Elective Recovery – Outpatient and Elective Activity | Month 2 [May] 2023-24

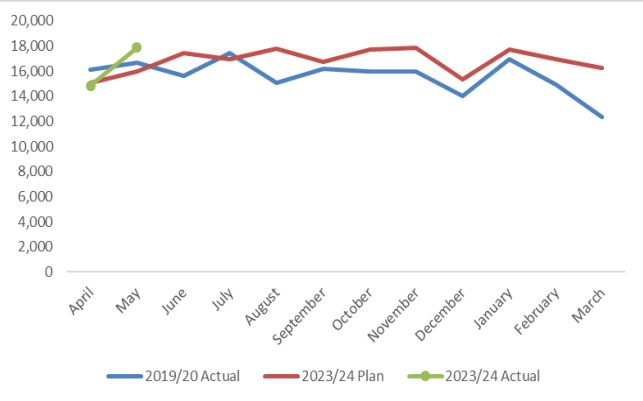
Responsible Director: Chief Operating Officer | Unvalidated for May 2023 (Second SUS Submission)

NHS Worcestershire Acute Hospitals NHS Trust

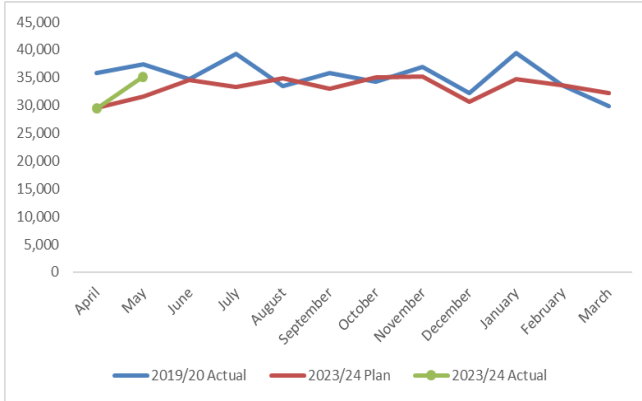
Elective Activity comparing May-20 to submitted Annual Plan 23/24 and May-23

Activity		May-19	Submitted Plan	May-23
Outpatient (reclassified)	New	16,637	15,949	18,093
	Follow-up NHS	37,344	31,546	36,162
	Total	**53,981**	**47,495**	**54,255**
Elective	Day Case	6,560	6,240	6,318
	Inpatient	690	565	516
	Total	**7250**	**6,805**	**6,834**

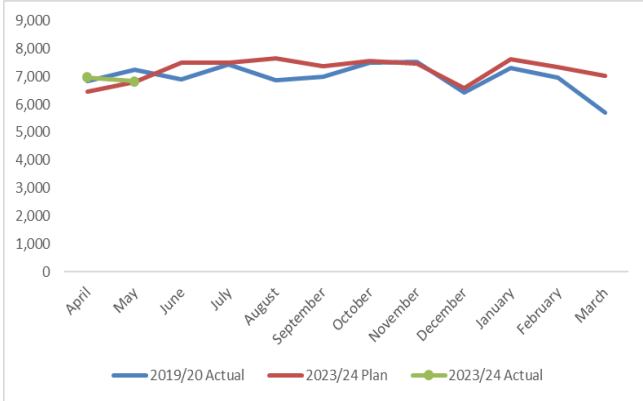
Outpatient New Activity Trend



Outpatient Follow-up Activity Trend



Day Case and Inpatient Activity Trend



Elective Recovery - Theatre Utilisation | Month 2 [May] 2023-24

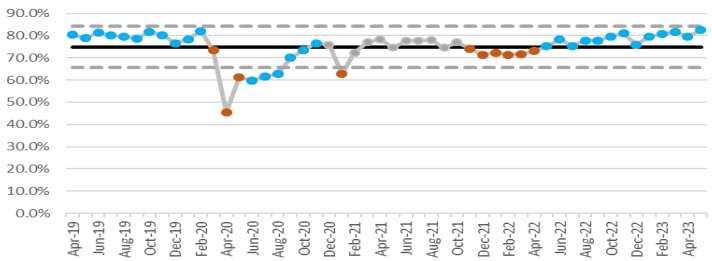
Responsible Director: Chief Operating Officer | Validated for May-23 as at 14th June 2023

Worcestershire Acute Hospitals NHS Trust

Actual Theatre session utilisation (%)

83%

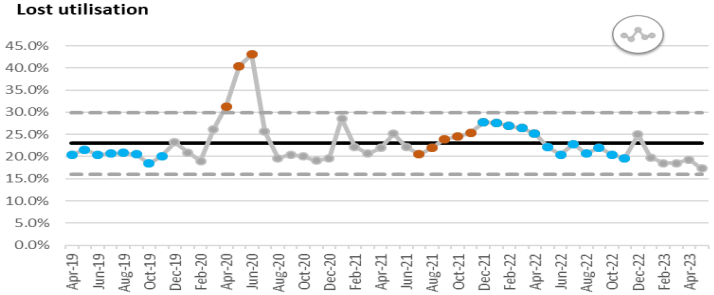
Theatre Utilisation



Lost utilisation to late starts and early finishes

17%

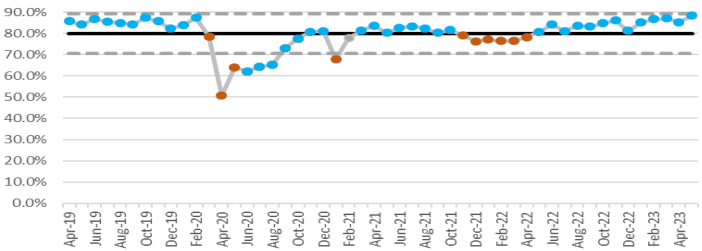
Lost utilisation



Actual Theatre session utilisation incl. allowed downtime (%)

88%

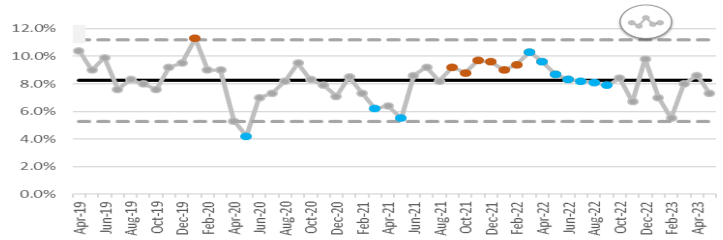
Theatre Utilisation (incl. downtime)



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

7%

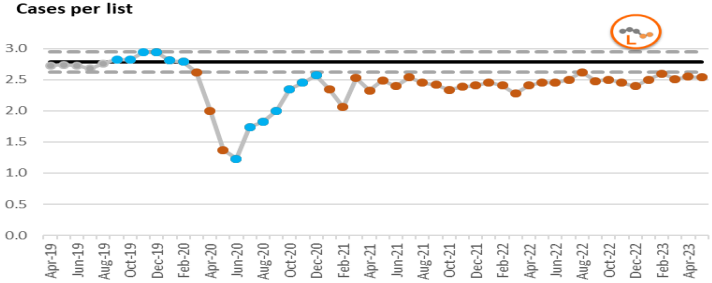
On the day cancellations



Completed procedures per 4 hour session

2.5

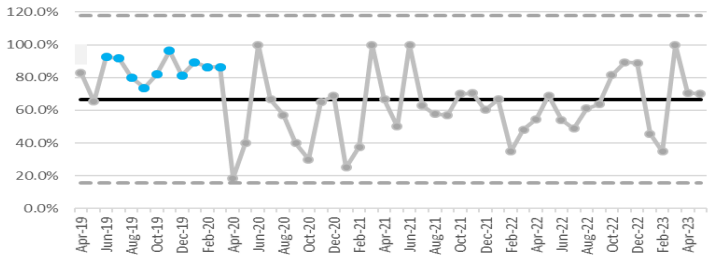
Cases per list



% patients rebooked with 28 days of cancellation

70%

% rebooked within 28 days



All graphs include May-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

NHS Worcestershire Acute Hospitals NHS Trust

Annual Plan Activity	MRI	CT	Non-obstetric ultrasound	Colonoscopy	Flexi Sigmoidoscopy	Gastroscopy	Echocardiography	DM01	% patients waiting 6+ weeks	
Target achieved?	✗ (-234)	✓ (+524)	✓ (+405)	✗ (-4)	✓ (+20)	✓ (+100)	✓ (+177)		H	F

What does the data tell us?

DM01 Waiting List

- The DM01 performance is validated at 83% of patients waiting less than 6 weeks for their diagnostic test remaining special cause improvement.
- The diagnostic waiting list increased by 1,074 patients (10% increase) and the total number of patients waiting 6+ weeks has increased by 245 patients to 1,687 (7% increase).
- There are 371 patients waiting over 13 weeks (462 in Apr-23). 140 of those patients are waiting for a cystoscopy and the graphs on slides 20 and 21 show progress to date by modality.
- Radiology has the largest number of patients waiting, at 5,519 and the number of patients 6+ weeks has increased from 613 to 756 at the end of May-23 (86% of Imaging breaches are waiting for NOUS).
- The total number of patients waiting for an endoscopy decreased by 96 and the number of patients waiting over 6+ weeks increased (+35). 58% of all patients waiting over 6 weeks for an endoscopy are cystoscopy patients.
- Physiological science modalities saw a decrease in their total PTL (-190) but there was a 67 patient increase in breaching patients.

Activity

- 18,490 DM01 diagnostic tests were undertaken in May-23.
- 24% (4,469 tests) of our total DM01 activity was classified as unscheduled / emergency. 67% were waiting list tests and 9% were planned tests.
- Five modalities achieved their plan for May-23 and as noted above Colonoscopy was very close to the plan derived from capacity.
- MRI is the furthest away from plan. Initial investigation indicate that more complex scans have reduced our patients per hour capacity. The MRI Mobile over-delivered on its contribution to plan.
- Overall we delivered more than the diagnostics plan for May-23 and this was 2,041 more tests than May-19.

RADIOLOGY

What have we been doing?

- Continue with interventions CT Insourcing & MRI mobile
- Monitored the intervention of moving CT Colon capacity across county, moved out standard CT OP bookings to WLI to book colons in working hours and increase this capacity- in support of 28 Day diagnosis
- Reviewing potential 13 week breaches to accommodate
- Continue to undertake Increased arthrogram slots to reduce potential breaches
- Continue to Undertake Cardiac MRI WLI lists, to reduce waiting list
- Continued discussions for Paed GA list in conjunction with W&C Division - to reduce waiting times
- Increased WLI for MRI Paed GA led to significant reduction
- Provide cancer RAP and monitoring performance
- Formulated Radiographer CT training plans for CT/MRI
- Engaged with both NHS and Private providers to support with Proctogram referrals
- H&C Trust agreed to replace Evesham US equipment
- Held an away day 12th June with Radiology band 8s and consultant modality leads to look at strategy and annual planning, promoting responsibility to deliver against plans and be involved in future service planning and compiled list of 'I have an idea' for potential business cases

What have we been doing?

- Continue to plan Paed MRI GA options and implement regular session
- Review CT Colon capacity
- Continue to undertake US WLI to reduce 6 week waiting and ensure no 13 week breaches
- Follow up with Cancer Alliance team offer of patient tracker- this will support monitoring patients report for MDT etc.
- Continue to discuss with BMI and NHS trusts to support with Proctograms,
- X-ray equipment at POWCH pending replacement
- Reviewing Lung pathway with respiratory team to work towards BPP
- Implementing software on MRI scanner at Alex which should assist in reducing exam time and increase capacity
- Work with W&C to support reduction of 78+ week breaches- identify resources/funding to achieve this
- Submit NIDC annual data submission by COP16/6/23
- Interviews scheduled for 3x reporting radiographers

Issues

- BMI have reduced US exams they will accept, they will only accept 10 MSK and 5 Thyroid exams per week and have no capacity until June. These exams are not where we have the pressures, so does not help manage referrals.
- Delay to SLA with BMI for Proctograms due to Trust contracting staff off sick
- MRI prostate exams increased form 4-7 days due to May bank holidays and no scope to increase capacity- will affect 28 day pathway
- Reporting Radiographer, who provided large volumes of chest x-ray reports left in April. Left significant gap on reporting time for these exams and working towards improving Lung pathway.
- Concern over volume of CT colon requests vs capacity
- Radiographers have been sent ballots for strike action, potential strike pending results.

ENDOSCOPY (inc. Gynaecology & Urology)

What have we been doing?

- Appointed Consultant Gastroenterologist as spoke academy lead.
- Provided Immersion training for Clinical endoscopist who has his colonoscopy assessment booked in July.
- Continued to use Envoy text messaging to target specific patient groups (13+ week) as well as signposting patients to the Trust links for advice on Low fibre diet and instructions for taking bowel preparation
- Best practice pathway position remains consistent
- Commence the use of cancer SMART PTL to provide updates
- Continuing to work on the implementation of Solus however the rollout has been deferred to September as there are a number of application issues that HD the supplier need to resolve.
- Clinical endoscopist is now managing the FIT negative flexible sigmoidoscopy pathway.
- Advertised for 2 additional trainee clinical endoscopists position.
- Working on reducing waiting list for patients >13 week
- Recruiting to vacant booking co-ordinator posts
- Admin team commenced the use of prism remote printing for appointments / TCI documentation

What are we going to do next?

- Roll out TNE service at KTC, ECH and Alex endoscopy units
- Advertise for 2 Specialist Drs in endoscopoy.
- Renegotiate the 18 week Insourcing contract for 23/24.
- Continue engagement with Surgical Directorate for Urology waiting list > 13 weeks continue to offer available weekend waiting lists.
- Progress the Directorate workforce structure changes for Admin & Clerical Team

Issues

- Increasing number of urology patients >13 weeks

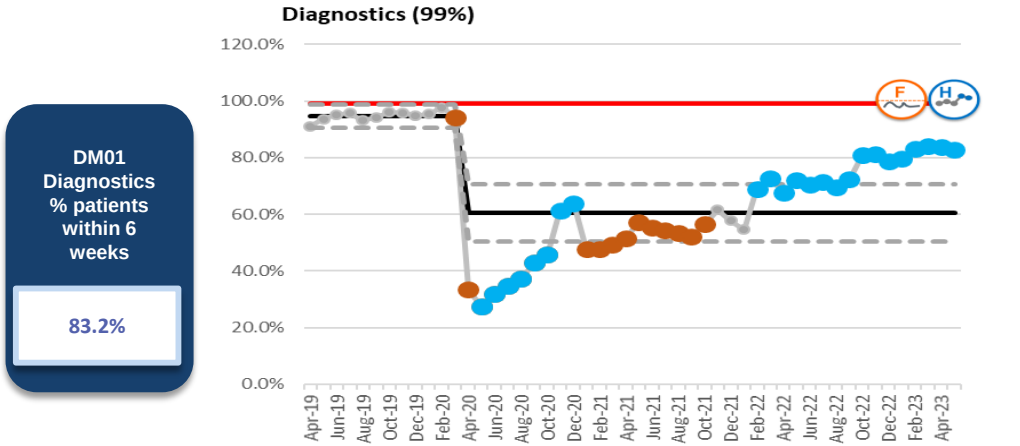
Elective Recovery: DM01 Diagnostics | Waiting List and Activity

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

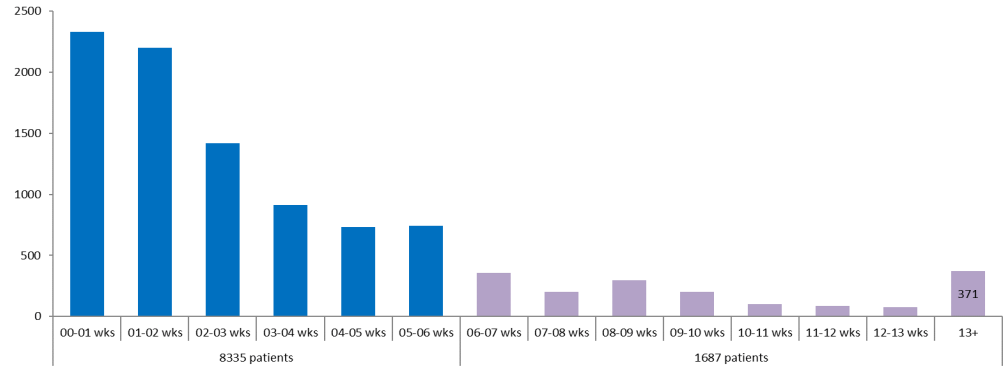
NHS Worcestershire Acute Hospitals NHS Trust

DM01 Diagnostics % patients within 6 weeks

83.2%



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



CARDIOLOGY – ECHO

What have we been doing?

- Continued WLI activity across county for further backlog reduction
- FT locum at ALX
- Reviewed impact of B7 retiree
- Accelerated complex echo list with WLI plus incorporating DSE booking to CIU
- Mini audit at ALX (demand outweighs capacity)
- Considering greater efficiency in use of scanners - limited by staff numbers

What are we going to do next?

- Continue WLI
- Countywide audit
- Vacant posts out to advert
- Interviews and recruitment ongoing

Issues

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

AUDIOLOGY

What have we been doing?

- Currently employing 2 locums to increase capacity
- Staff working overtime on weekends to reduce waiting list

What are we going to do next?

- Advertise for 2 new B5 Audiologists once ATR approved
- Training to A & C staff as some patients referrals not entered correctly and showing breaches which are false
- Funding secured for the rebuild of new consulting room and additional soundproof booth at Kidderminster

Issues

- Locum ENT consultant employed for 6 months to help with ENT backlog. This equates to 8 clinics per week which need Audiology cover but no additional funding released to provide this.
- Capacity of clinics limited due to lack of soundproof booths countywide. There is more capacity on a weekend but not all staff interested to provide this.
- While building work is taking place at Kidderminster activity is likely to be reduced.

Current Assurance Level: 5 (Jun-23)

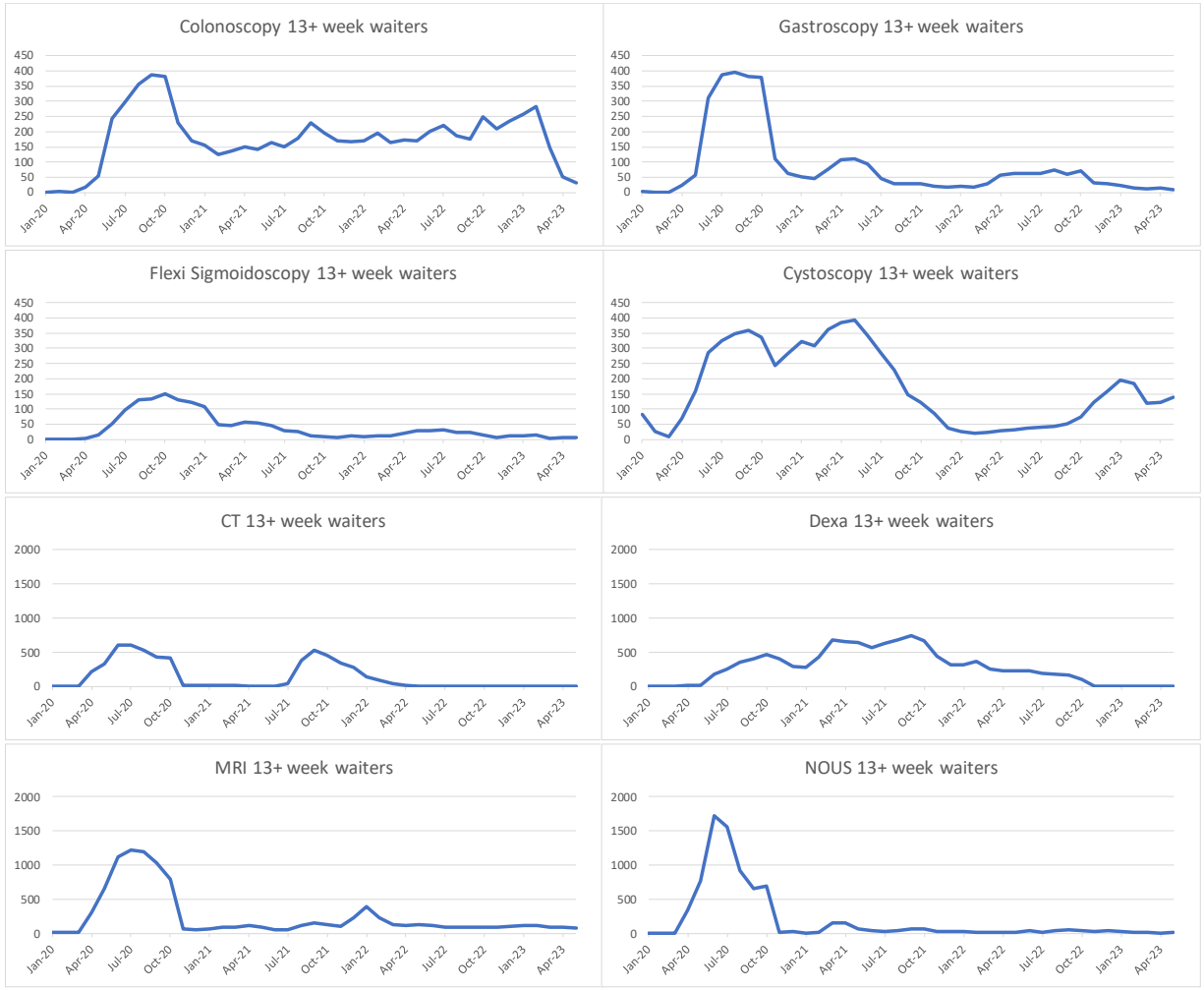
Previous assurance level: 5 (May-23)

When expected to move to next level of assurance: This is dependent on balancing Cancer, Emergency, Urgent and Routine referrals against core and intervention linked capacity and achievement of associated performance targets.

SRO: Chief Operating Officer

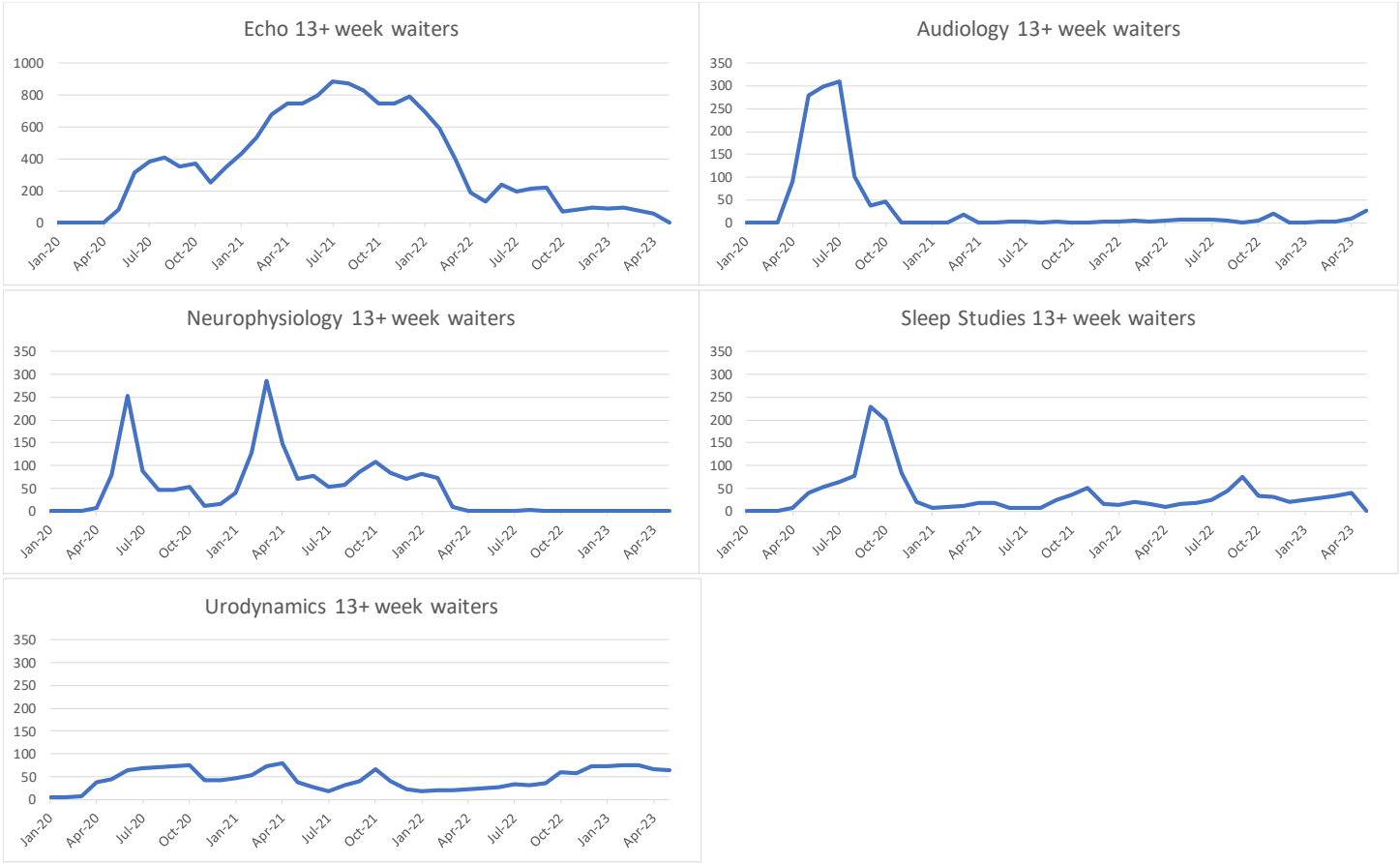
DM01 Diagnostics – Reduction of 13+ week waiters| Month 2 [May] 2023-24

Responsible Director: Chief Operating Officer | Validated for May-23 as at 14th June 2023



DM01 Diagnostics – Reduction of 13+ week waiters| Month 2 [May] 2023-24

Responsible Director: Chief Operating Officer | Validated for May-23 as at 14th June 2023



Elective Recovery DM01 Diagnostics | Month 2 [May] 2023-24

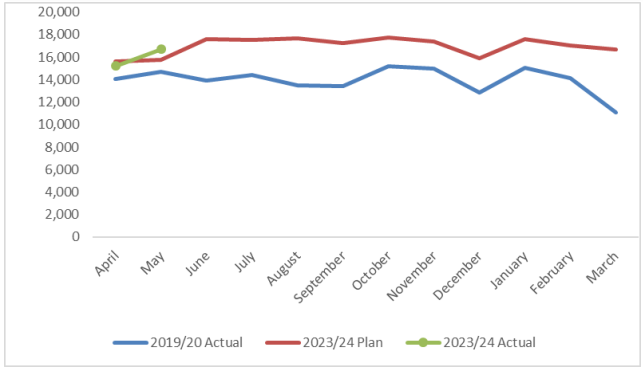
Responsible Director: Chief Operating Officer | Unvalidated for May-23 as at 14th June 2023

NHS Worcestershire Acute Hospitals NHS Trust

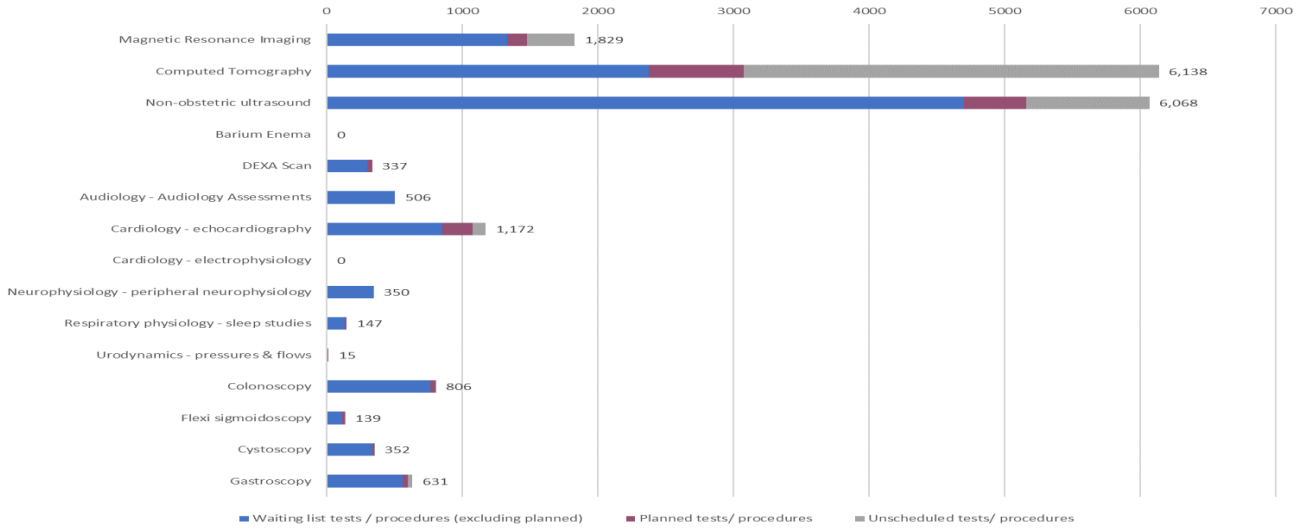
Diagnostic Activity | Annual Plan Monitoring

Annual Plan Activity Modalities		May-19	Submitted Plan	May-23
Imaging	MRI	1,703	2,063	1,829
	CT	4,984	5,614	6,138
	Non-obstetric ultrasound	5,309	5,663	6,068
Endoscopy	Colonoscopy	629	812	806
	Flexi Sigmoidoscopy	314	118	139
	Gastroscopy	725	517	631
Echocardiography		984	972	1,172
Diagnostics Total		**14,673**	**15,759**	**16,714**

Annual Plan Diagnostics Activity Trend



Total DM01 Activity split by modality and type



MRI, CT, NOUS, Colonoscopy and Echocardiography exceeded May-19 activity which remains the benchmark of delivery.

CT, NOUS, flexi sigmoidoscopy, gastroscopy and echocardiography achieved their submitted plan. Colonoscopy was very close to achieving the levels agreed in the plan. MRI was furthest away from plan.

69% of all unscheduled activity in May-23 were CT tests. 24% (4,469) of all tests undertaken in the month were unscheduled.

22

Operational Performance: Diagnostics (DM01) Benchmarking

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

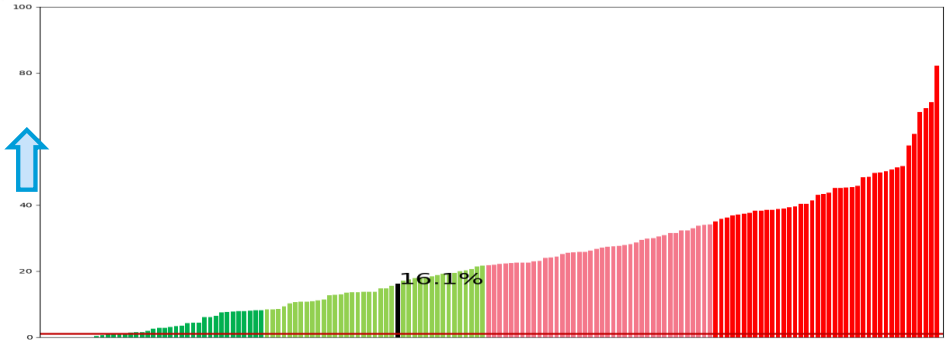
NHS Worcestershire Acute Hospitals NHS Trust

National Benchmarking (April 2023)

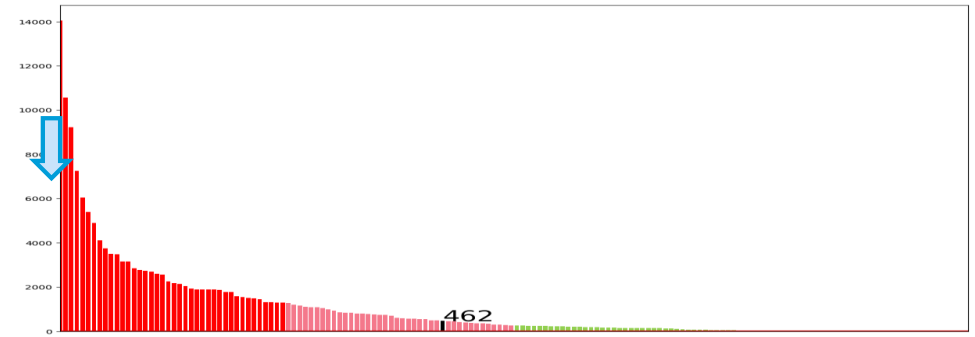
12 West Midlands Trusts, including WAHT, saw a increase in performance between Mar-23 and Apr-23. This Trust was ranked 3 out of 13; we were ranked 4 the previous month. The peer group performance ranged from 7.8% to 51.7% with a peer group average of 30.1%,improving from 26.5% the previous month. The England average for Apr-23 was 27.6%; a 2.6% increase from 25.0% in Mar-23.

- Nationally, there were 430,804 patients recorded as waiting 6+ weeks for their diagnostic test; 1,442 (0.33%) of these patients were from WAHT.
- Nationally, there were 166,730 patients recorded as waiting 13+ weeks for their diagnostic test; 462 (0.28%) of these patients were from WAHT.

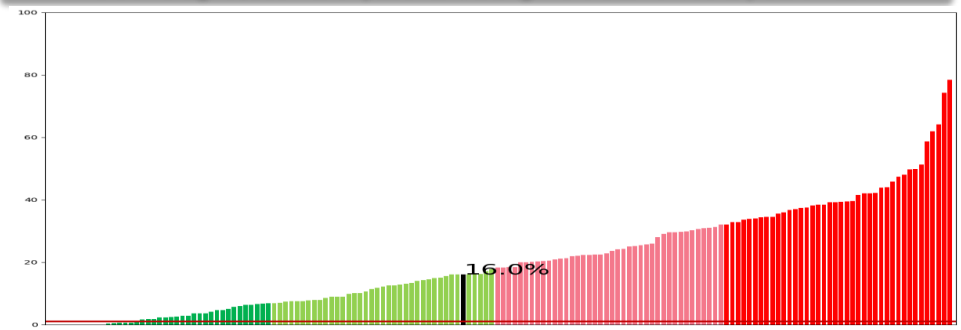
DM01 Diagnostics - % of patients waiting more than 6 weeks | April-23



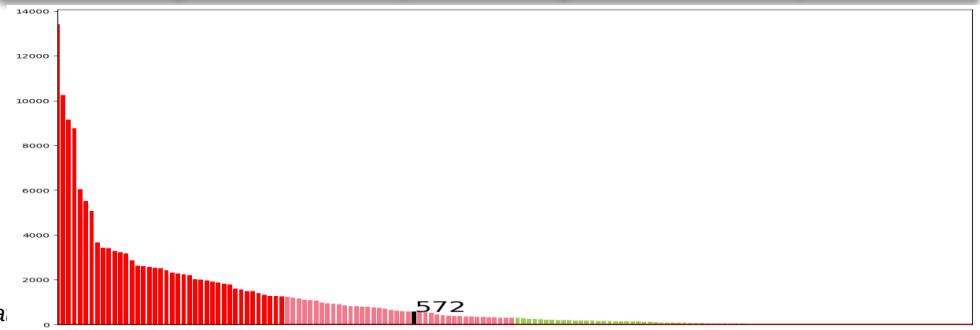
DM01 Diagnostics - number of patients waiting more than 13 weeks | April-23



DM01 Diagnostics - % of patients waiting more than 6 weeks | March-23



DM01 Diagnostics - number of patients waiting more than 13 weeks | March-23



Quality & Safety

Integrated Quality Performance Report - Headlines

Quality Performance	Comments (All metrics on this slide have additional Improvement Statements later in this report)
Infection Control	• We were compliant with the in-month infection targets for E-Coli, Klebsiella and Pseudomonas in May-23. We are also compliant with the year to date targets for these infections. • We breached three of the in-month infection targets: C-Diff, MSSA and MRSA. • The reported MRSA infection is the first reported by the Trust since Mar-21. • We have breached the year to date targets for C-Diff and MSSA, and we have breached the year end target for MRSA. • Hand Hygiene Audit Participation was unchanged in May-23 at 84.1% which is not compliant with the target (100%) • Hand Hygiene Compliance was unchanged at 99.7%, and has been compliant with the target (98%) for the past 13 months. • All of the high impact intervention audits in May-23 achieved a compliance of over 95%.
Antimicrobial Stewardship	• A total of 345 audits were submitted in May-23, compared to 223 in Apr-23. • Antimicrobial Stewardship overall compliance increased very slightly in May-23 to 90.8% and achieved the target of 90%. This metric has shown special cause variation of improvement for the past 6 months.
SEPSIS 6	• Our performance against the sepsis bundle being given within 1 hour has increased in May-23 to 82.7%, but remains non compliant with the 90% target. • The Sepsis screening compliance increased in Apr-23 to 88.4% , but failed to meet the target. • Antibiotics provided within 1 hour dropped in May-23 to 82.7% and failed to achieve the target of 90%.
#NOF	• Latest benchmarking data shows that we are the 4th lowest in the region for crude mortality for fractured neck of femur. • Fractured NOF to Surgery performance is improving but is still not at the national standard, the performance remains impacted by theatre capacity and patients not medically suitable for Surgery. • The Trust's length of stay (Apr-22 to Mar-23) is 9.57 days, which is the lowest in the Midlands.
Stroke	• SSNAP published data for Q4 2022/23 confirmed the Trust in house calculations of a score of 72, maintaining a Level B as expected. • There has been a marked reduction in meeting the Therapy metrics during the last two quarters. This has been as a result of staff vacancies, particularly within the Occupational Therapy teams and has impacted on their ability to offer a 7 day service. These vacancies have now been recruited to, and therefore the compliance to the therapy domains should show an improvement from Quarter 2.

Integrated Quality Performance Report - Headlines

Quality Performance	Comments (All metrics on this slide have additional Improvement Statements later in this report)
Friends & Family Test	• Following rebasing, both Inpatient and Outpatient charts now indicate that the recommended rates will consistently hit the target. • After rebasing A&E remains unchanged, still indicating that the metric is expected to consistently fail the target. However, between Oct-22 and Jan-23 the Trust had the highest A&E Recommended rate in the West Midlands Peer Group, and was 2nd highest in Feb-23[1]. • Based on the Maternity data which has been identified on Badgernet, the recommended rate is expected to be inconsistently met, being subject to random variation. Badgernet is not the sole data source for Maternity and additional options including cards and text messaging are in place/development.
Falls	• The total number of falls fell in May-23 to 112. • We were on trajectory in May-23 with 4.6 Total Falls per 1,000 Bed Days. • There were 0 SI falls in May-23. • We were on trajectory in May-23 with 0 SI Falls per 1,000 Bed Days.
Hospital Acquired Pressure Ulcers (HAPU)	• The total number of HAPUs for May 23 dropped to 17 • Total HAPUs as a % of Emergency Admissions dropped to 0.51% in May (from 0.62% in Apr) • There were zero HAPUs causing harm in May-23.
Learning From Deaths	• The Trust's SHMI is in the **'As Expected'** banding for both Worcestershire and Alexandra sites. • The Trust's HSMR alert level is Green.
Complaints	• The % of complaints responded to within 25 days dropped in Mar-23 to 55.6%, and was still below target (80%). • This the lowest since Sep-20, and is the 9th consecutive month that the target has been missed.

2.1 Care that is Safe - Infection Prevention and Control

Embed our current infection prevention and control policies and practices | Full compliance with our Key Standards to Prevent

C-Diff (Target 78)		E-Coli (Target 69)		MSSA (Target 17)		MRSA (Target 0)		Klebsiella species (Target 21)		Pseudomonas aeruginosa (Target 12)	
May actual vs target	Year to date actual / year to date target	May actual vs target	Year to date actual / year to date target	May actual vs target	Year to date actual / year to date target	May actual vs target	Year to date actual / year to date target	May actual vs target	Year to date actual / year to date target	May actual vs target	Year to date actual / year to date target
9/6	17/13	3/6	9/13	6/1	7/4	1/0	1/0	1/1	2/5	1/1	1/2

What does the data tell us?

- We were compliant with the in-month infection targets for E-Coli, Klebsiella and Pseudomonas in May-23. We are also compliant with the year to date targets for these infections.
- We breached three of the in-month infection targets: C-Diff, MSSA and MRSA.
- The reported MRSA infection is the first reported by the Trust since Mar-21.
- We have breached the year to date targets for C-Diff and MSSA, and we have breached the year end target for MRSA.
- MSSA and MRSA are both showing special cause variation of concern.
- C-diff remains higher than the National and Midlands per 100,000 rates – see next slide.
- Hand Hygiene Audit Participation was unchanged in May-23 at 84.1% (95/113) which is not compliant with the target (100%)
- Hand Hygiene Compliance was unchanged at 99.7%, and has been compliant with the target (98%) for the past 13 months.
- 12 new COVID outbreaks were declared in May-23 (and 1 to date in June).
- There are currently 5 ongoing active COVID outbreaks, and 4 in the monitoring phase (12/06/2023).
- There are currently 4 ongoing D&V/Norovirus outbreaks (12/06/2023).
- All of the high impact intervention audits in May-23 achieved a compliance of over 95%.
- 2023/24 Quality Priorities includes a commitment to a "reduction in amber and red lapses in care". A baseline for 2022/23 will be provided when the final episodes of care have been reviewed.

What are we doing to make improvements?

Cdiff

- New contractual performance trajectories have been published and the new trajectory is 78, one less than last year
- Active action plan in place and progressing well
- Trust Quality Priority set to reduce Cdiff numbers
- Baseline data to be set to determine improvement in lapses
- AMS has also been set as a Trust priority and reporting improved divisional compliance with AMS audit

MRSA

- Identified as a contaminant
- Trust commended by the ICB fore the high level of scrutiny that was undertaken despite being a contaminant
- Blood culture contaminant for AMU for April reported at 0%
- Targeted training and review of compliance has taken place and bespoke training for the unit to be delivered
- Patient outcome: repeat blood cultures negative, repeat screen negative, discharged

Hand Hygiene

- Compliance is escalated through Governance Teams and CCG
- Review of data to take place as some area function and location has changed

Norovirus

- Confirmed laboratory cases at the Alex site, all outbreak management actions in place

COVID

- Improved position with regards to number of cases requiring isolation
- Screening protocol adopted as per national guidance
- Mask wearing regulations relaxed

Current Assurance Level – 4 (Jun-23) Reason: above trajectory for cdiff and continued norovirus outbreaks	**When expected to move to next level of assurance for non Covid**: August 2023
Previous assurance level - Level 4 COVID-19 / Level 4 for non-Covid to remain the same	SRO: Chief Nursing Officer (CNO)

Infection Prevention and Control Benchmarking

Source: Fingertips / Public Health Data (up to Mar 2023)

C. Difficile – Out of 24 Acute Trusts in the Midlands, our Trust sits the 22nd best, and is **above** both the Midlands and England rates.

E.Coli – Out of the 24 Acute Trusts in the Midlands, our Trust sits the 9th best, and is **below** both the Midlands and England rates.

MSSA – Out of 24 Acute Trusts in the Midlands, our Trust sits the 8th best, and is **below** both the Midlands and England rates.

MRSA – Out of the 24 Acute Trusts in the Midlands, our Trust sits equal 1st, and is **below** both the Midlands and England rates.

C. Difficile infection counts and 12-month rolling rates of hospital onset-healthcare associated cases

Area	Count	Per 100,000 bed days
England	7,197	20.6
Midlands NHS Region (Pre ICB)	1,235	19.0
Worcestershire Acute Hospitals	73	28.3

E. Coli hospital-onset cases counts and 12-month rolling rates

Area	Count	Per 100,000 bed days
England	7,881	22.5
Midlands NHS Region (Pre ICB)	1,321	20.4
Worcestershire Acute Hospitals	40	15.5

MSSA bacteraemia cases counts and 12-month rolling rates of hospital-onset

Area	Count	Per 100,000 bed days
England	3,903	11.2
Midlands NHS Region (Pre ICB)	654	10.1
Worcestershire Acute Hospitals	19	7.4

MRSA cases counts and 12-month rolling rates of hospital-onset

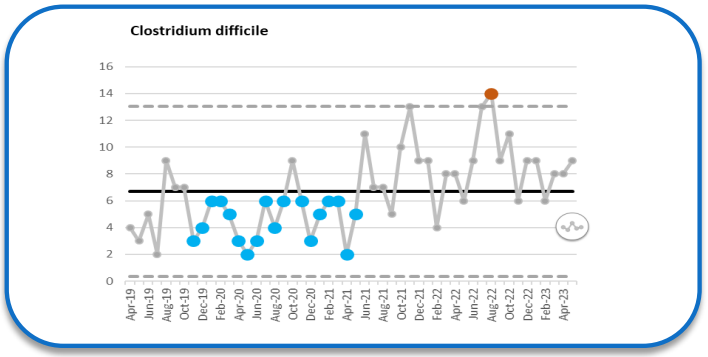
Area	Count	Per 100,000 bed days
England	295	0.8
Midlands NHS Region (Pre ICB)	31	0.5
Worcestershire Acute Hospitals	0	0.0

Month 2 [May] | 2023-24 Quality & Safety - Care that is Safe

Responsible Director: Chief Nursing Officer, Chief Medical Officer | Validated position for May-23 as 12th June 2023

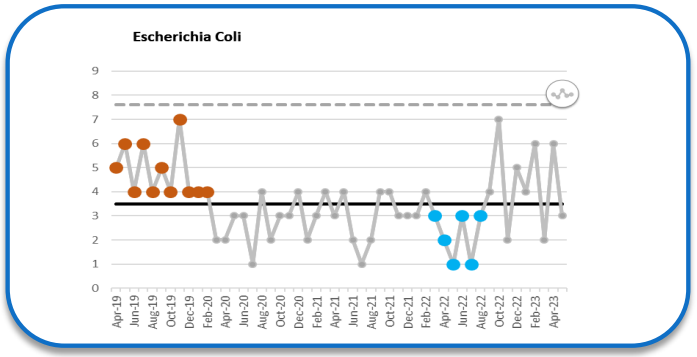
C-Diff

9



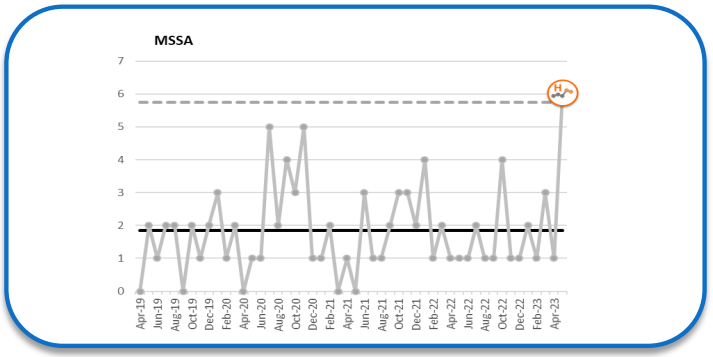
E-Coli

3



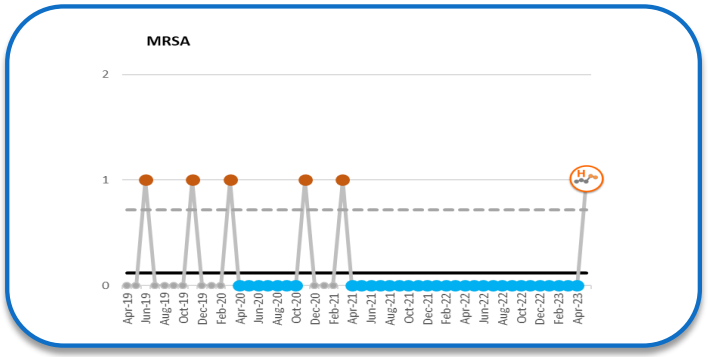
MSSA

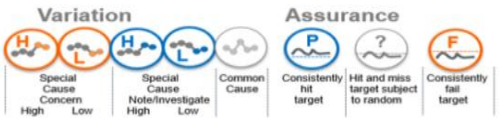
6



MRSA

1



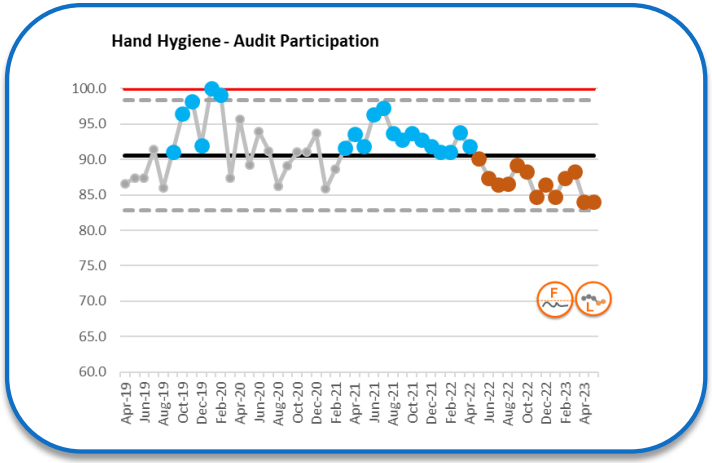


Month 2 [May] | 2023-24 Quality & Safety - Care that is Safe

Responsible Director: Chief Nursing Officer, Chief Medical Officer | Validated for May-23 as 12th June 2023

Hand Hygiene Audit Participation (%)

84.1



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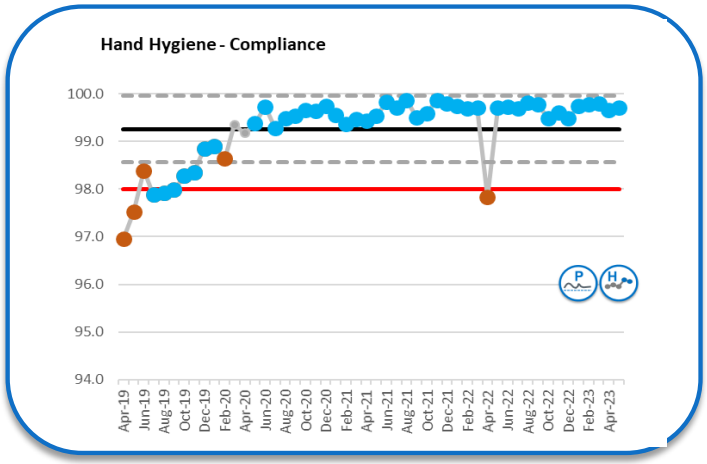
Hand Hygiene Compliance (%)

99.7



Please note that % axis does not start at zero.

Lockdown Period

COVID Wave

2.1 Care that is Safe – Antimicrobial Stewardship

Overall Compliance	Antibiotics in line with guidance (Target 90%)		Antibiotics reviewed within 72 hours (Target 90%)	
May-23	Apr-23	May-23	Apr-23	May-23
	93.2%	95.4%	95.3%	92.0%

What does the data tell us?

- A total of 345 audits were submitted in May-23, compared to 223 in Apr-23.
- Antimicrobial Stewardship overall compliance increased very slightly in May-23 to 90.8% and achieved the target of 90%. This metric has shown special cause variation of improvement for the past 6 months.
- Patients on Antibiotics in line with guidance or based on specialist advice increased in May-23 and achieved the target.
- Patients on Antibiotics reviewed within 72 hours dropped in May-23 but still achieved the target.
- Of the 8 elements of the audit, 3 have failed to reach the target this month
    - Drug Allergy Status Recorded: 84.4% (up from 80.7% in Apr-23)
    - Appropriate Tests Requested: 89.2% (up from 87.2% in Apr-23)
    - Duration of Antimicrobial: 75.7% (down from 80.0% in Apr-23)
- Medication incidents causing harm has been showing special cause variation of improvement since Jun-20

What will we be doing?

- Divisional AMS clinical leads will continue to promote the Start Smart Then Focus monthly audits with their junior doctors
- Identifying actions to drive improvement in quality (KPIs) of these SSTF audits with focus on reducing length of course
- Divisions will be developing action plans to improve their Quarterly Point Prevalence Survey results
- Continuing to monitor the compliance with antimicrobial guidelines and antimicrobial consumption with a view to achieving reduction targets specified in standard contract for Watch and Reserve categories.
- Focusing on learning from C diff case reviews where antibiotics may be implicated & developing actions pertaining to AMS to address the recommendations in Prof Wilcox report
- Reviewing the Trustwide quarterly incident report for themes and trends relating to antimicrobial medicines
- Developing a communication and action plan to promote IV to oral switches (CQUIN for 23/24)
- Identifying recruitment plan for the vacant AMS lead pharmacist post
- Identifying reasons for special cause variation of improvements through discussion at ASG (for AMS) and MSC. (for medication incidents)

Current Assurance Level – 5 (Jun-23)
Reason: As evidenced by regular scrutiny of AMS action plans by divisions and demonstration of improved outcomes and consistent participation in audits

When expected to move to next level of assurance –
This will be next reviewed in June 23, when divisions have reviewed the 3 months data to analyse what AMS elements are not being met and propose new actions to improve

Assurance level – Level 6

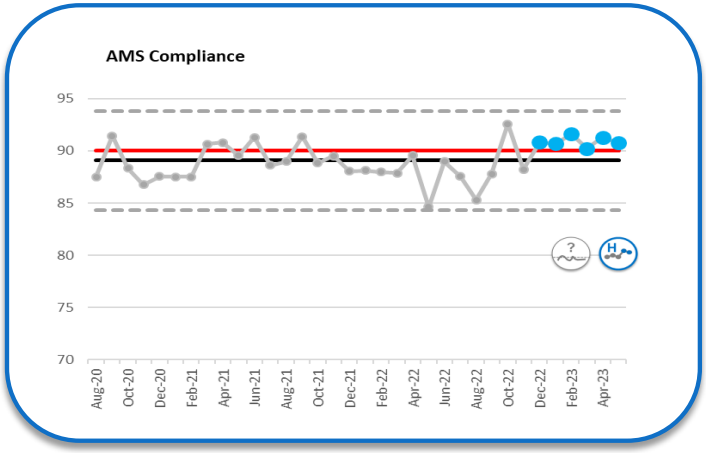
SRO: Chief Nursing Officer (CNO)

Month 2 [May] | 2023-24 Quality & Safety - Care that is Effective

Responsible Director: Chief Nursing Officer, Chief Medical Officer | Validated for May-23 as 6th June 2023

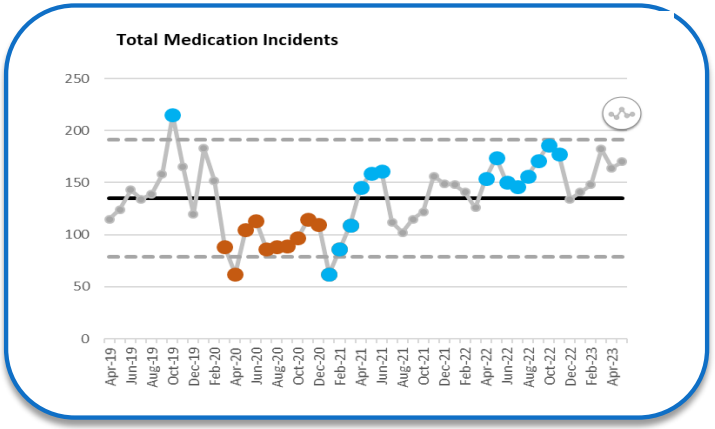
AMS Compliance

90.8%



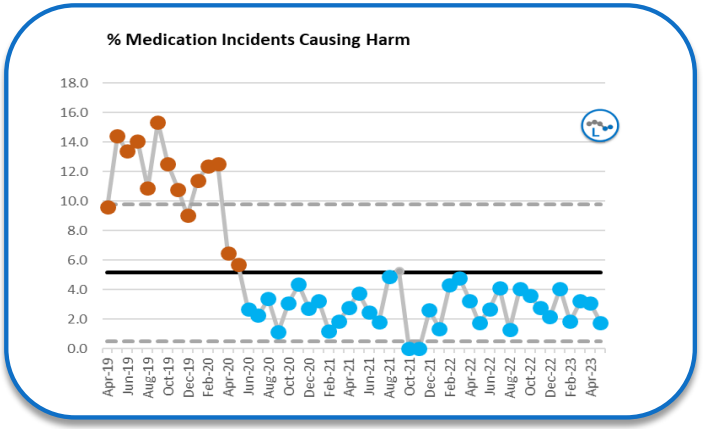
Total Medicine incidents reported

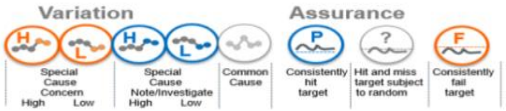
170



Medicine incidents causing harm (%)

1.8%





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

Sepsis six bundle completed in one hour	Sepsis screening Compliance Audit	% Antibiotics provided within one hour	Urine	Oxygen	IV Fluid Bolus	Lactate	Blood Cultures
			93.1%	100%	89.7%	93.1%	96.6%

What does the data tell us?

- Our performance against the sepsis bundle being given within 1 hour has increased in May-23 to 82.7%, but remains non compliant with the 90% target.
- This metric shows special cause improving variation for the last 13 months, but as the target is outside the upper control limit, it is unlikely to be achieved without a change in process or increased focus on existing processes.
- The Sepsis screening compliance increased in Apr-23 to 88.4% , but failed to meet the target.
- The target is within the common cause variation but performance continues to fluctuate.
- Antibiotics provided within 1 hour dropped in May-23 to 82.7% and failed to achieve the target of 90%.
- This metric has show special cause variation of concern for the last 9 months.
- Four of the remaining five elements of the Sepsis Six bundle achieved the target of 90%, with Oxygen hitting 100% compliance.
- The Trust's 12 Month Rolling Crude Death rate up to Mar-23 for Septicemia (except in labour) is 26.9% (In Hospital 15.5% & Out of Hospital 11.4%), which is the 8th lowest in the Midlands (out of 22).[1]
- The Trust's ALOS (Apr-22 to Mar-23) is 10.64 days, which is the 9th lowest in the Midlands (out of 22).[1]

[1] *Source: HED, accessed 12/06/2023.*

Actions:

Sepsis screening is currently reliant on a manual audit of a sample of clinical records. With the introduction of the sepsis module into the EPR in all patients with potential sepsis should be able to be audited which will provide more accurate information.

The sepsis module is due to go live in EPR as part of Phase 3, which is currently scheduled to go live in Mid/Late September 2023.

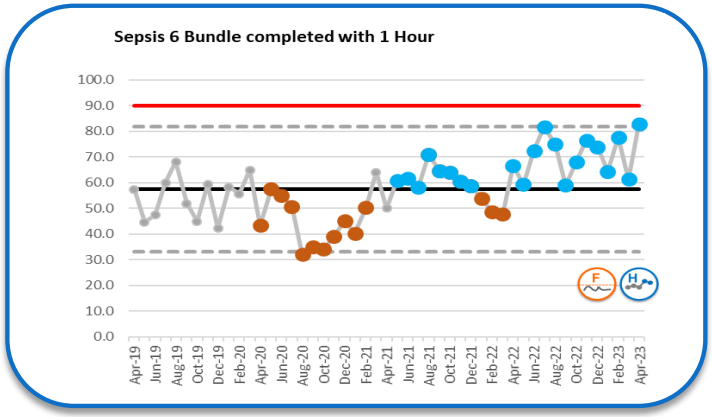
Current Assurance Level – 5 (Jun-23)	**When expected to move to next level of assurance**:
Previous assurance level – 5	SRO: Christine Blanshard (CMO)

Month 1 [April] | 2023-24 Quality & Safety - Care that is Effective

Responsible Director: Chief Nursing Officer, Chief Medical Officer | Validated for Apr-23 as at 12th June 2023

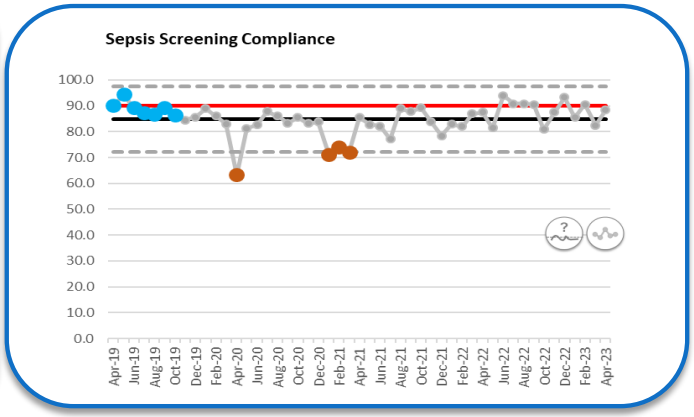
Sepsis 6 Bundle within 1 Hour Compliance (audit)

82.7%



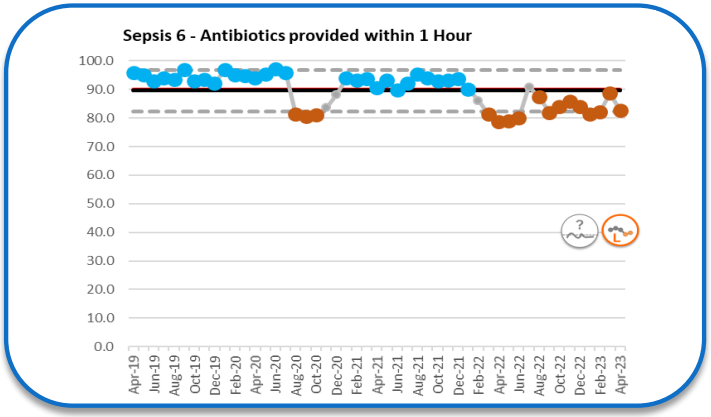
Sepsis Screening Compliance (audit)

88.4%



Sepsis Screening Antibiotics Compliance (audit)

82.7%



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

#NOF – Time to Theatre <= 36 Hours

What does the data tell us?

- #NOF compliance increased to 65% in May-23, but did not reach the target.
- This is the 4th highest figure in the last 12 months.
- The #NOF target of 85% has not been achieved since Mar-20.
- There were 79 #NOF admissions in May-23.
- There were a total of 28 breaches in May-23.
- The primary reasons for delays were;
  - 60.0% (15 patients) due to theatre capacity
  - 24.0% (6 patients) due to patients being medically unfit
- The average time to theatre in May-23 was 36.0 hours.
- The Trust's 12 Month Rolling Crude Death rate up to Mar-23 for #NOF is 10.99% (In Hospital 4.16% & Out of Hospital 6.84%), which is the 4th lowest in the Midlands (out of 22).[1]
- The Trust's ALOS (Apr-22 to Mar-23) is 9.57 days, which is the lowest in the Midlands.[1]

[1] *Source: HED, accessed 09/06/2023.*

What will we be doing?

- **Improvements in mortality rate regionally**
  - WRH mortality rate has been improving as reported on NHFD and the latest release of data indicates that we are fourth lowest in the region.
- **Capacity**
  - Beds – review of bed modelling to assess need for additional beds for #NOF. NOF beds on Hazel Unit still not ringfenced.
  - Theatre – additional theatre capacity enabled by utilising CEPOD 2, especially when spike in #NOF numbers.
- **Orthogeriatric Cover**
  - Substantive CoE supported by experienced Locum support.
  - Alternative models of provision to manage with recruitment difficulties are under constant review.
- **Other Updates**
  - New Trauma Matron Appointed.
  - NHFD Quarterly Governance Meetings April and June both cancelled due to Junior Doctor Strike – Reschedule to July.
  - Discussions with H&CT regarding pathway and discharge timings.

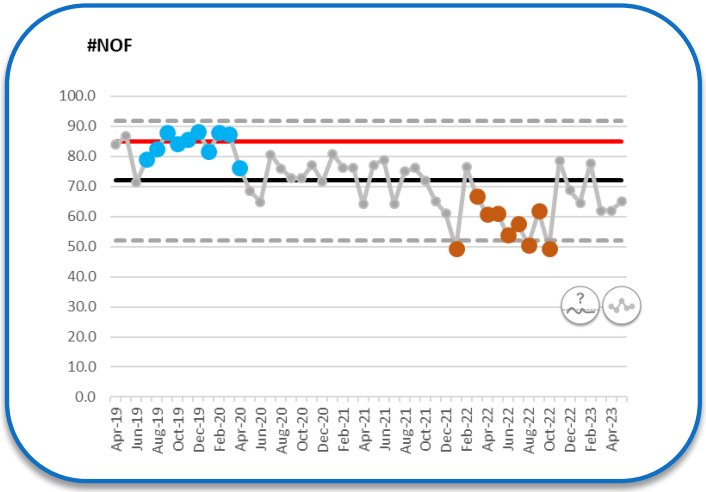
Current assurance level: 5	**When expected to move to next level of assurance**: TBC
Previous assurance level: 5	SRO: Chief Medical Officer (CMO)

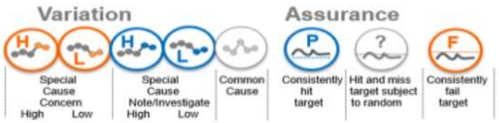
Month 2 [May] | 2023-24 Quality & Safety - Care that is Effective

Responsible Director: Chief Nursing Officer, Chief Medical Officer | Validated for May-23 as 9th June 2023

#NOF time to theatre </=36 hours

65%





Lockdown Period

COVID Wave

Stroke

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

Patients spending 90% of time on a Stroke Ward		Patients who had Direct Admission (via A&E) to a Stroke Ward within 4 hours		Patients who had a CT within 60 minutes of arrival		Patients seen in TIA clinic within 24 hours		SSNAP Q4 22-23 Jan-23 to Mar-23			
	E		E		A		N/A	Score	72.0	Grade	B

What does the data tell us?

- SSNAP published data for Q4 2022/23 confirmed the Trust in house calculations of a score of 72, maintaining a Level B as expected.

Domain improvements were seen in;

Scanning

- 10% improvement in scanning within 1 hour.
- 40 minute reduction in median time.

Thrombolysis

- 30% improvement in patients scanned within 60 minutes.
- Specialist Assessments
- 6 hour reduction in median time for being assessed by stroke consultant.
- 33 minute reduction in median time for being assessed by nurse.

Reduction in performance was observed in;

OT

- Median % of days on which OT received dropped by 17%

Physio

- Median % of days on which Physio received dropped by 17%

Standards by Discharge

- 25% reduction in applicable patients who are screened for nutrition and seen by a dietician.

All SPC Charts are showing common cause variation.

Direct admission to a stroke ward is still showing that it will consistently fail to hit the target, and with the target being outside the control limits it is unlikely that this will change without a refocus on, or change in, processes.

What are we doing to improve?

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

- To improve the scanning times, there has been ongoing discussions with ED and how we can support the Stroke pathway between both the ED and Stroke teams. ED has agreed to support the Stroke CNS team during out of hours with unstable or non-stroke patients. This enables the Stroke nurses to start their assessments within the ambulances if patients are not able to be off-loaded, impacting on scanning times, but more importantly improving patient outcomes and experience.
- By identifying Stroke patients earlier it offers the stroke unit the opportunity to pull patients to the ward in a more timely manner which is supported by a project on the ward that is being led by a band 6 nurse. Her project involves improving flow between ED and the Stroke unit as through the evidence we know that earlier admission to the stroke unit improves long-term outcome and mortality.
- During the most recent industrial action (Junior Doctor strikes 14-16 June 2023), the Stroke Consultants have created and managed a local rota whereby they offered 24 hour on-site cover for any Stroke referrals improving early access to the stroke team and early decision making regarding ongoing care.
- The Stroke coordinator post that has been advertised has attracted some good potential candidates and the interviews will be completed on the 278th of June 2023. This post holder will work across the pathway between the Health and Care trust and Acute to improve the patient journey and patient flow.
- To further improve data inputting and the Quality thereof, a further administrative post to support data inputting has been advertised and the interviews will be held on the 5th of July 2023. By ensuring that our data is accurate, it can be used to identify common trends that may highlight areas for improvement to the team.
- The 20 bedded stroke unit remains ring-fenced for stroke and neurology patients. To facilitate flow, two boarding spaces have been created on the ward. One of these spaces remain free to ensure that there is a bed available at all times to Thrombolise a patient if required.
- In order to promote flow throughout the stroke pathway, the on-call Stroke team continues to assess patients alongside the therapy teams, if appropriate, to prioritise discharging patients directly home from ED/AMU. Ongoing investigations are then requested on an out-patient basis. This ensures that ASU beds are only used for those patients who are not medically fit for discharge.
- There has been a marked reduction in meeting the Therapy metrics during the last two quarters. This has been as a result of staff vacancies, particularly within the Occupational Therapy teams and has impacted on their ability to offer a 7 day service. These vacancies have now been recruited to, and therefore the compliance to the therapy domains should show an improvement from Quarter 2.
- After a recent ISDN meeting it was agreed that, if possible, patients that are re-admitted from ECH to the Acute trust should be transferred to the ASU if Stroke remains their main issue to manage flow and ongoing stroke input to improve long-term outcomes.
- Ongoing Countywide therapy meetings which include the Health and Care Trust are ongoing – these include therapists in the county meeting regularly with the Acute Trust consultant. This encourages communication throughout the stroke pathway to discuss any concerns/issues with patients on the stroke pathway being admitted and discharge which is improving communications and thus helping to support flow. This improved communication allows a shared understanding of Trust issues with regards to flow and allows our community partners to support patient flow.
- When accepting referrals from AGH, patient demographics are continued to be checked prior to accepting patients to ensure that ASU do not accept out of area patients, thereby impacting on flow through the unit. This has shown to improve transferring only appropriate patients to Worcester Royal Hospital.

Thrombolysis:

- The positive impact of ongoing face-to-face stroke simulation training alongside in-house consultant cover for advice and guidance after 5pm is ongoing and this impacts on the good working relationship with the on-call medical registrars. The next course is booked for the 30th of June and has been opened up to the relevant staff not only in Worcestershire, but also in Herefordshire and Cambridgeshire.

Current Assurance Level – 5 (Jun-23)	**When expected to move to next level of assurance:** Moving to assurance level 6 is dependent on achieving the main stroke metrics and demonstrable **sustained** improvements in the SSNAP score / grade.
Previous Assurance Level: 5 (Apr-23)	**SRO:** Christine Blanshard (CMO)

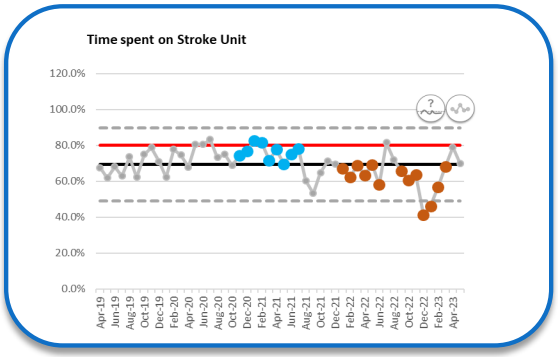
Month 2 [May] | 2023-24 Quality & Safety - Care that is Effective

Responsible Director: Chief Medical Officer | Validated for Apr-23 as at 12th June 2023

NHS Worcestershire Acute Hospitals NHS Trust

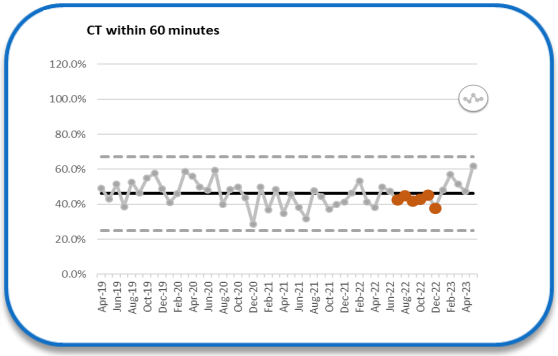
Stroke: % patients spending 90% of time on stroke unit

70.0%



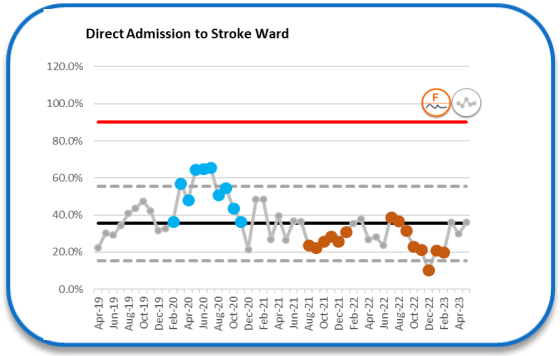
Stroke : % CT scan within 60 minutes

62.0%



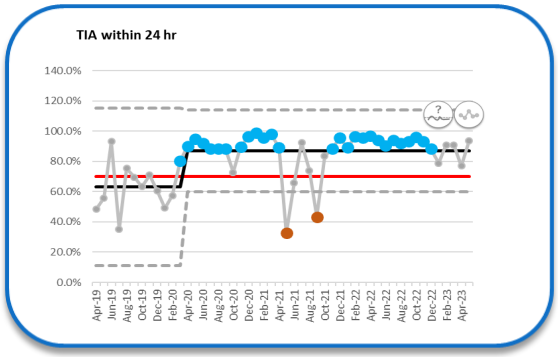
Stroke : % Direct Admission to Stroke ward

36.0%



Stroke: % seen in TIA clinic within 24 hours

93.8%



2.3 Care that is a positive experience – Friends and Family

FFT Inpatient Recommended	FFT Outpatient Recommended	FFT AE Recommended	FFT Maternity Recommended
May-23	May-23	May-23	May-23

What does the data tell us?

- As stated in the previous IPR, performance for A&E, Inpatient and Outpatient Recommended rates have all shown special cause variation of improvement for the last 13-15 months consecutively, and consequently the associated SPC charts have been rebased.
- As a result both Inpatient and Outpatient charts now indicate that the metric will consistently hit the target.
- But after rebasing A&E is unchanged, still indicating that the metric will consistently fail the target. However, between Oct-22 and Jan-23 the Trust had the highest A&E Recommended rate in the West Midlands Peer Group, and was 2nd highest in Feb-23[1].
  Previous analysis of data (October 2022-January 2023) demonstrated that Worcestershire Acute Hospitals trust was the only trust with a recommended rate of 90%+, indicating the challenge with meeting the expected target of >95% across NHS trusts.
- Maternity data for April onwards is mainly recorded on Badgernet. The figures from Badgernet provided on the SPC chart for these months are provisional as validation of the data extraction process is finalised. This is showing that the recommended rate will be inconsistently met, being subject to random variation. Although, it should be noted that the cohort of responses is very low having peaked at 3.5% in the last year.

[1] Feb-23 is the latest national data published by NHSE

- Advertising feedback is now in place across all three sites with the provision of cards and boxes, volunteers will support in delivering completed cards to relevant departments.
- The FFT Optimisation Project (pilot) involving Outpatients and UEC has again been delayed due to capacity in the IT department and will not be ready to launch as expected in June 2023. This project aims to support greater actionable insights and understanding from what our patients, carers, their family and friends are telling us and is based on the "I want great care" initiative. Members of the task and finish group have informed options which will be presented to senior management. These include a launch in Q2, a delayed projected launch and outsourcing to an external agency.
- W&C Division is keen to progress with text messaging as an alternative feedback mechanism to generate a greater response. IG considerations will need to be progressed.
- Divisions continue to report FFT data and actions to the quarterly Patient, Carer and Public Engagement steering group to support understanding of themes.

Current Assurance Level – 5 (Jun-23)
Reason: sustained improvement seen across areas with the exception of maternity where the response rate remains low. Supportive actions are in development however further action is required in maternity. The launch of the Optimisation project has been delayed. Improvement is expected during Q2 2023-2024.

When expected to move to next level of assurance: Q3

Previous assurance level – 4

SRO: Chief Nursing Officer (CNO)

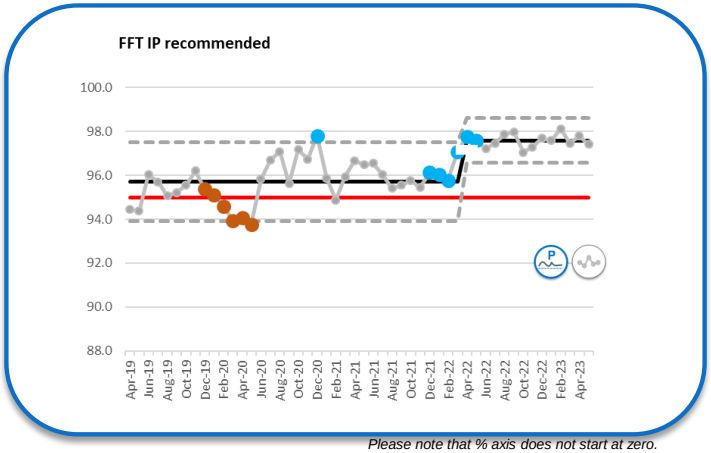
Month 2 [May] 2023-24 Quality & Safety - Care that is a positive experience for patients/ carers

Responsible Director: Chief Nursing Officer, Chief Medical Officer | Validated for May-23 as at 6th June 2023.

NHS Worcestershire Acute Hospitals NHS Trust

FFT Inpatient Recommended %

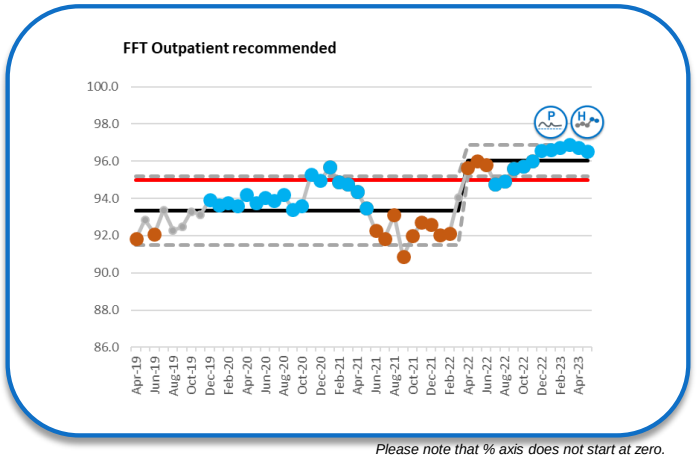
97.4



Please note that % axis does not start at zero.

FFT Outpatient Recommended %

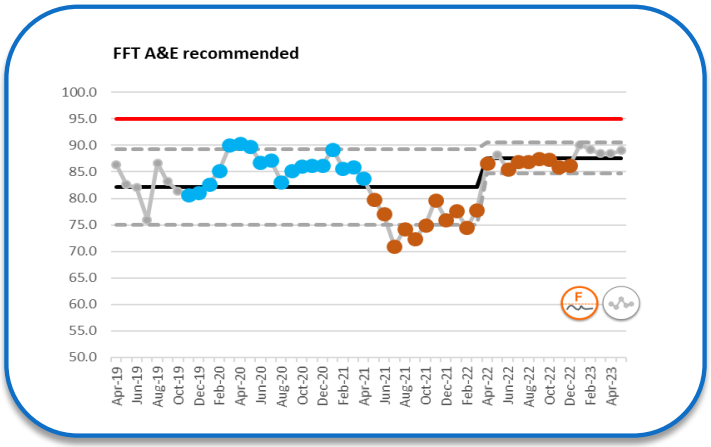
96.5



Please note that % axis does not start at zero.

FFT AE Recommended %

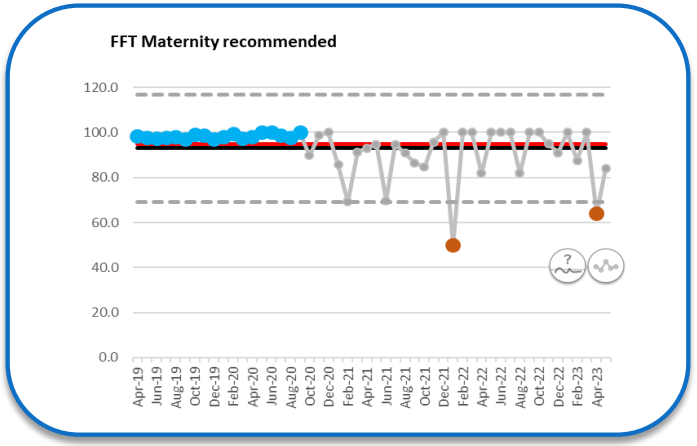
89.0



Please note that % axis does not start at zero.

FFT Maternity Recommended

84.0



2.1 Care that is Safe – Falls

Total Inpatient Falls	Inpatient Falls resulting in Serious Harm	Falls per 1,000 bed days	Falls per 1,000 bed days (serious harm)
May-23	May-23	May-23	May-23
			

What does the data tell us?

Benchmarking for 2023/24 is based on Falls per 1,000 Bed Days.
The National Targets are;

- 6.63 Total Falls per 1,000 Bed Days
- 0.19 Serious Incident Falls per 1,000 Bed Days

Total Inpatient Falls

- The total number of falls fell in May-23 to 112.
- Of these 112 falls the harm caused was: 37 Insignificant, 73 Minor and 2 Moderate.
- We were on trajectory in May-23 with 4.6 Total Falls per 1,000 Bed Days.

Inpatient falls resulting in Serious Harm

- There were 0 SI falls in May-23.
- We were on trajectory in May-23 with 0 SI Falls per 1,000 Bed Days.

What improvements will we make?

- Continue to monitor all falls and falls with harm on a weekly basis identifying hotpot areas for review and intervention where necessary
- Encourage registered staff to complete falls e-learning
- Establish appropriate training for non-registered staff
- Re-establish Falls champions
- Ensure all policies and guidelines are easily accessible via falls intranet page
- Obtain funding for replacement hover matt on WRH site and service plans for all hover jacks across the trust
- Spread of 'snack and snooze' and 'yellow bundle' initiatives
- Review of NAIF KPI's and recommendations for implementation where necessary

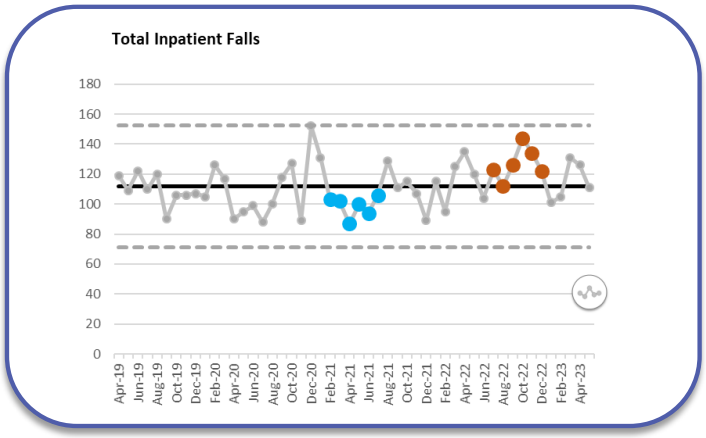
Current Assurance level (Quarter 4) Falls – Level 6	**When expected to move to next level of assurance** Aim to maintain 2023/24
Previous assurance level (Quarter 3) Falls – Level 6	SRO: Chief Nursing Officer (CNO)

Month 2 [May] | 2023-24 Quality & Safety - Care that is Effective

Responsible Director: Chief Nursing Officer, Chief Medical Officer | Validated for May-23 as 6th June 2023

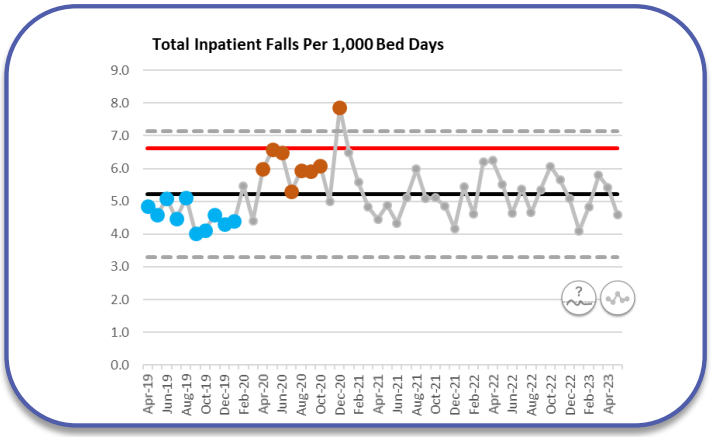
Total Falls

112



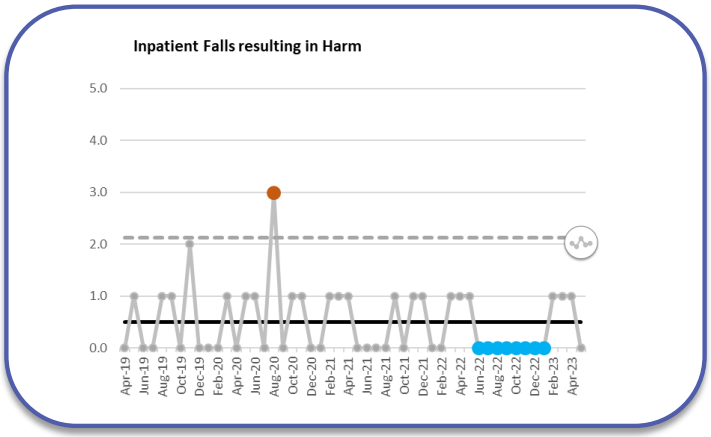
Total Falls per 1,000 bed days

4.6



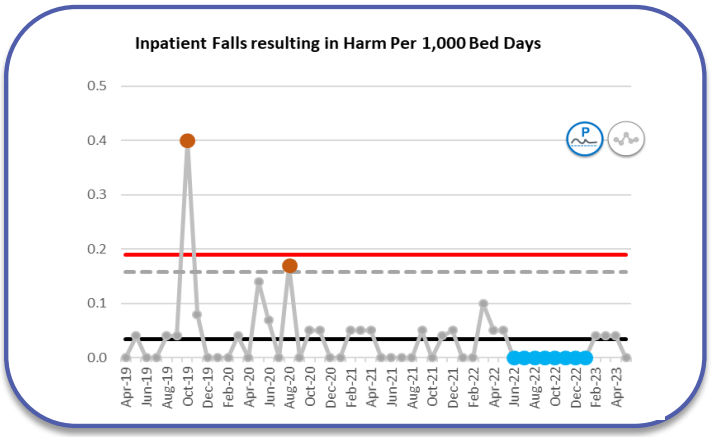
Total SI Falls

0



SI Falls per 1,000 bed days

0.00



2.1 Care that is Safe – Pressure Ulcers

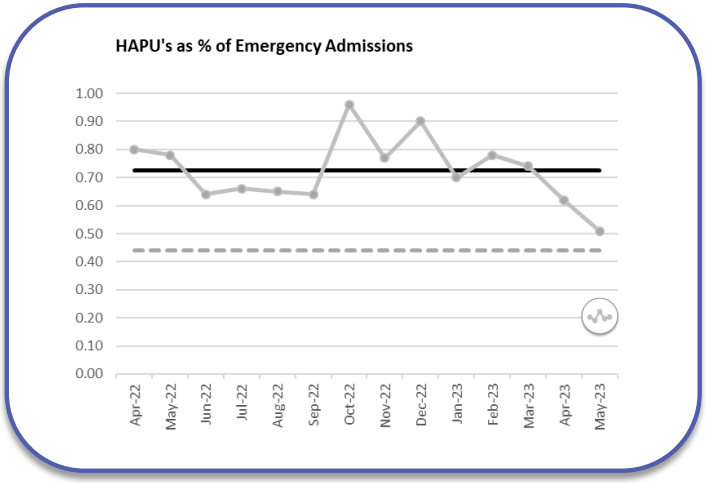
Total Hospital Acquired Pressure Ulcers (HAPUs) as a % of Emergency Admissions	Hospital Acquired Pressure Ulcers Causing Harm as a % of Emergency Admissions
May 2023	May 2023
	
What does the data tell us? • For 2023/24 a new metric is being used to monitor HAPU's. This is the total number of HAPUs as a percentage of Emergency Admissions. There is currently no agreed target. • Note that there is no national data that can be used to benchmark this metric against. • To add context to the 2023/24 figures, this calculation has been applied to the 2022/23 figures (see SPC charts) **Total HAPU's** • The total number of HAPUs for May 23 dropped to 17 • Total HAPUs as a % of Emergency Admissions dropped to 0.51% in May (from 0.62% in Apr) **HAPU's causing Harm** • There were zero HAPUs causing harm in May-23.	**What improvements will we make?** • Tissue Viability Documentation now live on EPR from 18th May to improve documentation. • Continue to support divisions with Educational Training programmes training for all health professional . • Pressure Ulcer Prevention Training go Live on ESR as essential to role. • New TV mirrors funded by Charitable funds distributed to all wards to support staff with ability to check pressure areas . • Bespoke training for Urgent care division when highlighted increase of HAPU and low training attendance • CQUIN 12 continues . (Documentation of a full pressure ulcer risk assessment (within 6hrs) using a validated scale, such as Waterlow in progress to support Quality and improvement .
Current Assurance Level – 5 (Jun-23)	**When expected to move to next level of assurance:** Reviewed once Jun-23 data is available
Previous assurance level: 5	SRO: Chief Nursing Officer (CNO)

Month 2 [May] | 2023-24 Quality & Safety - Care that is Effective

Responsible Director: Chief Nursing Officer, Chief Medical Officer | Validated for May-23 as 9th June 2023

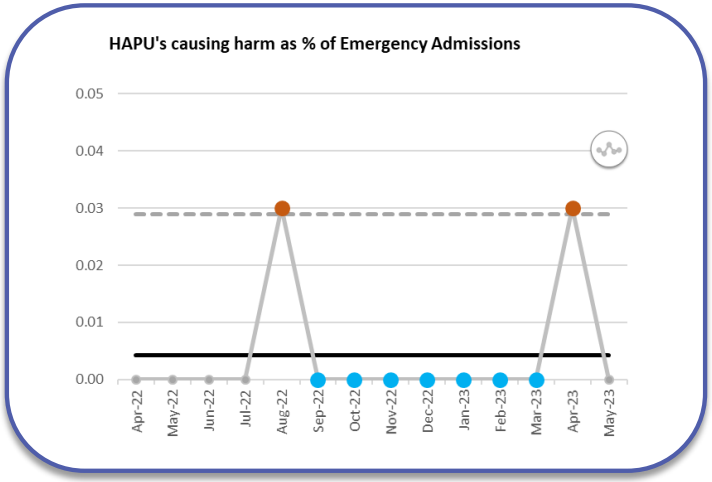
Total HAPU's as % of Emergency Admissions

0.51%



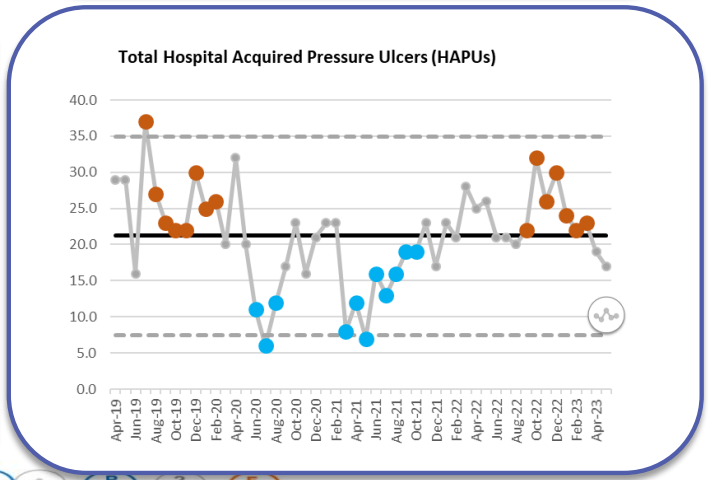
HAPU's Causing Harm as a % of Emergency Admissions

0%



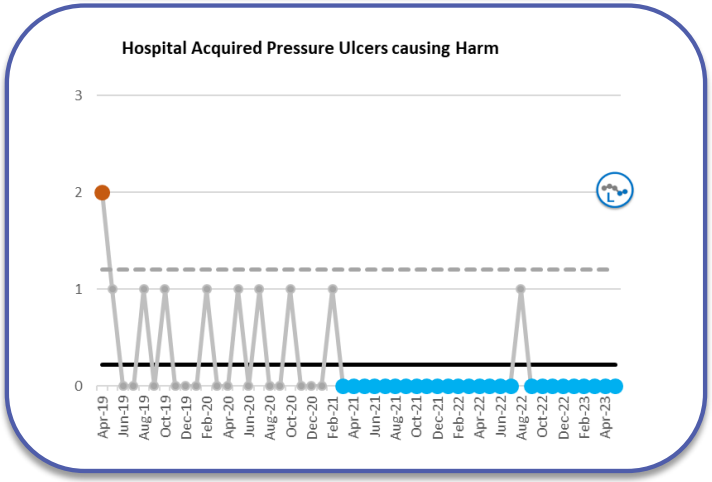
Total HAPU's

17



HAPU's Causing Harm

0



2.2 Care that is Effective – Learning From Deaths

SHMI	HSMR
1.0370 'As Expected'	100.61 Alert Level 'Green'

What does the data tell us?

Summary Hospital-level Mortality Indicator (SHMI)
- The Trust's SHMI is in the **'As Expected'** banding for both Worcestershire and Alexandra sites.
- The Trust has been **'As Expected'** for 41 consecutive months.
- Latest reported time frame January 2022 – December 2022 (published by NHSE 11th May 2023).

Hospital Standardised Mortality Ratio (HSMR)
- The Trust's HSMR alert level is Green.
- The Trust score of 100.61 is below our Midland Peer Group (102.97).
- Latest reported time frame April 2022 – Mar 2023 (published by HED, last accessed 14/06/2023).

Crude Mortality Rate
There are several methodologies which are used to calculate Crude Mortality – each of which must be interpreted in the context of the algorithm used to calculate the metric.
- HSMR crude mortality rate is 2.83%. This only includes 56 CCS (HED – Apr 22 to Mar 23)
- SHMI crude mortality for elective admissions 1% (NHSE Jan 22 to Dec 22) which is in line with the NHS average.
- SHMI crude mortality rate for non-elective admissions 4.2% (NHSE Jan 22 Dec 22), which is in line with the NHS average.
- Trust data, excluding paediatric and ED deaths, shows a 3.21% crude mortality rate for Jan 22 to Dec 22, 3.29% for Apr 22 to Mar 23 and 3.38% for Jun 22 to May 23.

Note: Mortality metrics are not a quality of care indicator. A higher number of deaths should not immediately be interpreted as indicating poor performance, but as a flag that further investigation is required. Care must also be taken when comparing mortality indicators between Trusts, for example SHMI makes no adjustment for the severity of the condition the patient is in hospital for (https://files.digital.nhs.uk/E8/1AE28E/SHMI%20FAQs.pdf).

Actions:
- Data gives high assurance that there is not a 'quantity' problem with deaths, so focus is now on 'quality'
- Learning from deaths group has been streamlined and integrated with care of the deteriorating patients and end of life care groups
- Learning from deaths group at Trust level now represented at ICB and regional level, and integrated with LEDER process
- This has produced richer and deeper understanding of issues faced by dying patients
- Unacceptably high numbers (approximately 10% of all deaths) of patients continue to die in our emergency departments, many after several hours of care during which time they should have been moved to the wards (approx.75-90% of all ED deaths occur after the patients has been in the ED for more than 4 hours). This will be presented to the site management team.
- Flow remains extremely challenging however.
- RESPECT forms are not being brought in by patients or ambulance staff, so moving to a digital solution is a priority
- The Trust has received one Section 28 notification from the Coroner concerning patients who need steroid replacement. An improvement piece of work has been completed.

Assurance level – 7

Reason: All nationally recognised metrics for numbers of deaths are in the 'as expected' range, and have been for several years

When expected to move to next level of assurance: N/A

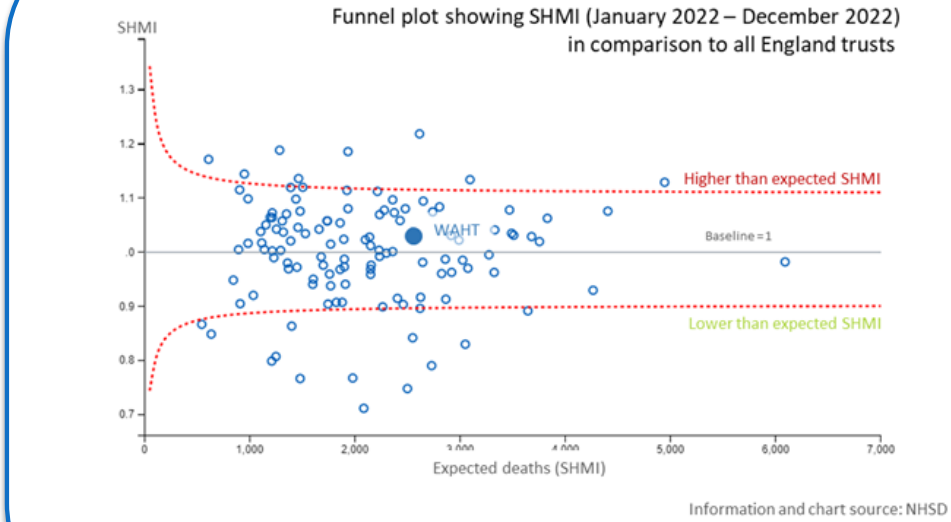
SRO: Chief Medical Officer (CMO)

Quality & Safety - Care that is a positive experience for patients/ carers

Responsible Director: Chief Nursing Officer, Chief Medical Officer | Validated for Dec-22 as at 14th June 2023.

SHMI

As Expected



Please note that % axis does not start at zero.

2.3 Care that is a positive experience – Complaints

Complaints Responded to Within 25 Days

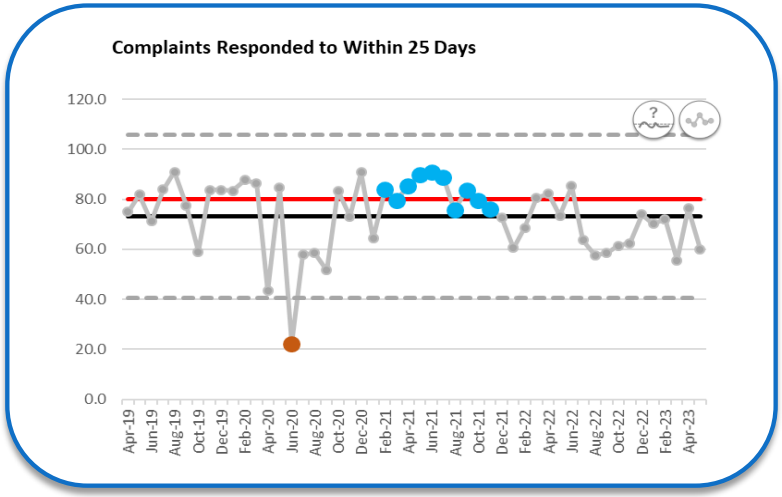
What does the data tell us?	What improvements will we make?
• In total there were 57 new formal complaints received within May with 21 called within 5 days to discuss the complaint. • The Trust had 132 complaints still open at then end of May, of which 16 have been reopened. • Of these 132 complaints, 63 have breached 25 days (7 of which have been reopened) • The Surgery Division accounts for 48 of the complaints which have breached 25 days, 7 of which have been reopened. • Compliance with complaints closed within 25 days dropped this month to 60%, which is the 11th consecutive month that the target has been missed. • The target is within the common cause variation but performance continues to fluctuate. The SPC chart indicates that more robust processes and / or increased focus / capacity would enable us to meet the target consistently.	• The Surgical Division is recruiting a temporary staff member via NHSP at 0.4 WTE to focus solely on working to resolve overdue surgical cases. • Until the backlog of surgical breach cases (48 as of 12/06/2023) has been addressed, it will not be possible to improve performance levels; in fact, if significant progress is made and a large number of breach cases are closed, performance percentage against KPI will likely worsen. • Breach numbers must be stabilised at ~15 overdue open across the Trust, in order to ensure >80% closed in month are in time. • Complaints Manager linking with new Surgical temporary staff member to provide all information and trackers necessary to prioritise cases by timescale & severity.
Current Assurance Level – 5 (Jun-23) Reason: The high number of breaches is confined to one Division; this demonstrates that demand established processes work, however increased focus is needed within Surgical Division in order to improve	**When expected to move to next level of assurance:** Q2; dependent on reduction of backlog/incoming complaint numbers
Previous assurance level - 5	SRO: Chief Medical Officer (CMO)

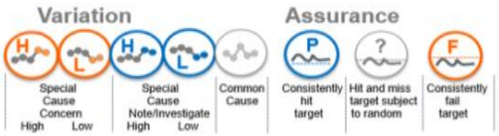
Month 2 [May] 2023-24 Quality & Safety - Care that is a positive experience for patients/ carers

Responsible Director: Chief Nursing Officer, Chief Medical Officer | Validated for May-23 as 7th June 2023

Complaints Responded to Within 25 Days (%)

60%





CQUINS 2022/23 Summary

CQUIN Description	2022/23			
	Q1	Q2	Q3	Q4
Achieving 90% uptake of flu vaccinations for staff with patient contact.	N/A	N/A	46% overall (44% patient facing)	46% overall (44% patient facing)
Achieving 60% of all antibiotic prescriptions for UTI in patients aged 16+ years that meet NICE guidance for diagnosis and treatment.	58%	50%	51%	48%
Achieving 65% of referrals for suspected prostate, colorectal, lung and oesophago-gastric cancer meeting timed pathway milestones as set out in the rapid cancer diagnostic and assessment pathways	2.10%	12.70%	20.20%	24.50%
Achieving 35% inpatients (with at least 1-night stay) with a diagnosis of alcohol dependence who have an order or referral for a test to diagnose cirrhosis or advanced liver fibrosis.	56%	61%	45%	40%
Achieving 60% of all unplanned critical care unit admissions from non-critical care wards of patients aged 18+, having a NEWS2 score, time of escalation (T0) and time of clinical response (T1) recorded.	N/A	N/A	90%	90%

CQUINS 2023/24

The CQUINs which the Trust will be completing in 2023/24 are;

- CQUIN01: Achieving 80% uptake of flu vaccinations by frontline staff with patient contact.
- CQUIN02: Ensuring 80% of surgical inpatients are supported to drink, eat and mobilise within 24 hours of surgery ending.
- CQUIN03: Achieving 40% (or fewer) patients still receiving IV antibiotics past the point at which they meet switching criteria.
- CQUIN04: Achieving 55% of referrals for suspected prostate, colorectal, lung, oesophago-gastric, head & neck and gynaecological cancers meeting timed pathway milestones as set out in the rapid cancer diagnostic and assessment pathways
- CQUIN05: Achieving 30% of patients aged 65 and over attending A&E or same-day emergency care (SDEC) receiving a clinical frailty assessment and appropriate follow up.
- CQUIN06: Achieving 1.5% of acute trust inpatients having changes to medicines communicated with the patient's chosen community pharmacy within 48 hours following discharge, in line with NICE Guideline 5, via secure electronic message

CQUINS 2023/24

- CQUIN07: Achieving 30% of unplanned critical care unit admissions from non-critical care wards having a timely response to deterioration, with the NEWS2 score, escalation and response times recorded in clinical notes
- CQUIN08: Following guidance published by the Vascular Society, to reduce the delays in assessment, investigation, and revascularisation in patients with chronic limb threatening ischaemia, and in turn to reduce length of stay, in-hospital mortality rates, readmissions and amputation rates.
- CQUIN10: Achieving 85% of adult patients with non-small-cell lung cancer (NSCLC) stage I or II and good performance status (WHO 0-2) referred for treatment with curative intent, as per the NICE QS17 recommendation.
- CQUIN12: Achieving 85% of acute and community hospital inpatients aged 18+ having a pressure ulcer risk assessment that meets NICE guidance with evidence of actions against all identified risks.

Updates will be provided quarterly.

Maternity

Maternity | Month 2 [May] | 2023-24

Responsible Director: Chief Nursing Officer | Unvalidated for May 2023

NHS Worcestershire Acute Hospitals NHS Trust

Admission of full-term babies to neonatal care	Neonatal Deaths (>24+0 weeks gestation)	Stillbirths	Maternal Deaths	Pre-term births	Induction of labour	Home births	Booked before 12+6 weeks	Births	Babies
							 	376	384

What does the data tell us?

- In May-23 there were 376 births and 384 babies born by our Trust. By comparison, there were 372 births and 378 babies born in May-22.
- The only metric to show special cause concern is women booked before 12^{+6} weeks noting that the target (90%) may or may not be achieved.
- The remaining core metrics have not changed significantly and show either a level of natural variation you would expect to see or the statistical significant improvement has been maintained
- There were no stillbirths, neonatal deaths or maternal deaths in May-23.

What have we been doing?

- Work can now be completed on the local Escalation Policy as the Regional guidance has been updated (V2)
- Initial meetings with regards to Single Point of Access have commenced.
- Maintaining contact with the 24 midwives due to commence in Sept 2023
- Awaiting start dates for 10WTE MSWS/MCAs

What are we going to do?

- Restart engagement events when staffing levels allow
- Develop new sitrep to mirror information now required for regional oversight
- Advertise 2 new leadership roles to support MSWs and retention of staff.
- Review governance structure and propose new quality and safety framework

Current Assurance Level - 5 (Jun-23)

When expected to move to next level of assurance:

- Completion of work outlined in service improvement plan
- No midwifery vacancies
- No medical staffing vacancies

Previous Assurance Level - 5 (May-23)

SRO: Jackie Edwards (Interim CNO)

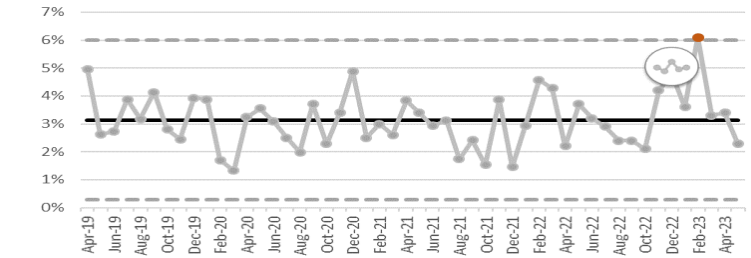
Maternity | Month 2 [May] | 2023-24

Responsible Director: Chief Nursing Officer | Unvalidated for May 2023

NHS Worcestershire Acute Hospitals NHS Trust

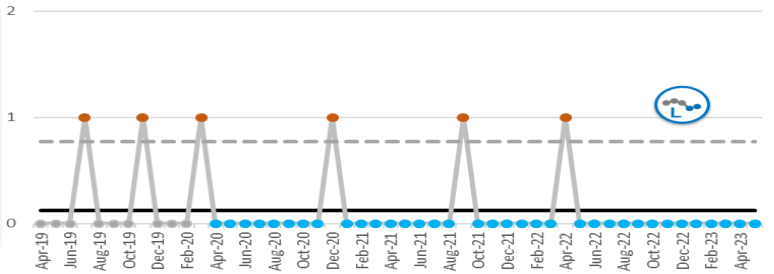
% admission of full-tern babies to neonatal care

2.3% (9 babies)



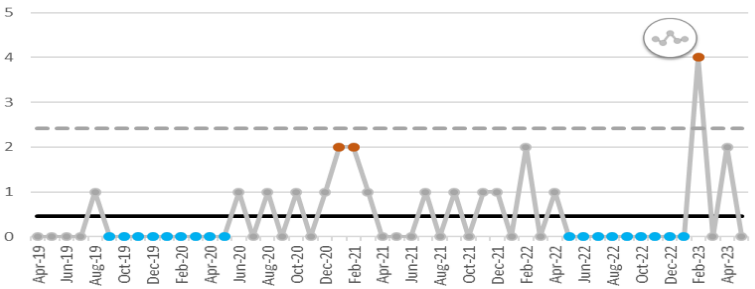
Maternal Deaths

0



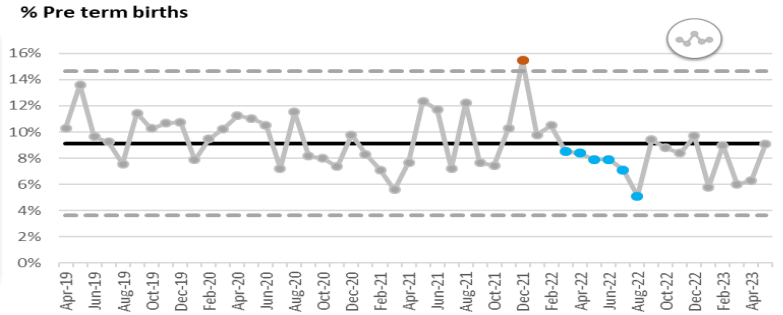
Neonatal Deaths (>24+0 weeks gestation)

0



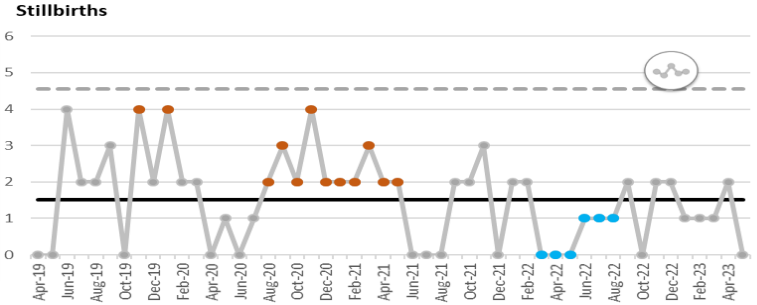
% Pre term births

9.1% (35 babies)



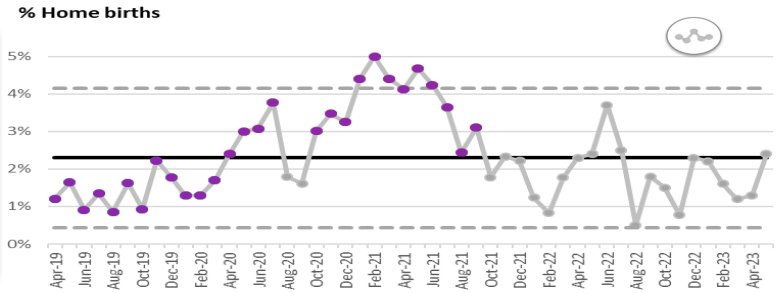
Stillbirths

0



% Home births

2.4% (9 babies)



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

Graphs include Apr-23 data – presentation is using the national SPC toolkit.

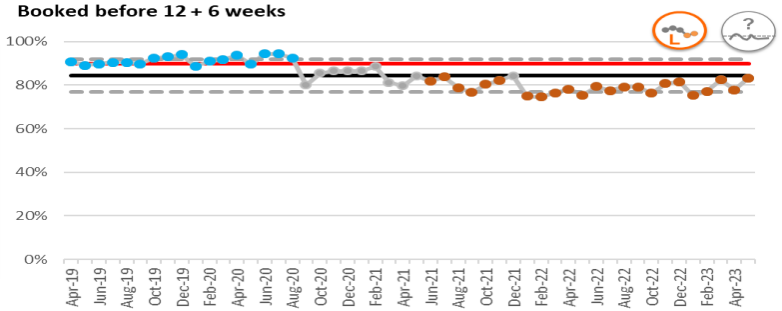
Maternity | Month 2 [May] | 2023-24

Responsible Director: Chief Nursing Officer | Unvalidated for May 2023

NHS Worcestershire Acute Hospitals NHS Trust

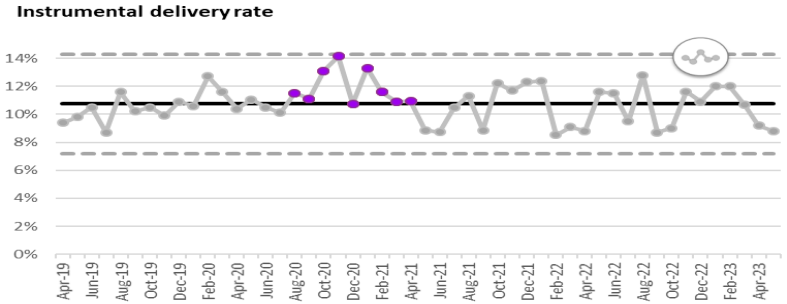
Booked before 12+6 weeks

83.2%



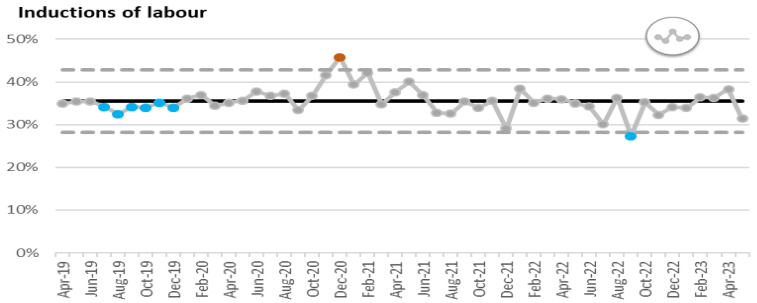
Instrumental Delivery

8.8%



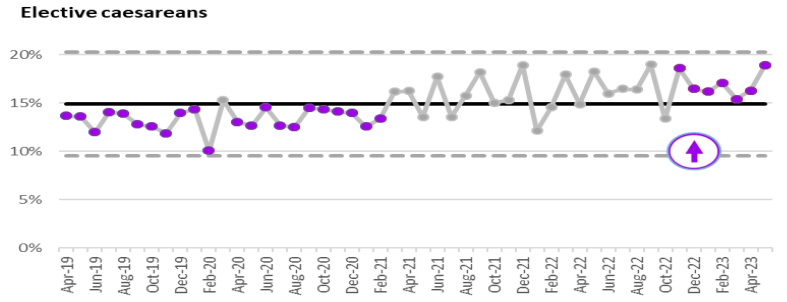
Inductions of labour

31.4%



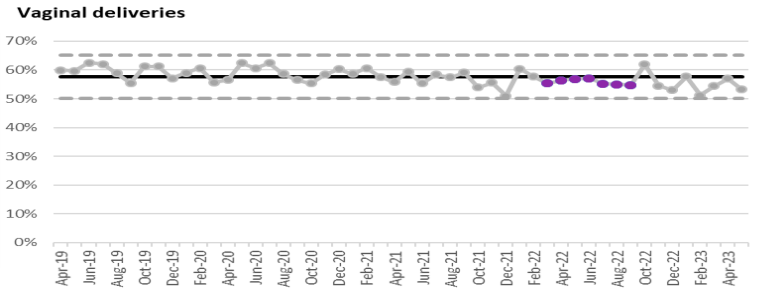
Elective Caesarean

18.9%



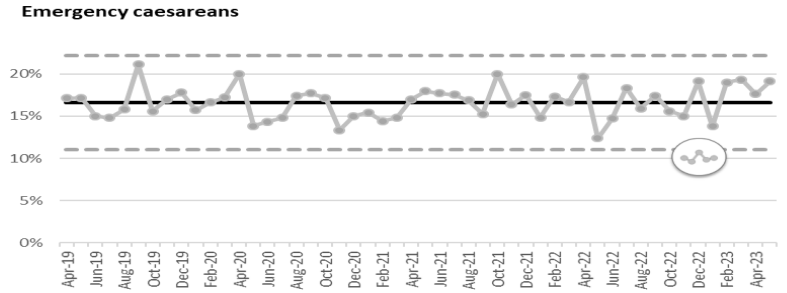
Vaginal Deliveries (non-instrumental)

53.2%



Emergency Caesarean

19.1%



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

Graphs include Apr-23 data – presentation is using the national SPC toolkit.

Workforce

People and Culture Performance Report Month 2 2023-

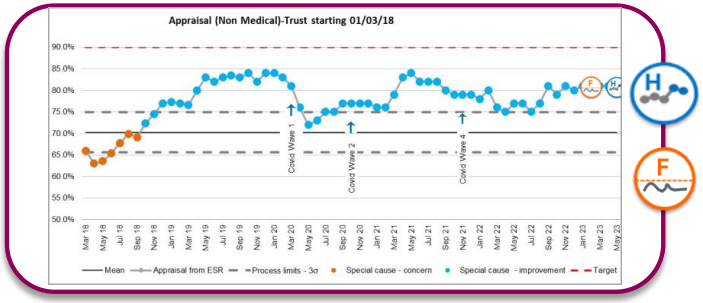
	Comments
Getting the Basics Right	• Overall **Mandatory Training Compliance** has remained on target at 90% against a Model Hospital average of 88.4% (2021/22 rates is most recent data on model system) 3 Divisions have improved and none have deteriorated. Digital , SCSD, Specialty Medicine and Estates and Facilities all meet the Trust target of 90%. The Medical and Dental staff group remain outliers across all divisions although on an improving trajectory with a further 2% improvement. • **Non-Medical appraisal** has remained at 81% against a target of 90%. This is 4% higher than the same period last year against a national average on Model Hospital of 76.3%. **Medical Appraisal** has increased by 10% to 93% this month. Consultant Job Planning compliance is unchanged at 61%. A corrective action plan is to be submitted to the Finance & Performance Committee.
Performance Against Plan	• **Funded establishment** has grown by 20.8 wte this month. Further work is being undertaken with Finance to understand the increase in establishment this month. There are 56 posts in Central Trustwide establishment which are not apportioned to any division. As these posts will have no staff in post against them they are inflating our vacancies. Finance have confirmed that these are reserves pending transaction of business cases. • **Vacancies** have Increased this month by 1 wte to 882. This is due to the fact that the gross establishment has increased by 21 wte with staff in post increasing by 20 wte overall. Our gross vacancy rate on ESR has reduced slightly from 12.64%. to 12.61%. • **Recruitment** –We recruited 25 more starters than leavers this month. 97 new starters were recruited by our centralised Recruitment and Medical Resourcing teams. SCSD are in a worse position by 4 wte and Women and Children by 1 wte, but all other divisions are in a better position this month. Specialty Medicine saw a growth of 12 wte. • We have submitted a **workforce plan** which will require an additional 355.72 wte recruitment to vacancies by 31st March 2024. We are currently slightly behind of our revised workforce plan by 5.48 wte despite recruiting 97 new staff.
Drivers of Bank & Agency Reductions	• Our **annual staff turnover** has improved by 0.03% to 11.98% which is 1.43% better than the same period last year against a local target of 11.5% • Our s**taff retention** rate has improved by 3% and is currently 90% which is drop from 98% last year. Our latest performance on Model Hospital for retention rate is 98.3% against an average of 98.4% and Peer Average of 98.6% (March 2022 rates). • **Agency usage** has increased by 8 wte and by 0.27% to 9.49% of gross cost. This is primarily due to cover for the 3 bank holidays. Agency Spend is 0.74% higher than the same period last year.
Staff Health & Wellbeing	• **Cumulative sickness absence** (rolling 12 months) is broadly unchanged at 5.82% which is above our 5.5% target but remains better than the 6.2% national average (6.5% peer average) • Sickness due to S10 (stress and anxiety) has remained at 1.50% and covid absence has almost halved to 0.34%. • Sickness absence has increased by 0.06% this month to 5.46% and is 0.53% higher than the same period last year. Covid Absence is no longer of concern. TME and JNCC will be asked to note that in future Covid absence will count towards triggers and will be managed in the same way as all other absence. Long Term Sickness has increased by 0.03% to 3.35% and Short Term has improved by 0.01% to at 2.47% which meets our target. Estates and Facilities have the highest long term and short-term cumulative sickness.

March - Month 2 2023/24 Workforce Compliance "Getting the Basics Right" Summary

Responsible Director: Director of People and Culture | Validated for May 2023 as 15th June 2023

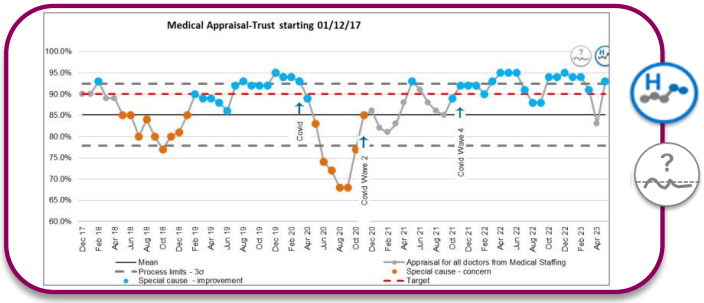
Appraisal (Non-Medical)

81%



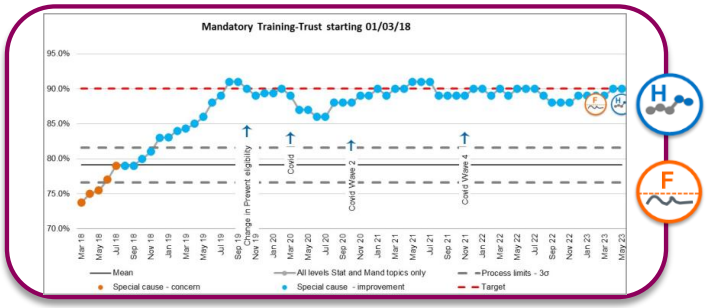
Medical Appraisal

83%



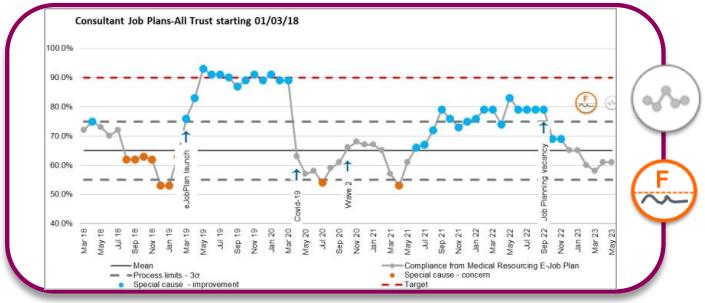
Mandatory Training

90%



Consultant Job Plans

61%



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

Workforce Compliance Month 2 – May 2023: - Workforce Growth

Substantive Gross Funded Establishment (ADI)	Contracted Substantive Staff in Post (ESR)	Planned Substantive SIP by March 2024 (WFP)	Gross Vacancy Rate (ESR)	Annual Staff Turnover (ESR)	Total Hours Worked (ADI)
6,992 wte	6,110 wte	6,426 wte	12.61% (Target 7.5%)	11.98% (Target 11.5%)	6,779 wte

What does the data tell us?

- **Establishment** - Our gross establishment has increased by 20.8 wte to 6,992 wte. Further work is being undertaken with Finance to understand the reasons behind this increase.
- **Staff in Post** – has increased by 20.52 wte to 6,110 wte which means that our vacancy rate is broadly unchanged.
- **Planned SIP by March 2024** – we are currently 5.48 behind plan despite having 97 wte new starters. We will require recruitment to a further 315.20 wte posts to meet our plan for March 2024.
- **Growth by Staff Groups** – We have included new SPC charts this month that show the growth in Staff in Post on ESR by staff Group. The majority of staff groups have increased, except Registered Nurses and Midwives who have dropped by 2.50 wte, and Additional Professional Scientific and Technical who have dropped by 0.93 wte.
- **Gross Vacancy Rate** – Our gross vacancy rate has only dropped by 0.03% even though we have 25 more starters than leavers. This is primarily due to the increase in establishment but also reductions in contracted hours by some staff.
- **Annual Staff Turnover** – Our annual turnover has improved by 0.03% to 11.98 wte. This compares to turnover of 13.41% last year so is on an improving trajectory. Our target has been reduced to 11.5%.
- **Total Hours worked** – The overall picture is an improving trajectory although this has been impacted by the 3 bank holidays and ambulance and Teachers strike action in May. There has been a 44 wte increase in the overall hours worked which includes a 12 wte increase in bank, 8 wte increase in Agency and 24 wte increase in Substantive.

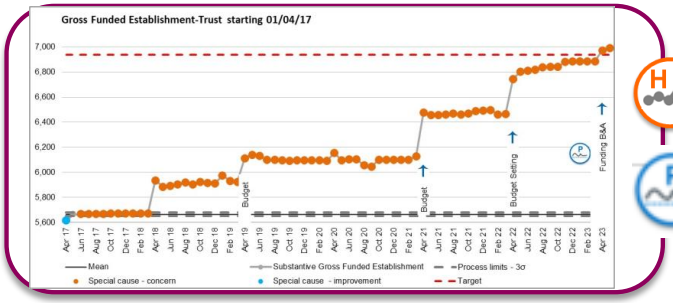
National Benchmarking (May 2023)
We are at the 3rd quartile for all staff Turnover. Our Registered Nurses, Registered Midwives, Administrative and Clerical, and Estates and Ancillary are all at Quartile 1 (best) compared to Model Hospital. The other 4 staff groups are at Quartile 3 (March 2023 data).

Month 2 - May 2023 Workforce Growth Summary

Responsible Director: Director of People and Culture | Validated for May 2023 as 15th June 2023

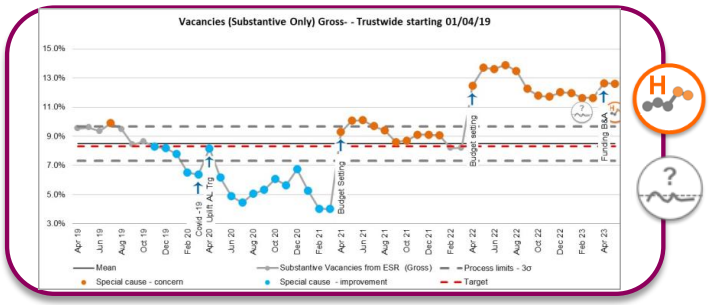
Gross Funded Establishment

6,992 wte



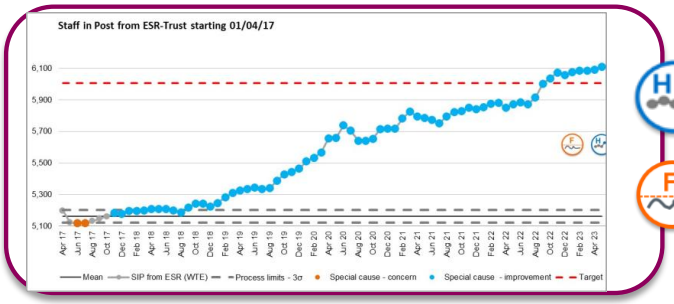
Gross Vacancy % (ESR)

12.61%



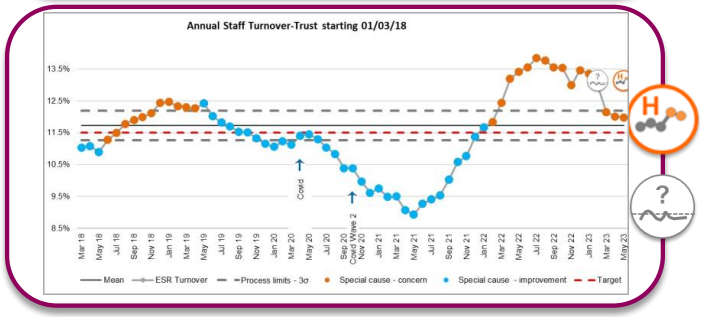
Staff in Post (ESR)

6,111 wte



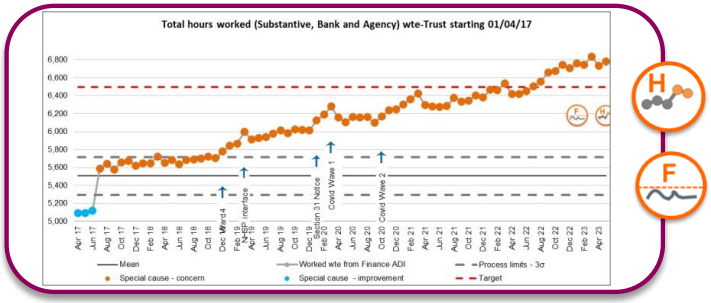
Annual Staff Turnover

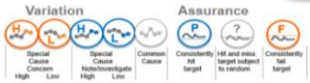
11.98%



Total Hours Worked (ADI)

6,779 wte





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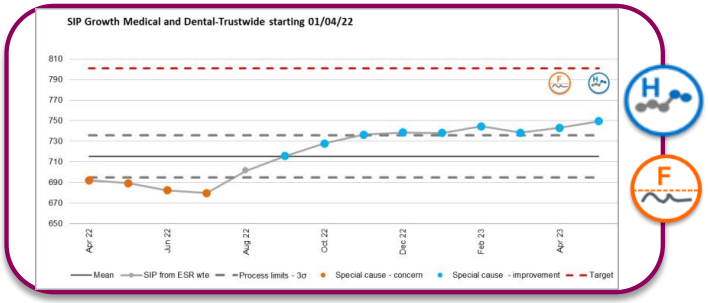
Month 2 - May 2023 Workforce Growth (SIP) by Staff Group from ESR Summary

Responsible Director: Director of People and Culture | Validated for May 2023 as 15th June 2023

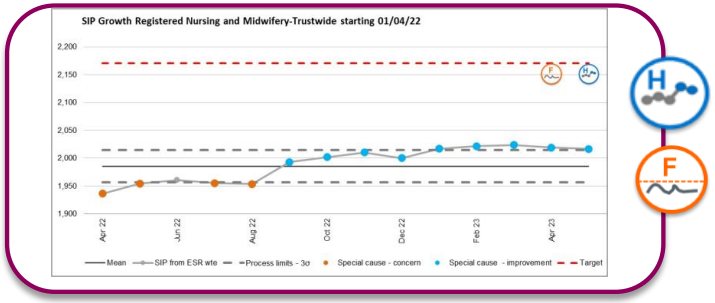
Medical and Dental SIP

749 wte



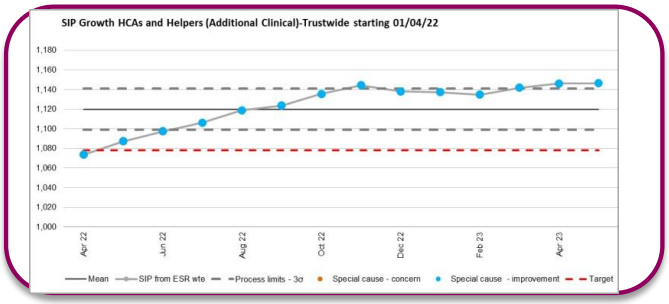
Registered Nurses and Midwives SIP

2,017 wte



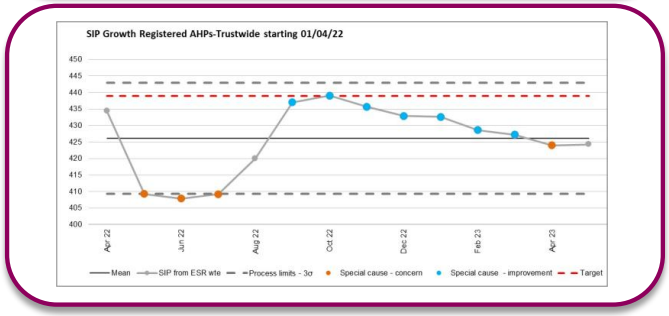
HCAs (Additional Clinical) SIP

1,146 wte



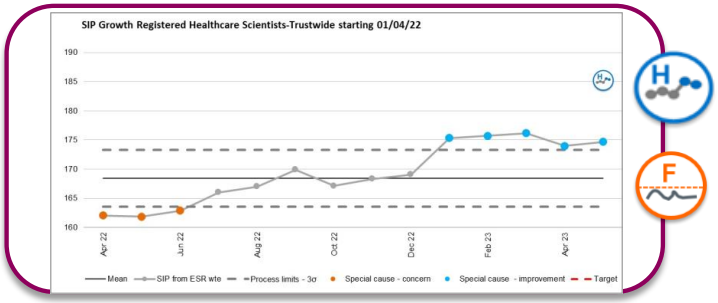
AHPs SIP

424 wte



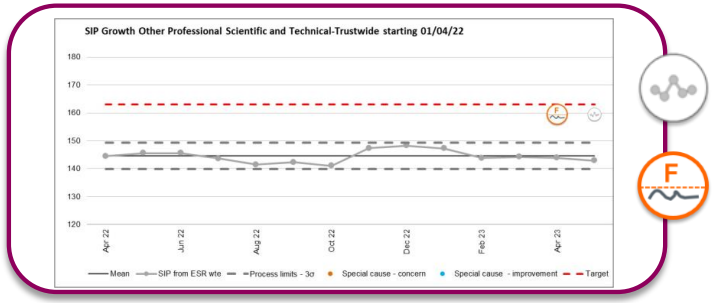
Healthcare Scientists SIP

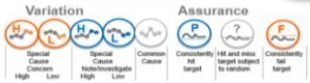
175 wte



Other Additional Prof and Tech SIP

143 wte





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

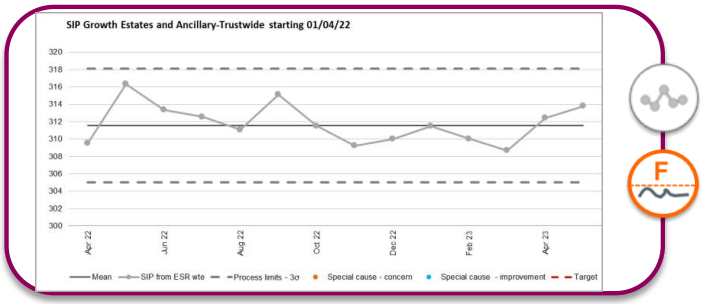
Month 2 - May 2023 Workforce Growth (SIP) by Staff Group from ESR Summary

Responsible Director: Director of People and Culture | Validated for May 2023 as 15th June 2023

Worcestershire Acute Hospitals NHS Trust

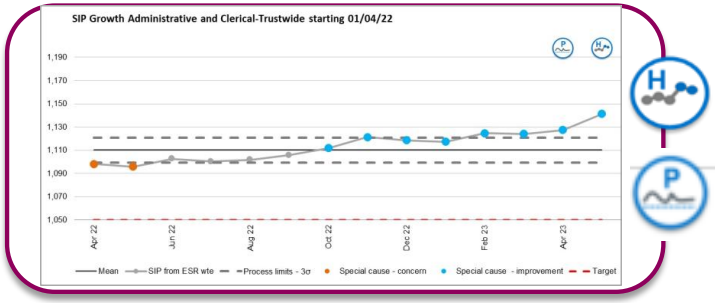
Estates and Ancillary SIP

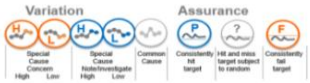
314 wte



Admin and Clerical SIP

1141 wte





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

Workforce Compliance Month 2 – May 23): - Drivers of Bank and Agency Reductions

Monthly Sickness Absence	Bank Spend as a % of Gross Spend (ADI)	Agency Spend as a % of Gross Spend (ADI)
5.46% 333 wte average per calendar day	7.71%	9.49%

What does the data tell us?

- **Monthly Sickness Absence Rate** –Sickness rates have increased slightly by 0.06% to 5.46% which is 0.53% worse than the same period last year. However, the spike in Urgent Care has continued with 6.93% this month and there has been a big increase (1.62%) in Estates and Facilities who are now reporting 7.6% sickness with 5.41% of this being Long-term sickness. Absence due to S27 (Covid Symptoms) has reduced by 0.26%. Long term sickness and short-term sickness have remained broadly unchanged at 3.35% and 2.47% respectively. Absence due to Stress and Anxiety has remained at 1.5% this month (27.46% of the total absence. Women and Children's Divisions are outliers with 37% of their absence attributed to this factor). Cumulative sickness for the year is broadly unchanged at 5.82% against our target of 5.5%.
- **Agency Spend as a % of Gross Cost** – Agency usage has increased slightly by 8 wte and spend has increased to 9.49% of gross cost. Agency Spend is 0.74% higher than the same period last year. The overall bank and agency usage has increased this month by 20 wte which will be a mixture of 1 extra day in the month and three bank holidays as well as half term. Surgery is an outlier with a 1.17% increase in agency spend and usage. Specialty Medicine, Urgent Care and Surgery all have high bank and agency usage.
- **Bank spend as a % of gross cost** - Bank spend has increased by 0.22% to 7.71%. Urgent care is an outlier followed by Surgery.

National Benchmarking (May 2023)

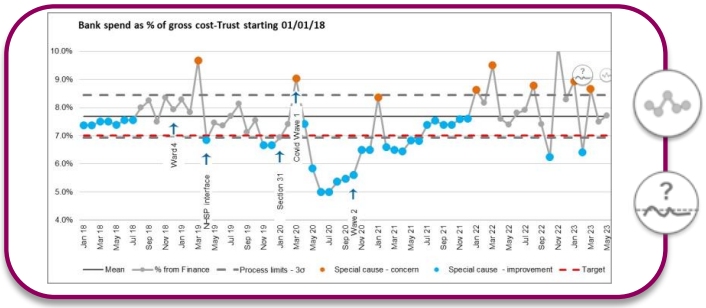
- We are currently in the 2nd Quartile in terms of Sickness on Model Hospital when our sickness was 5.8% against a National median of 6.2% and a Peer Average of 6.8 but latest data for this metric is March 2022 and will not be refreshed until the annual Corporate benchmarking exercise. Sickness rates are high (Quartile 4) compared to Model Hospital Benchmark for Registered Midwives. Medical and Dental and Healthcare Scientists are best at Quartile 1. All other staff groups are good at Quartile 2.
- We are at 4th Quartile (worst) for Agency spend for Registered Nurses but have improved to the 3rd Quartile for Medics (Mar 2023 data). Overall we are Quartile 4 for Agency and Quartile 3 for Bank (Nov 2022 rates)

March - Month 2 – May 2023 Workforce "Drivers of Bank & Agency Reductions" Summary

Responsible Director: Director of People and Culture | Validated for May 2023 as 15th June 2023

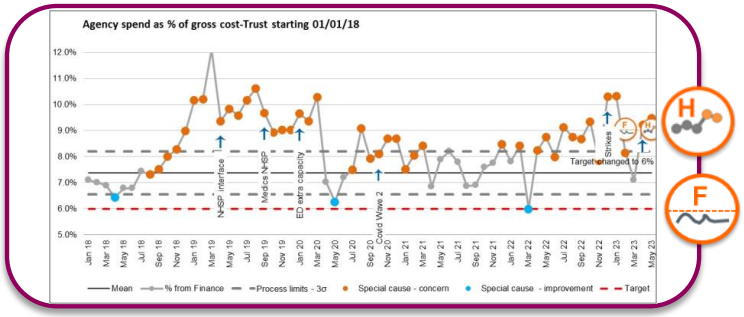
Bank Spend as a % of Gross Cost

7.71%



Agency Spend as a % of Gross Cost

9.49%



Time to Hire – advert closed to start date

60.35 working days

Model Hospital Benchmark	March 2022	March 2023
59.4 working days	85.5 working days	64.04 working days (All substantive staff)

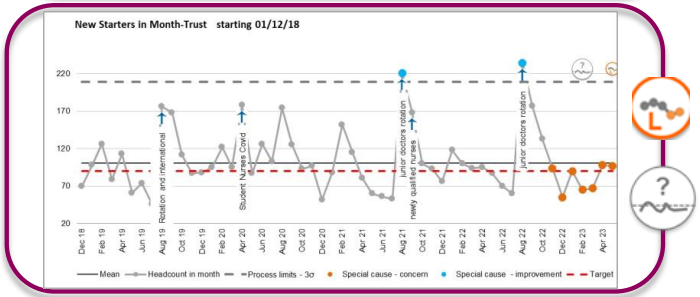
Time to Hire – Conditional to Unconditional

27.5 Working Days

Model Hospital Benchmark	March 2022	March 2023
Not applicable	Tbc working days	27.5 working days (All substantive staff) *[Unvalidated Data]*

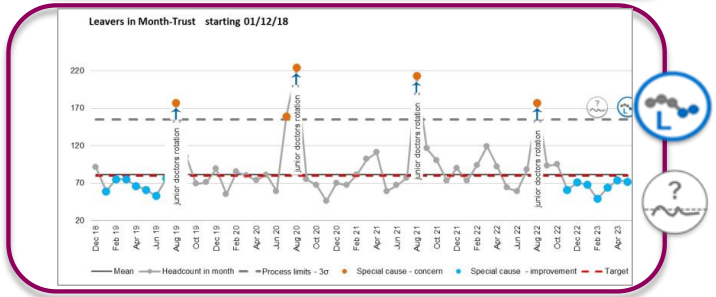
New Starters in Month (Headcount)

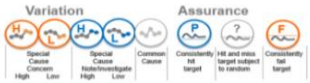
97



Leavers in Month (Headcount)

72





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

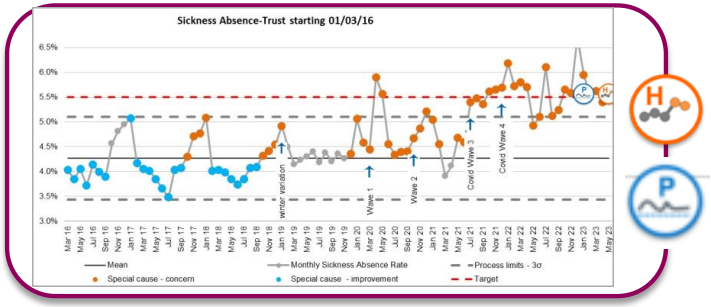
Month 2 - May 2023 Workforce "Health and Wellbeing" Summary

Responsible Director: Director of People and Culture | Validated for May23 as 15th June 2023

NHS Worcestershire Acute Hospitals NHS Trust

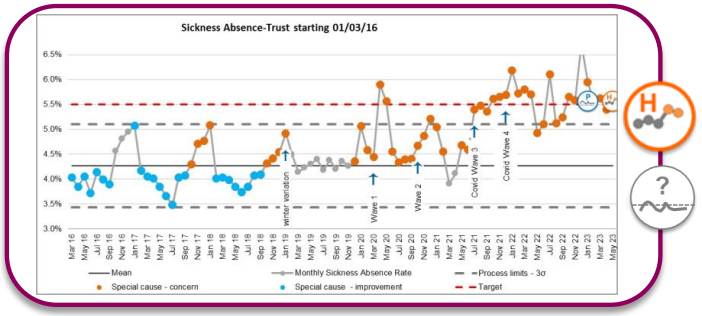
Monthly Staff Sickness Absence Rate

5.46%



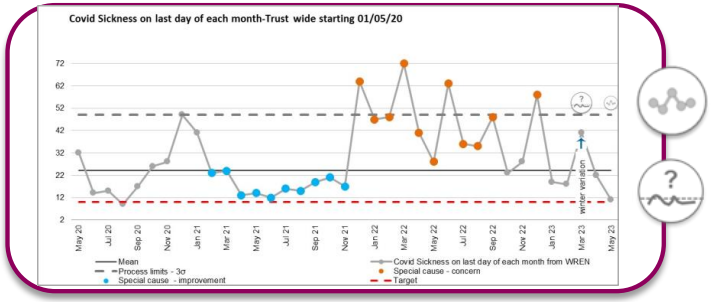
% Staff absent due to Stress and Anxietv (S10)

1.50%



Covid Sickness (S27)

11



Top 6 Sickness Absence Reasons by Division

FTE Days Lost by Division

Top 6 Sickness reasons by Division	Corporate	Digital	Estates & Facilities	SCSD	Specialty Medicine	Surgery	Urgent Care	Women & Children
S10 Anxiety/stress/depression/other psychiatric illnesses	229.18	15.00	127.17	906.34	416.89	382.76	327.81	431.16
S12 Other musculoskeletal problems	66.05		115.79	472.85	118.29	185.52	96.57	46.36
S13 Cold, Cough, Flu - Influenza	25.21		43.40	193.05	169.78	41.89	75.29	27.53
S25 Gastrointestinal problems	33.20	1.00	38.87	200.32	166.27	79.23	141.42	95.04
S27 Infectious diseases	39.40		34.33	183.97	179.95	66.77	59.81	109.29
S98 Other known causes - not elsewhere classified	169.89		51.73	245.36	97.25	49.19	34.61	220.72

Reasons for Sickness Absence For the Month of May 2023

Absence Reason	FTE days lost	% of Sickness
S10 Anxiety/stress/depression/other psychiatric illnesses	2,836.32	27.46%
S11 Back Problems	443.13	4.29%
S12 Other musculoskeletal problems	1,101.44	10.67%
S13 Cold, Cough, Flu - Influenza	576.16	5.58%
S14 Asthma	73.61	0.71%
S15 Chest & respiratory problems	313.79	3.04%
S16 Headache / migraine	287.07	2.78%
S17 Benign and malignant tumours, cancers	456.82	4.42%
S18 Blood disorders	19.01	0.18%
S19 Heart, cardiac & circulatory problems	221.39	2.14%
S20 Burns, poisoning, frostbite, hypothermia	14.00	0.14%
S21 Ear, nose, throat (ENT)	219.71	2.13%
S22 Dental and oral problems	72.25	0.70%
S23 Eye problems	49.01	0.47%
S24 Endocrine / glandular problems	64.39	0.62%
S25 Gastrointestinal problems	755.34	7.31%
S26 Genitourinary & gynaecological disorders	319.41	3.09%
S27 Infectious diseases	673.53	6.52%
S28 Injury, fracture	447.95	4.34%
S29 Nervous system disorders	62.40	0.60%
S30 Pregnancy related disorders	325.40	3.15%
S31 Skin disorders	93.28	0.90%
S32 Substance abuse	2.00	0.02%
S98 Other known causes - not elsewhere classified	868.75	8.41%
S99 Unknown causes / Not specified	31.00	0.30%
Grand Total	**10,327.17**	**5.46%**

Variation Assurance

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

Strategic Priorities: Workforce

Strategic Business Priorities			
BP1: Leadership ***An empowered, well led workforce that delivers better outcomes and performance for our patients***	**BP2: Workforce** ***The right-sized, cost effective workforce that is organised for success. A Staff offer that attracts and retains the best people***	**BP3: Staff Experience** ***A just, learning, and innovative culture where colleagues feel respected, valued, included and well at work***	**BP4: People Function** *A people function that is organised around the optimum employee journey*

Best People – Our people are recruited, retained and developed so they have the right skills to provide high quality care and work with pride putting patients first

How have we been doing?	**What improvements will we make?**
The areas requiring improvement are: • To reduce our vacancy rate to 7.5% to mitigate the reliance on the temporary workforce. • To reduce agency spend to 6% of our total pay bill • To improve Job planning compliance – linking job plans to required activity • To provide colleagues who are absent due to S10 (stress/ anxiety/ depression) with targeted support	• Specific projects including the 4ward behaviours refresh, the development of a behavioural toolkit, the embedding of the Behavioural Charter with a zero-tolerance approach and the establishment of our 'staff offer' will all help to address key themes identified in the 2022 Staff Survey, particularly around raising concerns and recommending the Trust as a place to work. • The reduction in agency spend will be driven through our PEP programme • Improvement in job planning compliance is being driven through the Chief Operating officer. • Colleagues who are absent due to mental health conditions are referred to Occupational Health and are signposted to relevant support. We have a wide range of support within out health and wellbeing pin wheel.
Overarching Workforce Performance Level – 5 – May 2023 **Previous Assurance Level - 5 – April 2023**	**To work towards improvement to next assurance level by October 2023**

Finance

Finance | Key Messages

2023/24 Plan

Our 2023/24 operational financial plan has been developed from a roll forward of the recurrent cost and non patient income actuals from 22/23 adjusting for workforce and activity trajectories, inflationary pressures and the full year effect of any PEP schemes or Business cases which started part way through 22/23. We have then overlaid any new PEP Schemes, new Business Cases and applied a vacancy factor.

The Trust originally submitted a full year plan deficit of £(50.4)m in March 2023. Recognising the risks of loss of autonomy and access to capital Board members agreed that we should consider whether we could go further. CFO put forward a proposal and requested approval to negotiate as follows: Stretch the PEP by an additional £4m on the proviso that the ICB lead both pieces of work bringing the system together to support delivery > £2m reduction in spend linked to excess temporary capacity incl. corridor care / high cost temporary staffing and £2m reduction in non clinical vacancies linked in particular to a review of back office services. Acceptance of this positive movement from the ICB was reflected by the sharing out of the ICB surplus in a way that resulted in a break even plan.

M2 Financial Reporting

Month 2

There was no requirement to report month 1 to NHSE. This report therefore shows the year to date income and expenditure for month 2. **YTD M2 actual deficit of £(7.8)m against a plan of £(4.4)m deficit, an adverse variance of £3.4m.**

Statement of comprehensive income	Year to Date Plan £'000	Actual £'000	Variance £'000
INCOME & EXPENDITURE			
Operating income from patient care activities	100,700	100,592	(108)
Other operating income	4,516	4,738	222
Employee expenses	(63,986)	(66,039)	(2,053)
Operating expenses excluding employee expenses	(41,786)	(43,274)	(1,488)
OPERATING SURPLUS / (DEFICIT)	**(556)**	**(3,983)**	**(3,427)**
FINANCE COSTS			
Finance income	260	269	9
Finance expense	(2,560)	(2,558)	2
PDC dividends payable/refundable	(1,606)	(1,569)	37
NET FINANCE COSTS	**(3,906)**	**(3,858)**	**48**
Other gains/(losses) including disposal of assets	0	0	0
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**(4,462)**	**(7,841)**	**(3,379)**
Add back all I&E impairments/(reversals)	0	0	0
Surplus/(deficit) before impairments and transfers	**(4,462)**	**(7,841)**	**(3,379)**
Remove capital donations/grants I&E impact	20	21	1
Adjusted financial performance surplus/(deficit)	**(4,442)**	**(7,820)**	**(3,378)**
Less gains on disposal of assets	0	0	0
Adjusted financial performance surplus/(deficit) for the purposes of system achievement	**(4,442)**	**(7,820)**	**(3,378)**

The Combined Income (including PbR pass-through drugs & devices and Other Operating Income) was £0.1m favourable year to date (YTD at M2).

Employee expenses are £2.1m adverse year to date at M2.

Operating expenses are £1.5m adverse year to date at M2.

Note – c£1m of the YTD adverse variance is as a result of a phasing issue with the submitted plan which will rectify itself throughout the year.

I&E Delivery Assurance Level: **Level 3**

Reason: Breakeven plan submitted for 23/24. The following risks need addressing in order to reach the next level of assurance:

- Further improvement in the level 4 maturity against the £28m PEP target
- Delivery of activity plans in order to receive the planned income
- Confirmation that further funds will not be required to support operational performance / pressures above that which is agreed in the plan or provided externally.

Finance | Key Messages

Income

The Combined Income (including PbR pass-through drugs & devices and Other Operating Income) was £0.1m favourable year to date (YTD at M2). Adverse variances due to activity below YTD plan have been offset by favourable variances due to income for Covid pathology testing and the Injury Cost Recovery scheme.

	YTD			
Income £'m	**Plan**	**Actual**	**Variance**	**Note on variance**
ICBs inside the system	£78.9	£78.8	-£0.1	Activity related
ICBs outside of the system	£4.7	£4.6	-£0.1	Activity related
NHS England	£14.1	£13.8	-£0.3	Activity related
NHS Trusts & Foundation Trusts	£0.1	£0.1	£0.0	
NHS other (including PHE)	£0.1	£0.2	£0.0	
Injury Cost recovery	£0.2	£0.3	£0.1	
Additional Funding	£0.1	£0.1	£0.0	
O/S COVID	£0.0	£0.2	£0.2	Income Matching Spend, no Covid Pathology testing included in plan
CDH	£0.6	£0.6	-£0.0	Income accrued in line with activity
UEC Funding	£0.0	£0.0	£0.0	Not in plan until Q2
External Depn PDC funding	£0.9	£0.9	£0.0	
PDU	£0.5	£0.5	£0.0	
HC Income Total	**£100.2**	**£100.1**	**-£0.2**	
Directorate Income	£5.0	£5.3	£0.3	
Income	**£105.2**	**£105.3**	**£0.1**	

Finance | Key Messages

Expenditure – Employee Expenses

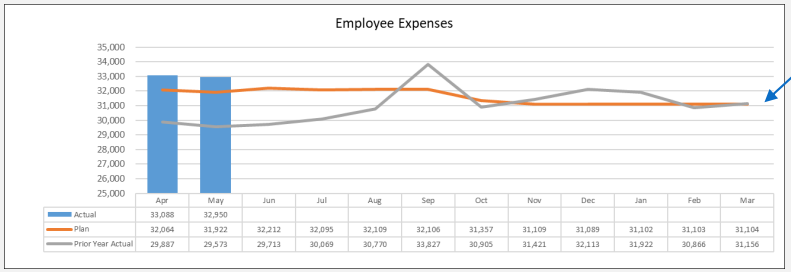
Employee Expenses

Employee Expenses	Year to Date			WTE		
	Plan £000s	Actual £000s	Variance £000s	Funded WTE	Contracted WTE	Worked WTE
Medical & Dental	(19,238)	(19,941)	(703)	923	793	930
Nursing & Midwifery	(26,559)	(27,614)	(1,055)	3,316	2,914	3,352
Scientific, Therapeutic & Technical	(8,079)	(8,073)	6	1,124	967	1,505
NHS Infrastructure Support	(9,858)	(10,145)	(287)	1,630	1,468	992
Other Pay	(252)	(264)	(12)	0	0	0
Grand Total	**(63,986)**	**(66,038)**	**(2,052)**	**6,992**	**6,141**	**6,779**

Employee expenses £2.1m adverse YTD - Included in this YTD variance are £0.3m of Industrial Action costs incurred in April, £0.3m backdated pay costs to overseas nurses resulting from recognition of overseas work experience and £0.3m undelivered PEP which is partly offset by £0.4m favourable variance on developments and £0.1m on Bank incentives. I&E offsetting items including Cancer Alliance and smoking cessation posts representing a further £0.5m. The remaining variances of c £1m are driven by phasing issues with the submitted plan including bank holiday budgets (£0.5m). Note - this will rectify itself throughout the year and does not impact on the overall financial plan.

Employee expenses of £33.0m in month 2, this includes an accrual of £0.7m for the 23/24 pay award which is expected to be paid in month 3 (and was included in the plan) and £0.4m for the three bank holidays in May. Substantive pay is a reduction of £0.3m compared with last month due to the acting up/down payments for industrial action that were paid in M1, the benefit from this has been partially offset by the additional bank holiday this month.

Total temporary staffing spend of £5.7m was 17.2% of the total pay bill. **Agency** spend in month was £3.1m, an increase of £0.1m compared with last month, mostly to cover ST&T vacancies in Pharmacy, Radiology and Pathology. **Bank** spend in month was £2.5m, largely consistent with last month with increases relating to in Interim COO and additional usage in patient experience. Note – medical agency position is carried from M1 due to incomplete financial report supplied by NHSP.



** In month 12 of 22/23 we receive a notional pension contribution value from NHSE which we report in both income and costs, this is the additional 6.3% employer contribution to the pension scheme paid by NHSE on the Trust's behalf.*

M12 adjusted for one offs:
- Notional Pension Contribution £13.6m
- EWTD £0.4k
- Annual Leave (£0.7m)
- Medics Retro £0.2m
- Pay Award £11.6m
- Strike Action £0.1m
- Overseas Nurses Recognition £0.2m
- Bank Pay Award £0.4m

Employee Expenses	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Mvmt	YTD
Agency	(2,462)	(2,588)	(2,374)	(2,745)	(2,695)	(2,934)	(2,886)	(2,425)	(3,184)	(3,189)	(2,518)	(3,080)	(3,051)	(3,128)	(77)	(6,179)
Bank	(2,269)	(2,184)	(2,313)	(2,380)	(2,702)	(2,505)	(1,928)	(3,165)	(2,558)	(2,764)	(1,982)	(3,757)	(2,477)	(2,542)	(65)	(5,018)
Temporary Total	**(4,731)**	**(4,772)**	**(4,687)**	**(5,125)**	**(5,397)**	**(5,439)**	**(4,814)**	**(5,590)**	**(5,742)**	**(5,954)**	**(4,500)**	**(6,837)**	**(5,528)**	**(5,669)**	**(141)**	**(11,197)**
Substantive	(25,156)	(24,801)	(25,026)	(24,944)	(25,373)	(28,388)	(26,091)	(25,832)	(26,371)	(25,968)	(26,366)	(36,565)	(27,560)	(27,281)	279	(54,841)
Other	0	0	0	0	0	0	0	0	0	0	0	(13,563)	0	0	0	0
Employee Expenses Total	**(29,887)**	**(29,573)**	**(29,713)**	**(30,069)**	**(30,770)**	**(33,827)**	**(30,905)**	**(31,421)**	**(32,113)**	**(31,922)**	**(30,866)**	**(56,965)**	**(33,088)**	**(32,950)**	**137**	**(66,038)**
Agency %	8.2%	8.8%	8.0%	9.1%	8.8%	8.7%	9.3%	7.7%	9.9%	10.0%	8.2%	5.4%	9.2%	9.5%	0.3%	9.4%
Bank %	7.6%	7.4%	7.8%	7.9%	8.8%	7.4%	6.2%	10.1%	8.0%	8.7%	6.4%	6.6%	7.5%	7.7%	0.2%	7.6%
Bank & Agency %	15.8%	16.1%	15.8%	17.0%	17.5%	16.1%	15.6%	17.8%	17.9%	18.7%	14.6%	12.0%	16.7%	17.2%	0.5%	17.0%

Note – in Feb-23 the Agency and Bank % of Employee expenses would have been 11% and 10% respectively without the beneficial impact of the balance sheet release. Mar-23 figures are significantly skewed by substantive and bank pay awards and by Bank EWTD accrual.

Finance | Key Messages

Expenditure – Operating Expenses exc Employee Expenses

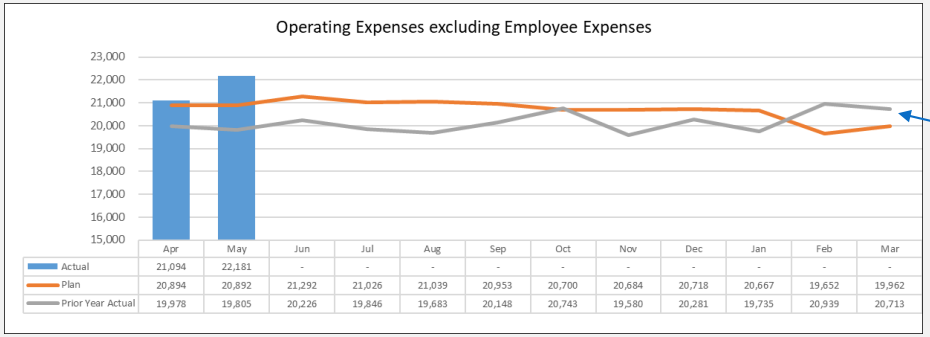
Operating Expenses excluding Employee Expenses

Operating Expenditure excluding Employee Expenses	Year to Date		
	Plan £000s	Actual £000s	Variance £000s
Purchase of services from NHS bodies outside of the system	(1,018)	(833)	185
Purchase of services from non NHS bodies	(752)	(1,480)	(728)
Drugs Costs	(9,484)	(9,905)	(421)
Supplies and services	(13,856)	(13,763)	93
Other Operating Costs	(16,676)	(17,293)	(617)
Operating Expenditure Total	**(41,786)**	**(43,275)**	**(1,489)**

Operating expenses £1.5m adverse YTD - Of this YTD variance £0.4m Non PbR drugs and devices and £0.2m COVID testing both of which have been offset by income, £0.2m phasing of Utilities, £0.2 relating to contract terms linked to Retail Price Indices being at 13.5% rather than 10.7% projected in the plan, £0.1m undelivered PEP and £0.4m use of insourcing/outsourcing within General Surgery, Orthodontics, Dermatology and Radiology in to address backlog 78 week waits.

Operating expenses of £22.2m in month 2. An increase of £1.1m compared with the April position of which £0.4m is Non PbR drugs in Oncology, £0.1m is Non PbR devices with increases in expenditure on insulin pumps (£0.2m) being partially offset by reductions on cardiac devices (£0.1m).

The remainder of the increase in mainly on expenditure on Purchase of Healthcare from Non NHS Bodies (£0.3m), £0.2m of this in SCSD and £0.1m in Surgery due to additional insourcing and Premises – Other (£0.1m) due to actuals for water being higher than expected as well as costs relating to Ophthalmology roof extension leads & various works in Kings Court.



M12 adjusted for one offs:

- Impairments £9.7m
- Donated PPE £1.3m
- Depreciation £0.9m

Operating Expenditure excluding Employee Expenses	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Mvmt	YTD
Purchase of Services from NHS bodies outside of the system	(466)	(426)	(565)	(504)	(536)	(522)	(565)	(515)	(577)	(232)	(474)	(275)	(437)	(396)	41	(833)
Purchase of Services from non NHS bodies	(309)	(276)	(316)	(282)	(392)	(571)	(575)	(619)	(937)	(980)	(827)	(2,709)	(591)	(889)	(298)	(1,480)
Drugs Costs	(4,489)	(5,464)	(4,225)	(4,590)	(5,190)	(4,935)	(5,050)	(5,146)	(5,185)	(4,801)	(4,679)	(5,190)	(4,740)	(5,165)	(424)	(9,905)
Supplies and Services	(7,513)	(7,003)	(7,569)	(7,242)	(7,037)	(6,921)	(6,702)	(5,503)	(7,544)	(8,584)	(7,538)	(7,919)	(6,843)	(6,920)	(77)	(13,763)
Other Operating Costs	(7,201)	(6,636)	(7,551)	(7,229)	(6,528)	(7,199)	(7,849)	(7,797)	(6,038)	(5,138)	(7,421)	(16,488)	(8,482)	(8,811)	(329)	(17,293)
Operating Expenditure Total	**(19,978)**	**(19,805)**	**(20,226)**	**(19,846)**	**(19,683)**	**(20,148)**	**(20,743)**	**(19,580)**	**(20,281)**	**(19,735)**	**(20,939)**	**(32,582)**	**(21,094)**	**(22,181)**	**(1,087)**	**(43,275)**

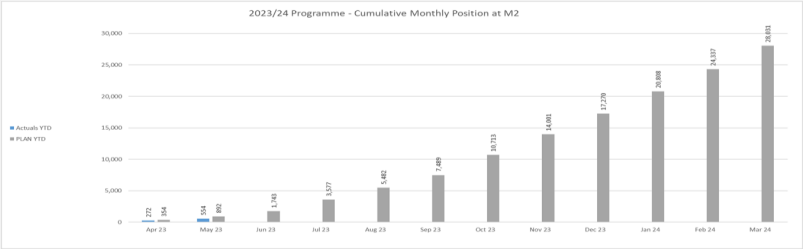
Finance | Key Messages

Productivity & Efficiency

The Productivity and Efficiency Programme target for 23/24 as submitted to NHSE is £28.0m.

M2 delivered £0.282m of actuals against the plan as submitted to NHSE in May 2023 of £0.538m. A negative variance of £0.256m.

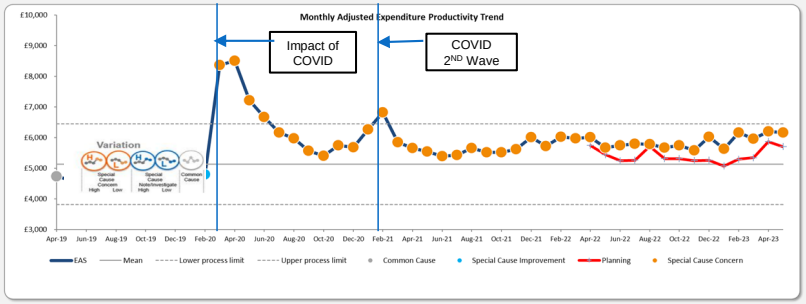
Year to date, the overall position is actuals £0.554m against a plan of £0.892m, an under delivery of £0.338m.



Adjusted Expenditure Productivity Trend

This SPC measures expenditure against activity, allowing us to follow productivity changes. Tracking is currently available at Trust wide level only. Weighted Activity Unit (WAU) has been used based upon Inpatient/Outpatient/ED activity, adjusted to be weighted equally and allow for working day variations. Expenditure is adjusted for inflation each year. Similar to the Model Hospital cost/WAU metric. As the WAU relies on coded activity, recent months can still move until coding is complete.

- For **May** the Acute has delivered an Adjusted Cost per WAU which is **8% higher than plan**. This means that the acute is spending more per activity delivered than was in the operational and financial plan.
- This is caused by expenditure being **4% higher** than plan, so we are spending more than planned and WAU being **2% lower than plan**, so are delivering less weighted Inpatient, Emergency, Outpatient and ED activity, primarily Emergency and ED activity.
- **YTD** the Acute has delivered an Adjusted Cost per WAU which is **7% higher than plan**.
- This is caused by expenditure being **3% higher than plan**, so we are spending more than planned and the WAU being **3% lower than plan**, so are delivering less weighted Inpatient, Emergency, Outpatient and ED activity.



Finance | Key Messages

Capital

The Trust Capital plan for 2023/24 is £30,089m. The Trust agreed with the Regional NHSE team to return £800k PDC for the KTC RAAC (roofing) Scheme in 22/23, but are expecting approval on the resubmitted business case for this to be returned to complete the works in 23/24. Expenditure to date is £3.342m as of Month 2. It should be noted that for reporting purposes nationally, if there is no plan for capital expenditure the Trust is unable to report the actual expenditure against the scheme. RAAC has not been formally approved yet and as such we cannot report any spend against this scheme.
Discussions are being held regarding a longer term brokerage solution with ICB and Region due to the risks associated with the Trust having insufficient capital for in 2023/24, risking the delay of a significant proportion of spend on backlog maintenance and equipment replacement in particular. All work stream leads are collating their urgent backlog maintenance and equipment required for 2023/24 to evidence the shortfall in capital funds against the funding available to enable conversations to progress with NHSE Regional Office on potential solutions.
This includes all strategic scheme and externally funded schemes compared to the business cases approved to identify any potential overspends for the projects.
The finance team are in the process of collating the details provided to date to identify the shortfall in funding for 23/24 ahead of presentation to June Finance and Performance Committee

Capital Assurance Level: Level 3
Reason: Capital assurance levels reduced due to lack of available resource to deliver backlog maintenance and equipment replacement programme.

Cash Balance

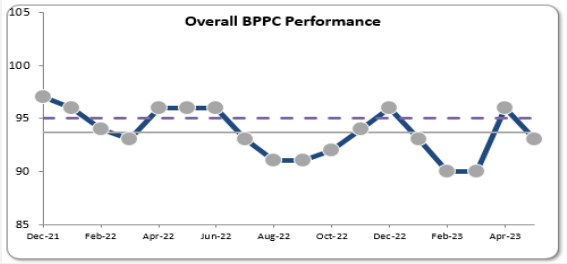
At the end of May 2023, the cash balance was £7.6m against a plan of £16.5m. The planed external capital funding of £4.4m has not been drawn down as the Trust has not received the MOU's. Approval has been provided to submit the MOU's for TIF £7m and CDC2 £1.6m in June.

Cash Assurance Level: Level 5
Reason: Due to delays in receiving the capital funding as per plan (£6.7m), we are monitoring the cash balances due to the timing of the Trust's main income being received on 15th of each month.

Better Payment Practice Code (BPPC) performance has remained stable.

The BPPC performance for the month is 94% based on volume of invoices paid and 93% based on value;
- 8,562 invoices paid out of 9,124 due.
- £34.3m worth of invoices out of £36.9m were paid on time this month.

We are 1% under the BPPC target YTD for Value and under 2% for Volume at 94.22% and 93.74% respectively (94% Volume 94% Value). The percentages are relatively static in 2023/24, although we do still have issues with the approval of invoices performed by SBS.
Finance continue to work with SBS to resolve the delays in scanning supplier invoices.



Appendices

Variation/Performance Icons			
Icon	***Technical Description***	***What does this mean?***	***What should we do?***
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable**. If the process limits are far apart you may want to change something to reduce the variation in performance.
	Special cause variation of an CONCERNING nature where the measure is significantly HIGHER.	**Something's going on!** Your aim is to have low numbers but you have some high numbers – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one off event that you can explain? Or do you need to change something?
	Special cause variation of an CONCERNING nature where the measure is significantly LOWER.	**Something's going on!** Your aim is to have high numbers but you have some low numbers - something one-off, or a continued trend or shift of low numbers.	
	Special cause variation of an IMPROVING nature where the measure is significantly HIGHER.	**Something good is happening!** Your aim is high numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	Find out what is happening/ happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?
	Special cause variation of an IMPROVING nature where the measure is significantly LOWER.	**Something good is happening!** Your aim is low numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	
	Special cause variation of an increasing nature where UP is not necessarily improving nor concerning.	**Something's going on!** This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one off event that you can explain? Do you need to change something? Or can you celebrate a success or improvement?
	Special cause variation of an increasing nature where DOWN is not necessarily improving nor concerning.	Something's going on! This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of low numbers.	

Assurance Icons			
Icon	***Technical Description***	***What does this mean?***	***What should we do?***
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random.	Consider whether this is acceptable and if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the wrong direction** then you know that the target cannot be achieved.	**You need to change something in the system or process if you want to meet the target.** The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the right direction** then you know that the target can consistently be achieved.	**Celebrate the achievement**. Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

Variation/Performance	Assurance: P	Assurance: ?	Assurance: F	Assurance: (blank)
H	**Excellent | Celebrate and Learn** • This metric is improving. • Your aim is high numbers and you have some. • You are consistently achieving the target because the current range of performance is above the target.	**Good | Celebrate and Understand** • This metric is improving. • Your aim is high numbers and you have some. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning | Celebrate but Take Action** • This metric is improving. • Your aim is high numbers and you have some. • HOWEVER your target lies above the current process limits so we know that the target will not be achieved without change.	**Excellent | Celebrate** • This metric is improving. • Your aim is high numbers and you have some. • There is currently no target set for this metric.
L	**Excellent | Celebrate and Learn** • This metric is improving. • Your aim is low numbers and you have some. • You are consistently achieving the target because the current range of performance is below the target.	**Good | Celebrate and Understand** • This metric is improving. • Your aim is low numbers and you have some. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning | Celebrate but Take Action** • This metric is improving. • Your aim is low numbers and you have some. • HOWEVER your target lies below the current process limits so we know that the target will not be achieved without change.	**Excellent | Celebrate** • This metric is improving. • Your aim is low numbers and you have some. • There is currently no target set for this metric.
(common cause)	**Good | Celebrate and Understand** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • HOWEVER you are consistently achieving the target because the current range of performance exceeds the target.	**Average | Investigate and Understand** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning | Investigate and Take Action** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • HOWEVER your target lies outside the current process limits and the target will not be achieved without change.	**Average | Understand** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • There is currently no target set for this metric.
H	**Concerning | Investigate and Understand** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • HOWEVER you are consistently achieving the target because the current range of performance is below the target.	**Concerning | Investigate and Take Action** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • Your target lies within the process limits so we know that the target may or may not be missed.	**Very Concerning | Investigate and Take Action** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • Your target lies below the current process limits so we know that the target will not be achieved without change	**Concerning | Investigate** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • There is currently no target set for this metric.
L	**Concerning | Investigate and Understand** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • HOWEVER you are consistently achieving the target because the current range of performance is above the target.	**Concerning | Investigate and Take Action** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • Your target lies within the process limits so we know that the target may or may not be missed.	**Very Concerning | Investigate and Take Action** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • Your target lies above the current process limits so we know that the target will not be achieved without change	**Concerning |Investigate** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • There is currently no target set for this metric.
↗				**Unsure | Investigate and Understand** • This metric is showing a statistically significant variation. • There has been a one off event above the upper process limits; a continued upward trend or shift above the mean. • There is no target set for this metric.
↘				**Unsure | Investigate and Understand** • This metric is showing a statistically significant variation. • There has been a one off event below the lower process limits; a continued downward trend or shift below the mean. • There is no target set for this metric.
(blank)				**Unknown | Watch and Learn** • There is insufficient data to create a SPC chart. • At the moment we cannot determine either special or common cause. • There is currently no target set for this metric

NHS System Oversight Framework | 2022/23

The following Acute Trust metrics are included in the 22/23 NHS System Oversight Framework – those in black can be found in this version of the IPR and are labelled with this icon - NHS

9. Total patients waiting more than 52 (S009a), 78 (S009b) and 104 (S009c) weeks to start consultant-led treatment
10a. Cancer first treatments (S010a)
11. People waiting longer than 62 days (S011a)
12. % meeting faster diagnosis standard (S012a)
13a. Diagnostic activity levels – Imaging (S013a)
13b.Diagnostic activity levels – Physiological measurement (S013b)
13c. Diagnostic activity levels – Endoscopy (S013c)
19. Ambulance handover delays over 30 minutes as a proportion of ambulance arrivals. (SO19a)
22. Number of stillbirths per 1,000 total births (S022a)
34. Summary Hospital-Level Mortality Indicator (SHMI) (S034a)
35. Overall CQC rating (provision of high-quality care) (S035a)
36. NHS staff survey safety culture theme score (S036a)
38. National Patient Safety Alerts not declared complete by deadline (S038a)
39. Consistency of reporting patient safety incidents (S039a)
40. Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia infections (S040a)
41. Clostridium difficile infections (S041a)
42. E. coli blood stream infections (S042a)
44a. Antimicrobial resistance: total prescribing of antibiotics in primary care (S044a)
44b. Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care (S044b)
59. CQC well-led rating (S059a)
60. NHS Staff Survey compassionate leadership people promise element sub-score (S060a)
63a. Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from managers (S063a, S063b, S063c)
63b. Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from other colleagues
63c. Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from patients/service users, their relatives or other members of the public
67. NHS Staff Leaver Rate (S067a)
69. NHS Staff Survey Staff engagement theme score (S069a)
72. Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age.
101. Outpatient follow-up activity levels compared with 2019/20 baseline
103. Proportion of patients spending more than 12 hours in an emergency department
104. Number of neonatal deaths per 1,000 total live births (S104a)
105. Proportion of patients discharged to usual place of residence (S105a)
116. Proportion of (a) adult acute inpatient or (b) maternity settings offering Tobacco Dependence services
118. Financial Stability (S118a)
119. Financial Efficiency (S119a)
120. Finance – Agency Spend vs agency ceiling(S120a), Agency spend price cap compliance (S120b)

Annual Plan 23/24 Monitoring

NHS Worcestershire Acute Hospitals NHS Trust

Outpatient and Inpatient Activity

New	April	May	June	July	August	September	October	November	December	January	February	March
2019/20 Actual	16,074	16,637	15,645	17,421	15,072	16,203	15,960	15,998	14,021	16,940	14,900	12,314
2023/24 Plan	15,090	15,949	17,394	16,931	17,748	16,732	17,737	17,823	15,340	17,720	16,957	16,255
2023/24 Actual	14,822	18,080										
2023/24 Plan Achievement (%)	98.22%	113.36%										
2023/24 Plan Variance (n)	-268	2,131										

Follow-Up	April	May	June	July	August	September	October	November	December	January	February	March
2019/20 Actual	35,810	37,344	34,688	39,266	33,493	35,860	34,299	36,988	32,218	39,419	33,664	29,905
2023/24 Plan	29,571	31,546	34,618	33,238	34,821	33,045	34,967	35,154	30,647	34,779	33,621	32,216
2023/24 Actual	29,447	36,021										
2023/24 Plan Achievement (%)	99.58%	114.19%										
2023/24 Plan Variance (n)	-124	4,475										

Day Case	April	May	June	July	August	September	October	November	December	January	February	March
2019/20 Actual	6,190	6,560	6,202	6,706	6,185	6,333	6,730	6,821	5,836	6,703	6,269	5,189
2023/24 Plan	5,920	6,240	6,868	6,885	7,017	6,702	6,852	6,756	5,983	6,920	6,683	6,387
2023/24 Actual	6,531	6,316										
2023/24 Plan Achievement (%)	110.32%	101.22%										
2023/24 Plan Variance (n)	611	76										

Elective	April	May	June	July	August	September	October	November	December	January	February	March
2019/20 Actual	627	690	686	737	690	653	758	716	597	594	682	498
2023/24 Plan	536	565	636	620	638	661	687	687	600	689	658	638
2023/24 Actual	432	515										
2023/24 Plan Achievement (%)	80.60%	91.15%										
2023/24 Plan Variance (n)	-104	-50										

Combined Day Case and Elective	April	May	June	July	August	September	October	November	December	January	February	March
2019/20 Actual	6,817	7,250	6,888	7,443	6,875	6,986	7,488	7,537	6,433	7,297	6,951	5,687
2023/24 Plan	6,457	6,804	7,504	7,504	7,656	7,363	7,540	7,444	6,583	7,609	7,341	7,025
2023/24 Actual	6,963	6,831										
2023/24 Plan Achievement (%)	107.84%	100.40%										
2023/24 Plan Variance (n)	506	27										

Patient Initiated Follow-Up (PIFU) Outcomes

Metric	April	May	June	July	August	September	October	November	December	January	February	March
2023/24 Plan	1,196	1,308	1,471	1,458	1,570	1,526	1,658	1,708	2,204	2,174	2,326	2,432
2023/24 Actual PIFU Outcomes	1,482	1,678										
2023/24 Total Outpatient Attendances	44,269	54,101										
2023/24 PIFU Outcomes as % of Outpatient Attendances	3.35%	3.10%										

Annual Plan 23/24 Monitoring

NHS Worcestershire Acute Hospitals NHS Trust

Diagnostic Activity

Non-Obstetric US	April	May	June	July	August	September	October	November	December	January	February	March
2019/20 Actual	5,207	5,309	5,234	5,790	5,287	5,243	6,474	6,024	4,979	5,707	5,406	4,054
2023/24 Plan	5,499	5,663	6,365	6,255	6,447	6,182	6,492	6,418	5,662	6,472	6,178	5,966
2023/24 Actual	5,377	6,068										
2023/24 Plan Achievement (%)	97.78%	107.15%										
2023/24 Plan Variance (n)	-122	405										

Echocardiography	April	May	June	July	August	September	October	November	December	January	February	March
2019/20 Actual	984	1,009	901	936	789	898	936	838	782	883	717	397
2023/24 Plan	921	972	1,126	1,075	1,126	1,075	1,126	1,126	972	1,126	1,075	1,024
2023/24 Actual	1,071	1,121										
2023/24 Plan Achievement (%)	116.29%	115.33%										
2023/24 Plan Variance (n)	150	149										

Colonoscopy	April	May	June	July	August	September	October	November	December	January	February	March
2019/20 Actual	619	629	623	573	640	612	528	660	523	657	588	496
2023/24 Plan	830	812	892	917	889	893	708	664	615	745	745	741
2023/24 Actual	698	800										
2023/24 Plan Achievement (%)	84.10%	98.52%										
2023/24 Plan Variance (n)	-132	-12										

Flexi Sigmoidoscopy	April	May	June	July	August	September	October	November	December	January	February	March
2019/20 Actual	384	314	458	303	285	250	194	349	182	392	354	244
2023/24 Plan	121	118	136	140	136	135	144	136	124	151	150	148
2023/24 Actual	119	146										
2023/24 Plan Achievement (%)	98.35%	123.73%										
2023/24 Plan Variance (n)	-2	28										

Gastroscopy	April	May	June	July	August	September	October	November	December	January	February	March
2019/20 Actual	685	725	677	514	552	463	542	628	511	690	693	546
2023/24 Plan	527	517	594	609	592	590	628	591	541	658	654	646
2023/24 Actual	510	607										
2023/24 Plan Achievement (%)	96.77%	117.41%										
2023/24 Plan Variance (n)	-17	90										

CT	April	May	June	July	August	September	October	November	December	January	February	March
2019/20 Actual	4,442	4,984	4,303	4,480	4,310	4,317	4,692	4,684	4,267	4,774	4,687	4,011
2023/24 Plan	5,699	5,614	6,206	6,291	6,206	6,162	6,336	6,206	5,896	6,206	6,008	5,964
2023/24 Actual	5,678	6,138										
2023/24 Plan Achievement (%)	99.63%	109.33%										
2023/24 Plan Variance (n)	-21	524										

MRI	April	May	June	July	August	September	October	November	December	January	February	March
2019/20 Actual	1,742	1,703	1,723	1,824	1,664	1,630	1,799	1,766	1,620	1,981	1,653	1,331
2023/24 Plan	2,047	2,063	2,275	2,260	2,275	2,244	2,291	2,275	2,118	2,275	2,204	2,173
2023/24 Actual	1,744	1,829										
2023/24 Plan Achievement (%)	85.20%	88.66%										
2023/24 Plan Variance (n)	-303	-234										

Levels of Assurance

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

MAY 2023 IN NUMBERS

Worcestershire Acute Hospitals NHS Trust

10,939

Self-presentation patients (A&E)

3,775

Patients arriving by ambulance

11,500

Inpatients

42,643

Face to Face outpatients

10,323

Telephone consultations

384

Babies

1,343

Elective operations

154

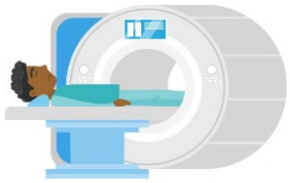
Trauma Operations

199

Emergency Operations

6.8

Average length of stay



18,496

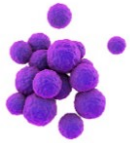
Diagnostics

Putting Patients First

QUALITY AND SAFETY IN NUMBERS

May 2023

NHS Worcestershire Acute Hospitals NHS Trust

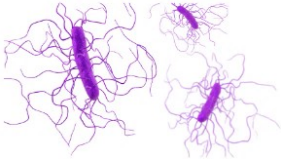


MRSA

1

ECOLI

0



CDIFF

0

MSSA

2

Hand Hygiene

Participation	**84.1**
Compliance	**99.7**

SEPSIS

Sepsis

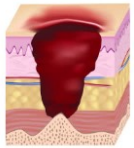
Screening Compliance	**98**
Sepsis 6 bundle compliance	**83.7**

ICE reports viewed

Radiology	**86.9**
Pathology	**94.0**

Falls per 1,000 bed days causing harm

0.04



Pressure Ulcers

All hospital acquired pressure ulcers	**22**
Serious incident pressure ulcers	**0**

Response Rate

A&E	**21.2**
Inpatients	**38.1**
Maternity	**0.4**
Outpatients	**11.5**

Recommended Rate

A&E	**89.4**
Inpatients	**97.4**
Maternity	**100**
Outpatients	**95.9**

HSMR 12 months rolling (March 22) **102.44**

Mortality Reviews completed </=30 days (Nov-20) **35.50**

Risks overdue review **170**

Risks with overdue actions **247**

Discharged before midday

13.9

Complaints Responses </=25 days

60

Total Medicine incidents reported **173**

Medicine incidents causing harm (%) **1.7**

Putting Patients First 4ward

WORKFORCE COMPOSITION IN NUMBERS

NHS Worcestershire Acute Hospitals NHS Trust

May 2023

Employees

7052

BAME employees

22%

Part-time workers

44%

Female

82%

Registered nurses

2,048 (29%)

Registered midwives

254 (4%)

HCAs, helpers and assistants

1372 (19%)

Doctors

796 (11%)

Other clinical and scientific staff

856 (12%)

>55

Over age 55

19%

≤30

30 years and under

19%

Staff with less than 2 years service

29%

Staff with 20 years service or over

11%

Integrated Performance Report

NHS Worcestershire Acute Hospitals NHS Trust

Committee Assurance Reports

June 2023 Meetings

Trust Board

13th July 2023

Finance & Performance Committee Assurance Report: 28 June 2023

Accountable Non-Executive Director	Presented By	Author
Richard Oosterom – Associate Non-Executive Director	Richard Oosterom – Associate Non-Executive Director	Rebecca O'Connor Director of Corporate Governance

Assurance: Does this report provide assurance in respect of the Board Assurance Framework strategic risks?	Y	**BAF number(s)**	7, 8, 13, 16, 18, 19, 20

Executive Summary

The Committee met virtually on 28 June 2023 and the following key points were raised : Escalations to Board:

Item	Rationale for escalation	Action required by Trust Board
Contract Governance Awards	Delegated limits	To approve the CAGs
Health Records Contract	Delegated limits	For approval
Technology Services Contract	Delegated limits	For approval

The following levels of assurance were approved:

Item	Level of Assurance	Change	BAF Risk
Annual Plan Priorities	Level 4	Maintained	7, 8, 9, 11, 14, 18, 19
Integrated Performance Report	Level 4	Maintained	2, 3, 4, 7, 8 ,9, 10, 11, 13, 14, 15, 16, 17, 18, 19, 20
Finance Report: Income and Expenditure	Level 3	Decreased	7
Strategic Programme Board Update	Not reported		8, 21
Land Sales Update	Level 2	Maintained	8
PEP & Transformation Delivery Board Update	Level 3	N/A	7
IT Services Contract	Level 5	N/A	13, 16
Othicon Hearing Aids CAG	Level 6	N/A	3
Radiology Insourcing CAG	Level 4	N/A	4
Board Assurance Framework	Level 5	N/A	7, 8, 13, 16, 18, 19, 20

Finance and Performance Committee Assurance Report

Executive Summary

The Committee met virtually on 28 June 2023 and the following key points were raised :

Item	Discussion
Escalations	Audit – accounts due to be submitted by the end of the week. They are likely to be delayed due to increased sampling which is now required. Establishment of an ICB investment committee was discussed and a number of concerns regarding the proposed approach were outlined
5YfP	Brings together the ICS strategy and HWB strategies. Ambition to deliver left shift change and aligns with the Trust Three Year Plan. It proposes a programme board approach to delivery. The need to create headroom to focus on prevention was noted, there is more input from providers required overall. A board development session on the plan was suggested.
Land sales/car park	The commercial position was outlined and the impact of TIF was noted.
Systemic Anti-Cancer Treatment business case	Demand for chemotherapy continues to rise and the service is at capacity. The business case look to extend the service hours and open on a Saturday. Costs is offset by income. The cancer alliance will also pump prime, there is a potential shortfall of £50k, but this is expected to be covered for the first year. The environment of the unit at WRH was also discussed. The business case addresses the patient needs and waiting lists. Recruitment was discussed, via bank in the first instance, followed by a recruitment programme which will take into next year. The financial risk was discussed, a bid for ERF funding will support the bank staffing but this is for the short term in one unit. **Approved subject to confirmation of ICB income and financing of two months bank on Rowan Suite from ERF funding.**
Integrated Performance Report	The report format and content was discussed. The impact of strikes was noted during the reporting period in June and the Trust's response was reflected as positive. The strategic role of the elective taskforce was welcomed and the longer term impact of industrial action was noted. Ongoing work with system partners to address urgent care pressures, ED attendances and frailty was outlined and this included the Trust response to the Ian Sturgess report. Cancer performance 2WW breast and 28 day faster diagnosis showed improvement., 63 day and 104 day backlogs have increased. There is a key focus on urology with good system working, robot commissioning and mutual aid arrangements were discussed. 78 weeks RTT is positive. The trust is aiming to step down from tier one for elective and cancer. The core capacity and the impact of insourcing/outsourcing was discussed and will come through the PRMs. Good progress overall was noted. Discharge, follow ups and MRI would be discussed in more detail at the next meeting. Recruitment and the translation of reduction in time to hire into outcomes was being addressed. The increase in establishment was noted, there is a full audit trail and the budgets are in the process of being agreed. **The assurance level of 4 overall and the individual assurance levels were approved as presented.**
Finance report	The YTD M2 actual deficit is £(7.8)m against a budget of £(4.4)m deficit, an adverse variance of £3.4m (3.2%). Employee expenses are £2.1m (3.2%) adverse year to date and Operating expenses are £1.5m (3.6%) adverse year to date at M2. Impact of Full year Forecast was discussed; more work is needed to understand the variances in income. PEP Month 2 delivered £0.282m of actuals against the plan of £0.538m. There was a £30m capital programme for this year which has been fully identified. A risk-based assessment is being drafted. Cash balance is low but is not of concern currently. A Corporate services data collection is underway and it had been agreed that Corporate benchmarking would be used as a baseline across the system.
Procurement	The update was noted. Spend covered by the Contract Management System was increasing. Year to date £750k of savings had been achieved. Team Capacity was increasing with 4 new recruits to be in place by September. Cleansing was ongoing.
Health records contract	The commercial offer was outlined and the contract recommended for approval .

Finance and Performance Committee Assurance Report

Executive Summary

The Committee met virtually on 28 June 2023 and the following key points were raised :

Item	Discussion
Technology services contract	The commercial offer was outlined, risks were noted and the contract recommended for approval .
PEP/TDB update	Work is progressing, accountability walls are in place and assurance against progress in delivering the milestones has been discussed. Measurement at consultant level is being developed. There needs to be visibility, oversight and assurance and this will be progressed via the TDG and TDB. Capacity to deliver of the TDG is being considered and potential for utilisation of further resource will be explored. The maturity of PEP schemes and the sense of urgency remains of concern, however the impact of the process in improving assurance was noted. The governance mechanisms were to be reviewed and the prioritisation of schemes to be considered against the scale of the impact. **Assurance level of 3 was approved**
4ward improvement scheme update	Good attendance at foundation training, but this needs to be improved in the consultant body. Training targets and KPIs were discussed along with the impact of pace and the barriers to it. Delivery of training has been flexible but leaders training is key along with releasing time for staff to attend. Implementation of change from RPIWs was debated and this is being prioritised. Leadership should enable all staff to set aside time to focus on improvement. **Assurance level of 3 was approved**
SPB update	The highlight report was noted.
CAG Gynae	The CAG was recommended for approval at Trust Board.
CAG Portland	The CAG was recommended for approval at Trust Board.
CAG gastro	The CAG was recommended for approval at Trust Board.
CAG dermatology	The CAG was recommended for approval at Trust Board.
CAG general surgery	The CAG was recommended for approval at Trust Board.