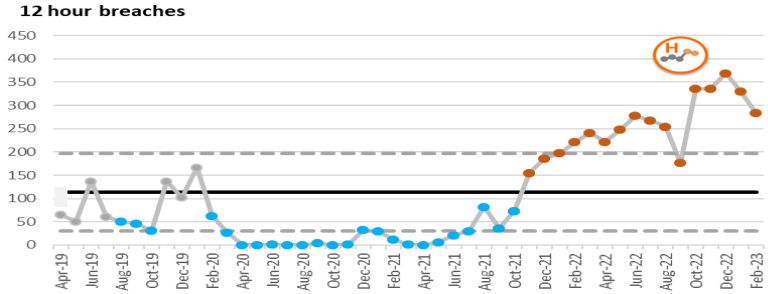
60 minute ambulance handover delays



12 Hour Trolley Breaches

283

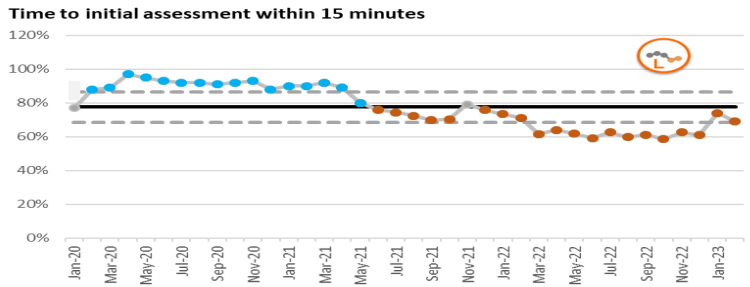
12 hour breaches



Time to Initial Assessment - % within 15 minutes

69%

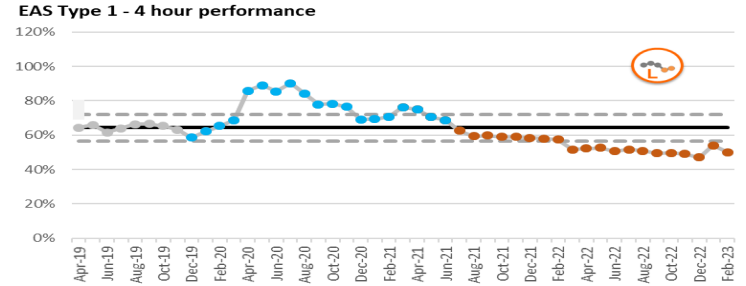
Time to initial assessment within 15 minutes



4 Hour EAS (Type 1)

50%
5,385 of 10,792

EAS Type 1 - 4 hour performance



All graphs include Feb-23 data

Patient Flow | Month 11 [February] | 2022-23

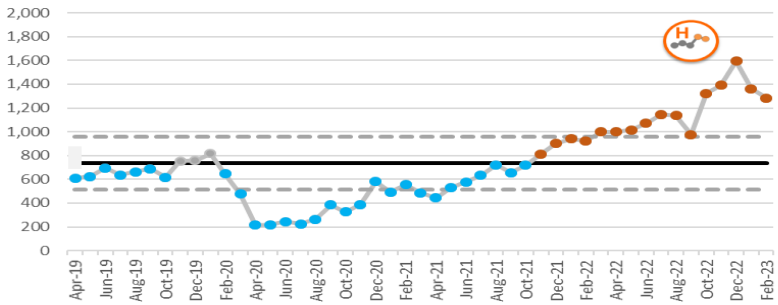
Responsible Director: Chief Operating Officer | Validated for Feb-23 as at 17th February 2023

NHS Worcestershire Acute Hospitals NHS Trust

Aggregated Patient Delay (APD)

Aggregated Patient Delay (APD)

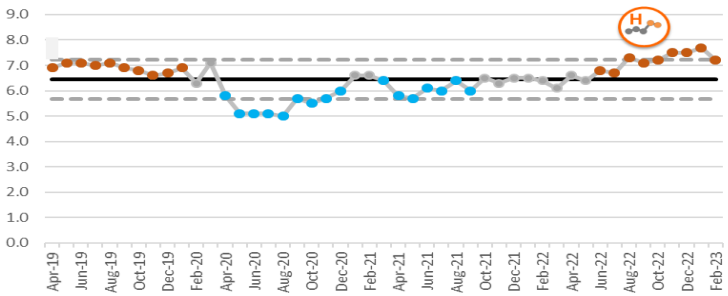
1,283



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

7.2 days

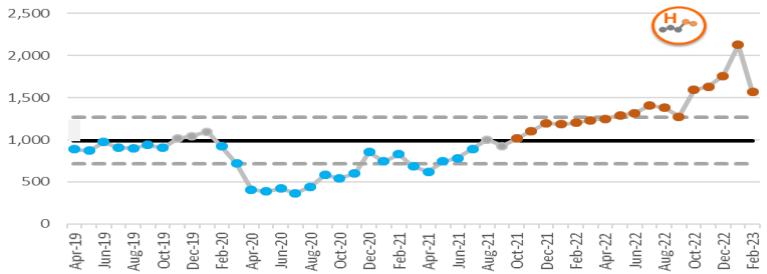
AVG LOS - NEL



Total Time in A&E

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

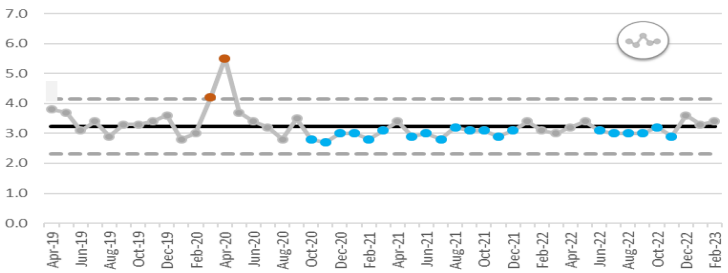
1,566 minutes



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

3.4 days

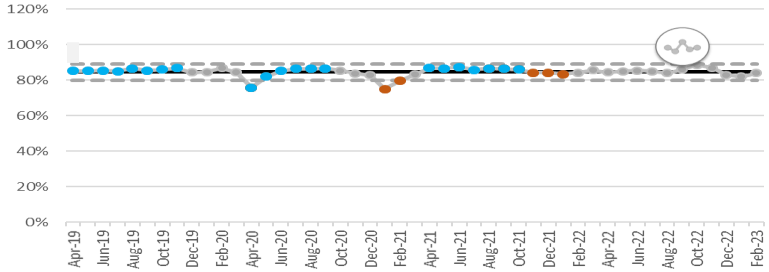
AVG LOS - EL



Usual Place of Residence

Patients discharged to usual place of residence

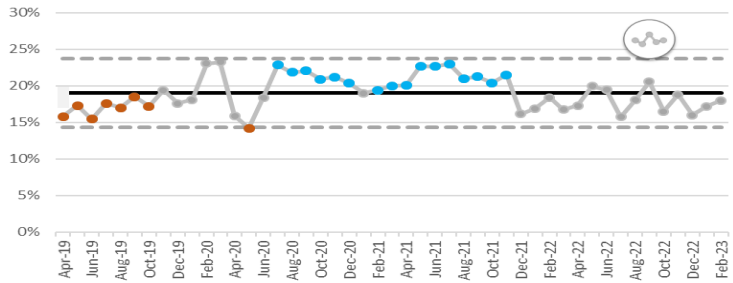
83.7%



% Discharges before midday

18%

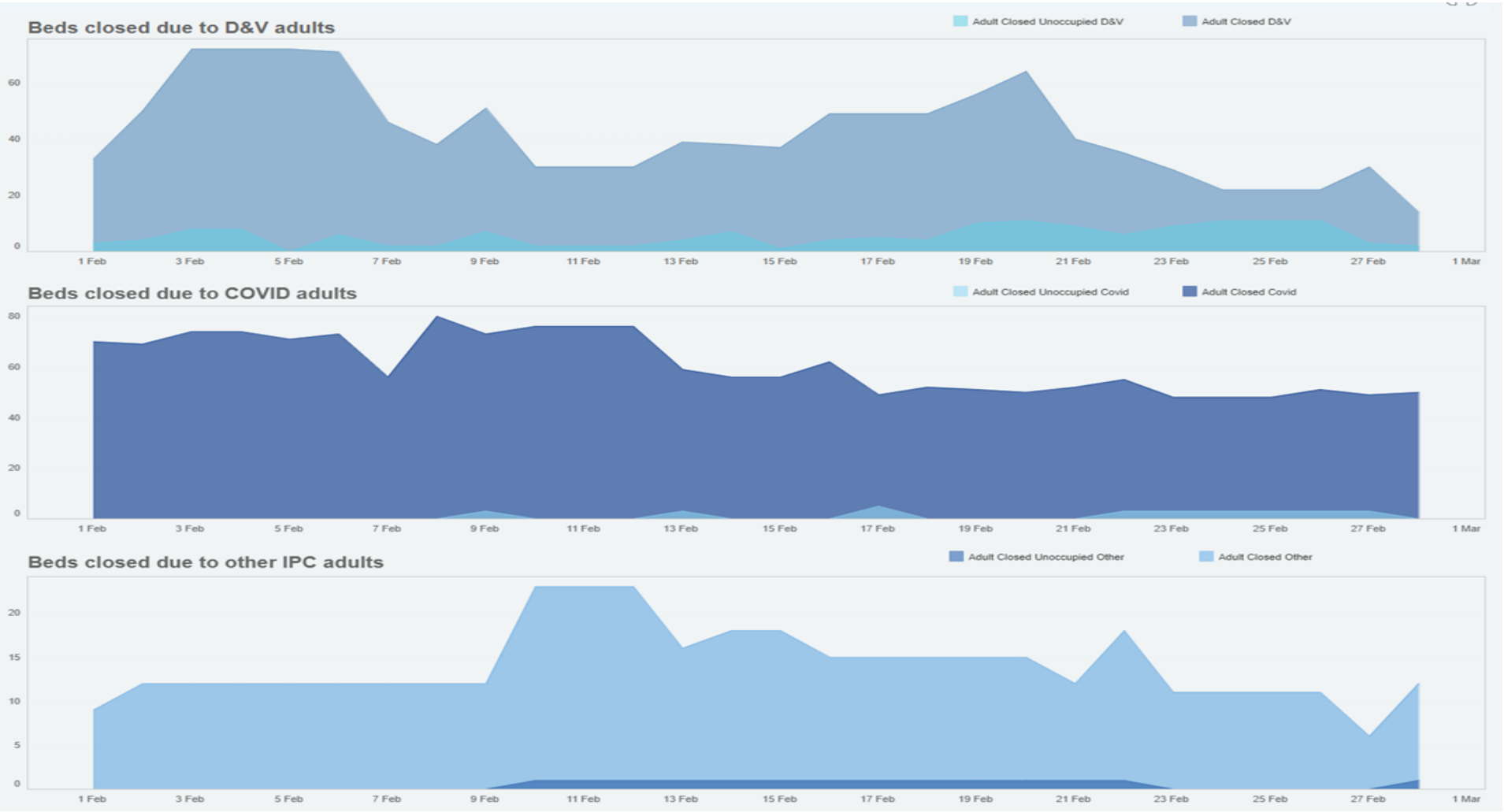
Discharges before midday



All graphs include Feb-23 data

Patient Flow – Beds occupied or closed due to infection prevention | Month 11 [February] 2022-23

As submitted on the UEC Daily Sitrep (DSIT)



7

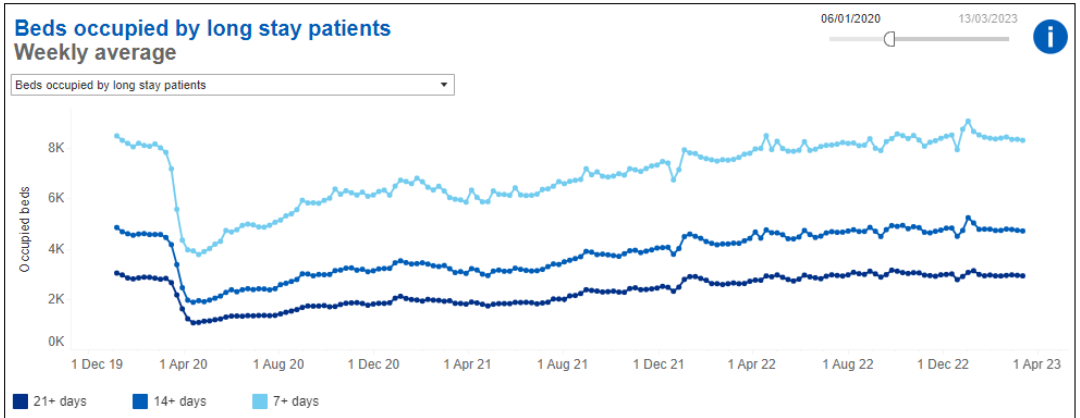
Patient Flow – Beds occupied by long stay patients| Month 11 [February] 2022-23

Midlands aggregated position to 13th March 2023

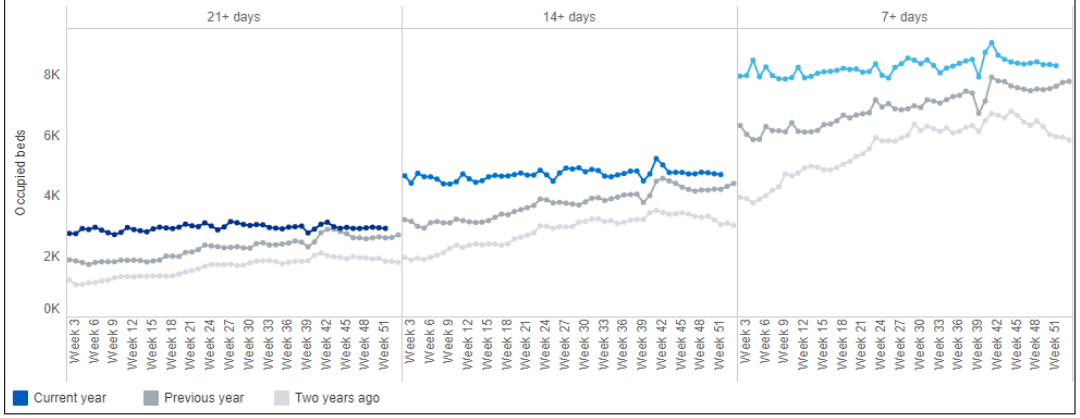
Worcestershire Acute Hospitals NHS Trust

Beds occupied by adult patients in an acute hospital for 21+, 14+, and 7+ days

Beds occupied by long stay patients
Weekly average

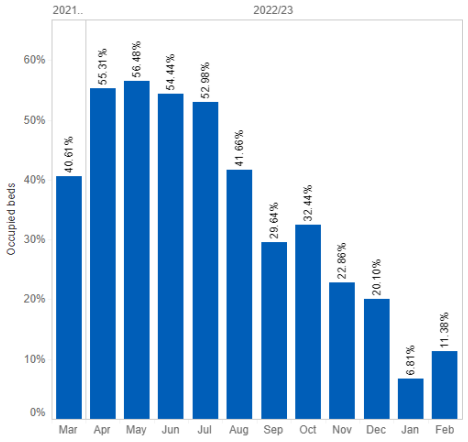


Beds occupied by long stay patients
Year on year comparison



Monthly average of beds occupied by adult patients in an acute hospital for 21+ days

% difference of year on year comparison



Year on year comparison data table

	2021/22	2022/23	Monthly avg difference	Monthly avg difference %
Apr	1,809	2,810	1,001	55.31%
May	1,802	2,819	1,017	56.48%
Jun	1,856	2,867	1,011	54.44%
Jul	1,905	2,915	1,009	52.98%
Aug	2,126	3,012	886	41.66%
Sep	2,316	3,003	687	29.64%
Oct	2,313	3,063	750	32.44%
Nov	2,400	2,949	549	22.86%
Dec	2,424	2,911	487	20.10%
Jan	2,822	3,014	192	6.81%
Feb	2,628	2,927	299	11.38%
Mar	2,623			

EAS Benchmarking

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

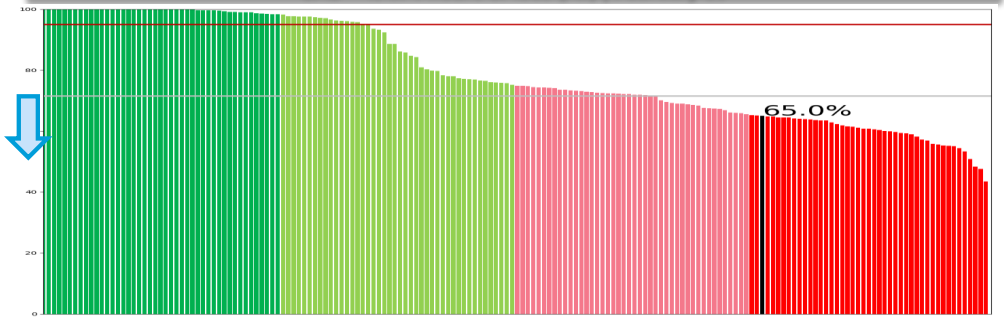
National Benchmarking (February 2023)

EAS (All) – 7 West Midlands Trusts, including WAHT, saw a decrease in performance between Jan-23 and Feb-23. This Trust was ranked 9 out of 13; we were ranked 6 the previous month. The peer group performance ranged from 47.6% to 77.9% with a peer group average of 65.8%; declining from 66.1% the previous month. The England average for Feb-23 was 71.5%; a 0.9% decrease from 72.4% in Jan-23.

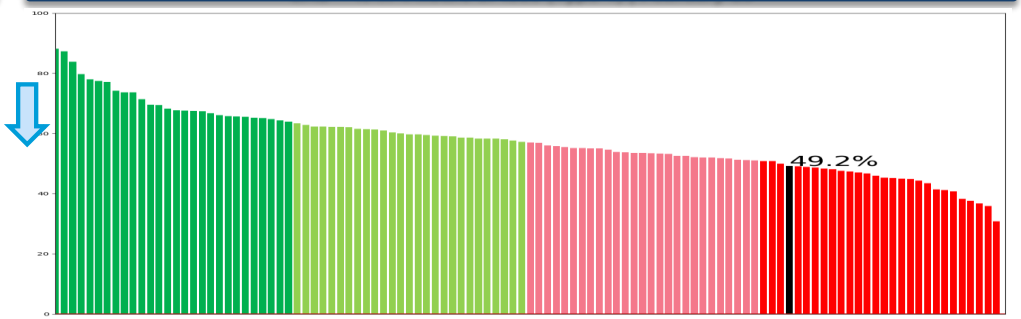
EAS (Type 1) – 8 West Midlands Trusts, including WAHT, saw a decrease in performance between Jan-23 and Feb-23. This Trust was ranked 9 out of 13; we were ranked 10 the previous month. The peer group performance ranged from 35.89% to 67.66% with a peer group average of 52.08%; declining from 54.08% the previous month. The England average for Feb-23 was 56.8%; a 1.2% decrease from 58.0% in Jan-23.

In Feb-23, there were 47,735 patients recorded as spending >12 hours from decision to admit to admission. 283 of these patients were from WAHT; 0.59% of the total.

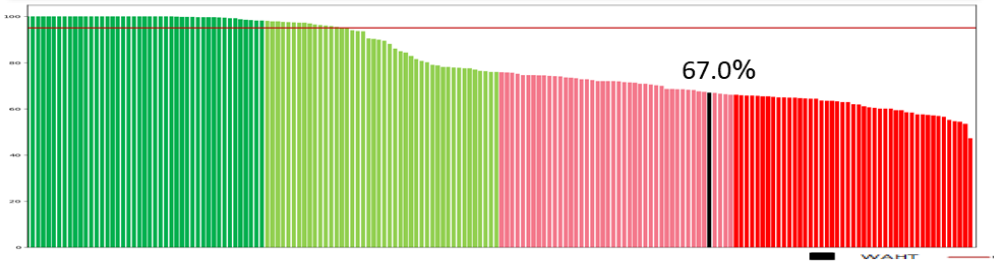
EAS – % in 4 hours or less (All) | February-23



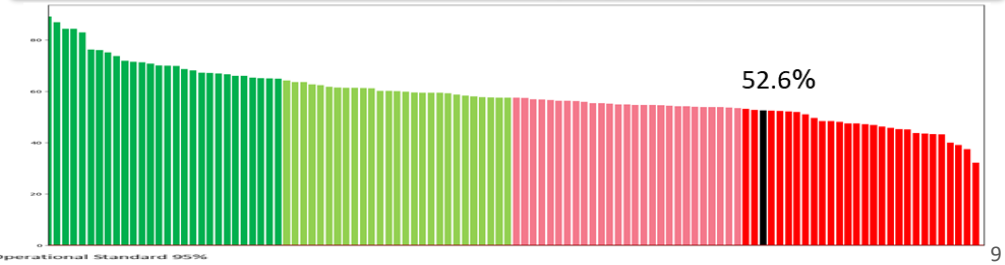
EAS – % in 4 hours or less (Type 1) | February-23



EAS – % in 4 hours or less (All) | January-23



EAS – % in 4 hours or less (Type 1) | January-23



9

Elective Recovery - Cancer

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

Worcestershire Acute Hospitals NHS Trust

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

What does the data tells us?

- **2WW referrals** in February have increased in-line with seasonal variation and back to levels seen before December. Lower GI, Skin and Urology are again the specialties seeing the most demand.
- **2WW** has remained at special cause improvement with 93% of patients seen within 14 days. 5 specialties achieved the operational standard.
- **2WW Breast Symptomatic** has remained special cause improvement this month with 99% of patients seen within 2 weeks.
- **28 Faster Diagnosis** is still showing normal variation with 4 specialities achieving operational standard. The target of 75% is achievable but not consistently.
- **31 Day:** This metric is still deteriorating and the target is unlikely be achieved without intervention.
- **62 Day:** This metric is still deteriorating and the target will not be achieved without intervention and will be limited by needing to reduce the backlog of patients over 62 days.
- **Cancer PTL** has remained static between January (3,217) and February (3,128). 348 patients have been diagnosed and 2,780 are classified as suspected.
- **Backlog:** The 62+ day backlog is now showing as special cause improvement due to the downward trend over 6 months. The total number of patients waiting 63+ days is 418 and the number of patients waiting 104+ days has decreased to 182. Accountability as a Tier 1 Trust focuses on the urgent suspected referral backlog which, as at 5th March, had reduced to 302 (11% of PTL) of which 152 are waiting over 104 days. Urology remains the specialty of focus with 172 patients breaching 62 days.

What have we been doing?

- Early indications are that the Trust has achieved the overall 2ww target for the second consecutive month in January 2023 (validation still ongoing), with a strong start made to February 2023 also. This is in spite of delays owing to the Christmas and New Year holidays and also disruption to some services as a result of nursing industrial action, with the specialties of Breast, Colorectal, Haematology, Head and Neck, Skin and Urology all delivering strong performances.
- 28 day FDS performance continues to stabilise with improvements in Colorectal and Skin helping to bring this matric up a few further percentage points than we saw for the first 7 months of the year.
- In line with expectations and new guidance, tertiary referrals are now excluded from our reported backlog to NHSEI alongside previously excluded screening and upgrade patients. Attention is now turning to specialties where certain diagnostic procedures can be classed as treatments (following histology confirmation) to exclude these from backlog submissions slightly earlier than would otherwise be possible.
- Cancer backlog of 401 patients over 62 days week ending 05/02/2023 is now less than half it was at its peak of 830 week ending 18/09/2022, with biggest reductions coming from Skin, Colorectal, Urology, Breast and Lung.

What are we doing next?

- Progress update is required regarding the continuation of external resourcing support for the 2ww Skin pathway, with the 18 Week Support contract due to stop at the end of March 2023 and referrals set to start increasing around then in line with usual seasonal variation.
- New remedial action plan (RAP) templates have been issued by our Director of Performance with a deadline of 22nd February 2023; this with a view to producing bottom-up plans and trajectories to achieve both the 28 day FDS and backlog targets for 2023/24.
- Work continues on understanding the extent of fixed term and externally funded workforce that is supporting the cancer services agenda, across a wide range of posts and directorates / departments.

Current Assurance Levels (Feb-23)	Previous Assurance Levels (Jan-23)
2WW – Level 5 ***CHANGE***	2WW - Level 4
31 Day Treatment - Level 5	31 Day Treatment - Level 5
62 Day Referral to Treatment – Level 3	62 Day Referral to Treatment - Level 3

When expected to move to next levels of assurance: when we are consistently meeting the operational standards of cancer waiting times and the backlog of patients waiting for diagnosis / treatment starts to decrease.

SRO: Chief Operating Officer

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Elective Recovery - Cancer | Month 11 [February] 2022-23

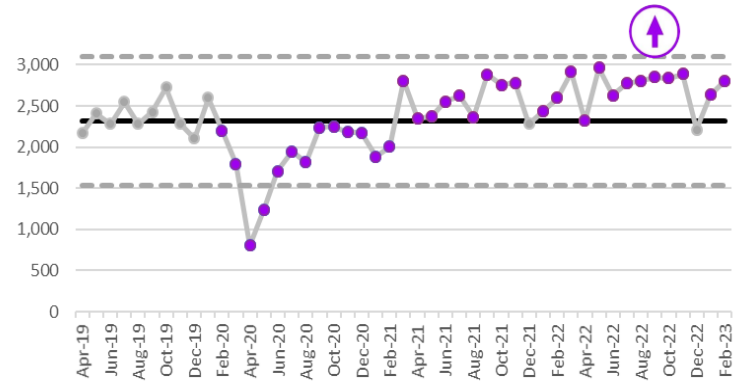
Responsible Director: Chief Operating Officer | Unvalidated for Feb-23 as at 9th March 2023

NHS Worcestershire Acute Hospitals NHS Trust

2WW Referrals

2,808

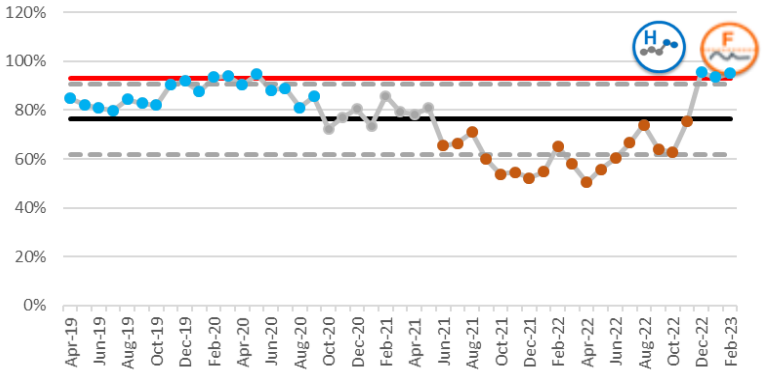
2WW Cancer Referrals



2WW Cancer

95%
2,418 patients seen

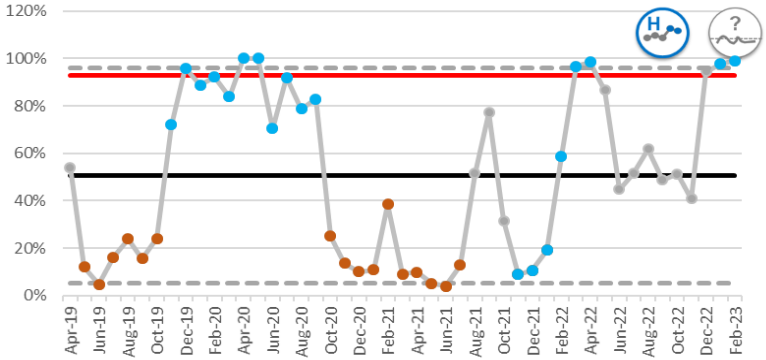
2WW Cancer (All)



2WW Breast Symptomatic

99%
109 patients seen

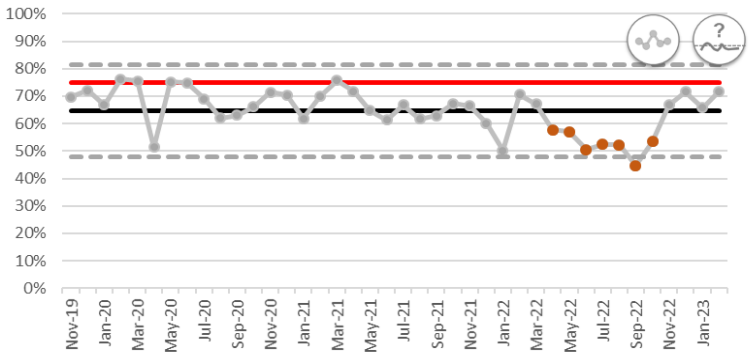
2WW Cancer Breast Symptomatic



28 Day Faster Diagnosis

72%
1,802 patients told

28 Day Faster Diagnosis



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

All graphs include Feb-23 data

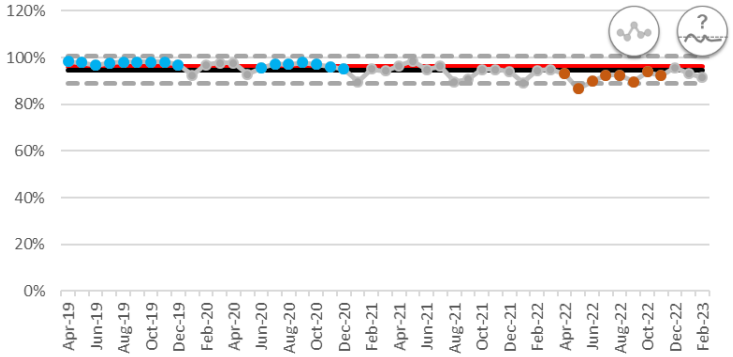
Elective Recovery - Cancer | Month 11 [February] 2022-23

Responsible Director: Chief Operating Officer | Unvalidated for Feb-23 as at 9th March 2023

NHS Worcestershire Acute Hospitals NHS Trust

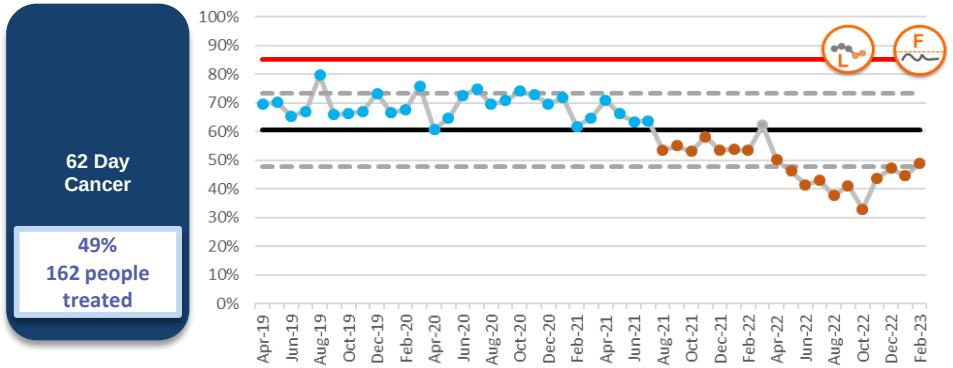
31 Day Cancer

92%
247 patients treated



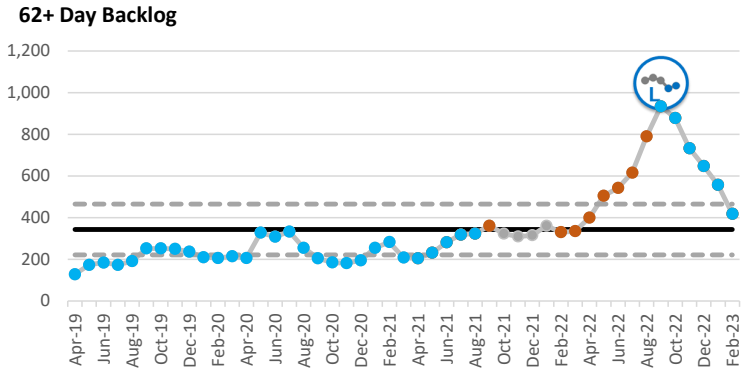
62 Day Cancer

49%
162 people treated



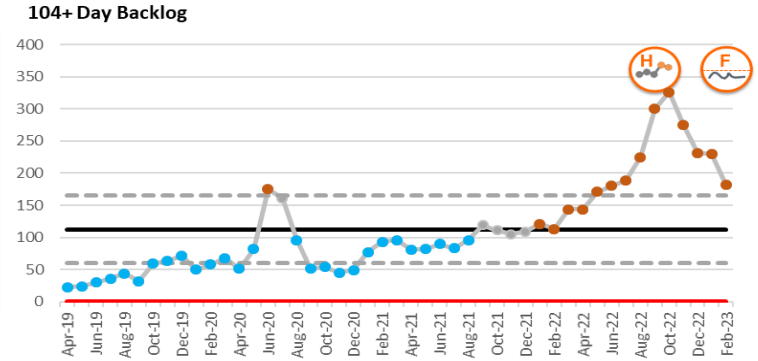
Backlog Patients waiting 63 days or more*

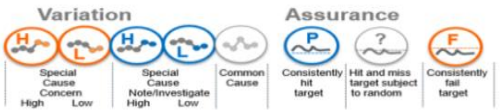
418



Backlog Patients waiting 104 day or more*

182





Key

- Internal target
- Operational standard

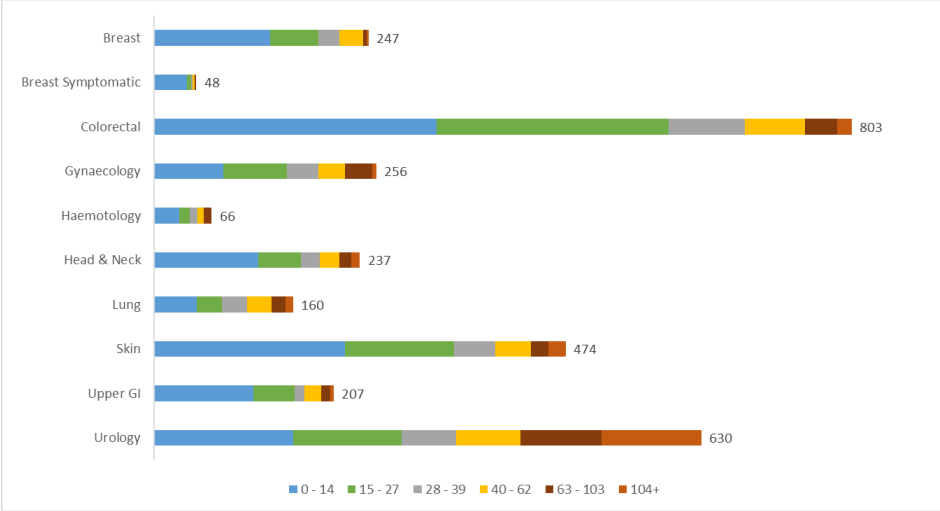
All graphs include Feb-23 data

Elective Recovery - Cancer | Month 11 [February] 2022-23

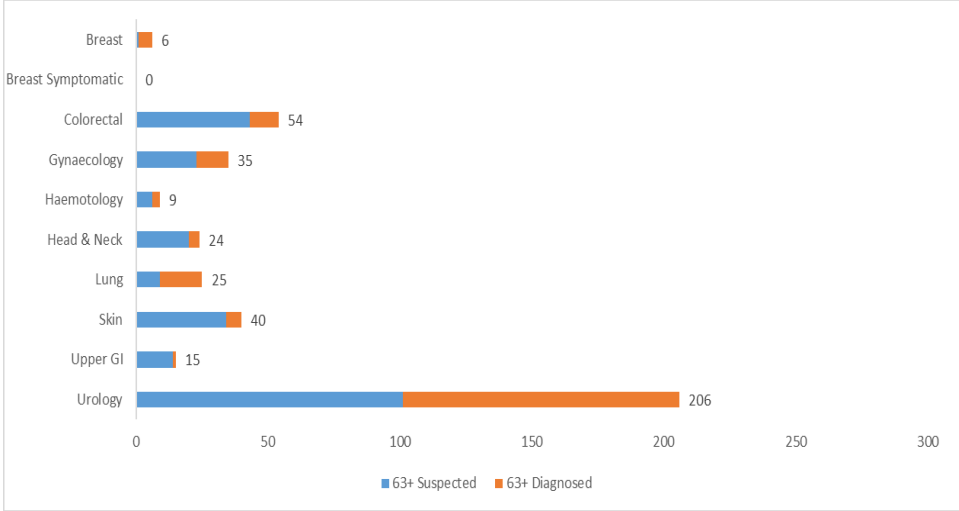
Responsible Director: Chief Operating Officer | Validated for Feb-23 as at 9th March 2023

NHS Worcestershire Acute Hospitals NHS Trust

Cancer PTL by Specialty and Days Wait



Cancer Long Waiter Backlog by Specialty and Status

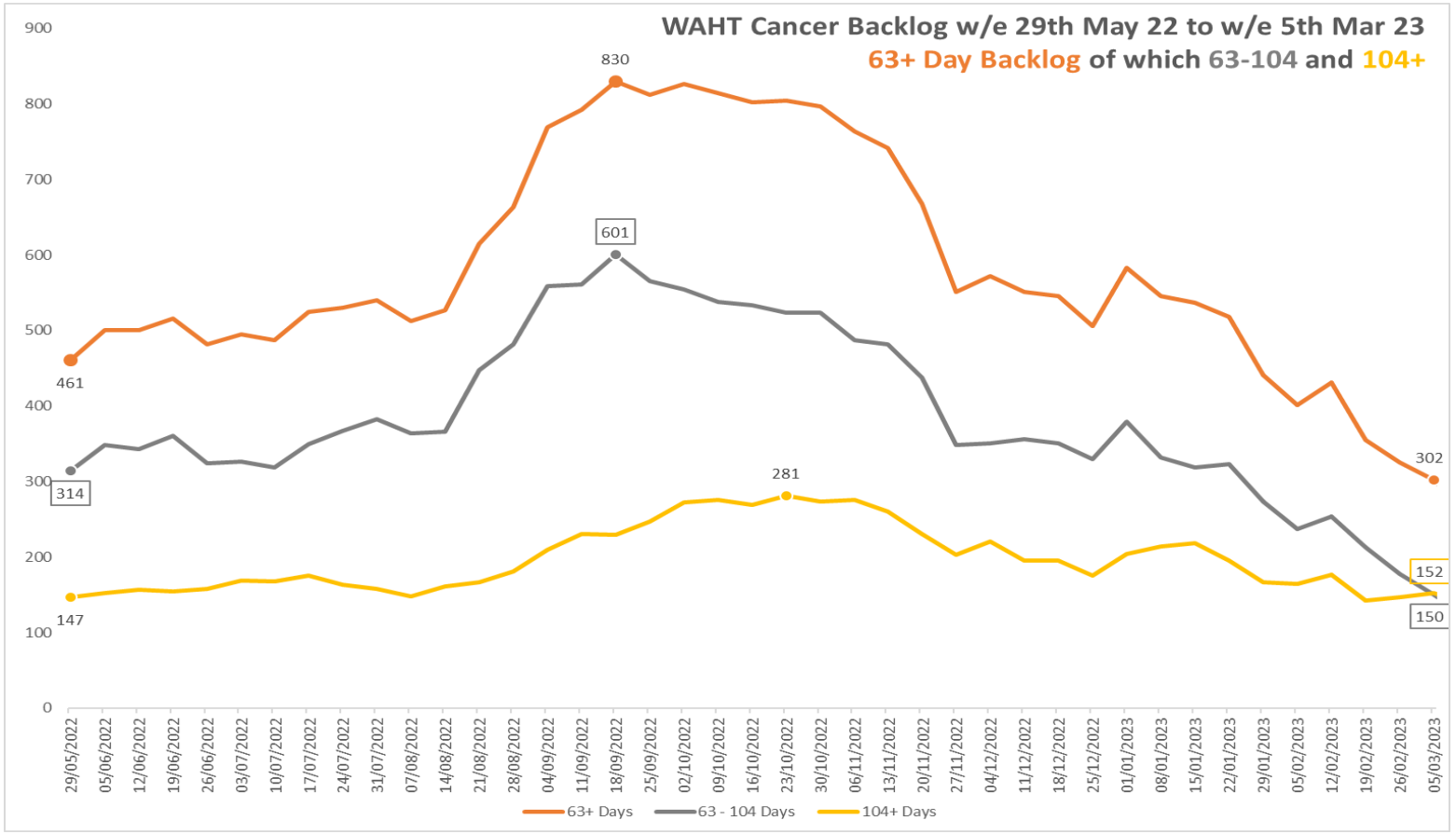


The graphs above show the number of cancer patients on our PTL and split by days waiting.

Colorectal, Skin and Urology have the largest PTLs and patients waiting over 63 days.

Elective Recovery - Cancer | Month 11 [February] 2022-23

Responsible Director: Chief Operating Officer | Validated for w/e 5th March as at 6th March 2023



The graphs above show the reduction in our cancer PTL and the improved position in reducing the **urgent suspected referral backlog cohort** (those waiting over 62 days).

14

Cancer Benchmarking

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

National Benchmarking (January 2023)

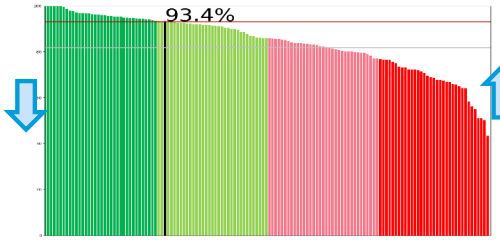
2WW: The Trust was one of 6 of 13 West Midlands Trusts which saw a decrease in performance between Dec-22 and Jan-23. This Trust was ranked 4 out of 13; we were ranked 3 the previous month. The peer group performance ranged from 64.0% to 97.6% with a peer group average of 85.0%; improving from 83.5% the previous month. The England average for Jan-23 was 81.8%; a 1.5% increase from 80.3% in Dec-22.

2WW BS: The Trust was one of 9 of 13 West Midlands Trusts which saw an increase in performance between Dec-22 and Jan-23. This Trust was ranked 4 out of 13; we were ranked 5 the previous month. The peer group performance ranged from 3.7% to 99.2% with a peer group average of 85.4%; improving from 81.1% the previous month. The England average for Jan-23 was 76.9%; a 4.4% increase from 72.5% in Dec-22.

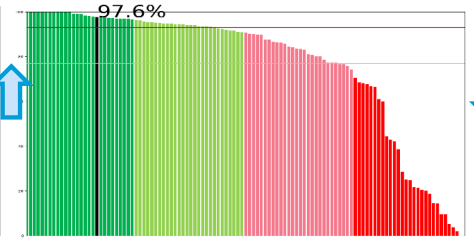
31 days: The Trust was one of 10 of 13 West Midlands Trusts which saw a decrease in performance between Dec-22 and Jan-23. This Trust was ranked 4 out of 13; we were ranked 3 the previous month. The peer group performance ranged from 76.4% to 100.0% with a peer group average of 83.9%; declining from 88.0% the previous month. The England average for Jan-23 was 88.5%; a 4.2% decrease from 92.7% in Dec-22.

62 Days: The Trust was one of 11 of 13 West Midlands Trusts which saw a decrease in performance between Dec-22 and Jan-23. This Trust was ranked 9 out of 13; we were ranked 10 the previous month. The peer group performance ranged from 27.9% to 66.2% with a peer group average of 44.2%; declining from 48.8% the previous month. The England average for Jan-23 was 54.4%; a 7.4% decrease from 61.8% in Dec-22.

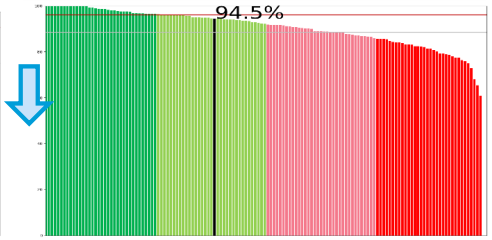
2WW (All cancers) | January-23



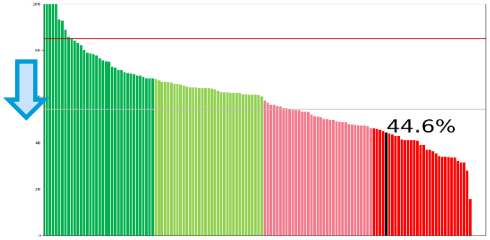
2WW Breast Symptomatic | January-23



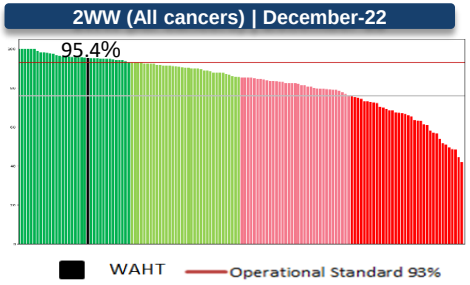
Cancer 31 Day (All cancers) | January-23



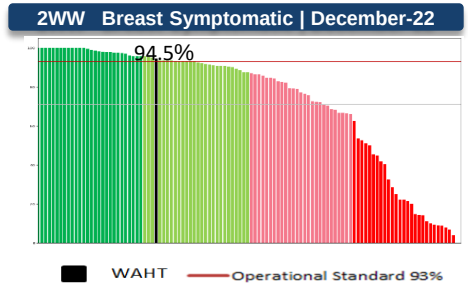
Cancer 62 day (All cancers) | January-23



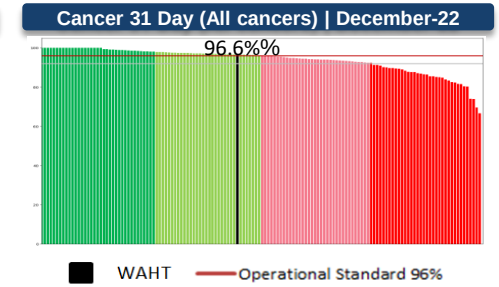
2WW (All cancers) | December-22



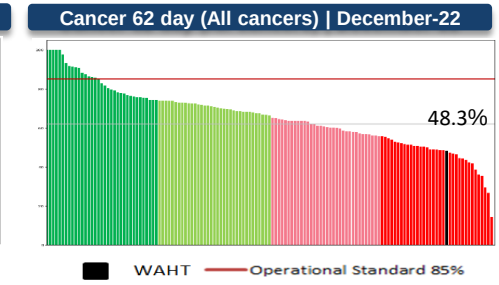
2WW Breast Symptomatic | December-22



Cancer 31 Day (All cancers) | December-22



Cancer 62 day (All cancers) | December-22



15

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) 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 NHS	Of whom, waiting 78+ weeks NHS	Of whom, waiting 104+ weeks NHS
Total	Not available at time of writing						
Non-2WW							

What does the data tells us?

Referrals (unvalidated)

Referral To Treatment Time (validated)

- The RTT Incomplete waiting list is validated at 67,210. This is not a significant change from the previous months but is the second consecutive decrease in 22/23.
- RTT performance for Feb-23 is validated at 45.7% compared to 45.1% in Jan-23 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 7,158, a 98 patient decrease from the previous month. Of that cohort, 713 patients have been waiting over 78 weeks, decreased from 1,092 the previous month, and there were no patients over 104 weeks.

What have we been doing?

- Continuing with the administration validation – contacting all patients over 26 weeks wait has begun – 11% of the cohort who have responded have been discharged as they no longer required their appointments (16,711/21,790 responses so far of which 1,285 have said appointment not required).
- We continue to focus on the longest waiting patients to achieve the Mar-23 78+ week breaches target and prioritising patients for a route to zero in the following months.
- An in-sourcing arrangement has been put in place to reduce the number of long waiter patients requiring a first OPA in General Surgery.

What are we doing next?

- Increased focus on accessing capacity with local independent sector providers continues and teams are exploring capacity outside of the area for patient willing to travel, this is line with the national process via DMAS (digital mutual aid system).
- Mapping the outcomes of the administration validation for, where necessary, clinical / operational review and complete the validation to 12 weeks (completion due in May-23).
- Review performance modelling for RTT once the final annual plan has been submitted. We already know that we need to complete 57,000 pathways to prevent 65 week breaches at the end of 23/24, double what we had to achieve this year.

Current Assurance Level: 3 (Feb-23)	**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 (Jan-23)	**SRO: Chief Operating Officer**

Elective Recovery – Referral To Treatment | Month 11 [February] 2022-23

Responsible Director: Chief Operating Officer | Validated for Feb-23 as at 17th March 2023

NHS Worcestershire Acute Hospitals NHS Trust

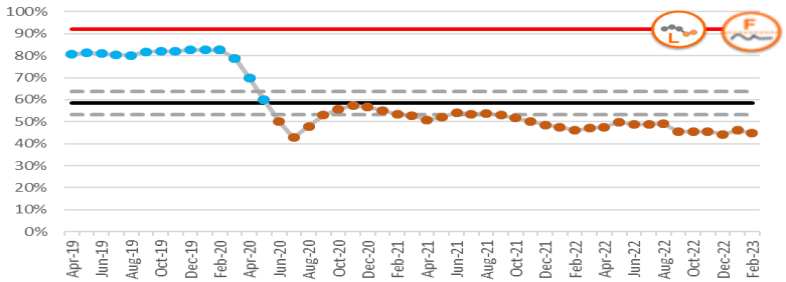
Electronic Referrals Profile (non-2WW)

Not available at time of writing

RTT % within 18 weeks

45.7%

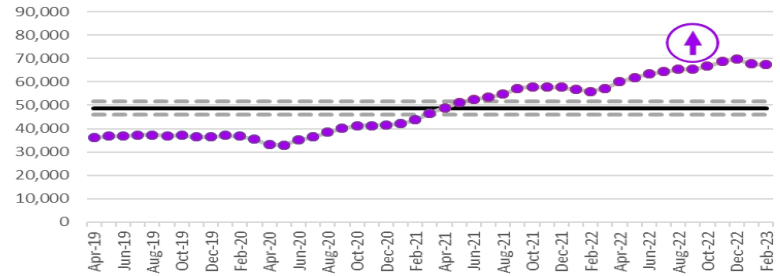
RTT - % Incomplete



RTT Incomplete PTL

67,210

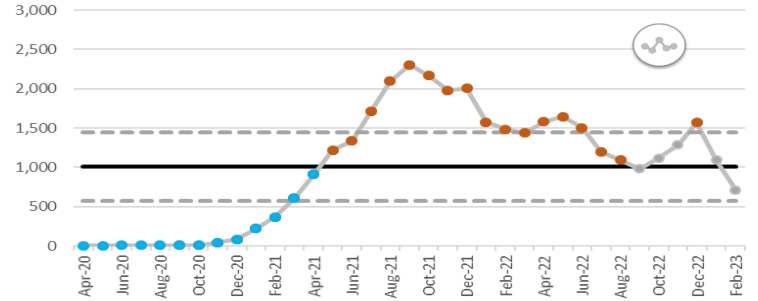
RTT Waiting List



78+ week waits

713

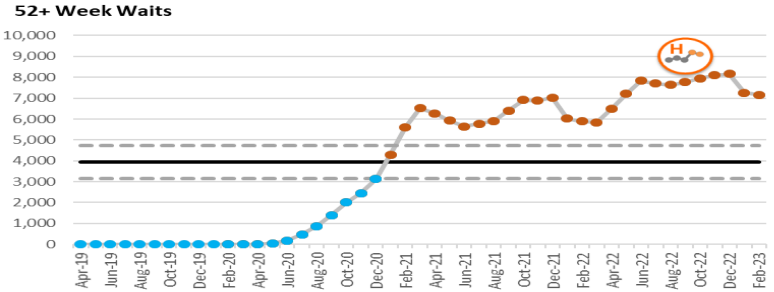
78+ Week Waits



52+ week waits

7,158

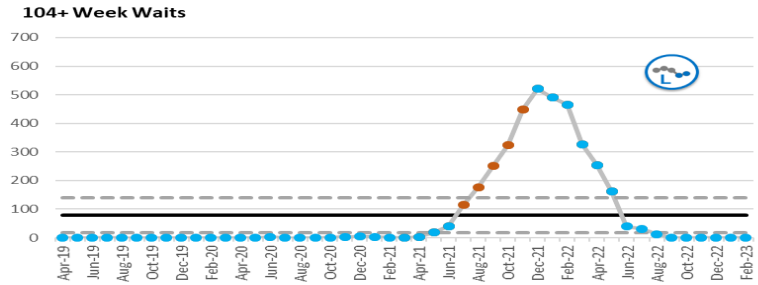
52+ Week Waits



104+ week waits

0

104+ Week Waits



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

All graphs include Feb-23 data

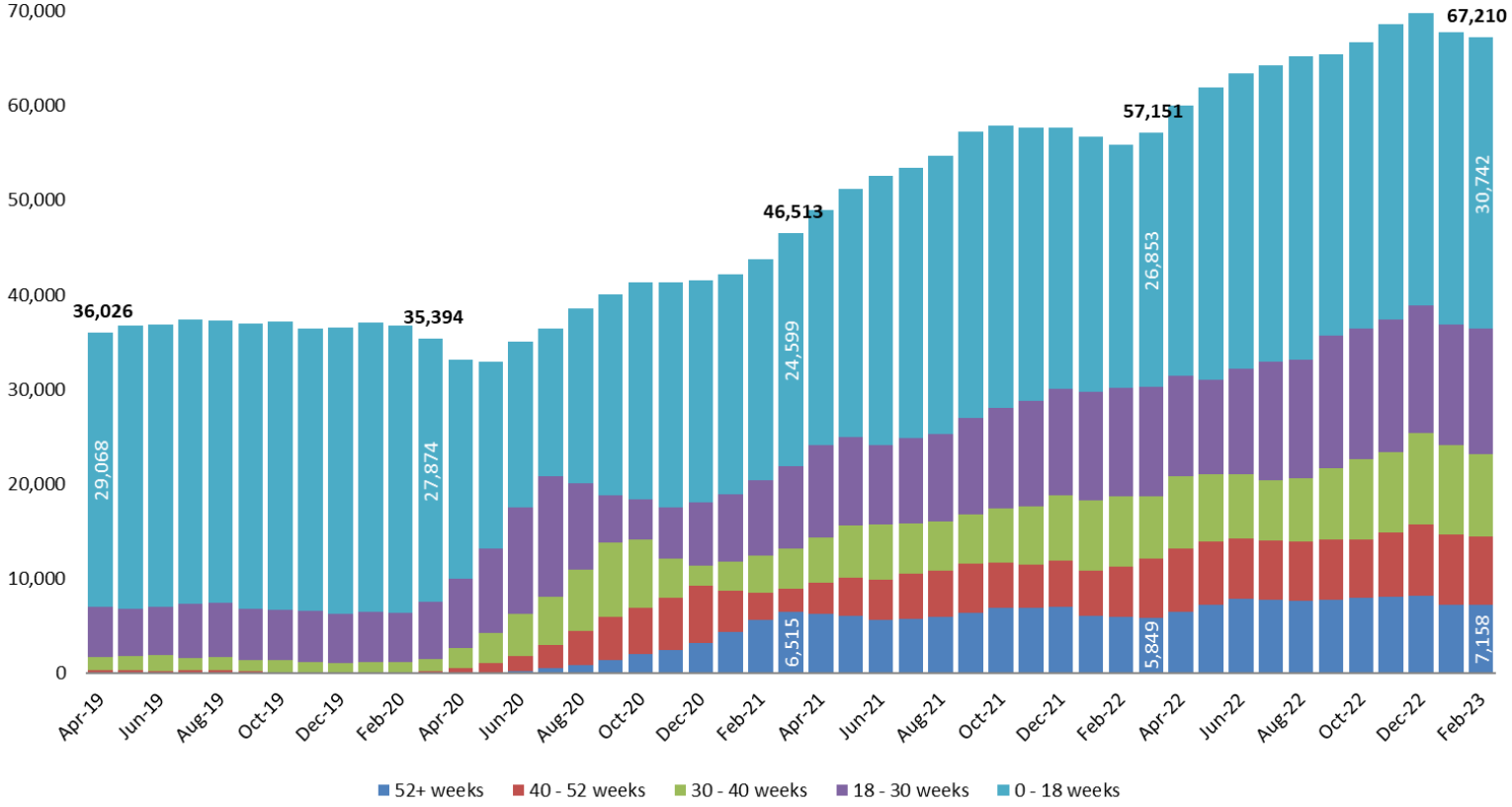
Elective Recovery - RTT Incomplete Waiting List | Month 11 [February] | 2022-23

Responsible Director: Chief Operating Officer | Validated for Feb-23 as at 17th March 2023

NHS Worcestershire Acute Hospitals NHS Trust

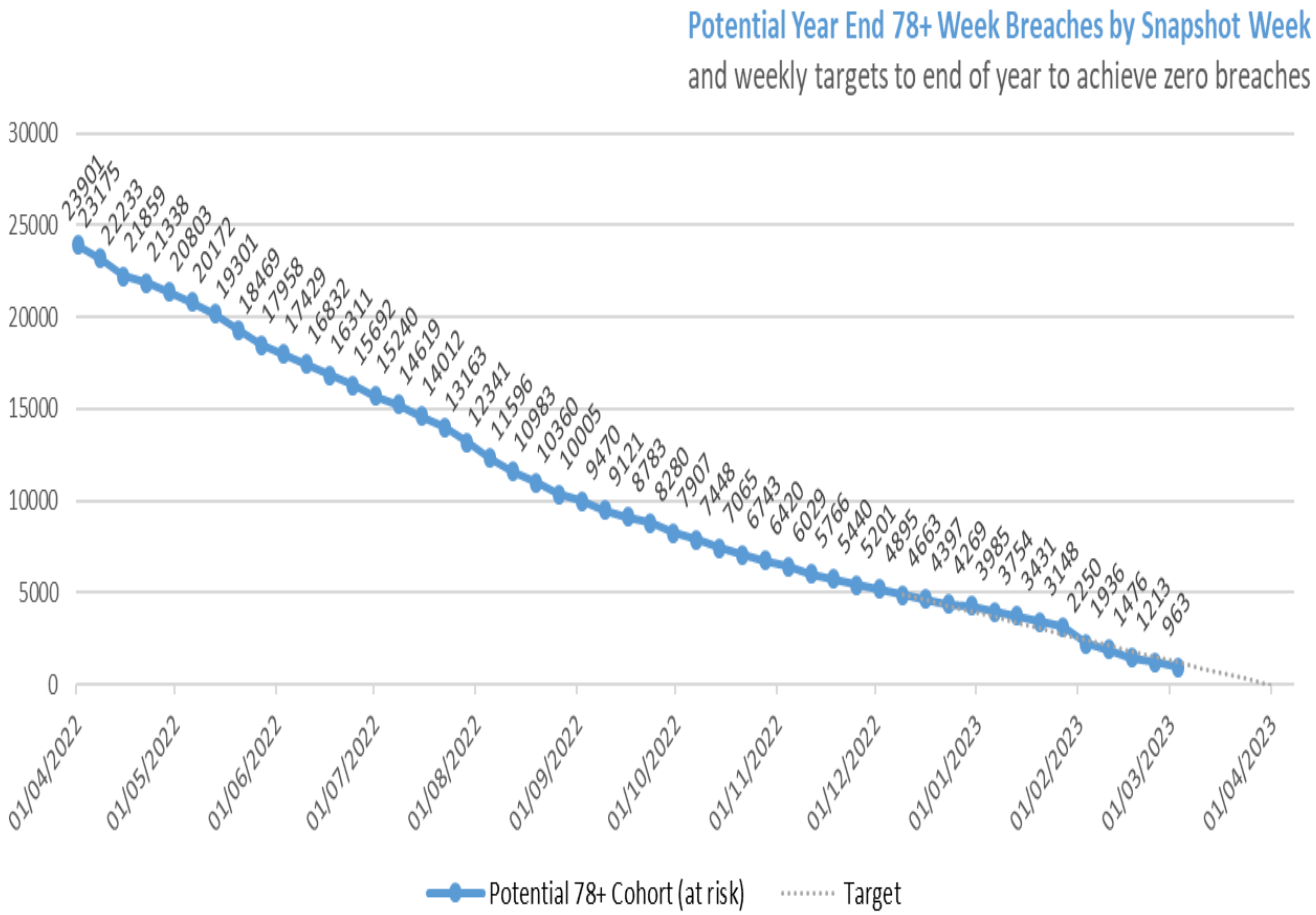
Patients waiting for first definitive treatment Apr-19 to Feb-23

Split by weeks waiting



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

Responsible Director: Chief Operating Officer | Validated to 3rd March 2023



The graph shows an updated position on our weekly progress to date in reducing the patients who will otherwise breach by April. The target line is still based on ~305 clock stops a week for the remaining 6 weeks to result in zero breaches at month end Mar-23.

At the time of writing, the improvement has been from 1,936 (reported in the previous IPR) to 963 patients.

The forecasted position is that we will end the year at ~400 breaching patients still requiring a clock stop with the majority requiring tests, follow-ups and surgery rather than OPA New.

Referral To Treatment Benchmarking

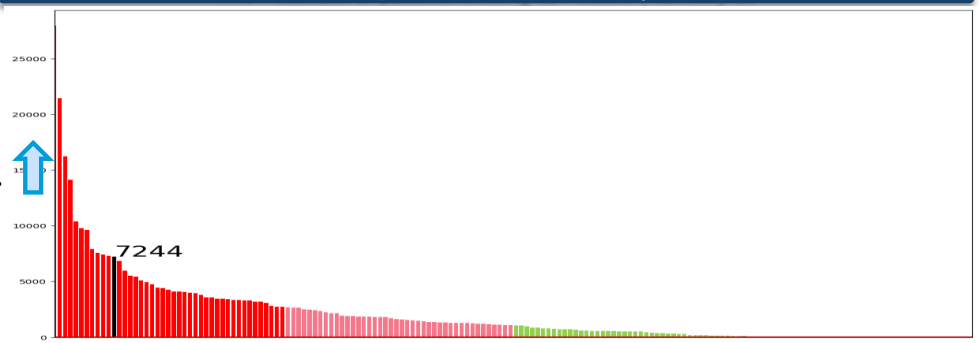
STRATEGIC OBJECTIVE TWO: BEST EXPERIENCE OF CARE AND BEST OUTCOMES FOR OUR PATIENTS | BEC1: elective recovery and reset

National Benchmarking (January 2023) | The Trust was one of 10 of 12 West Midlands Trusts which saw an increase in performance between Dec-22 and Jan-23. This Trust was ranked 12 out of 13; no change from the previous month. The peer group performance ranged from 41.98% to 69.79% with a peer group average of 52.07%; improving from 51.01% the previous month. The England average for Jan-23 was 58.30%; a 0.3% increase from 58.00% in Dec-22.

- Nationally, there were 379,245 patients waiting 52+ weeks, 7,244 (1.91%) of that cohort were our patients.

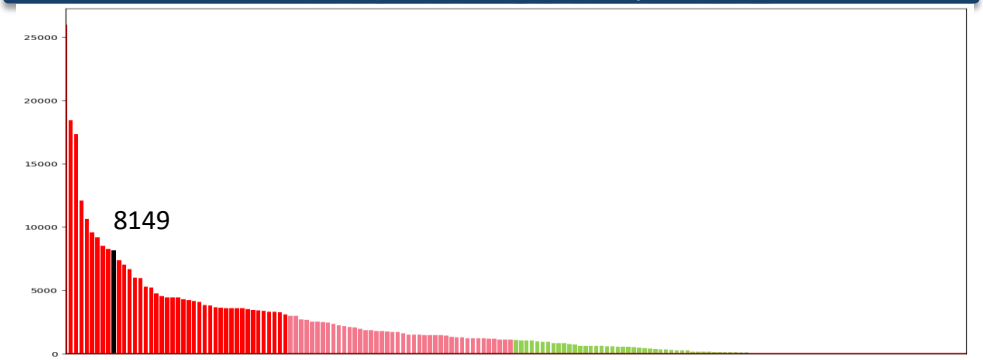
RTT - % patients within 18 weeks | January-23

RTT – number of patients waiting 52+ weeks | January-23



RTT - % patients within 18 weeks | December-22

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



20

Elective Recovery | Outpatients and Elective Inpatients

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

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

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

- The OP data on slide 21 compares our second SUS submission for Feb-23 outpatient attendances to Feb-20 and our annual plan activity targets. As noted in the top row of this table we did not achieve our submitted plan, noting that appointments were rescheduled due to industrial action.
- In the RTT Clock Ticking outpatient cohort, there are over 34,000 patients waiting for their first appointment. 32% of the total cohort waiting for a first appointment have been dated. Of those not dated 1,838 patients have been waiting over 52 weeks (1,975 last month) noting 16 are waiting 78+ weeks and 83 between 65 and 78 weeks.
- The top five specialties with the most 52+ week waiters in the outpatient new cohort remains unchanged and are ENT, General Surgery, Urology, Gynaecology and Oral Surgery.

Planned Admissions of Elective Inpatients - what does the data tell us?

- In Feb-23, the total number of day cases and EL IP decreased and both day case (427) and EL IP (-329) were below the annual plan target for the month noting that elective admission were rescheduled due to industrial action.
- Theatre utilisation continues to showing positive improvement.
- Although the cases per list shows deteriorating performance, it did increase to 2.6 in Feb-23; however this does require improvement in order to bridge the gap to annual plan activity targets in 22/23 and into 23/24.
- Lost utilisation due to late start / early finish remains at normal variation. 395 hours were lost in Feb-23 and is made up of 170 hours that are due to late starts and 226 hours that were early finishes. An average of 1 hour 13 minutes were lost per 4 hour session, noting this is apportioning out the total time lost across all 324 sessions delivered in Feb-23, even if a session itself was fully utilised.
- On the day cancellations are still showing normal variation.
- 35% of eligible patients were rebooked within 28 days for their cancelled operation in Jan-23; this is 8 of 23 patients being rebooked within the required timeframe but no significant change from the "normal" outcome.

What have we been doing?

- Continuation of developments within the personalised patient portal that will provide higher visibility and self-management for patients.
- Finalise the opportunities for consideration in annual planning from the GIRFT programme.
- TIF2 – Elective Care Hub modelling has been completed. This will come on-stream in August 2023.

What are we doing next?

- Working with the CSU who are identifying opportunities for productive changes to our operational business model which include:
  - A review of booking processes to ensure consistency across our hybrid model (centralised and devolved teams)
  - Strengthening policies e.g. moving from 6 to 8 weeks notice for annual leave
  - Assessing our physical space vs utilised space to determine the most efficient delivery model and consider if there are opportunities for rental to other providers
- ICS support for PIFU is currently reviewing of the pros and cons of the Leicester delivery model. This could involve contacting the entire follow-up waiting list.
- Digital are working with Booking Teams to remove the reliance of two separate databases that currently support clinic cancellation.

Current Assurance Level: 4 (Feb-23)	**When expected to move to next level of assurance: :** This is dependent on the success of the programme of restoration for increasing outpatient appointments and planned admissions for surgery being maintained and in-line with annual planning expectations from NSHE for 2022/23.
Previous Assurance Level: 4 (Jan-22)	**SRO: Chief Operating Officer**

Elective Recovery – Outpatient and Elective Activity | Month 11 [February] 2022-23

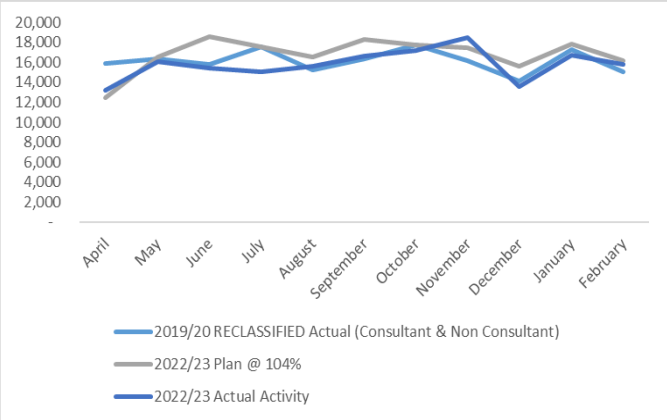
Responsible Director: Chief Operating Officer | Unvalidated for February 2023 (Second SUS Submission)

Worcestershire Acute Hospitals NHS Trust

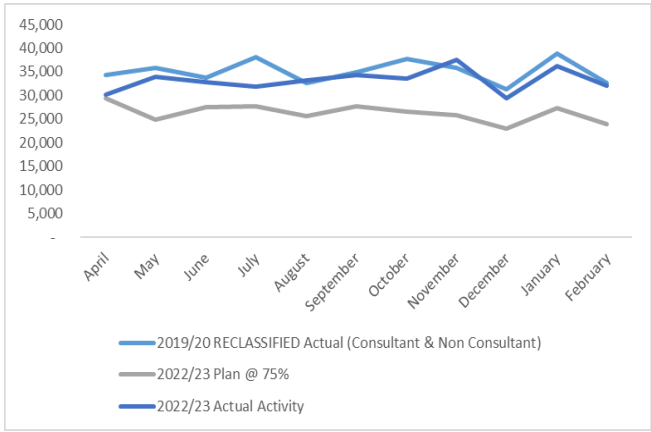
Elective Activity comparing Jan-20 to submitted Annual Plan 22/23 and Feb-23

Activity		Feb-20	Submitted Plan	Feb-23
Outpatient (reclassified)	New	15,034	16,156	16,083
	Follow-up NHS	32,702	23,001	32,122
	Total	**47,736**	**40,157**	**48,205**
Elective	Day Case	6,976	7,248	6,821
	Inpatient	678	808	479
	Total	**7,657**	**8,056**	**7,300**

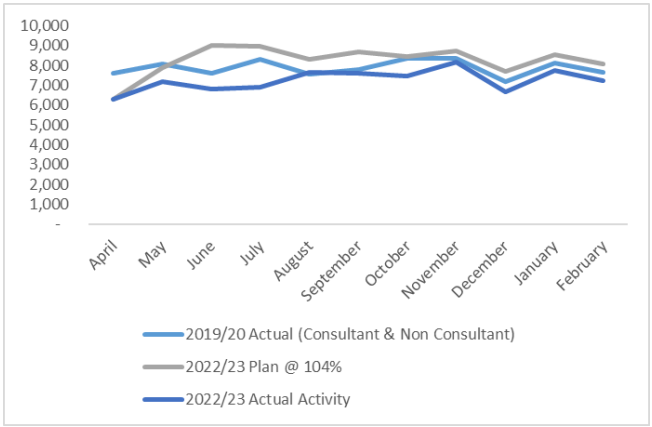
Outpatient New Activity Trend



Outpatient Follow-up Activity Trend



Day Case and Inpatient Activity Trend



Elective Recovery - Theatre Utilisation | Month 11 [February] 2022-23

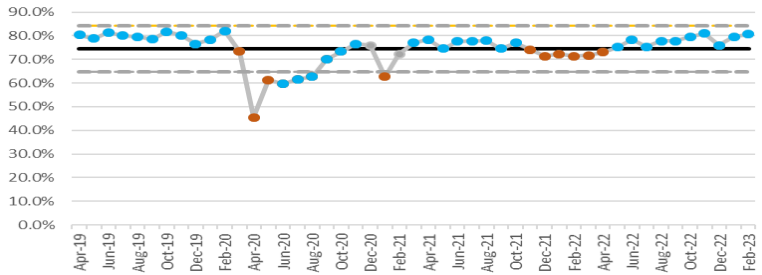
Responsible Director: Chief Operating Officer | Validated for Feb-23 as at 9th March 2023

Worcestershire Acute Hospitals NHS Trust

Actual Theatre session utilisation (%)

80.7%

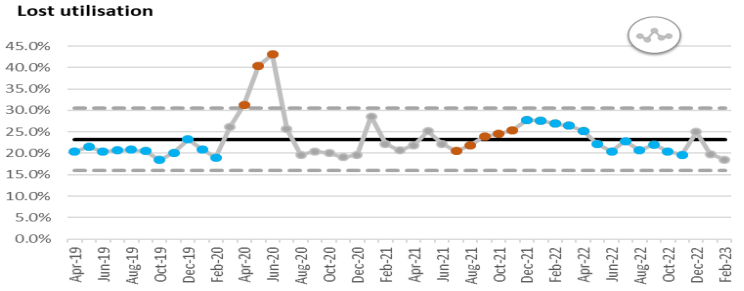
Theatre Utilisation



Lost utilisation to late starts and early finishes

18.5%

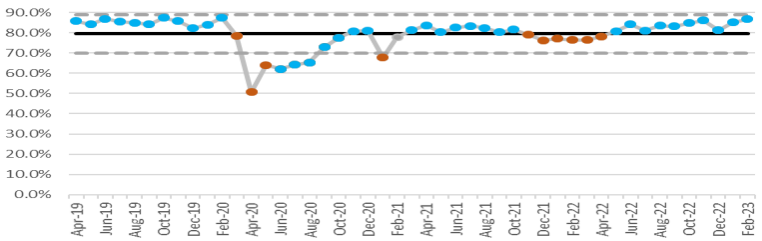
Lost utilisation



Actual Theatre session utilisation incl. allowed downtime (%)

86.7%

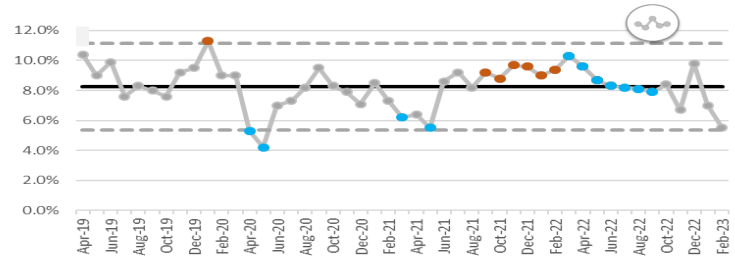
Theatre Utilisation (incl. downtime)



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

5.5%

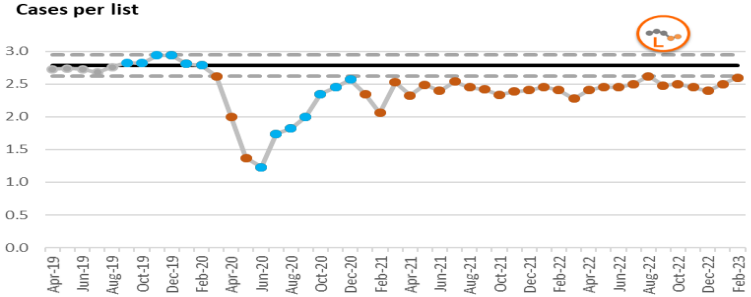
On the day cancellations



Completed procedures per 4 hour session

2.6

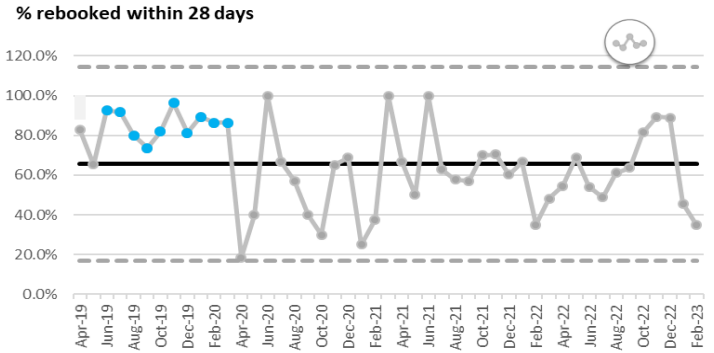
Cases per list



% patients rebooked with 28 days of cancellation

34.8%

% rebooked within 28 days



All graphs include Feb-23 data

Elective Recovery: DM01 Diagnostics | Waiting List and Activity

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

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

What does the data tell us?

DM01 Waiting List

- The DM01 performance is validated at 83.3% of patients waiting less than 6 weeks for their diagnostic test remaining special cause improvement and is our best performance since pre-pandemic.
- The diagnostic waiting list has increased by 167 patients (2%) and the total number of patients waiting 6+ weeks has decreased by 321 patients to 1,614. There are 826 patients waiting over 13 weeks (811 in Jan-23).
- Radiology has the largest number of patients waiting, at 4,859 and the number of patients 6+ weeks has decreased from 594 to 380 at the end of Jan-23 (58% of Imaging breaches are waiting for NOUS).
- The total number of patients waiting for an endoscopy reduced as did the number of patients waiting over 6+ weeks (-71). Cytoscopy has arranged in-sourced weekend activity to run for five weekends to reduce their backlog – the impact of this should be apparent in Mar-23 data.
- Physiological science modalities saw an increase in their total PTL and a 36 patient decrease in breaching patients.

Activity

- 17,757 DM01 diagnostic tests were undertaken in Feb-23.
- 23% (4,080 tests) of our total DM01 activity was classified as unscheduled / emergency. 66% were waiting list tests and 11% were planned tests.
- No modality achieved their H2 plan for Feb-23.
- Overall we delivered 90% of this months diagnostics plan and YTD, 11 completed months, we have delivered 95% of the plan. This is 20,789 more tests than YTD 19/20.

RADIOLOGY

What have we been doing?

- Submitted CAG for approval to extend CT interventions until Dec 23, to line up with workforce plan of training and recruitment
- Submitted national SR21 bid for US machines x 2 and Mii
- Identified external reporting for Proctograms
- Agreed BMI undertake MRI Proctograms

What are we going to do next?

- Work with BI and Cancer team to identify and deliver further improvements on 28 day faster diagnosis.
- CAGs written for insourcing x 2 (CT3 and CDC) and extension of mobile MRI
- Review vetting resource requirements - improving faster vetting, will support improving time to an appointment being allocated
- Obtain financial approval to continue US WLIs
- Improve capacity/demand modelling using Pythia
- Work on reducing >13wk waiters with W&C focussing on paediatric breaches by utilising WLIs

Issues

- Increase in 2ww CT Colon referrals, specialised Radiographers perform these which minimises capacity

ENDOSCOPY (inc. Gynaecology & Urology)

What have we been doing?

- Reduced activity due to Junior Doctors strike; moved patients to alternative lists and / or backfilled where able
- Commenced use of retired Gastroenterologist via NHSP
- Explored the use of Envoy text messaging to target specific patient groups (13+ week)
- Immersive training for specialist registrar commenced 13th March for a 4-week duration
- Commenced weekend insourcing for 2ww colorectal patients; providing additional capacity across other lists for 13+ week patients, as well as reducing the need for follow-up therapeutic appointment
- Recruited 1 WTE Booking Co-ordinator
- Best practice pathway position continues to improve

What are we going to do next?

- Implement text messaging to 13+ week waiters once access rights have been increased
- Recruitment of second Booking Co-ordinator
- Continuing to have discussions with surgery re opportunities to recruit Physician's Associate for scoping roles.
- CAG written to use Circle Health for surveillance patients to reduce waiting list.
- CAG written to extend current insourcing weekend activity at Malvern.

Issues

- Recruitment / retention of nursing teams to reduce reliance on supported insourcing lists
- Patient declines / short notice cancellations