Trust Board Public

Tue 23 July 2024, 13:00 - 14:30

Agenda

13:00 - 13:00
0 min

1. Welcome and Apologies for Absence

Information *Russell Hardy*

13:00 - 13:00
0 min

2. Declarations of Interest and Matters Arising

Information *Russell Hardy*

13:00 - 13:05
5 min

3. Minutes of WAHT Board Meeting held on 11th June and Actions Update

Decision *Russell Hardy*

All actions are complete

Minutes Public Board June 24.pdf (8 pages)

13:05 - 13:45
40 min

4. Items for Review and Assurance

4.1. Chief Executive's Report

Discussion *Glen Burley*

CEO Board Report 0724 Final.pdf (6 pages)

4.2. Integrated Performance Report

Discussion *Stephen Collman*

Trust Board IPR Jul-24 (May-24_Data)_0-1.pdf (34 pages)
Trust Board KPI Dashboard (to May-24).pdf (4 pages)

4.2.1. Activity Performance

Helen Lancaster

4.2.2. Quality

Sarah Shingler

4.2.3. Workforce

Alison Koeltgen

4.2.4. Finance Performance

NEIL COOK

4.3. Perinatal Report

Information *Justine Jeffery*

- Perinatal Safety Report - May 2024 SS.pdf (16 pages)
- Perinatal Safety Report - App 1.pdf (2 pages)
- Appendix 2 Sustainability Plan.pdf (6 pages)

4.4. Safe Staffing Reports

Information *Sarah Shingler/Justine Jeffrey*

- Midwifery Safe Staffing Report May 2024 SS.pdf (6 pages)
- June safer staffing report - FINAL FOR BOARD SS .pdf (9 pages)
- staffing app 1.pdf (1 pages)

13:45 - 14:00
15 min

5. Items for Approval

5.1. Climate Adaptation Plan

Decision *Jo Newton*

- Climate Change Adaptation Plan Covering Report - Board July 24.pdf (2 pages)
- WAHT Climate Adaptation 2024v0.2.pdf (28 pages)

14:00 - 14:20
20 min

6. Items for Noting and Information

6.1. 2024/25 Operational Plan

Information *Jo Newton*

- Annual Plan Covering Report - TB 2024-07-23v0.2.pdf (3 pages)

6.2. Patient Safety & Quality of Care in Pressurised Services

Discussion *Sarah Shingler*

- Trust Board paper UEC Fundamentals of Care paper NHSE letter 26 June 24_.pdf (4 pages)
- PRN01417 Patient safety and quality of care in pressurised services .pdf (3 pages)

6.3. Committee Summary Reports and Minutes

Information *Committee Chairs*

6.3.1. Quality Governance Committee

Julie Moore

Verbal Update

- QGC Minutes 30 May.pdf (7 pages)

6.3.2. Audit and Assurance Committee

Colin Horwath

Verbal Update

- Audit Minutes May.pdf (8 pages)

6.3.3. People & Culture Committee

Karen Martin

Verbal Update. Previous Minutes presented at June Trust Board.

14:20 - 14:20
0 min

7. Any Other Business

Russell Hardy

14:20 - 14:20
0 min

8. Questions from Members of the Public

Russell Hardy

14:20 - 14:20
0 min

9. Date of Next Meeting

Information *Russell Hardy*

10th September 2024

14:20 - 14:20
0 min

10. Acronyms

Information

Z Acronyms.pdf (3 pages)

MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON TUESDAY 11 JUNE 2024 AT 1:00 PM VIA MICROSOFT TEAMS AND STREAMED ON YOUTUBE

Present:		
Chair:	Simon Murphy	Deputy Chair
Board members: (voting)	Dame Julie Moore	Non-Executive Director
	Colin Horwath	Non-Executive Director
	Karen Martin	Non-Executive Director
	Stephen Collman	Managing Director
	Tony Bramley	Non-Executive Director
	Sarah Shingler	Chief Nursing Officer
	Joanne Kirwan	Deputy Chief Finance Officer
Board members: (non-voting)	Sue Sinclair	Associate Non-Executive Director
	Richard Haynes	Director of Communications and Engagement
	Jo Newton	Director of Strategy & Planning
	Alison Koeltgen	Chief People Officer
	Richard Oosterom	Associate Non-Executive Director
	Helen Lancaster	Chief Operating Officer
	Michelle Lynch	Associate Non-Executive Director
	Vikki Lewis	Chief Digital Information Officer
In attendance	Justine Jeffery	Director of Midwifery
	Chris Byrne	Healthwatch
	Erica Hermon	Company Secretary
	Jules Walton	Acting Chief Medical Officer
	Julian Berlet	Acting Chief Medical Officer
Public		Via YouTube
Apologies	Russell Hardy	Chair
	Glen Burley	Chief Executive
	Neil Cook	Chief Finance Officer

001/24 **WELCOME**

Mr Murphy advised that the Board had received a patient story earlier in the day during the Board Workshop which showed that there was still more work to do by the Trust to ensure that our patients and families receive the support and services that they require. Learning was being taken from the case. The ICB attended and gave a presentation on bed modelling across the system reinforcing the focus of ensuring that patients are treated at the right place at the right time. Discussion also took place around frailty and length of stay.

Mr Murphy thanked Mr Oosterom for his assistance over the last 7 years at the Trust and wished him well for the future.

002/24 **DECLARATIONS OF INTERESTS**

The full list of declarations of interest is on the Trust's website. Mr Murphy advised that he needed to update his declaration to include the subsidiary companies that he is a Director of and Independent Chair.

003/24 **MINUTES OF THE PUBLIC TRUST BOARD MEETING HELD ON 9 APRIL 2024 AND ACTIONS UPDATE**

The minutes were approved and the actions updated.

Mr Collman informed that the Trust was working with other public sector partners in regard to car parking schemes. An update would be provided to the Board within the next couple of months. A number of situations had been reported where parking fines had been issued to staff who had been unable to park appropriately, which were being resolved. The Worcester reception desk was under review and a proposal had been circulated to the Executives for consideration.

RESOLVED THAT: The Minutes of the public meeting held on 9 April 2024 were confirmed as a correct record.

004/24 **FOUNDATION GROUP BOARD MINUTES AND ACTIONS UPDATE**

The minutes and actions were reviewed.

Items for Review & Assurance

005/24 **CHIEF EXECUTIVE'S REPORT**

Mr Collman highlighted the following areas within the report:

- Improvement Week had taken place and a number of sessions were held which received positive feedback. Examples of best practice and learning across the Foundation Group were shared.
- The Trust has been using the Virginia Mason methodology and thanks were extended to the Leeds Teaching Hospitals for their accommodating of a visit by the senior team.
- Financial escalation meetings have been taking place. A revised deficit of c£60m had been reached and the Trust were working closely with ICS colleagues.
- The Cost Productivity Improvement Plan is set around £45m and 6.6% of turnover. There is risk and challenge to deliver the ambitious target but there was good engagement with teams. A key element of the plan is productivity and work was underway with Group colleagues.
- 2 day case knee replacements had been completed at the Trust and thanks were extended to the teams involved in this area.
- Thanks were passed on to the Critical Care Team following a CQC visit and received an overall rating of Good.

RESOLVED THAT: The report was noted.

006/24 **INTEGRATED PERFORMANCE REPORT**

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

- Cancer and elective demand remains high.
- Continued growth was reported within urgent and emergency care against previous years of the same period.

<u>Operational Performance</u>

Ms Lancaster highlighted the following key points:

Improvements were being seen across a number of metrics. Cancer performance is steadily improving. Thanks had been received from the national team.

The Trust was still challenged across a number of tumour sites but improvements are now being seen.
A deterioration in diagnostics had been seen but particular focus had been on cancer recovery. The urology intervention unit was coming online which will release some MRI capacity back into routine diagnostics.
The 78 week elective position had shown a slight improvement. No 104 week waits were reported.
UEC were still challenged with EAS target.
Ambulance handover delays had reduced along with ambulance hours lost.
A reduction in over 12 hours in ED was also was being seen.
Work redirecting patients from ED continued. 82% of walk ins are discharged from ED and 51% of patients on ambulances are discharged.

Mr Horwath noted that divisions are developing operational delivery plans to increase the volume of activity, and given the pressures that teams were under, Mr Horwath queried whether sufficient progress was being made. Ms Lancaster replied that there was support of driving productivity and maximising opportunities.

Quality
Ms Shingler advised that complaint compliance continued to struggle. During April, the 25 day response performance was reported as 47.7%. Surgery continued to struggle with clearing overdue complaint responses.
Falls and hospital acquired pressure ulcers performed well.
There had been challenges with the Friends & Family Test response rates and there is targeted work underway.
Antimicrobial stewardship compliance did drop in April to 88.9% and failed to achieve the target, however the new AMS Lead Pharmacist was now in post.

Ms Walton stated that work on the fractured neck of femur pathway continued. Improved metrics were anticipated over the coming months.
Sepsis remains an area of focus.

Ms Martin referred to complaints and remained concerned around the position within the surgery division. Additional support does not appear to be having a sustained impact and queried the next steps and whether learning was being lost. Ms Shingler replied that the Executives shared the concerns around governance and sustainability. The issue is sheer volume but clinician involvement has been a positive step. Governance structures have been reviewed and there is assurance that learning is being shared.

Workforce
Ms Koeltgen advised that there was an error in the report regarding agency spend which should read that there had been a reduction to 8.61% against a target of 6%. There is challenge around medical agency use and divisions are being supported with plans. Arrangements need to be exited responsibly.
Improvement to sickness management is being supported. Focused effort is on fully exploiting all of the steps within the Sickness Policy to wrap support around colleagues.
Focus was on job planning compliance as there had been a slight dip in compliance.
Turnover and sickness was detailed within the report, particularly in relation to Healthcare Support Workers and Midwifery colleagues. HSW's do see higher turnover than other staff groups.
Compliance with statutory mandatory training has been consistently good and benchmarks favourably.

Ms Martin applauded sustaining mandatory training compliance. Ms Martin queried the consultant job planning and alignment links to the appraisal process. Ms Koeltgen replied that upon scrutiny, some of the job planning activity has not been recorded appropriately. There is further work to do with the analysis in this area.

Mr Oosterom queried the trajectory for job planning improvement and referred to bank and agency timescales. Ms Koeltgen replied that bank and agency is a complex issue, particularly with medical staffing. Grip and control plans are reported through the Financial Recovery Board. Exit plans are being produced and shared across divisions.

Mr Collman highlighted work underway with the Improvement Director. Faster decisions around recruitment needed to be made.

Ms Walton referred to job plans and advised there had been a disassociation with links to appraisals. Job planning had been an issue for some time and would take time to resolve. A further update would be provided at the next meeting.

Ms Sinclair advised that Rosemary Smart from the Patient and Public Forum had raised issues with supported professional activities and non direct clinical care in job plans.

Finance Performance

Ms Kirwan advised that there were no mandated reporting submissions in month 1 but oversight of key items remained.
Small favourable variances were reported across pay and non-pay. £100k on pay and £200k on non-pay.
No CPIP had been declared in month 1 due to year end and planning submissions.
Cashing up is underway.
Performance across activity and income for elective activity indicated £1m higher than the plan.
Cash risk support were highlighted.
A new finance framework was introduced last week.
Capital risks were outlined and workstreams continued to itemise and prioritise schemes against the limited capital allocation.

Ms Lynch queried why income was understated against the actual income of £10m. Ms Kirwan replied that some is linked to the phasing of the plan and productivity.

Ms Oosterom expressed concern around the equipment and maintenance backlog and asked that a risk analysis is undertaken. Ms Kirwan replied that as part of the framework, an assessment of deficit is undertaken and a risk assessment is underway.

RESOLVED THAT: The report was noted for assurance.

007/24 **PERINATAL SAFETY REPORT**

Ms Jeffrey highlighted the following:
KPI's for booking 12 weeks had not been met. There had been delays with maternity self-referrals and further imbedding was required.
Perinatal mortality remained below the national average.
No stillbirths or neo-natal deaths were reported in April.
Workforce KPIs are moving in the right direction but there had been sickness spikes within the neonatal unit and are being managed closely.
Training is on trajectory to meet 90% compliance by December.
An ongoing challenge is the timely completion of PDRs.

Challenges were reported with junior and middle-grade staffing but mitigations are in place.
F&FT recommendation rates were good but a low response rate remained. Focus is on improving the response rate.
A significant decrease was reported with delays in induction.
The CNST quarterly report was included. Element 1 remained amber due to a late notification.
Safety Champions discussed a reduced image quality on some of the scan machines in the antenatal clinic but mitigations are in place and continues to be monitored.

RESOLVED THAT: The report was noted for assurance.

008/24 **MBRRACE REPORT 2022**

Ms Jeffrey presented the report which detailed 22 cases reported.
Overall, the Trust was within 5% of comparator Trusts, which is a sustained position.
2023 data looks to demonstrate an improved position.
17 stillbirths had been reported and of those, 5 were graded that different care may have made a difference to the outcome. The majority were raised as serious incidents or processes reviewed.
Of the 5 neonatal deaths, only 1 was graded C or above and was also reported as a serious incident and learning taken from it.
There were a number of areas of good practice reported.

RESOLVED THAT: The report was noted for assurance.

009/24 **SAFE STAFFING REPORTS**

Ms Shingler informed that staffing on paediatrics, neonates and adults maintained safe levels throughout April.
Agency spend is continuing to reduce and swap outs of staff continued.
RN vacancies was an improving position as are support worker vacancies.
RN total absence in March was 292. Of those, 90 were on maternity leave. Funding maternity leave within funded establishment was under review in order to reduce agency spend.
No serious issues were reported in relation to staffing throughout March or April.
26 insignificant minor instances were reported.
The team had been supporting other hospitals with international nurse recruitment which had bought in a small additional income of £17k. Further opportunities were being explored with the ICS and regional colleagues.

Ms Martin congratulated the team on the progress made with vacancy rates. Ms Martin queried whether a plan for over recruiting was being developed as there would always be an element of maternity leave. Ms Shingler agreed and replied that with escalation areas remaining open, staffing in these areas also required a review should they remain.

Ms Jeffrey updated that safe staffing levels were met for maternity.
Sickness and turnover had reduced.
Supernumerary status of the shift leader was not met. There were 2 occasions reported but acuity was met at 76% of the time which was an improvement on previous months.
16.5 wte equivalent posts had been offered to newly qualified midwives, who will join the Trust in September and October.

The 2 international midwives had received their pin numbers and were welcomed to working within the service.

RESOLVED THAT: The reports were noted for assurance.

Items for Approval

010/24 **5 Year Plan**

Ms Newton presented Joint Forward Plan for ratification and delegation in terms of the financial elements.
Ms Newton advised that it was a joint plan for a 5 year period and is the NHS contribution to the wider ICS Strategy and the 2 Health & Wellbeing Board Strategies.
The plan was presented a year ago and there were little material changes but updated to reflect joining the Foundation Group and focus on the best use of resources and benefits realisation. The ICB Board reviewed the plan last month where it was approved.
Focus over the next time period will concentrate on delivering best value of care.

RESOLVED THAT:

- **The 5 Year Plan was approved.**
- **Delegation of financial aspects to the Chief Executive and Managing Director was approved.**

011/24 **FINANCIAL RECOVERY PLAN**

Mr Collman advised that a number of discussions had taken place at Trust Board regarding the Financial Recovery Plan and the financial plan and settlement is being re-cast. It was suggested that the Plan is reviewed at a further Board Workshop for accuracy prior to final approval by Trust Board.

RESOLVED THAT: The Financial Recovery Plan would be reviewed at a Board Workshop prior to final approval at Trust Board.

012/24 **QUALITY ACCOUNT**

Ms Shingler advised that the Quality Account required publication by 28th June.
The Draft Quality Account has been reviewed at Trust Management Board and the Quality Governance Committee and was presented for approval.
Ms Shingler confirmed that the Quality Account does meet the legal requirements and is consistent with internal and external sources of information.
External views have been received from the ICB, Healthwatch and the Patient and Public Forum. Feedback consisted of the lack of reference to car parking and the work being undertaken around sepsis, which will be included.
The Account demonstrates the commitment of our divisions and teams in improving the quality and patient experience for our patients.

RESOLVED THAT: The Quality Account was approved with the addition of car parking and sepsis.

013/24 **IPC ANNUAL REPORT**

Ms Shingler advised that it had been a challenging year with healthcare associated infections. All 7 standards had been breached and detailed within the report. It was noted that both nationally and regionally, there had been an increase in the number of HCI cases.
Ms Shingler stated that she had seen improved working relationships within the teams and more assurance was being seen through TIPCC and QGC. Challenges and pressures were understood.
Following a self-assessment against the criteria in the hygiene code, the Trust is able to declare compliance with the hygiene code for the year 23/24 and also declare partial compliance with the IPC Board Assurance Framework. This is due to ongoing cleanliness concerns and ongoing conversations with the PFI provider. There are gaps in estates maintenance priorities on the Worcester site.

RESOLVED THAT: The Quality Account was approved.

014/24 **SAFEGUARDNG ANNUAL REPORT**

Ms Shingler informed that the Annual Report highlights the work undertaken in 23/24 to provide assurance that the Trust is compliant with statutory obligations in relation to children and adult safeguarding. The work in this area by the teams is commendable.

The Trust had met its obligations in relation to PREVENT and as a partner of the Worcestershire Children's Partnership and the Safeguarding Adults Board.

Mental Health Act detentions will be focused upon over the coming months as they do continue to exceed the number throughout the year.

RESOLVED THAT: The Safeguarding Annual Report was approved.

Items for Noting and Information

015/24 **COMMITTEE SUMMARY REPORTS AND MINUTES**

Quality Governance Committee

Ms Sinclair advised that good widespread work was ongoing in relation to retention of staff. The establishment of the Learning Disabilities Steering Group was welcome news and would make a difference to the quality of care of our patients.

Engagement and implementation of EPR had been discussed and assurance had been given regarding mitigation for the window issues within maternity.

Audit & Assurance Committee

Mr Horwath informed that 3 internal audit reports had been reviewed by the Committee. In one case, there was limited assurance regarding consultant job planning which was disappointing. An update would be received at the next meeting.

The Head of Internal Audit had advised that we will have a limited assurance Audit Opinion and though this was disappointing, was not a surprise. Factors that have contributed to the overall limited assurance was due to some limited assurance reports, responsiveness to recommendations and implementation of them has not been timely.

Committee have received a draft of the financial statements and thanks were given to the team involved for the timeliness. Ms Hermon added that the accounts were included on the Private Trust Board agenda for approval before they are published publicly.

People & Culture Committee

Ms Martin updated that at the last meeting, plans and proposals to improve the response rate to the staff survey were discussed along with a programme of work around overpayments and reframing of the risk register for the people directorate.

RESOLVED THAT: The Committee Minutes were taken as read and the updates noted.

016/24 **BAF AND EXTREME RISKS**

Ms Shingler advised that there had been gaps around reporting of risks. The Risk Management Strategy was approved by the Board last year and the risk management process had been reviewed. Reviews of the BAF and risk registers remain ongoing through the Corporate Risk Management Group and the Executive Risk Management Committee.

Ms Hermon added that the BAF is now hosted on Datix, which allows the linking of risks to the BAF. The most significant change to the BAF since the last Board review is digital resilience and is now more focused on cyber. Rollout training continues to be provided for the new risk strategy.

Mr Collman reiterated that work was ongoing with how risks are described and the language needed to be refined.

Mr Bramley queried the governance arrangements of committee oversight. Ms Hermon replied that Datix does allow the Trust to identify a monitoring committee and the Executive Risk Management Committee are reviewing the governance of the risk management process.

Mr Collman stated that there were some long standing risks but there was a commitment to obtain a resolution.

Ms Shingler added that high risks were under review but education and training is needed for consistency, which would take time.

RESOLVED THAT: The BAF and extreme risks were noted.

017/24 **ANY OTHER BUSINESS**
There was no other business and no questions from the public.

DATE OF NEXT MEETING
The next Public Trust Board will be held on Tuesday 23rd July 2024.

Signed _____ **Date** _____
Chair

Worcestershire Acute Hospitals NHS Trust

WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST COVERING REPORT 2023-2024

Report to:	**Public Board**
Date of Meeting:	**23/07/2024**
Title of Report:	Chief Executive Officer's Report
Status of report:	☐**Approval** ☐**Position statement** ☒**Information** ☐**Discussion**
Report Approval Route:	Other
If Other, provide details:	
Lead Chief Officer/Director:	**Chief Executive**
Author:	Glen Burley, Chief Executive
Documents covered by this report:	Click or tap here to enter text.

1. Purpose of the report

This report is to brief the Board on various local and national issues.

2. Recommendation(s)

The Trust Board is requested to note this report.

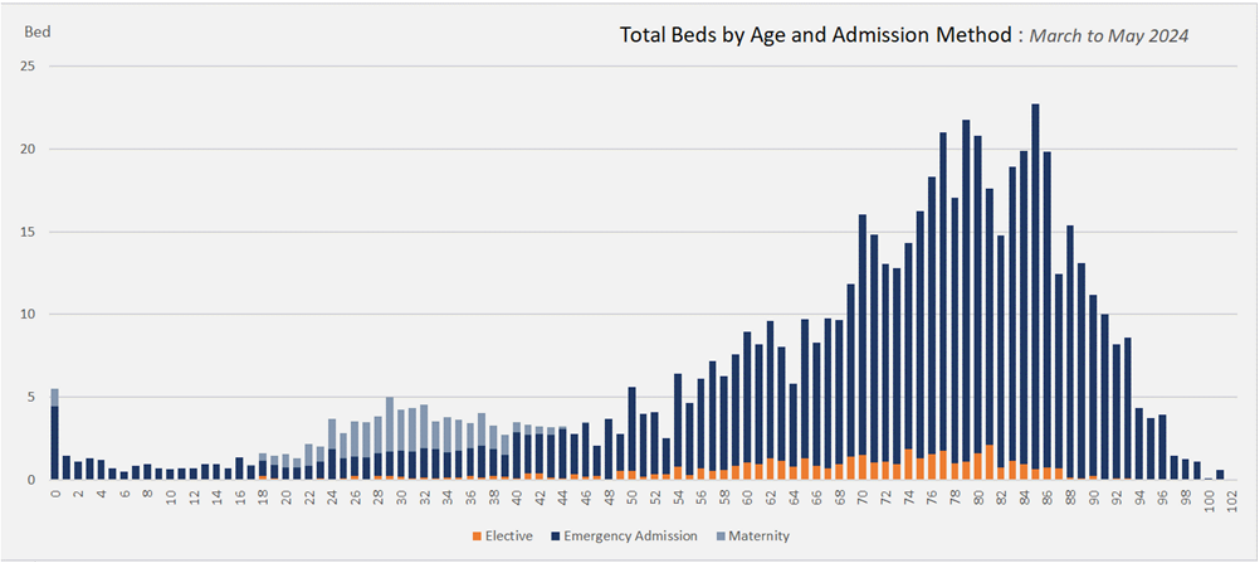
3. Chief Officer/Executive Director Opinion[1]

Developing our Frailty Service

The Ten Point Plan set out the need to expand and improve our Frailty Service. Frail older patients admitted as emergencies generally occupy around 75% of any NHS acute provider's beds. I asked our Informatics team to produce the chart below, which makes that point very strongly.

Graph 5: Beds

Total Beds by Age and Admission Method



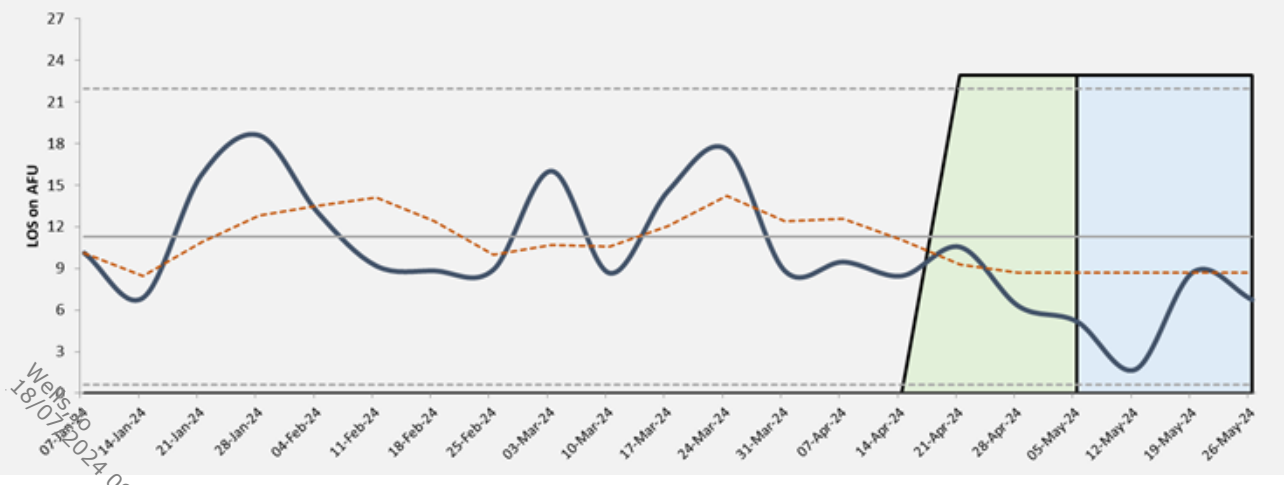
[1] Chief Officer opinion must be included and approved by the Chief Officer concerned prior to issue, except when the Chief Officer has given their consent for the report to be released.

Effective frailty services have several components, key to their success is the understanding that an acute hospital is not the best place for frail older patients to be unless this is the only setting where their clinical needs can be met. The connection between hospital-based Frailty teams and Primary Care and Out of Hospital alternative settings is vital in seeking to avoid unnecessary admission and to speed up discharge. Elderly Care Consultants are now very much in demand across the NHS which can make it very hard to recruit, particularly to a small team where on call commitments might be more onerous. We have certainly faced such a challenge locally, but I have been incredibly impressed with the way that we have responded. This includes the use of other clinical specialists.

Our initial focus has been on creating a stronger service at Worcestershire Royal Hospital (WRH). We have created new roles of Frailty Nurse Consultants utilising some vacant posts and securing some additional funding from the Integrated Care Board (ICB). One Nurse Consultant started in post in February 2024, we have two more starting in July/August 2024 and a fourth currently out to advert. We envisage these roles will provide more infrastructure to our advanced practice framework for Frailty, provide clinical care to patients in Same Day Emergency Care (SDEC), ward, virtual ward and clinics, supervision, and training for Advanced Clinical Practitioners (ACPs) and specialist nurses and lead some of our pathway transformation workstreams. We have nearly recruited to all of the long standing vacant ACPs roles. There is now only one more to fill which is out to advert. We have attracted a really good cohort of Trainee ACPs and ACPs since the overall nurse consultant leadership arrangements were put in place.

Our learning and evidence from WRH should then allow us to develop a similar solution for The Alexandra Hospital (The Alex) . We also have two specialist Nurses in post now who cover the Worcester site only. We plan to recruit more which should allow us to support the development of the Alex service. All of this has also had a positive impact on consultant recruitment. We have just recruited a new substantive Geriatrician which brings up to 2.2 WTE (4 part time Geriatricians). We aspire to have 7 days ACP cover on both sites, but this will require investment.

The key to making the case for further investment will be the impact on bed occupancy and outcomes. The chart below provides some evidence that the improvements to our Frailty pathways are starting to reduce length of stay. The data below focusses on the length of stay in the Acute Frailty Unit at WRH showing the impact of Frailty SDEC. The green shaded section shows when Frailty SDEC commenced whereas the blue shaded section shows the impact when capacity was constrained. From the first 6 weeks of operating frailty SDEC, the data shows how patients are 'pulled' straight to SDEC. They then receive a comprehensive geriatric assessment by the Multi-disciplinary Team (MDT). Those who need an inpatient stay on the Acute Frailty Unit then have a length of stay which on average will be 4 days less.



Financial Regime Changes

As previously reported to the Board, the System plans submitted on 2nd May 2024 forecast an aggregate national deficit of close to £3bn, well above levels at a similar point in previous years. As a consequence, NHS England (NHSE) met face to face with systems and providers to seek further improvements. The discussions centred on each system's ability to meet “revenue financial plan limits”. Subsequently changes have been made to the financial regime to seek to incentivise their delivery. Under the new rules, systems are given revised targets to breakeven or to hit a specified level of deficit. A further 'fair shares' allocation has been identified for each system which allocates a proportion of a national contingency pot. Systems that have a deficit above their fair share of funding will face capital penalties, with bonuses for areas in balance. The new financial framework introduces a helpful element of realism by setting targets that NHSE feel can be hit, whilst also formally acknowledging that some areas will take a while to get back to breakeven.

I have a concern that the focus remains on System level positions. The four Trusts in the Foundation Group are impacted in different ways by these rules, so we are in a relatively unique position to consider their impact. South Warwickshire University NHS Foundation Trust (SWFT) and George Eliot Hospital NHS Trust (GEH) have plans which deliver breakeven in a System which currently plans to be in deficit. This deficit should be above the 'fair shares' position, so we will probably hold on to the system level capital allocation, but the two Trusts will not receive an additional capital incentive. Wye Valley NHS Trust (WVT) and Worcestershire Acute Hospitals NHS Trusts (WHAT) both have deficit plans and whilst the system plan now delivers the overall level of deficit felt to be 'acceptable' by NHSE, because it exceeds the fair shares allocation we have seen a reduction in our capital allocation overall. Whilst there appears to be no guidance on how this should be handled within systems, I have agreed that the capital allocation to the Health and Care Trust (in breakeven) should not be affected by this penalty. We have therefore agreed a fair way of handling this between WVT and WAHT. But it would have been interesting to see how this would have played out if we hadn't been in a shared leadership model. Elsewhere it is feasible that Trusts in breakeven positions will face capital reductions due to overall system positions. One would question whether this is fair or whether it creates the right incentives for improvement or for effective system working.

Withholding capital from organisations in deficit is always controversial, with critics arguing that allocations should be based on need only and insisting that the restrictions hold back investment that could boost productivity. Many criticised the Payment by Results financial regime but, in my opinion, it helpfully provided an indication of the relative productivity of each provider and provided a clear incentive for improvement. Allocating funding based on activity volumes appears to be fairer than simply allocating funding to deficits. I also feel that systems can play an important role in the overall financial management of the NHS but we should not lose the focus and accountability of the constituent statutory bodies. Incentives generally work in life, so we should seek to maintain some in the NHS. The current regime is due for an overhaul and I continue to seek to influence national thinking on this where I get the opportunity.

Urgent and Emergency Care (UEC)

The ever-increasing demand experienced in UEC is also an area which trips into the NHS financial management debate. There was a time where activity volumes were linked to tariff payments and hence Trusts which experienced larger increases in demand had some means of funding capacity to improve flow. In my view this is one of the reasons why performance against the 4-hour standard has dropped. The financial argument is much less important than the quality and safety argument though. We know that, despite the flaws of a single key indicator, good performance against the 4-hour standard aligns to lower levels of mortality and better patient and staff experience. The counter argument to a full tariff-based system is that it potentially encourages the treatment and admissions of patients rather than thinking about demand reduction or delivering more care at home. I have therefore been suggesting a hybrid approach where we would incentivise best practice pathways as we do with other best practice tariffs, such as the very successful model supporting fractured neck or femur.

All other parts of the Foundation Group have integrated hospital and community services, albeit the GEH arrangement is in partnership with SWFT. These arrangements facilitate the move to more home first care more easily in that resources can be transferred within the Trusts to build capacity out of hospital. This still excludes

other key elements of the health and care service such as Primary Care, Mental Health Care, Ambulance Services, Social Care etc. But it provides a useful reminder that the best solutions to flow problems often sit in partner organisations and as we increasingly take on 'lead provider' responsibilities we will need to find ways to pool resources and move funding within our Places to invest in the best solutions.

Pathology Network

Lord Carter set out plans over two decades ago to create Pathology Networks across the NHS. These plans were founded on productivity and service sustainability principles which still hold today. When Lord Carter talked to our Foundation Group Boards Workshop recently, he expressed understandable frustration that the plan set out had still not been fully implemented. Meanwhile, the case to do so has become more compelling and technological advances have made it easier to operate virtual networks.

For a number of years there have been ongoing discussions about the scale of our local Pathology Network. The current consensus is that a suitable scale would embrace Coventry, Warwickshire, Herefordshire, and Worcestershire. The current Coventry and Warwickshire Pathology Network does not extend to WVT and WAHT, so a process is underway to seek to do so.

This is no small undertaking, but I feel that, done in the right way, there should be benefits to patients and savings for the Trusts. We are discussing how the model could work so that we achieve the right balance between local access and flexibility whist benefitting from the sustainability and value associated with the expanded Network scale. This has been added to the Foundation Group Strategy Committee July 2024 agenda for further discussion.

Dermatology Update

The Managing Director and I recently met with the operational teams from WVT and WAHT to review progress on creating a single service across the two counties. We were both impressed with the progress made which includes the development of more Nursing roles to meet the ever-increasing Skin Cancer referral demand. As part of the work, we will be exploring how best we can deliver an integrated service. The key will be to create more of a career structure and a more sustainable staffing model whilst ensuring that we provide rapid local access. Tele-Dermatology has advanced significantly in recent years and provides a very effective means of screening referrals from Primary Care. Using this more fully will be an important element of the plan

Improving Car Parking and Access to the Worcester Royal Site

Improving staff car parking was identified as a priority in the 10 Point Plan. This was prioritised due to the impact that the current arrangements have on the welfare of staff, many of whom either cannot park or spend large amounts of time queuing to leave the site after their shifts. For a number of months we have been in discussion with Local Authority colleagues who have been both sympathetic and constructive.

We are actively exploring a range of options to increase capacity as well as reducing traffic congestion. A planning application has now been made for a new school on the land adjacent to the site, and as part of this there is the possibility of building a multi-story car park. This would be for our exclusive use and would be serviced via a new roadway. The proposal is still at a very early stage, but we are keen to take full advantage of any opportunities the school development might offer to improve access and parking at our hospital. The Trust has little prospect of gaining additional capital funds to build such a facility ourselves, hence the proposition at this stage is that we would lease the car park from a third party.

Recognising that the above plans could take while to come to fruition, we are also in the advanced stages of securing a new staff park and ride agreement with the Council to use the Six Ways site.

Multi Agency Discharge Event (MADE)

A MADE took place between 11th-14th June. The aims of MADE are to unblock delays and simplify processes across the whole system. Such events can also create capacity and increasing flow as part of an escalation process and reduce length of stay (LOS) by increasing the number of daily discharges. For this MADE we focused on the WRH site due to the closure of Aconbury 0 and the reduction/closure of remaining winter capacity. The focused aims included a target of 33% discharges before midday ('*Home for Lunch'*), reduction in longest length of stay (LLOS - patients in hospital over 21 days) and transport improvement with pre-day booking.

There were many points of learning including that challenges remain with the tracker where pathway 1&2 referrals were rejected numerous times. There was also a lack of criteria led discharge on some wards. We use the 'red to green' methodology to improve flow. Green days are when something positive happens to progress discharge, red days are when no progress is made. We found a general lack of understanding of Red to Green principles, although the Head and Neck team demonstrated excellent performance on red to greens well as delays in diagnostics, delays in transport being booked, some whiteboards not working, and that task allocation lacked clarity on ownership.

It was probably one of the most successful MADE events that we have had in that it led to significant improvements including a decrease in LLOS. The week before MADE we averaged 90 such patients but this reduced to 77 following the event. Overall, 189 bed days were saved. Discharges from General and Acute beds increased by 45 compared to the week before and 24.7% of discharges took place before mid-day. Best practice was noted on Aconbury 1,2, and 4 for board rounds and ward rounds. The Acute Frailty Unit were also commended for trialling a new ward round book.

More from our great teams

The Source (our new Intranet) goes live: After several months of hard work by our communications and digital teams, and a final few weeks of intense preparation The Source (our new Trust intranet) went live in June.

This was a complex piece of work which brought a key internal communications platform in-house from an external host and replaced an outdated and user-unfriendly content management system with a responsive Sharepoint-powered one.

A small project team bringing together comms and digital colleagues built a new structure, transferred content, tested effectiveness and developed bespoke coding to offer additional functionality as well as delivering training for more than 100 content creators and editors before switching from the old intranet to the new on 25 June.

In the first two weeks of go-live The Source attracted 4,932 unique users and more than 170,000 page visits.

Feedback from users across the Trust has been positive and the new intranet offers significant opportunities for developing engaging content and offering additional functionality in the future, as well as aligning well with the other Microsoft products that are a feature of daily working life for our people. Ending reliance on external hosting and content management has also delivered greater resilience as well as a cost saving. Congratulations to everyone involved.

4. Please tick box to identify which of the Trust's 10 Point Plan the report relates to:	
☐ *Focus on Flow*	☐ *Think/Act as a Lead Provider*
☐ *Governance*	☐ *Improve Staff Experience*
☐ *Home First Mindset*	☐ *Tertiary Partnerships*
☐ *4ward Improvement System*	☐ *Leadership and Structures*
☐ *Elective Care: No Delays*	☐ *Strategic 'Big Moves'*

Integrated Performance Report

JULY 2024

TRUST BOARD| v0-1| Up to May-24 data

Last updated 28th June 2024

MANAGING DIRECTOR – EXECUTIVE SUMMARY

Stephen Collman

Managing Director

Context: This report is set against the highest activity the Trust has seen attended our emergency departments. The Trust has commenced the work on Aconbury 0 and reduce the additional capacity to the Pathway Discharge Unit. The financial position remained largely on plan, with a significant focus on the delivery of the Trust efficiency plan, driving productivity and activity. The high bed usage and extended length of stay have contributed to a number of quality indicators.

Operational performance: The Trusts emergency departments had 13,447 attend, 928 more attendances than May 23, and the highest recorded. 50.3% were treated in four hours. There has been a significant 10.5% increase in walk in attendances. 23% of patients brought by Ambulance waited longer than an hour. However, the total hours lost decreased, and followed a trend of the previous 3 months. The length of stay for non elective patients continues to rise from 2020 levels incrementally increasing, now 7.9 days. From the recent system discharge event areas of focus include some complex discharge patients. There was 2,948 new referrals for suspected cancer in May 2024. The unvalidated performance for 28 day faster diagnosis is currently 80%, the highest recorded. For 62 day cancer waiting time, unvalidated, is 61%. There are 48 patients waiting over 104 days. The Trust has 2089 patients waiting over 52 weeks, 464 patients waiting over 65 weeks and 14 over 78 weeks. The specialties with the greatest numbers waiting are Oral surgery and ENT.

Quality and Safety: Mortality remains within expected range. SHMI (Summary Health-Level Mortality Indicator) has a small increase at the Alexandra Hospital. Data for Sepsis screening is now collated from Electronic Patient Record. The first month has been problematic and colleagues are working with Divisions to improve. The Sepsis mortality figures remain within expected range. For infection control Klebsiella increased, and C.Diff, MDSSA and pseudomonas decreased. The complaint target for 25 days increased but did not meet target, the Surgical Division is a key area of focus. Falls remain below the national benchmark, with no Serious Incident falls. Health acquired Pressure Ulcers increased from the previous month, with none causing harm.

Workforce: Vacancies rate reduced to 681 (9.32%). Agency spend remains a challenge. This is driven by reduction in insourcing, winter capacity opened, escalation areas and nurse ‘specialing’. Specific focus is on Urgent care and speciality medicine division. Colleague turnover has reduced to 10.86%. Sickness absence reduced to 5.57%. Absence due to stress remains the higher than pre pandemic levels. For long term sickness Surgery and Urgent care are the highest, with Estates and facilities, SCSD and Urgent Care have the highest level of short term sickness. Consultant job planning reduced with urgent care the lowest and requiring immediate attention.

Finance: The Trust has reported a favourable variance of £0.1m against plan. The Capital plan has been resubmitted at £12.46m. The reduction of £1.90m is a proportion of the £2.53m across the system. The Trust continues to meet it the £45m efficiency challenge. Cash is £1.712m for the end of month 2.

OUR OPERATIONAL PERFORMANCE

Helen Lancaster

Chief Operating Officer

Thanks to the efforts of colleagues across the organisation, our cancer performance in May continues to demonstrate the progress we have made in 2024 in improving the timely access to diagnosis and treatment for patients living with cancer. For the first time, the Trust has informed more than 80% of patients within 28-day of referral of their diagnosis, helping us to ensure that an increasing number of patients are able to start their cancer treatment within 62 days, with over 60% of patients commencing treatment within 62-days. Whilst this absolutely isn't yet at the standard, I know colleagues feel is acceptable it continues to demonstrates our commitment to this key priority, though I recognise many patients are waiting too long to start their treatment.

Once again, we continue to reduce the number of patients waiting over 78 weeks. I'm disappointed we didn't achieve 0 in May, but I know also that colleagues are equally disappointed and are working with patients and clinicians to ensure no-one is waiting more than 65-weeks by the end of September 2024. Clinical and operational teams are working hard to deliver this, and our patients are helping this by attending their appointments (our DNA rate remains at 5% - well below the national average) and by telling us when they no longer want or need to remain on our waiting lists, through our contact and validation programme. Increasingly, we are working with partners near and far to ensure we can offer patients access to the treatment they need as quickly as possible, and we will continue to offer patients choice where we are able to do so.

Several of our other metrics that impact on our ability to treat patients as quickly as possible continue to improve and I'm particularly pleased in the delivery of Patient Initiated Follow ups, DNA rates, day case rates and theatre utilisation. There is more we can do in these areas and our theatre and outpatient programmes will be driving these forward further and faster.

Our Urgent and Emergency Care performance is showing improvement in several areas, and we are building a foundation through our patient flow work both within the Trust and with partners, which I am confident will start to show further improvement in the coming months. Our ambulance handover delays in the last three months are lower than the preceding three months, and we have also seen significant reduction in the length of the time outside, but I know all my colleagues at the Trust and across the system know that no delay is acceptable. Unfortunately, whilst we have seen some positive discharge numbers daily, a number of our patients have experienced significant stays in our hospitals waiting for complex pathway 3 discharge and Intensive Access and Rehabilitation. I know our place partners are working hard on a solution for these patients so that they can access the care they need in the most appropriate setting.

Our clinical divisions are developing operational delivery plans to increase the volumes of activity they can deliver through operational productivity so we can treat more patients this year particularly through the share and spread of the GIRFT Further Faster programme which will support us to help patients to attend their appointments, reduce the number of patients cancelled on the day of surgery and to ensure that we make best use of the resources we have across the organisation.

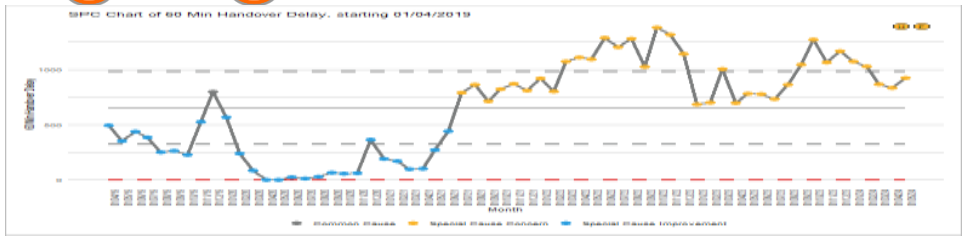
OUR OPERATIONAL PERFORMANCE - URGENT CARE

We are driving this measure because

The national Emergency Access Standard requires all patients to be seen, treated and either admitted or discharged within four hours of presentation at any Emergency Department. In addition, the effective and timely handover of patients arriving by ambulance enables patients waiting in the community to access care in a timelier manner and is an indicator of system flow.

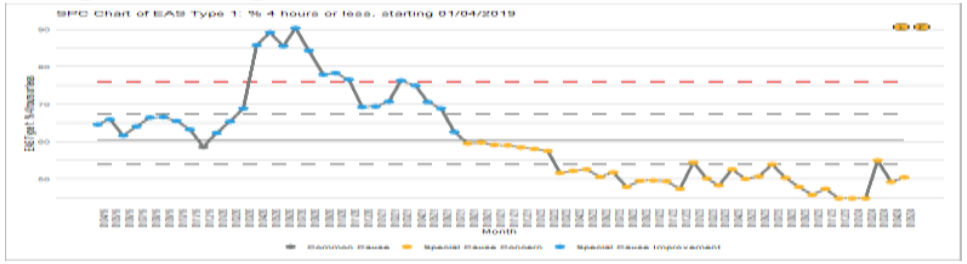
Assurance F **Variation** H

The Ambulance Handover metric is **deteriorating.** The target (0) lies below the process limits so we know that the **target will not be achieved** without change.



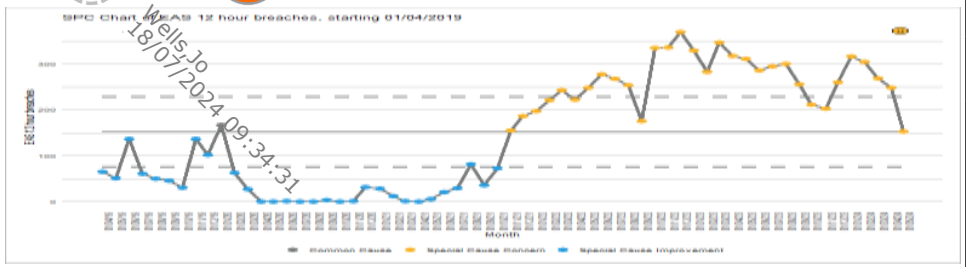
Assurance F **Variation** L

The EAS type 1 metric is **deteriorating.** The target (76%) lies above the process limits so we know that the **target will not be achieved** without change.



Assurance **Variation** H

The patients spending >12 hours in ED metric is **deteriorating.** There is currently no target for this metric.



Performance and Actions

13,447 patients attended the Trust's Emergency Departments in May-24; 928 more attendances than May-23 and the highest on record. 50.3% of those were treated and either admitted or discharged within four hours of arrival. There has been an increase of 8.5% in attendances compared to May-23, with a 10.5% increase in walk-in attendances.

Of the 3,920 patients who arrived by ambulance, 32% were 'handed over' within 15 minutes and 922 waited longer than 60 minutes to be handed over however total lost hours was down compared to the previous month and the preceding three months the total number of handover delays has decreased compared to the previous three-month period. 2,195 patients (16%) spent 12 hours or more in our emergency departments.

Update and Actions

- Single point of access in place – including 'call before convey' provision for West Midlands Ambulance Service with planned pilot access to CAD portal to support streaming into UCR and access to Adastra system to support management of patients referred via 111. WMAS call centre pilot planned for Q2.
- Continued focus on reducing ambulance handover delays as part of clinical site management role working with Emergency Department to reduce number and length of delays, with internal escalation process in place.
- GP streaming model under review, aligned to Place based UEC development of primary care overflow hubs
- Review of Directory of Services to support proactive divert away from Emergency Department
- Increased Surgical SDEC provision – working alongside Medical SDEC in the former Emergency Department Footprint.
- Frailty SDEC now live and undertaking an 8-week PDSA improvement cycle – impacted by use as surge area for bedded patients

Risks

- In-hospital and system flow constraints due to workforce and capacity
- Patient acuity
- Fluctuating demand
- Insufficient alternatives to Emergency Department for patient with urgent, non-emergency needs
- Closure of inpatient areas reducing available beds, impacting flow from ED and ability of Trust to meet Emergency Access standard

What the charts tell us

All three metrics have been a significant cause for concern since Jul-21.

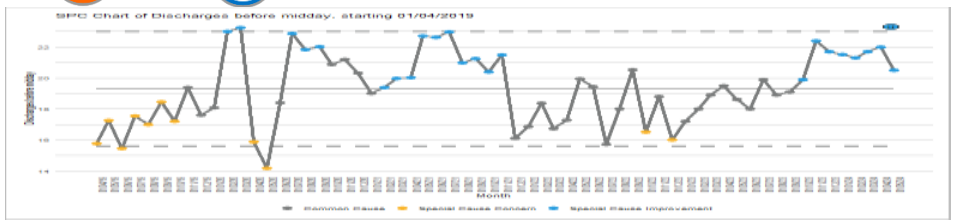
OUR OPERATIONAL PERFORMANCE – PATIENT FLOW

We are driving this measure because

Hospital flow is a significant contributor to overcrowding in the Trust' Emergency Departments and consequently on the safety of the Emergency Department. Improving these measures will support reduction in ambulance handover delays as well as reducing the time take patients stay in the Emergency Department. Most importantly, reducing the length of time patients are not in their usual place of residence (by reducing the length of stay) reduce the risks associated with functional hospital decline; and will enable those patients who need a bed in our hospitals to access the most appropriate bed in a timely manner.

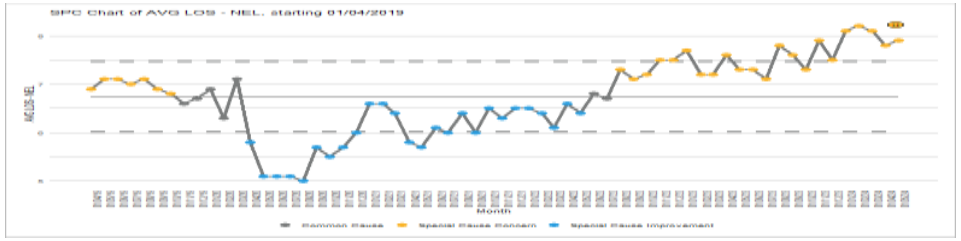
Assurance F **Variation** H

This metric is **improving.** The target (33%) lies above the process limits so we know that the **target will not be achieved** without change**.**



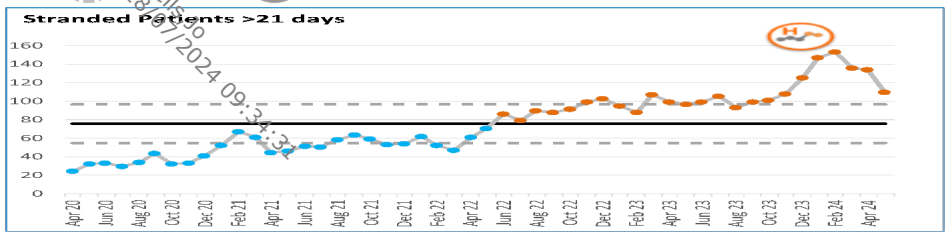
Assurance **Variation** H

This metric is **deteriorating.** There is no target for this metric.



Assurance **Variation** H

This metric is **deteriorating.** There is no target for this metric.



Performance and Actions

Discharges before midday showed no significant change in May-24 with an average of 21.9% of discharges occurring before midday. This is a contributory factor impacting on the Trust's ability to deliver effective hospital flow and ensure timely admission for patients from the Trust's Emergency Departments (and other emergency admissions). It is partially offset by patient utilisation of the discharge lounge on both acute sites.

The length of stay for non-elective admitted patients has continued to rise since August 2020 and remains on an upward trajectory. The Trust continues to utilise inpatient boarding as part of its escalation policy. There are internal and external drivers to this deteriorating position including the acuity of patients needing a longer acute phase of their treatment and the ongoing care needs leading to complex discharge pathways. Challenges with delays in discharge for patient requiring pathway three discharge and access to Intensive Access and Rehabilitation (IAR) have led to 25 patients contributing over 1,000 bed days because of discharge delays. Additional support required from place partners to reduce delays and facilitate timely discharge for these patients.

Actions include:

- Multi Agency Discharge Event (MADE) 11-24 June 24. Learning to be collated and actions added to patient flow programme has appropriate
- Integrated Frailty model programme – additional clinical staff recruited with start dates in June – August 2024, including additional nurse consultant posts and further recruitment planned in July
- Development of escalation process to support timely discharge and focus on patients with long length of stay
- Ward based metrics developed – monitored by patient flow team

With partners, other schemes to support system flow at Worcestershire place level include:

- Integrated approach to virtual wards with single clinical leadership
- Integrated approach to bed management
- Integrated Therapy service model

Risks

- Patient Acuity
- Clinical engagement
- Place partner support to enable timely discharge to IAR / pathway 3

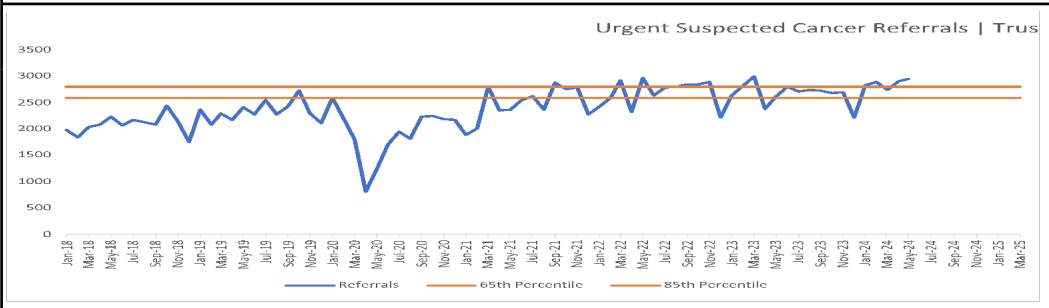
What the charts tell us

3,443 patients were discharged from G&A beds and 701 (20%) were before midday. The average LOS for a non-elective patient was 7.9 days; when you exclude patients for a zero LOS, this increases to 8.6 days.

OUR OPERATIONAL PERFORMANCE - CANCER | 28 DAY FASTER DIAGNOSIS STANDARD

We are driving this measure because

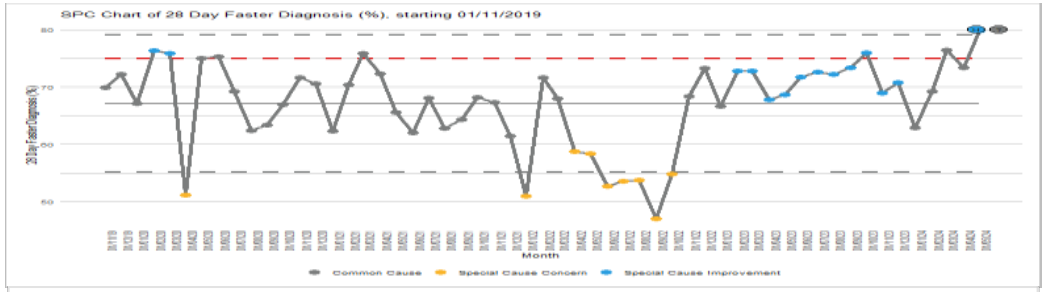
Cancer is one of the leading causes of mortality in the UK. Research suggest that someone in the UK is diagnosed with the disease every two minutes, and half of the population born since 1960 will be diagnosed with cancer in their lifetime. There are three key timeframes in which patients should be seen or treated as part of their pathway and those key measures are monitored in these slides. 75% of patients referred for suspected cancer should receive a diagnosis within 28 days (Faster Diagnosis Standard), 96% of patients should start their treatment with 31 days of a Decision to Treat and 85% of patients with a cancer diagnosis should start their treatment within 62 days.

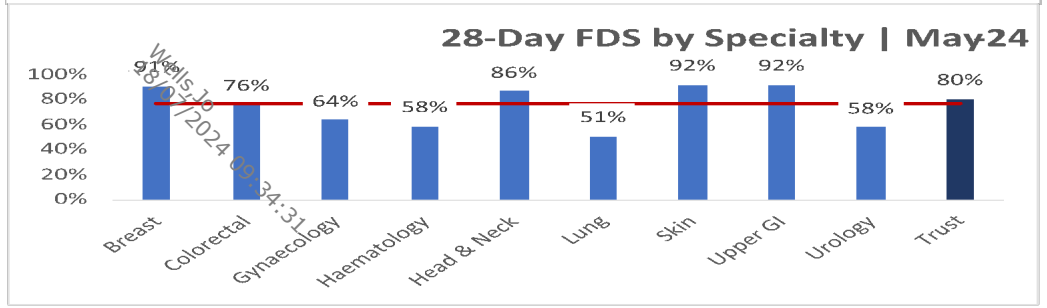


Assurance

Variation

This metric is **improving**. The target lies within the process limits so we know that the **target may or may not** be achieved**.**





Performance and Actions

There were 2,948 new GP referrals for suspected cancer in May-24. Our Trust **unvalidated** performance against the 28-day Faster Diagnosis Standard is currently 80% for May-24; this is the highest performance on record. The Trust informed 2,529 patients of their diagnosis with 488 breaches of the 28-days standard. Improvements have been particularly noticeable in colorectal and urology this month.

Updates and Actions

- At Trust level we are on track to deliver our annual planning commitments for FD though there remains variation in tumour site delivery. At month 2 (unvalidated) all tumour sites, except for lung, are in track to achieve tumour site level Q1 internal standards.
- Increasing focus on number of patients with cancer who are informed within 28-days as this is foundation for 62-day performance. A deep dive is being undertaken by Cancer Services FDS Lead in June 2024 to report back to Cancer Board July 2024.
- As forecast, colorectal has recovered its FDS performance in May.
- In Urology, triage capacity and post-MDT capacity continue to be reliant on additional capacity. Urology Intervention Unit due to open in Q2, with full impact expected from M6 into Q3. Pilot of Straight To Test MRI in August for agreed patient cohort in line with recognised good practice.
- Histopathology reporting supported by significant outsourcing of routine work to deliver 10-day turnaround time., with financial impact to the Trust.
- Cancer Bids submitted to NHSE regional team to support pump priming and short-term solutions in May 2024, pending outcome.

Risks

- Histology, radiology and urological clinical capacity for outpatient appointments remain an issue though this is improving through short term interventions
- Financial impact of additional capacity to support diagnostic pathway (particularly pathology and imaging)
- Impact on DM01 with focus of diagnostics capacity on cancer pathways

What the charts tell us

Referrals are above 85th percentile and third highest month on record. 28-FDS performance shows special cause improvement. Five specialties achieved the Mar-25 standard of 77%.

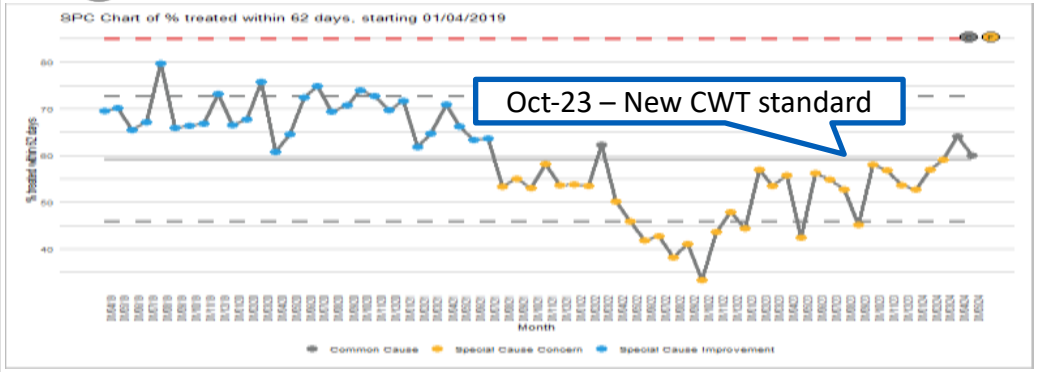
OUR OPERATIONAL PERFORMANCE - CANCER | 62 DAY & 31 DAY START OF TREATMENT STANDARD

We are driving this measure because

Cancer is one of the leading causes of mortality in the UK. Research suggest that someone in the UK is diagnosed with the disease every two minutes, and half of the population born since 1960 will be diagnosed with cancer in their lifetime. There are three key timeframes in which patients should be seen or treated as part of their pathway and those key measures are monitored in these slides. 75% of patients referred for suspected cancer should receive a diagnosis within 28 days (Faster Diagnosis Standard), 96% of patients should start their treatment with 31 days of a Decision to Treat and 85% of patients with a cancer diagnosis should start their treatment within 62 days.

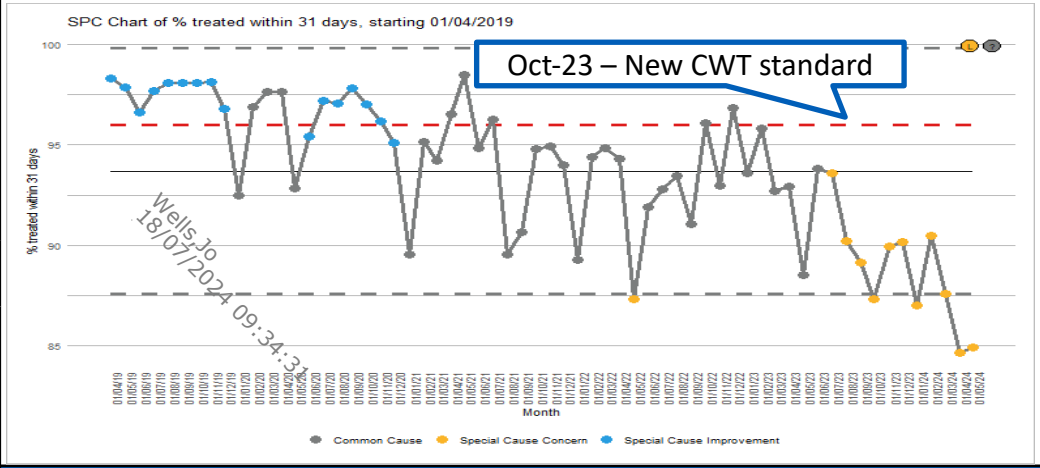
Assurance **Variation**

This metric is **not changing significantly**. The target lies above the process limits so we know that the **target will not be achieved** without change.



Assurance **Variation**

This metric is **deteriorating.** The target lies within the process limits so we know that the **target may or may not** be achieved.



Performance and Actions

The Trust's **unvalidated** position for 62 days cancer waiting time performance in May-24 is 61% with 134 recorded breaches and 340 patients treated. Our internal target for Q1 of 62% is expected to be achieved at Trust level with variation between specialties. Of note, Breast, Head and Neck, Lung and skin are off track.

Those patient waiting longer than 62 days (cancer backlog) continues to be reviewed and monitored daily. Quarterly targets have been confirmed at specialty level for **all pathways** (not just urgent suspected which was the focus in 23/24) with a year-end target of no more than 110 patients over 62 days and no patients over 104 days at the end of September. There were 218 (+20 from April) patients over 62 days at the end of May, 48 (-1 from April) of whom were over 104 days.

575 patients were recorded as receiving first or subsequent treatment after decision to treat in May-24, however, only 85% were treated within 31 days. Timeliness of first treatment and subsequent surgery treatments are the areas to improve.

Many of the drivers for performance align to the FDS performance. A focus on improving performance against the FDS standards for patients with cancer is being driven through the Elective and Cancer Delivery Group and Cancer Board, with deepdive being completed in June before reporting to Cancer Board in July 2024. In addition, there are challenges with treatment capacity in some specialties driven by a combination of access to appropriate theatre capacity and clinical vacancies.

- Breast – mismatch theatre capacity and demand – review of theatre allocation to be completed by August 2024.
- Head and Neck – access to beds on Worcestershire Royal site due to bed pressures. Additional Head and Neck surgeon being recruited, theatre schedule under review.
- Lung – tertiary and oncology access limiting performance.
- Skin – clearance of treatment backlog – expected to be complete in June 2024, with 62-day performance to recover from July 2024.
- Oncology capacity is impacting performance in several tumour sites – additional capacity clinics continue to support delivery however these are not sustainable in the long term, which represents a risk to delivery. Longer term workforce plan in development and expected in July 2024. Strategic partnerships to be explored to support sustainability.

Risks

- Ongoing impact of industrial action
- Histology, radiology and urological diagnostic capacity remain an issue
- Consultant capacity in Oncology
- Waiting times at Tertiary Centres

What the charts tell us

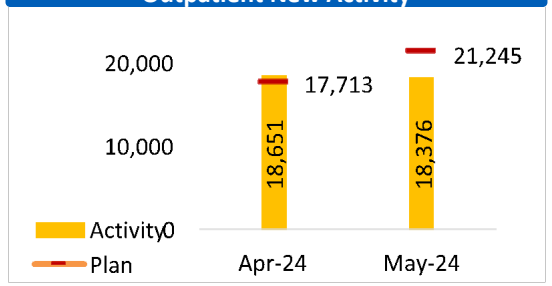
The CWT 85% target for 62 days has never been achieved, however, has transitioned from special cause concern to normal variation. 31-day has been special cause concern since Feb-23.

OUR OPERATIONAL PERFORMANCE - ELECTIVE RECOVERY

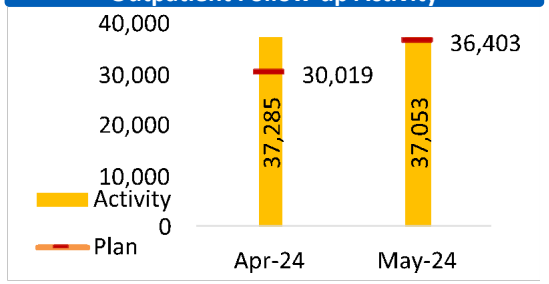
We are driving this measure because

Elective recovery is a key priority to ensure that patients can access the treatment they need in as timely a manner as possible. To reduce the impact of waiting for non-urgent, consultant-led treatment, the Trust made a commitment to deliver a maximum wait of 65 weeks by the end of the Sep-24 as part of our journey to recovering the 18-week Referral to Treatment standard as set out in the NHS constitution; and put in place annual activity plans to enable this.

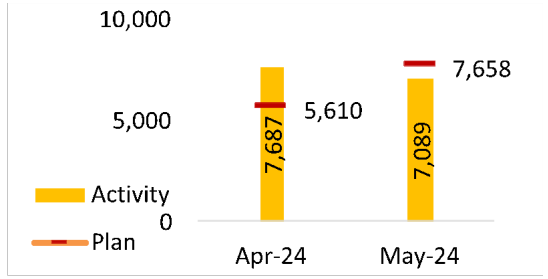
Outpatient New Activity



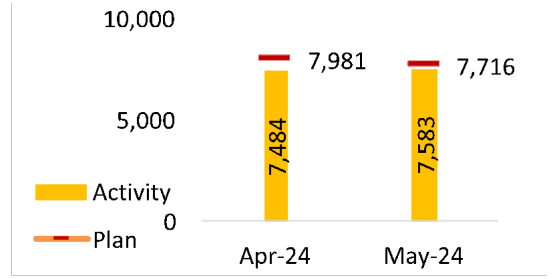
Outpatient Follow-up Activity



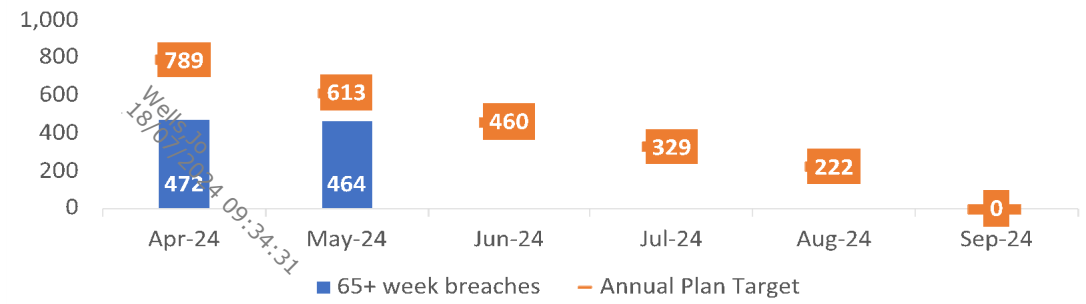
Outpatient Activity with a Procedure



Day Care and EL IP Activity



RTT 65+ Week Breaches Compared to Annual Plan Target



Performance and Actions

In May-24 (unvalidated), the Trust delivered 18,376 new outpatient appointments (-2,869 below plan) and 37,053 follow up appointments (+650 above plan). In-line with 24/25 annual planning guidance, we are now reporting on Outpatient appointments with a procedure which was -569 below plan. Inpatient and day case activity was below plan by 133 cases.

RTT unvalidated submission for May-24 is 2,089 patients waiting over 52 weeks, of whom 464 were waiting over 65 weeks, 14 over 78 weeks and there were no patients waiting over 104 weeks. Specialties of greatest concern for 65-weeks include Oral Surgery (>200) and ENT (>130) patients breaching at month end.

Actions

- Rolling 12-week patient contact and validation programme with patients on waiting list to confirm their ongoing position on waiting list – over 90% of patients contacted in previous 12 weeks in line with regional validation ambition
- Daily monitoring of 78-week risk cohort within surgery by Divisional Operations Director – decreasing at risk cohort. Expect to eliminate all except patient choice by June 2024.
- Reduction in total September 65-week cohort to 3471 as at end of May 2024, compared to 7574 at end of March 2024. Largest cohorts in Oral and Maxillofacial Surgery (753), ENT (665) and Urology (479)
- From cohort above, 254 undated for first OPA as at end of May – with 171 in Urology. Plans in place for these to be seen by mid-July.
- Additional mutual aid support for ENT from foundation group members and other NHS providers
- Focus on theatre productivity and cases per list through theatre programme and expansion of right procedure right place workstream. Review of specialty theatre allocation – target August 2024.
- Trust Access policy being refreshed to align to latest guidance – Approval target July 2024
- Additional capacity and productivity opportunities to support delivery – focus on outpatient transformation and impact of GIRFT Further Faster as well as full year impact of additional theatre capacity at Alexandra Hospital site.
- Focus on reducing elective length of stay – particularly for hip and knee replacements, supported by GIRFT programme (Anaesthetics and Peri-operative Medicine). First for Worcestershire Day case knee replacement completed April 2024, with further procedures completed and more planned. Additional support services support to implement sustainable delivery to reduce bed days and requirement for inpatient beds.
- Extension of theatre provision across 2.5 sessions , 6 days per week to be rolled out as part of Elective Hub to increase utilisation of available estate. Theatre hub accreditation visit planned 24 June 2024 to Kidderminster site.
- Options to support more rapid access to elective care through strategic partnerships to be explored to delivery overall reduction in elective waiting list by March 2025. Scoping phase through Q2.

Risks

- Urgent care demand impacting physical capacity and staffing
- Workforce challenges

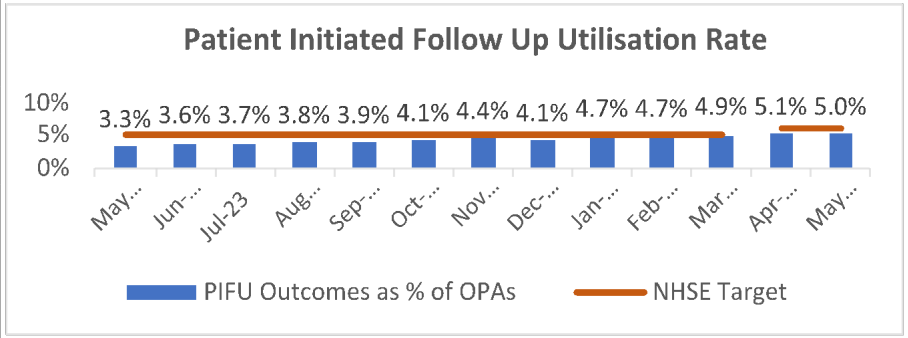
What the charts tell us

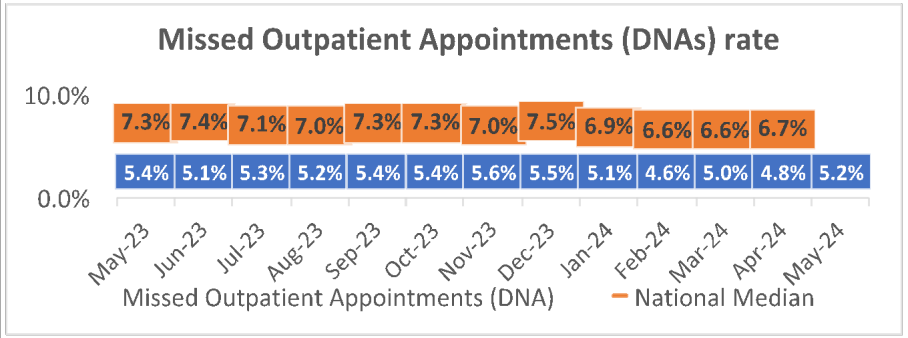
The bullet charts above compare our unvalidated activity for Apr-24 and May-24 to our submitted plan for 24/25. May-24 data is currently showing that we are below plan for OPA New, OPA with a procedure and total Day Case and EL activity. We also delivered more OPA follow-ups than was submitted as part of our annual plan.

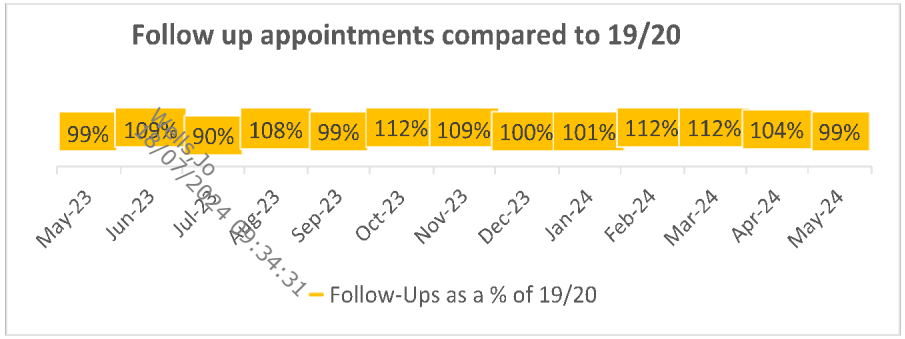
OUR OPERATIONAL PERFORMANCE - OUTPATIENT TRANSFORMATION

We are driving this measure because

Transforming and modernising how we deliver outpatient services so patients can be seen more quickly and interact with services in a way that suits their lives. This in turn, enables faster diagnosis and treatment to support Trust delivery of Referral to Treatment times as well as ensuring patients have more control and greater choice over how and when they access care.







Performance and Actions

Outpatient Transformation encompasses a broad remit. The focus in this report is on those elements that form part of annual plan expectations and immediate operational delivery, rather than the broader Trust Outpatients Transformation Programme.

Performance in Patient Initiated Follow Up (PIFU) is 5.0% in May-24. It continues to be the case that a large percentage of specialties are delivering PIFU more than their national median comparator.

Trust wide DNA rate in May-24 was 5.2% and remains below the national median benchmarking though at a specialty level there is some variation.

Actions

- Continued rollout and update in Patient Initiated Follow Up (PIFU) using new national toolkit – focussing on ENT, Oral and Maxillofacial surgery and Respiratory. Specific scheme support PIFU in Cardiology hot clinic activity
- Review of digital systems to support patient monitoring as part of remote monitoring schemes to enable increased PIFU
- DNA audit to commence w/c 10 June – contacting circa 2000 patients to understand drivers for not attending to inform further actions within Trust's DNA improvement plan
- Pilot of outpatient room booking system underway June 2024. System developed in-house. Subject to pilot, rollout plan to be developed by Outpatient Programme with operational oversight.
- Optimising treatment options through outpatient setting.
- Continued focus on waiting list validation, with rollout for non-RTT patients planned in Q2. Over 90% of patients on RTT waiting list validated within last 12 weeks.
- Focus on non-RTT backlog including overdue follow-up and patients on active monitoring.
- Relaunch of virtual consultation options planned for July 2024 utilising NHS England best practice toolkit

Risks

- Clinical engagement
- Capacity to implement changes alongside day-to-day operational delivery
- Balance between Advice & guidance response and outpatient appointment activity – impact on waiting times and financial impact
- Finance available to invest in people and technical solutions
- Size of follow-up waiting list limits opportunity to reduce follow-ups

What the charts tell us

PIFU – PIFU rate remains above 5%. **DNAs** remain below the national median with ~2,900 OP appointments a month currently being missed due to DNA. **Follow-Up reduction** – unvalidated data for May-24 shows that we delivered 1% fewer follows up compared to May-19 (~300 appointments).

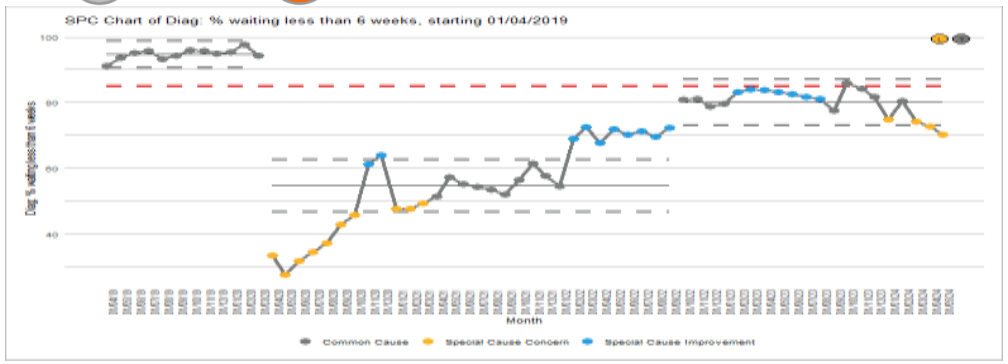
OUR OPERATIONAL PERFORMANCE – DIAGNOSTIC TESTING (DM01)

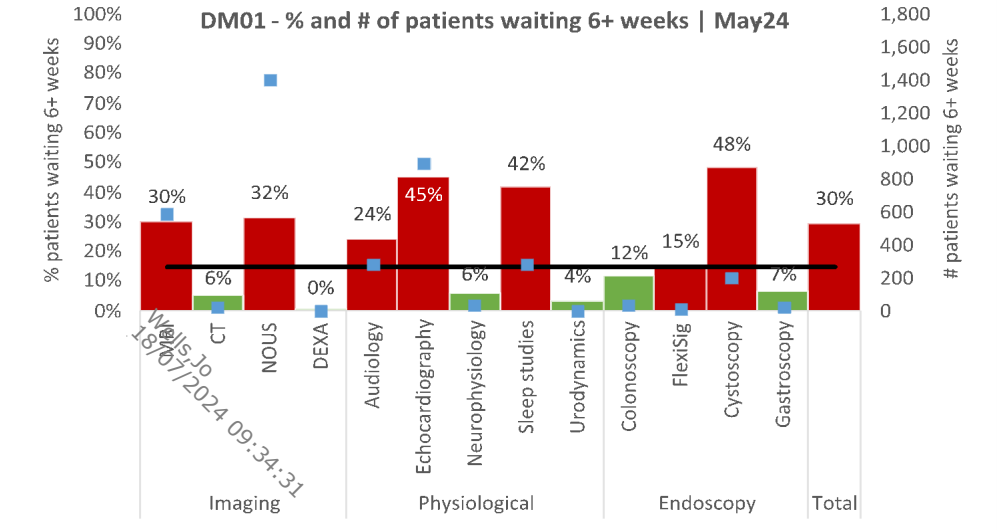
We are driving this measure because

Early diagnosis is important to patients and central to improving outcomes, for example early diagnosis of cancer improves survival rates. Bottlenecks in diagnostic services can significantly lengthen patient waiting times to start treatment.

Assurance **Variation**

This metric is **deteriorating.** The target lies within the process limits so we know that the **target may or may not** be achieved**.**





Performance and Actions

Our validated performance at the end of May-24 was 70% of our patients waiting less than 6 weeks (30% over 6 weeks) with 3,809 of them waiting over 6 weeks, of whom 894 were waiting over 13 weeks. The deterioration in performance observed in the last few months can be attributed to multiple modalities (second graph on the left).

Updates and Actions

Echocardiography

- Mismatch demand and capacity, impacted by vacancies within cardiopulmonary team – reliance on additional capacity outside of core to deliver service. Additional capacity delivery plan in place ahead of implementation of endoscopy support worker workforce plan

Audiology Assessments

- Recovery Trajectory and action plan in in place with ICB support. Trajectory to eliminate 13 week waits in Q2.

MRI

- Recent deterioration linked directly to increased focus on delivery of cancer standards with additional carve out to respond to increased demand, particularly in urology cancer because of media interest
- Additional mobile capacity from Wye Valley increases short term capacity with medium – long term strategic options being developed and expected August 2024
- Imaging Strategy in development – expected Q3.

Urology (Cystoscopy and Urodynamics)

- Urology diagnostic tests remain challenged though recent improvements in urodynamics shifts focus to cystoscopy.
- Increased capacity planned as part of Urology Intervention Unit business case. Implementation programme for UIU supported by Cancer Improvement Director. Recruitment in progress with phased increased in UIU capacity from June 2024, with full capacity expected September 2024

Sleep Studies

- Impacted by year-on-year increase in referrals
- Case set out for additional respiratory physiology staff – planned July 2024. following completion of demand and capacity
- Introduction of PIFU to sleep services to support capacity for sleep studies

Risks

- Financial impact due to reliance on additional capacity
- Delays in diagnostics impact elective and cancer recovery
- Competing priorities for diagnostics modalities (balancing cancer recovery, and Diagnostics waiting time standards)
- Ensuring sufficient capacity for surveillance patients for surveillance scans and tests

What the charts tell us

The first chart shows that performance of 70% is special cause concern; the fourth time since re-baselining the data. The second chart shows e.g. that 32% of non-obstetric ultrasound's (NOUS) waiting list is waiting > 6 weeks and this is 1,464 patients (the blue square).

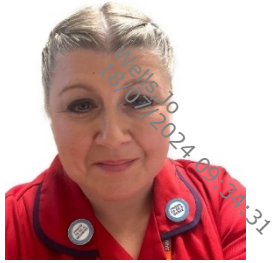
OUR QUALITY & SAFETY

Dr Jules Walton

Joint Chief Medical Officer

Dr Julian Berlet

Joint Chief Medical Officer



Sarah Shingler

Chief Nursing Officer

For the 54th consecutive month, our Trust Mortality Indices remain within expected range. The slightly increased SHMI observed at the Alexandra Site compared to the Worcestershire Royal site is being reviewed by our analytical team to understand the reasons for this and identify any actions required. We are seeing a "higher than expected" SHMI in one diagnostic group only – fluid and electrolyte disorders. This correlates with themes being observed through our Patient Safety Incident Review Group and work is underway to review themes relating to nutrition and hydration and identify appropriate actions.

The data for Sepsis screening is now being collected directly from our Electronic Patient Record. The first month of data is disappointing, but we are working with Divisions to improve compliance with the capture of this important information. Reassuringly, Sepsis mortality figures remain stable and within expected range.

The targets for 24/25 have not yet been published, however it is noted that in May 24 Klebsiella increased compared to April showing special cause variation of concern, whereas MRSA was unchanged and C.Diff, MSSA and pseudomonas decreased. There have been no flu outbreaks in May 24, and although covid and CPE outbreaks have continued they have been effectively managed with bay and ward closures. All 11 of the high impact intervention audits were compliant in May-24.

The complaint compliance target to close within 25 days increased to 62.0% but did not meet the target. The Trust had 127 complaints still open at the end of May 24, and there were 66 new formal complaints received with 36% called within 5 days to discuss the complaint. Of the 127 open complaints, 39 have breached 25 days, of which 32 are within the surgery division. There are specific actions regarding the complaints process within the Surgical Division.

The total number of falls remains below the national benchmark in May 24 with 4.33 total falls per 1,000 bed days (national benchmark of 6.63). There were no SI falls in May 24. The total number of HAPUs in May 24 was 28 (1.0 HAPU per 1,000 bed days), which is an increase from last month. There were zero HAPUs causing harm in May 24, and the overall staff PUP training compliance has increased to 79.8%.

The friends and family response rates and recommended rates have failed to meet the recommended target (95%) across, outpatients, A&E and Maternity in May 24 whilst inpatient wards remain unchanged (93.7%) . Patient Experience Lead Nurse and Quality Matron to monitor and will be reviewing the use of FFT throughout QAV visits and Ward Accreditation processes. A new Maternity Patient Experience Lead is now in post who will be engaging and launching methods of gaining feedback from all maternity areas and making links with Maternity Neonatal Voices Partnership. The use of posters and text messaging are also being utilised to meet the needs of population age group. All governance managers are aware of the FFT results for their divisions via Patient Carer and Public engagement meeting and have been asked to raise awareness at internal meetings about the decrease and to action and promote feedback making every contact count. However, the inpatient survey results have been launched for the first time in May (50 surveys per ward, per month).

OUR QUALITY & SAFETY - IMPROVE DELIVERY IN RESPECT OF THE SEPIS SIX BUNDLE

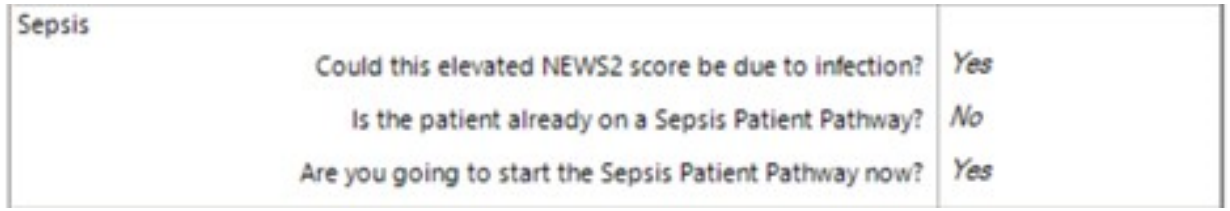
We are driving this measure because

Sepsis with shock is a life-threatening condition affecting all ages. NCEPOD 2015 highlighted sepsis as being a leading cause of avoidable death that kills more people than breast, bowel and prostate cancer combined.

Performance

- The SEPSIS EPR changes were implemented on the 8th May 2024.
- SEPSIS compliance results are now available on WREN.
- This shows that for May-24, after exclusions were applied (see WREN report for details) there were 155 observations with a NEWS>=5, of which 44.52% (69) had a SEPSIS pathway document completed.
- Of the 38 diagnosed as Septic, 3 (7.89%) had the complete SEPSIS 6 bundle completed in 1 hour.

Unfortunately, the new questions which were released on the Vital Signs document, and were meant to help with compliance reporting, are not being completed regularly (currently around 5%).



- If either the first question is answered ‘No’, or the second question as ‘Yes’ then the observation is excluded from compliance reporting. And could have a significant effect on the score.
- The compliance report on WREN includes a Data Quality section illustrating this issue.

Actions

- Review with Division teams first month of EPR data to identify improvement actions
- Working group planned to monitor and drive actions

Risks

Ambulance offload delays 3908
Crowding in Emergency Departments 4843, 4963, 4964
Insufficient staffing to deliver safe, timely care 3698, 4192

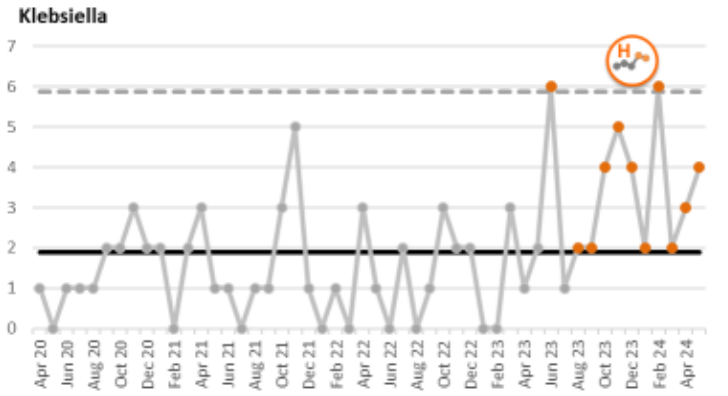
What the charts tell us

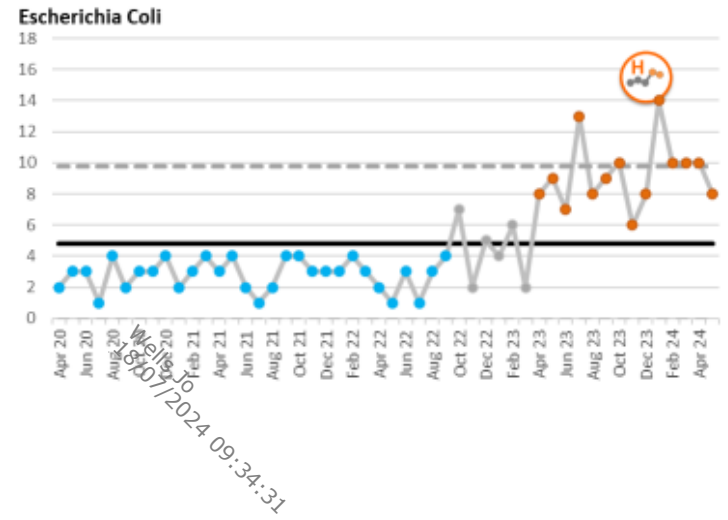
n/a

OUR QUALITY & SAFETY – INFECTION PREVENTION AND CONTROL

We are driving this measure because

There is a need to embed our current infection prevention and control policies and practices and achieve Full compliance with our Key Standards to Prevent Infection, specifically Hand Hygiene above 97%, Cleanliness in line with national standards and ongoing care of invasive devices.





Performance and Actions

- 2024/25 targets have not yet been published.
- Klebsiella (4) increased in May-24 compared to Apr-24 and is showing special cause variation of concern.
- MRSA (0) was unchanged in May-24 and is showing common cause variation.
- C.Diff (10), MSSA (3) and Pseudomonas (1) dropped in May-24 and are showing common cause variation.
- E-Coli (8) dropped in May-24 but has shown special cause variation of concern for 10 months.
- To date in Jun-24 there have been the following new outbreaks:
  COVID: Wards - Alex Ward 12 (10/06), Alex Ward 15 (07/06)
  COVID: Bay closures – WRH PDU (07/06)
  CPE: Bay closures – WRH ARU (07/06), Alex Ward 14 (10/06)
- All 11 of the high impact intervention audits were compliant in May-24.
- Three of these audits were 100% compliant - *"Prevent ventilator associated pneumonia", "Prevent surgical site infection - Preoperative phase" and "Prevent infection in chronic wounds"*

Actions

- PVD champion program being developed
- PVD packs promoted
- Finalising the PSIRF Cdiff actions to gain more contemporaneous learning, Divisional action plans in place
- BSI will follow the same process once Cdiff process in place
- Audit reviews of all areas where there has been a BSI/HCAI case – ward action plans in place
- CPE – HPV completed, and environmental swabs taken – all negative, concerned as not able to identify source, spray arm and food macerators removed/not in use. Continue to complete patient screening on admission.

Risks

Capacity: Level 4 actions impact on IPC actions as planned meetings involving clinical staff have been cancelled. IPC staffing senior nursing team leaving, IPC consultancy as an interim measure.

What the charts tell us

- Hand Hygiene Compliance has exceeded the target for the (98%) for the past 2 years and is showing common cause variation.
- However, Hand Hygiene Audit participation is still not compliant with the target (100%) but is showing special cause variation of improvement.

Infection Prevention and Control Benchmarking

Source: Fingertips / Public Health Data (Latest data Mar-24, accessed 11/06/2024)

C. Difficile – Out of 23 Acute Trusts in the Midlands (range 0 to 43.0), our Trust sits the 22 nd best, and is **above** both the Midlands and England rates.

E.Coli – Out of the 23 Acute Trusts in the Midlands (range 8.9 to 37.3), our Trust sits the 19 th best and is **below** the England rate, but **above** the Midlands rates.

MSSA – Out of 23 Acute Trusts in the Midlands (range 0 to 16.6), our Trust sits the 21 st best, and is **above** both the Midlands and England rates.

MRSA – Out of the 23 Acute Trusts in the Midlands (range 0 to 3.9), our Trust sits 11 th best, 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	7,517	21.0
Midlands NHS Region (Pre ICB)	1,454	21.6
Worcestershire Acute Hospitals	93	34.3

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

Area	Count	Per 100,000 bed days
England	8,141	22.7
Midlands NHS Region (Pre ICB)	1,388	20.6
Worcestershire Acute Hospitals	58	21.4

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

Area	Count	Per 100,000 bed days
England	3,872	10.8
Midlands NHS Region (Pre ICB)	602	8.9
Worcestershire Acute Hospitals	34	12.6

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

Area	Count	Per 100,000 bed days
England	566	1.6
Midlands NHS Region (Pre ICB)	74	1.1
Worcestershire Acute Hospitals	2	0.7

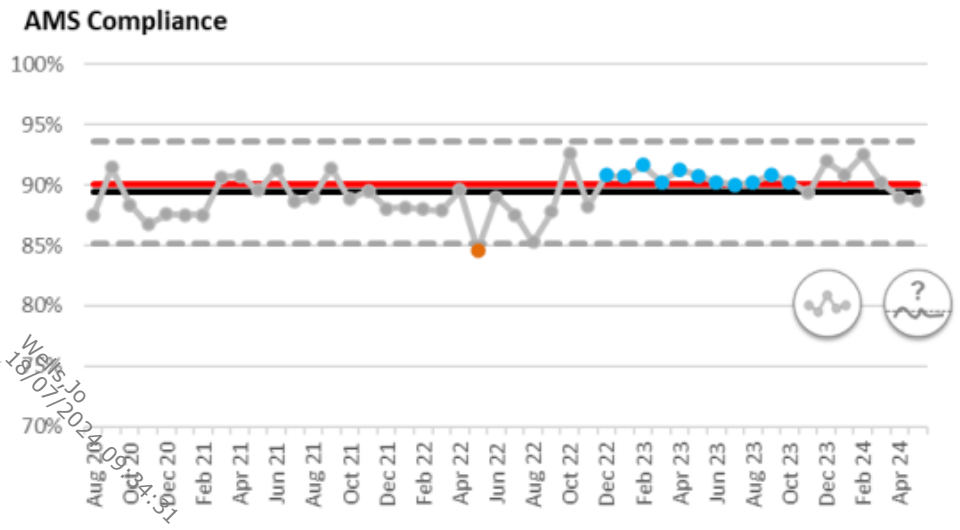
OUR QUALITY & SAFETY – ANTIMICROBIAL STEWARDSHIP

We are driving this measure because

We need an approach to promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness and using Start Smart The Focus principles to reduce the risk of antimicrobial resistance (AMR) while safeguarding the quality of care for patients with infection.

Performance

- A total of 340 audits were submitted in May-24, compared to 314 in Apr-24.
- Antimicrobial Stewardship overall compliance dropped slightly in May-24 to 88.70% (from 88.97%) and failed to achieve the target.
- Four of the elements are compliant with the target: “Antibiotics In Line with Guidance” (91.92%), “Documented on the Drug Chart” (96.44%), “Reviewed Within 72 hours” (92.79%) and “Test Results Been Reviewed” (97.51%)
- Four of the elements are non-compliant with the target: “Drug Allergy Status” (77.06%), “Appropriate Tests Requested” (82.90%), “Duration of IV” (89.30%) and “Duration of Antimicrobial” (79.60%).



Actions

- Focus on monthly audits and identify actions to drive improvement in quality (KPIs)
- Continuing to monitor the compliance with antimicrobial guidelines and consumption to achieve reduction targets specified in standard contract for Watch and Reserve categories- continue towards 10% reduction.
- Reviewing and developing an overarching C diff strategic action plan is underway to help inform divisional action plans to reduce cases where antibiotics may be implicated.
- Promoting IV to oral switches of antibiotics (target for 24/25 is Achieving 15% (or fewer) patients still receiving IV antibiotics past the point at which they meet switching criteria. Minimum < 25% and maximum 15% (lower % indicates better performance), and reducing length of course (e.g. reviewing PGDs and over-labelled prep-packs for 5 days cf 7 days).
- Reviewed the Antimicrobial Stewardship terms of reference including format and frequency of meetings to encourage wider stakeholder engagement including nurses and advanced clinical practitioners. Encouraging response to request for nursing attendance with first meeting at the end of June.
- Reviewed the Antimicrobial Stewardship policy and included role of group in reviewing patient group directives and role in implementing EPMA.
- Engaging with the ePMA team to ensure the system can support antimicrobial stewardship including documentation of allergies, length of course and compliance with guidance.
- Collaborating with the ICS Antimicrobial Resistance Forum to develop action plans to improve medicines optimisation and response to the UKHSA 5 year national plan

Risks

- Operational pressures and medical industrial action prevent necessary attention to AMS

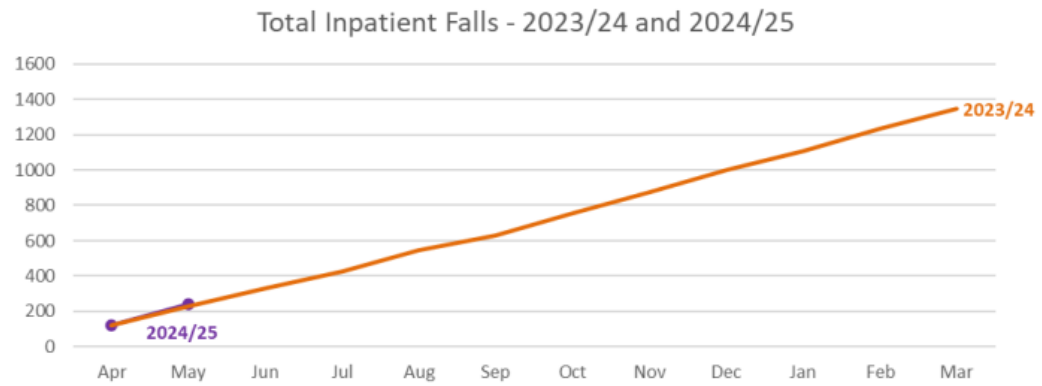
What the charts tell us

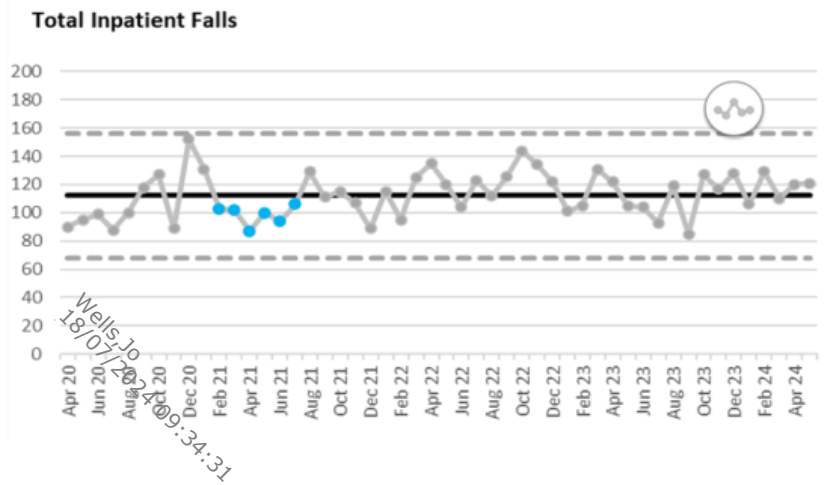
This metric has shown common cause variation for the last 7 months.

OUR QUALITY & SAFETY - FALLS

We are driving this measure because

Falls and falls related injuries are a major cause of disability and the leading cause of mortality due to injury in older people in the UK. Falls are associated with increased length of stay, additional surgery and unplanned treatment.





Performance and Actions

Total Inpatient Falls

- The total monthly number of falls increased slightly in May-24 (121 c.f. Apr-24 120).
- The year-to-date total falls is 241, which is higher than this time last year (227).
- Of these 121 falls the harm caused was: 35 Insignificant, 80 Minor, 5 Moderate & 1 Severe.
- We remained under the national benchmark with 4.33 Total Falls per 1,000 Bed Days (national target 6.63).

Inpatient falls resulting in Serious Harm

- There were 0 SI falls in Apr-24.
- The year-to-date total SI falls is 0, which is the same as this time last year.

Actions

- Continue to monitor all falls, including falls with harm weekly, identifying hotspot areas where quality improvement projects (QIP) may be required.
- All Divisions to participate in #EndPJParalysis audit.
- Divisions to improve participation of #EndPJParalysis audit
- Additional flay lifting equipment for WRH. Loan from AGH until delivery.

Risks

5470: Delayed Access to Flat Lifting Equipment (Hoverjack) Impacting Patient Outcomes – action above

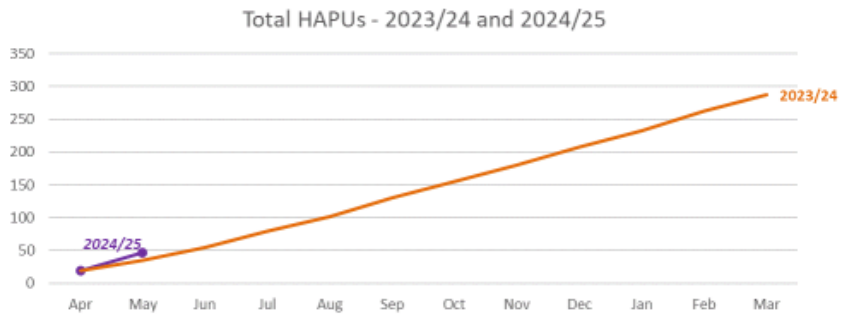
What the charts tell us

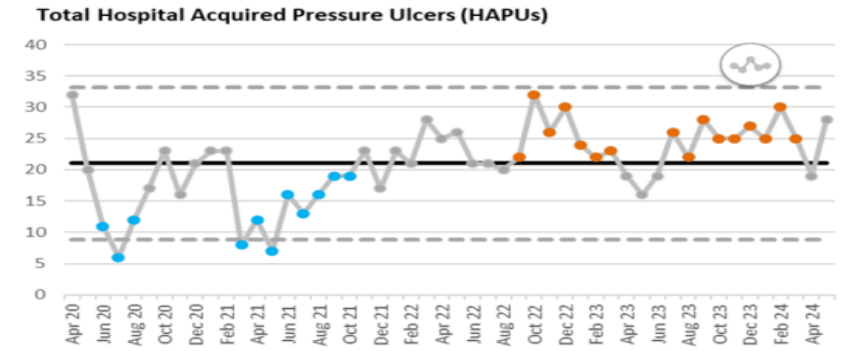
The total number of Inpatient falls is showing common cause variation.
Inpatient falls causing serious harm has shown special cause variation of improvement for 10 months.

OUR QUALITY & SAFETY – PRESSURE ULCERS

We are driving this measure because

In support of WAHT Quality and Patient safety plan priorities to improve on our progress achieved in reducing the number of causative hospital acquired pressure ulcers (HAPU).





Total HAPUs per 1,000 bed days increased in May-24 to 1.0 (0.72 in Apr)

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2023/24	Actual	0.83	0.67	0.81	1.13	0.90	1.20	1.07	0.98	1.09	0.93	1.16	0.91
2024/25	Actual	0.72	1.00										

Performance and Actions

Total HAPU's

- The number of HAPUs increased in May-24 to 28 (19 in Apr).
- The year-to-date number of HAPUs is 47, which is higher than the same time last year (35)
- Total HAPUs as a % of Emergency Admissions also increased to 0.75% in May (from 0.50% in Apr)

***Note an increase of beds on both sites compared to 2023 ***

HAPU's causing Harm

- The year-to-date number of HAPUs causing harm is 1, which is the same as this time last year.
- CAT 3 :Evolvement from SDTI Moderate harm with NEW learning identified

Actions

- **Staff PUP training :** May 24 = **Overall 79.8 % (3011 out of 3769 staff)**
  April 24 = overall 75.6% (2824 out of 3734 staff)

➢ New Monthly TV Divisional Governance improvement group feedback :

Learning Identified:	Actions:
Importance of Regular Repositioning of Vulnerable patients	**Ensure daily discussion in ward safety huddles**
Importance improved Waterlow documentation	**Waterlow Top Tips circulated to all ward areas to aid with PUP implementation**
Agency Nurse training	**Workforce Lead & NHSP working on**
Nutritional /Dietician support for patients with known Pressure damage	**TV raised with Lead Dietician to discuss process to ensure timely review of patients with pressure damage**
Inconsistent Completion of TV documentation in ED depts on both sites	**TV Team arranged & delivered education /support with accurate documentation completion**
Need to increase staff education /PUP training %s	**TV advised to send staff on Face 2 Face training**

Examples of good practice (extracted from monthly Divisional TV steering group slides)

Spec Med Division
Decrease in HAPUs in April
Spec Med Newsletter to disseminate good practice.

SCSD:
Laurel 2 will be doing some improvement project around minimising pressure damage with MSCC patients who are extremely vulnerable. A teaching package for new starters has been created.

SURGERY:
Watch & wait Pressure damage improved with pressure area care.

Urgent Care:
Weekly Divisional Governance 5 weekly TV Focus

Continue to support divisions with Educational Training programmes training for all health professional : PUP , Care certificate, Clinical advisors delivering training to ward areas.

- Essential to role PUP training to improve divisional training continues .

Risks

5306 (score 10) Incomplete Sskin Bundle completion
5173 (score 10) EPR TV documentation , increased risk inability for staff to document safe care.
5003 (score 10) TV vacancies : timely reviews affected .

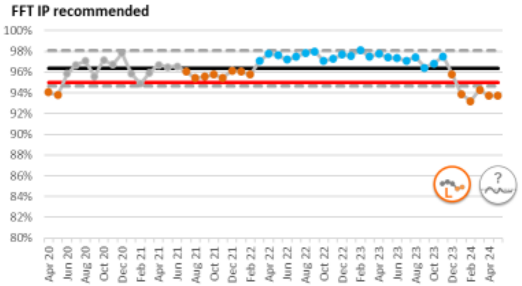
What the charts tell us

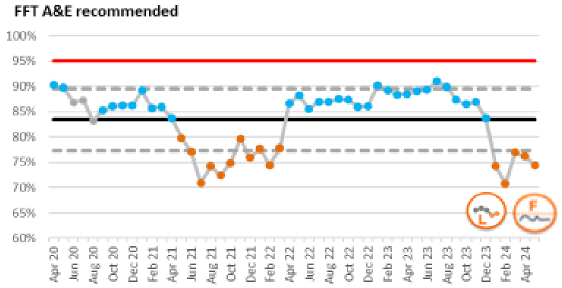
Total Hospital Acquired Pressure Ulcers is now showing common cause variation
Hospital Acquired Pressure Ulcers Causing Harm is also showing common cause variation

OUR QUALITY & SAFETY – FRIENDS AND FAMILY

We are driving this measure because

Our patients and their carers will be provided with a variety of methods for providing feedback on their experiences of our services, to ensure learning and improvements can be prioritised.





Please note that Y axis does not always start at zero.

Performance

- FFT recommended rates in May-24 dropped for A&E (down 1.8% to 74.4%), Maternity (down 8.3% to 91.7%) and OP slightly (down 0.3% to 93.6%), whilst IP (93.7%) remained unchanged.
- All areas were non-compliant with the target (95%).
- Inpatients has failed to reach the recommended target for the last 5 months (although still over 93% each month), having previously been compliant every month since Feb-21.
- Outpatients has failed to reach the recommended target for the last 5 months (although still reaching 93% every month), having previously been compliant every month since Aug-22.
- Although A&E have never met the recommended target, they had been above 85% since Apr-22 until the last 6 months.
- Maternity achieved the recommended target for 4 of the last 6 months

Risks

When patients leave FFT comments via text they have the ability to leave feedback only for the area they have resided on the longest amount of time e.g. the ward so the other areas A&E, MAU may not get feedback unless they were specifically asked to feedback whilst in that department.
Maternity – Following the trial and review, if FFT paper feedback does not increase percentages for feedback, the Trust will need to consider other data collection methods alongside West Midlands Peer Group actions taken to increase response rates.

Actions

Ongoing review of the use of FFT cards, texting and poster QR codes by Lead Nurse for Patient Experience & Quality Matron. Feedback should be easily accessible.
QAV and Ward Accreditation assessments to also review FFT used across areas and ongoing promotion to get feedback.

Communication sent in June to Matrons and Governance Managers so this can be reviewed within their areas and discussed at ward meetings and also placed on the daily task boards alongside the Inpatient Survey – so staff actively ask and promote feedback from patients and their families.

Maternity – new Patient Experience Lead continues to engage by launching methods of gaining feedback from all maternity areas and making links with Maternity Neonatal Voices Partnership to see how feedback can be shared. Close working planned between PE leads to improve rates. Considering the use of posters, text messaging to meet the needs of the population age group.
Maternity are having ongoing talks with IT and informatics to see if they can send text messages through PAS on Discharge from the ward and being able to select a more specific location on the FFT so a report on individual areas can be created this will hopefully boost staff engagement by getting specific feedback for their area..

A new FFT card has been developed which will be for Inpatients, Outpatients and A&E thereby making a 'generic' card that is not specifically for one particular area. The numbers on cards will be removed so the one card can be used anywhere, data entry will still be the same. This reduces the risk of reduce the risk of departments amending the original cards and questions and data being lost (as it cant be entered if not on the correct FFT template. Final amendments have been made and this is planned to be launched at the end of June. An internal communications will also be produced in line with the launch of the new cards to again raise awareness and promotion of FFT completion by staff in all areas.

Inpatient survey results have been launched for the first time in May so hopefully this will continue to alleviate the confusion between needing to do **both** FFT feedback and Inpatient survey feedback this has also been communicated to staff.

What the charts tell us

IP and A&E recommended rates are showing special cause variation of concern, whilst OP and Maternity recommended rates are showing common cause variation..
All response rates are showing common cause variation.

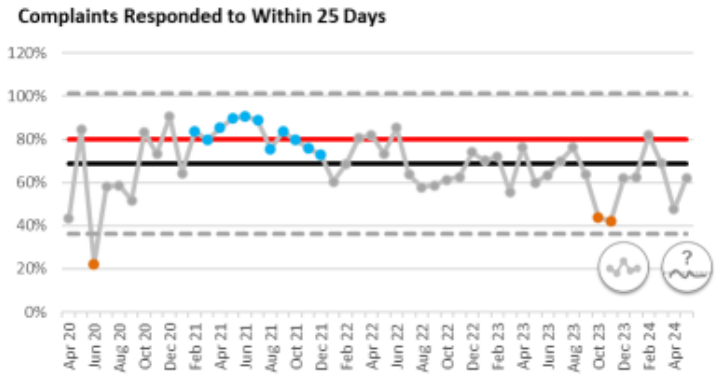
OUR QUALITY & SAFETY – COMPLAINTS

We are driving this measure because

We are aware from public feedback that a prompt, real-time, comprehensive service for the public using the Complaints services can be effective in resolving the majority of complaints, queries or outstanding concerns.

Performance

- In total there were 66 new formal complaints received within May-24 with 18 (36%[1]) called within 5 days to discuss the complaint.
- The Trust had 127 complaints still open at the end of May, of which 19 have been reopened.
- Of these 127 complaints, 39 have breached 25 days (6 of which have been reopened)



- The Surgery Division accounts for 67 (52.8%) of all open complaints and 32 (82.1%) of those that have already breached 25 days (4 of which have been reopened).
- Compliance with complaints closed within 25 days increased to 62.0% in May-24 but did not meet the target.

1 *The Denominator used when calculating the "% New Formal Complaints Telephoned in 5 Days" excludes those New Complaints received in the last 5 working days of the month*

Actions

- Performance has worsened this month, but breaches have reduced slightly again and remain stable at the time of reporting; it will not be possible to achieve the KPI until Surgery breaches are reduced to a manageable level (circa 5 or less) continuously.
- With the current number of breaches, and accounting for the larger proportion of open cases received which are due in June/July, there remains a risk of these breaches quickly growing back to an overwhelming number, as happened in February 2023.

- Surgical Division actions include:
  - Internal Divisional SOP devised, approved and circulated
  - Weekly divisional meeting to monitor and aid progress

- Complaints Manager is now reporting monthly on activity, as well as breaches and any potential upcoming issues to Head of Patient Safety and Complaints and Associate Director of Patient Safety & Risk, so that any concerns can be escalated.
- Compliance reporting is also circulated monthly to each Division, demonstrating where each needs to improve in relation to timeliness of responses, phone calls to complainants and completion of complaints actions and learning.
- Upcoming breach cases are highlighted in the narrative email sent with the Complaints Sitrep to more directly alert to investigators and senior staff.

Risks

Reputational Damage, further resource depletion due to ongoing correspondence with extended open cases, distress to patients and relatives

What the charts tell us

The metric still shows common cause variation and 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 as the target is within the control limits.

OUR WORKFORCE

Ali Koeltgen

Chief People Officer

Vacancies on ESR were impacted last month by a 257.93 increase in funded establishment due to transaction of business cases at budget setting which is normal at this time of year. This had the effect of increasing our vacancies from 466.91 wte (7.03% vacancy rate) to 713.62 wte (9.77% vacancy rate) in April. Our establishment has increased this month by a further 12.61 wte primarily in Corporate and Women and Children's divisions.

Our vacancy rate has reduced this month from 9.7% to 9.32% (681.70 vacancies) which although above the Trust target of 7.5%, still compares favourably to a vacancy rate of 12.61% in May last year.

Agency Spend remains our biggest challenge despite increased substantive staff in post. There has been a 68 wte increase in the total wte worked (Agency, Bank & Substantive) which is 600 wte higher than May last year partly due to staffing winter wards and PDU. We have also used 64 wte worked above our funded establishment due to Aconbury Zero being unfunded.

We have 117 wte worked over establishment in Specialty Medicine which is linked to additional winter wards. We are 87 wte worked over establishment in Urgent care for reasons including escalation areas and specialing, and 58 wte worked over establishment in Surgery. The two bank holidays in May will have had some impact on hours worked but cover for annual leave should be in the headroom for each ward budget.

Agency spend has increased by 0.38% to 8.99% of gross cost, against our target of 6%. Urgent Care remains an outlier with an increase of 2% this month taking their Agency Spend as a % of Gross Cost to 25.54%. Divisions continue to work hard to reduce Agency spend but this has been impacted by Level 4 escalation in Urgent Care and Winter Wards in Specialty Medicine. Our agency spend is 0.50% lower than the same period last year despite the landscape of having winter wards open that require c88 wte unfunded temporary staffing.

Our annual staff turnover has continued to meet our target of 11.5% and has reduced by 0.18% to 10.86% this month. Our monthly staff turnover is very good at 0.72% against a Model Hospital average of 1.13%.

Monthly sickness absence reduced by 0.34% in month to 5.57% which is 0.11% worse than May last year. Most divisions have had a reduction in sickness absence this month, except for Estates & Facilities and Urgent Care. Digital is the only division that meets the group target of 4% with the next closest being Corporate with 4.8%.

Absence due to stress remains higher than pre-pandemic with Corporate, and Women and Childrens outliers with over 42% of their absence attributed to S10. Digital also show as an outlier but this is skewed by being such a small division. Surgery and Urgent Care are showing as outliers for long-term sickness with 4.03% and 3.56%, respectively. Estates and Facilities, SCSD and Urgent Care have the highest levels of short-term sickness (3.36%, 2.63% and 2.57%). HRBP's are working closely with Divisions to manage sickness levels down.

Consultant Job Planning has deteriorated by a further 4% to 65%. All divisions are of concern with the highest compliance rate being 71% in SCSD and Surgery. Urgent Care have dropped by 31% this month to a concerning 31%.

Mandatory training compliance has remained unchanged at 91% which exceeds Trust target against a Model Hospital Benchmark of 89.6%. Non-medical appraisal is below target at 80% (1% lower than last year) and unchanged from last month.

OUR WORKFORCE – REDUCTION OF AGENCY SPEND

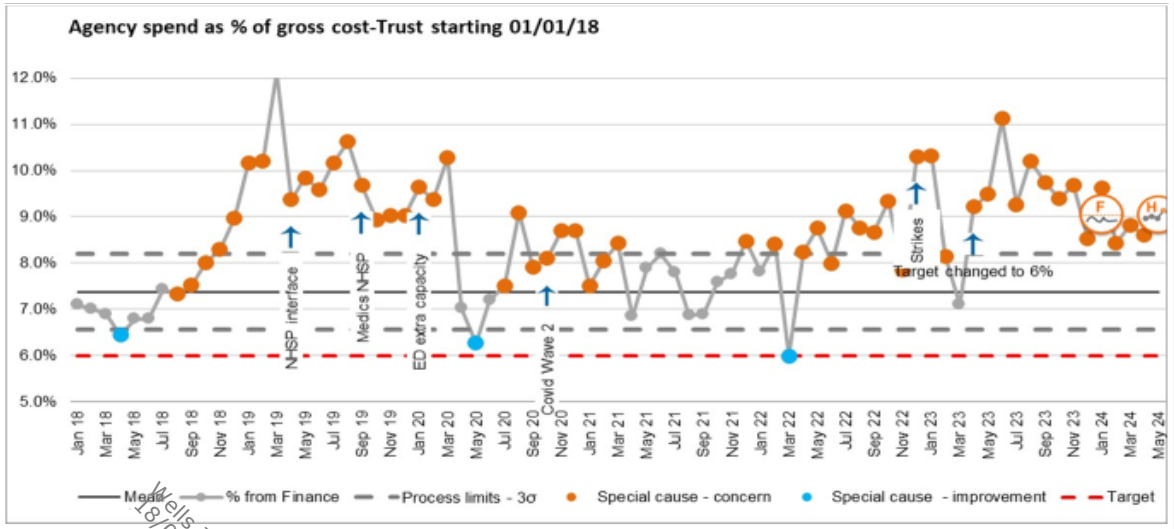
We are driving this measure because

To improve staffing levels, allowing the reduction of temporary staffing and maintaining a high quality of care for our patients and reduced cost to the Trust.

May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24
9.5%	11.1 %	9.3%	10.2 %	9.8%	9.4%	6.7%	8.5%	9.6%	8.4%	8.8%	8.6%	9.0%

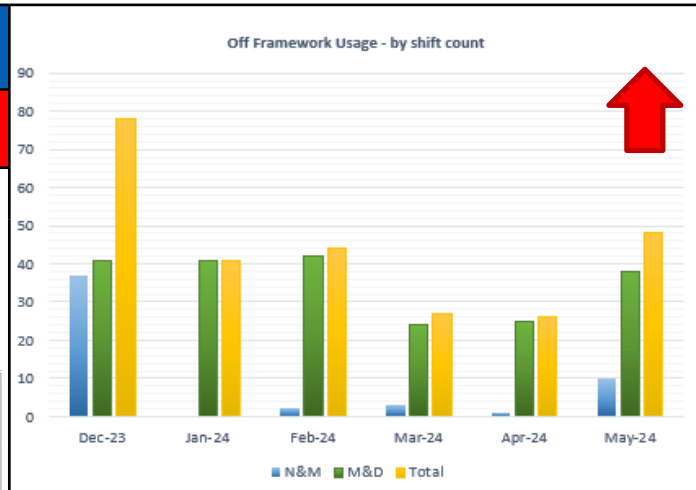
Assurance **Variation** **Data Quality Mark**

Reasonable Assurance

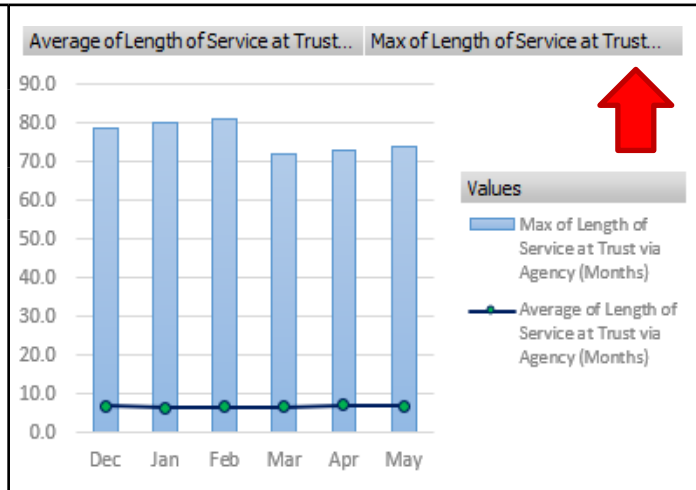


NHSP Actions in May-24

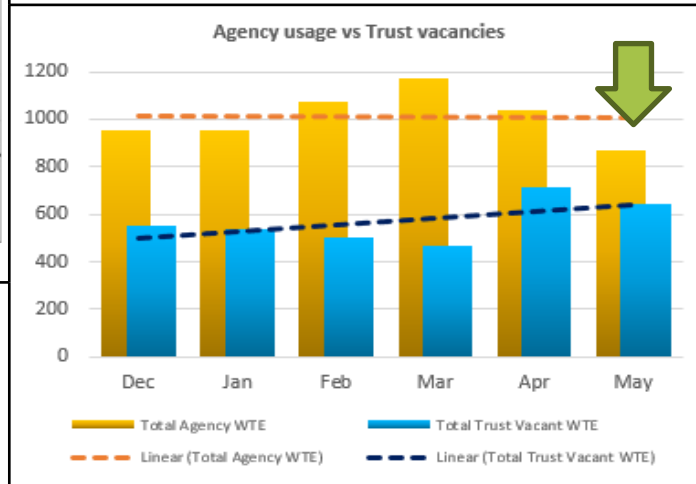
• 78 Ward walks carried out and weekly AGH and monthly KTC drop ins completed. Ward walks changed for new financial year with focus on visiting 40 highest users of NHSP. • Further agencies moved to tier 1 following agency reviews and lack of shifts now available to higher tiers. • Golden key moved above tier 1 for RN00 and added between tier 2 and 3 on critical cascade. Increased bank and tier 1 fill data on following slides. • 517 outbound calls made by shift fill team; 862 inbound calls handled. • Following NTL paper being approved, TOM working with D/DDNs and Deputy CoN to now monitor all NTL coding requests and usage. Added metrics to NWAG divisional slides. • TOM presented AHP agency reduction to CSSD senior management group with positive feedback and next steps to now be reviewed.



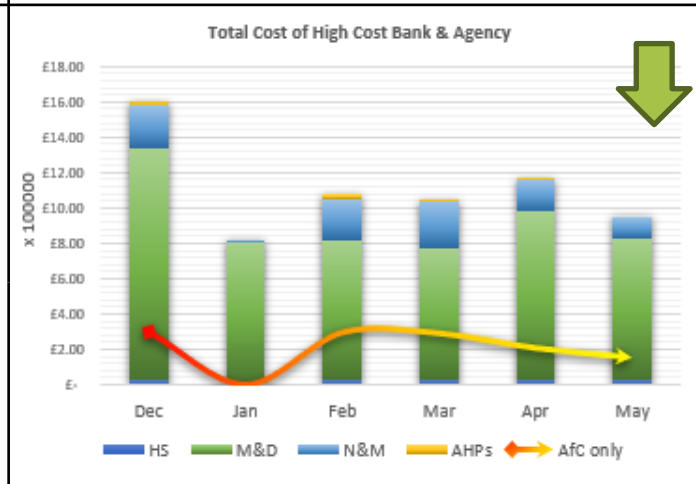
Off framework usage increased in May, with Medical & Dental still being the majority staff group with off framework temporary workers.



The maximum length of service has increased slightly in May. Unless further intervention is undertaken, this will continue to increase at a steady rate.



Agency usage at the Trust has decreased significantly in May. Alongside a slight decrease in Trust Total Vacancy, this is a positive movement in the data.



Usage of high-cost workers has decreased in May, with reductions across both AfC workers and M&D workers.

OUR WORKFORCE - VACANCY

We are driving this measure because

To improve staffing levels, allowing the reduction of temporary staffing and maintaining a high quality of care for our patients and improved morale for our staff.

May 23	Jun 23	Jul 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24
12.6%	12.3%	11.6%	10.6%	9.5%	9.3%	8.25%	8.33%	7.6%	7.13%	7.03%	9.77%	9.32%

Assurance

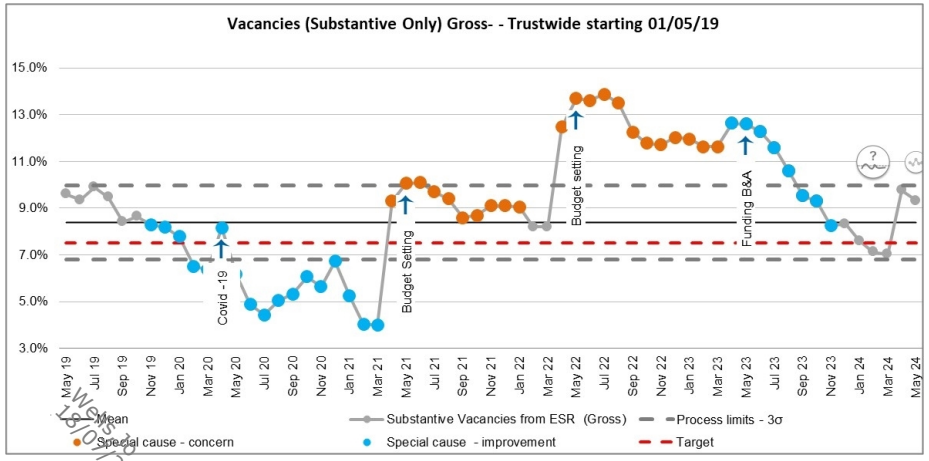
Hit and miss target - Subject to random variation

Variation

Common cause – no significant change

Data Quality Mark

Reasonable Assurance



Performance and Actions

- **Trust-wide Vacancies** increased by 246.71 wte as a direct result of additional posts being added due to transacted business cases at budget setting. This is a normal occurrence in M1. However, we have started to make inroads into this with a reduction from 9.77% to 9.32% in May (681.70 wte vacancies). This still compares favourably with May last year when it was 12.61% (199.87 wte less vacancies than last year).
- **Starters and Leavers** - We have recruited 48 more starters than leavers this month with 110 new starters processed in month (headcount) compared to 97 in May last year.
- **Healthcare Support Workers** – Our vacancy rate has reduced from 9.96% to 9.57% (102.34 wte vacancies) The high numbers of vacancies are primarily due to growth in establishment at budget setting. We have been actively recruiting HCSWs throughout the year
- **Nursing & Midwifery** - We currently have 160.92 wte vacancies compared to 178.5 vacancies last month and 57.9 wte in March. The increase is due to business cases transacted at budget setting. We brought in 151 international Nurses over the 23/24 financial year which met our target.
- **Allied Health Professionals** – We have 53.35 wte vacancies compared to 58.7 wte last month due to increased establishment at budget setting. Recruitment to this staff group is not keeping pace with leavers. We have struggled to gain traction with our AHP recruitment in the last 12 months.
- **Medical & Dental**. We have 63.66 wte consultant vacancies which is slightly worse than last month primarily due to growth in establishment. We also have 5.93 wte Career Grade and 51.12 wte Trainee Grade vacancies. Medical Resourcing are working with clinical directors on targeted recruitment campaigns.

Risks

Healthcare support worker retention, hard to recruit medical vacancies and an increasing establishment.

What the chart tells us

We are on an improving trajectory against a target of 7.5% other than for April 2023 and April 2024 budget setting where business cases were transacted into the establishment.
We benchmark well against Model Hospital for our vacancy rate with Registered Nursing at Quartile 1 and HCAs at Quartile 2. Medics and AHPs are Quartile 3 (December 2023 rates).

OUR WORKFORCE - SICKNESS

We are driving this measure because

Due to increased scrutiny and higher sickness levels following the pandemic the Trust aims to reduce sickness levels to provide high quality care, and reduction of agency spend, as well as improving morale of staff.

May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24
5.5%	5.3%	5.5%	5.6%	5.67%	6.21%	5.98%	6.34%	6.32%	5.93%	5.75%	5.91%	5.57%

Assurance

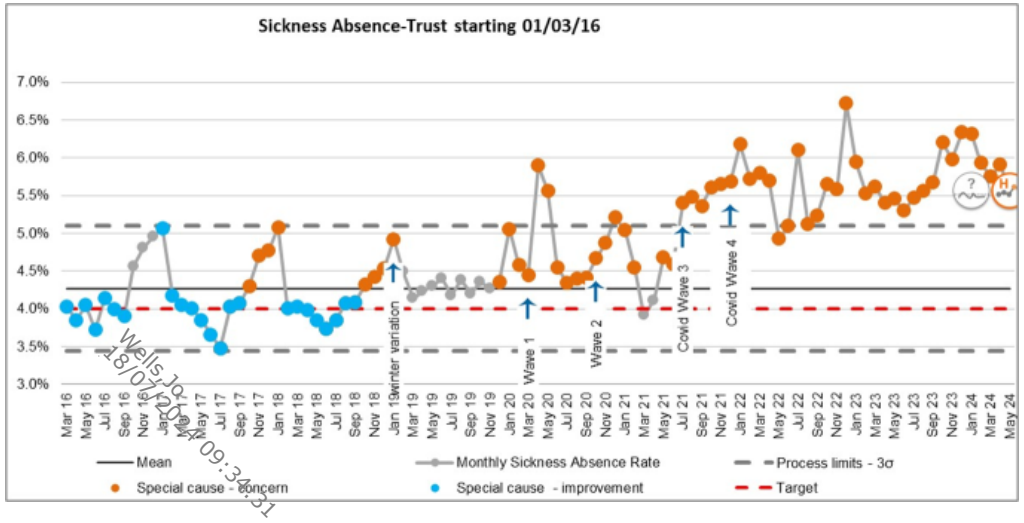
Hit and miss target - Subject to random variation

Variation

Special cause variation – Cause for concern (where high is a concern)

Data Quality Mark

Reasonable Assurance



Performance and Actions

- Monthly sickness absence reduced by 0.34% in month to 5.57% which is 0.11% worse than last May.
- The majority of divisions have had a reduction in sickness absence this month, with the exception of Estates and Facilities, and Urgent Care.
- Absence due to stress remains higher than pre-pandemic with Women and Children's and Corporate outliers with over 42% of their absence attributed to S10. Digital is showing as high but is skewed as only a small Division.
- Long term sickness has increased again this month by 0.04% in month to 3.28%. Highest rates are 4.03% (worsening position) in Surgery and 3.56% in Urgent Care.
- Short term absence has reduced by 0.38% to 2.29% with extremely high rates in Estates and Facilities (3.36%) and SCSD (2.63%)
- Our sickness is benchmarking poorly against the national position in HCA's, Estates and Ancillary, Registered Nursing and Midwifery, and Admin and Clerical:

Sickness Absence	2024 / 05			
	Trust	Region	Country	National
Add Prof Scientific and Technic	3.28%	3.83%	3.38%	3.39%
Additional Clinical Services	8.50%	6.70%	6.45%	6.54%
Administrative and Clerical	5.10%	4.11%	3.92%	3.96%
Allied Health Professionals	3.25%	3.78%	3.73%	3.75%
Estates and Ancillary	7.81%	6.93%	6.65%	6.80%
Healthcare Scientists	4.62%	3.13%	3.07%	3.06%
Medical and Dental	1.22%	1.73%	1.80%	1.81%
Nursing and Midwifery Registered	6.03%	5.18%	4.86%	4.94%
Students	0.00%	2.01%	2.14%	2.14%

Risks

Redeployment to cover additional winter beds, sustained Level 4 escalation, industrial action, and increased temporary staffing are expected to have an adverse impact on sickness levels and agency fill.

What the chart tells us

The elevated period between May 2021 and December 2022 reflects covid impact in addition to other winter pressures such as Flu. Since the peak in sickness absence in Dec 2022 (6.7%), the trajectory has improved but appears to be plateauing at about 5.5%.

OUR WORKFORCE - TURNOVER

We are driving this measure because

To improve retention, maintain staffing levels, improve morale, and enable the reduction of temporary staffing to maintain a high quality of care.

May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24
12.0%	12.1%	11.9%	11.9%	11.6%	11.3%	11.12%	11.07%	11.03%	11.12%	11.29%	11.04%	10.86%

Assurance

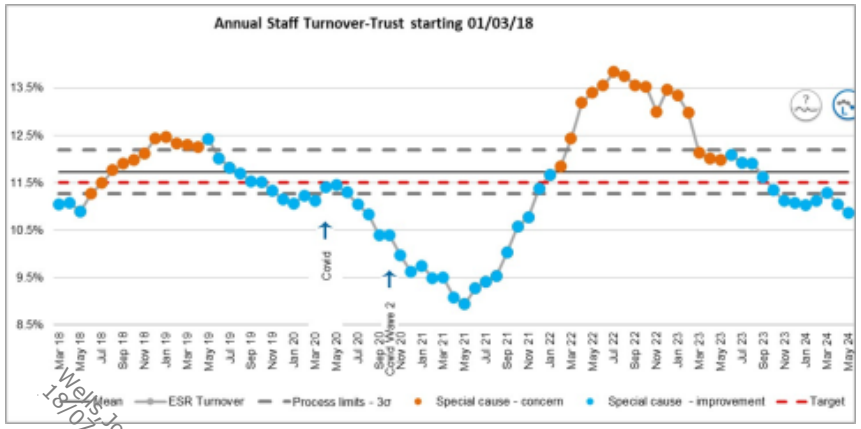
Hit and miss target - Subject to random variation

Variation

Special Cause of improving nature or lower pressures due to lower values.

Data Quality Mark

Reasonable Assurance



Weeks to 18/07/2024 09:34:31

Performance and Actions

- We continue to meet our 11.5% target for annual turnover at 10.86% which is 1.12% better than the same period last year and back to pre-pandemic levels.
- Our monthly turnover has increased by 0.06% in month and stands at 0.72%, which remains better than the Model Hospital average. We have 48 more starters than leavers in month.
- Women and Childrens and SCSD are outliers for monthly turnover. Urgent Care is an outlier for Annual Turnover. The current stability rate is 90.98% which is very good.

The Benchmark Report from ESR shows that the Trusts monthly turnover for May was worse than average for Medical and Dental, Registered Nurses and HCAs. All other staff groups are better than average.

In terms of reasons for leaving we benchmark poorly for Work Life Balance, Incompatible Working Relationships. We have a higher % accessing flexible retirement as demonstrated in this ESR benchmark report which is filtered to those reasons where we are worse than Average.

Monthly Turnover	2024 / 05			
	Trust	Region	Country	National
Add Prof Scientific and Technic	0.00%	0.69%	0.73%	0.71%
Additional Clinical Services	1.38%	0.80%	0.90%	0.89%
Administrative and Clerical	0.74%	0.81%	0.91%	0.89%
Allied Health Professionals	0.35%	0.66%	0.73%	0.73%
Estates and Ancillary	0.46%	0.70%	0.79%	0.80%
Healthcare Scientists	0.46%	0.48%	0.68%	0.67%
Medical and Dental	1.01%	0.50%	0.54%	0.54%
Nursing and Midwifery Registered	0.68%	0.56%	0.62%	0.61%
Students	0.00%	0.34%	0.65%	0.64%

Reason for Leaving	Trust	Region	Country	National
Voluntary Resignation - Work Life Balance	19.05%	7.19%	6.72%	6.68%
Voluntary Resignation - Relocation	17.46%	5.93%	6.51%	6.58%
Flexi Retirement	9.52%	1.80%	1.52%	1.58%
Voluntary Resignation - Incompatible Working Relationships	9.52%	0.71%	0.65%	0.63%
Retirement Age	7.94%	7.95%	5.93%	6.28%
Voluntary Resignation - Health	7.94%	2.56%	2.18%	2.22%
End of Fixed Term Contract - External Rotation	6.35%	0.50%	0.39%	0.38%
Voluntary Early Retirement - no Actuarial Reduction	4.76%	0.40%	0.38%	0.38%
Voluntary Resignation - Promotion	4.76%	4.51%	4.44%	4.48%

Risks

AHPs have moved into Quartile 4 for Turnover on Model Hospital which is very poor. Estates and Ancillary, and Medical and Dental are Quartile 3 (Feb 24 rates) Retention of these groups is important in terms of reducing bank and agency spend and improving morale of teams.

What the chart tells us

Annual Staff Turnover continues on an improving downward trajectory with the 11.5% target met for the seventh month in a row.

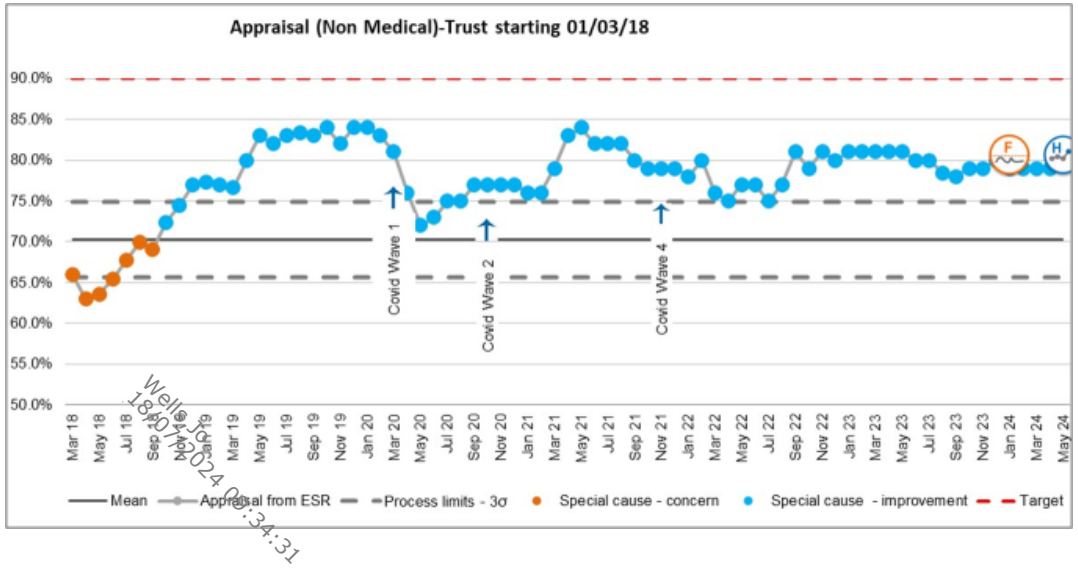
OUR WORKFORCE – APPRAISAL AND JOB PLANS

We are driving this measure because:

To ensure our staff feel heard and valued which will maintain high standards and improve retention.

May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24
81%	81%	80%	78%	78%	79%	79%	80%	79%	79%	79%	79%	80%

Assurance	Variation	Data Quality Mark
The system is expected to consistently Fail the target	Special Cause Variation where High requires investigation	Reasonable Assurance



Performance and Actions

Appraisal Rate has improved by 1% to 80% against a target of 90%. Compliance is 1% lower than the same period last year. All staff groups are below the 90% target with Admin and Clerical and Healthcare Scientists showing as outliers with 71% and 70% respectively. Digital are significant outliers in terms of the division with a drop to 41%.

This is against a Model Hospital average of 80.9% (revised 2022/23 rates). We are at Quartile 3 on model hospital.

Medical Appraisal has been fairly consistently above target of 90% since December 2021 and has improved to 96% this month with all divisions meeting target:

Consultant Job Planning has deteriorated by 4% again this month to 65%. All divisions except Surgery have deteriorated. Urgent Care remain an outlier with a further 31% drop to 31% which requires urgent attention.

All divisions are of concern with the highest compliance rate being a poor 71% in SCSD and Surgery.

Risks

Admin and Clerical staff (particularly those in Corporate Teams) have low levels of appraisal compliance.

What the chart tells us

The rolling 12-month appraisal position remains fairly consistent but is significantly below target of 90%. Medical Appraisal meets target in all Divisions. Job Plans are well below target.

OUR WORKFORCE – STATUTORY AND MANDATORY TRAINING

We are driving this measure because:

To ensure that all our staff maintain Mandatory and Essential to Role training which will ensure their safety and maintain high quality of care to our patients

May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24
90%	90%	90%	89%	88%	88%	88%	88%	90%	90%	91%	91%	91%

Assurance

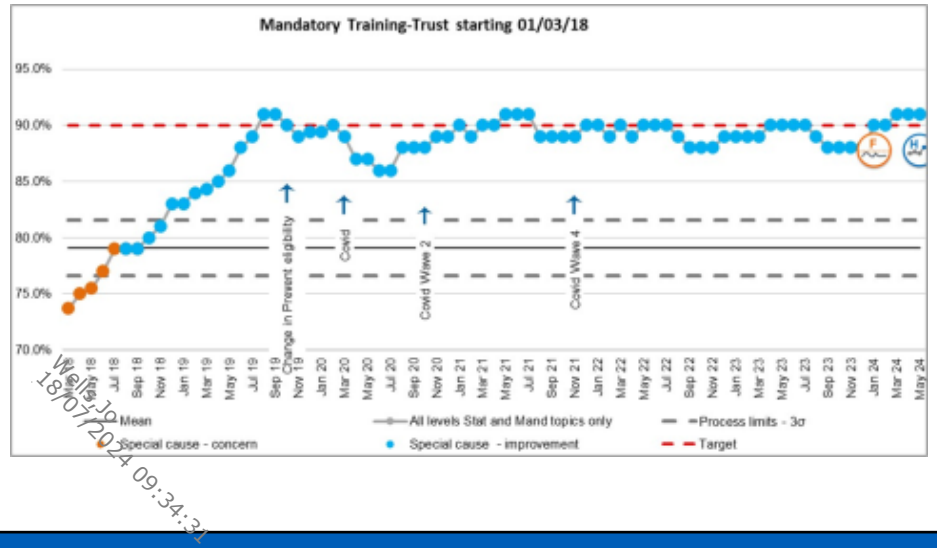
The system is expected to consistently Fail the target

Variation

Special Cause Variation where High requires investigation

Data Quality Mark

Reasonable Assurance



Performance and Actions

Overall mandatory training compliance has remained at 91% against a Model Hospital average of 89.6% (2022/23 rates). Women and Childrens are outliers at 88% followed by Urgent Care and Surgery at 89% although all three have 1% improvement.

Digital have dropped 2% this month and Specialty Medicine, and Corporate and SCSD have Both dropped 1% but all three meet target.

Medical and Dental are now the only staff group That are below Model Hospital average and Trust target and remain at 82%. This is impacted by Junior Doctor rotations.

Mandatory Training	2024 / 05			
	Trust	Region	Country	National
Add Prof Scientific and Technic	85.90%	79.98%	76.51%	77.00%
Additional Clinical Services	86.12%	79.96%	78.83%	79.17%
Administrative and Clerical	89.92%	84.54%	79.94%	80.79%
Allied Health Professionals	91.58%	80.60%	78.99%	79.19%
Estates and Ancillary	89.42%	76.94%	75.64%	76.00%
Healthcare Scientists	89.58%	81.75%	77.97%	79.25%
Medical and Dental	75.55%	60.25%	60.17%	58.74%
Nursing and Midwifery Registered	87.69%	78.67%	75.69%	76.35%
Students	90.00%	82.53%	75.59%	75.61%

The Trust continues to benchmark very well both regionally and nationally from ESR data. Indeed, we are better than Regional, and National in all staff groups. This would indicate that other Trusts are taking out exclusions in what they send to Model Hospital as ESR reports are from raw data with no exclusions.

Risks:

Medical and dental training compliance, and some challenges with legacy IT infrastructure which doesn't consistently support some of the e-learning modules. Escalation to Level 4 and ongoing industrial action means that some face to face training is cancelled.

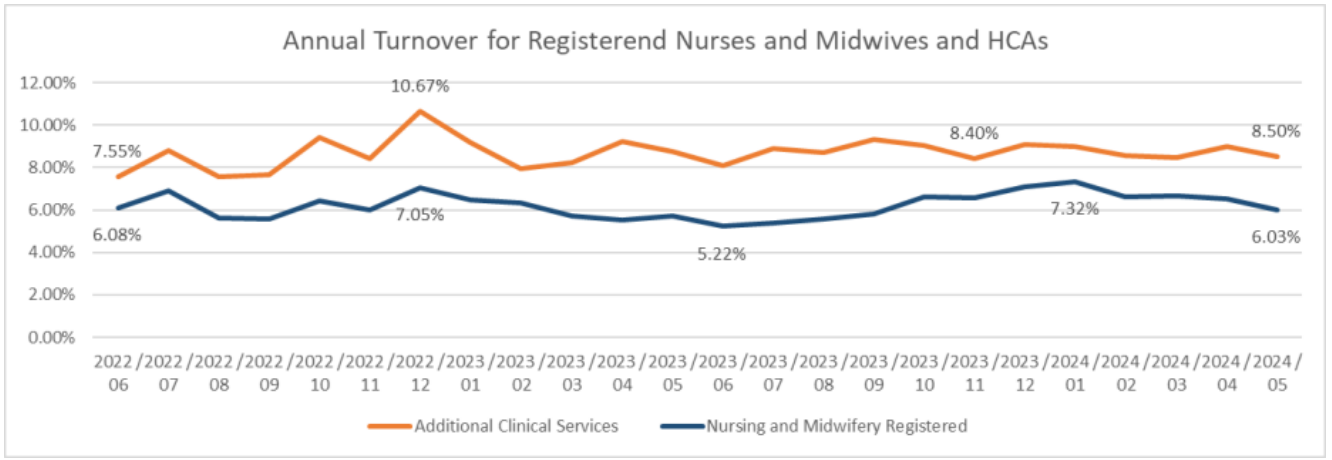
What the chart tells us:

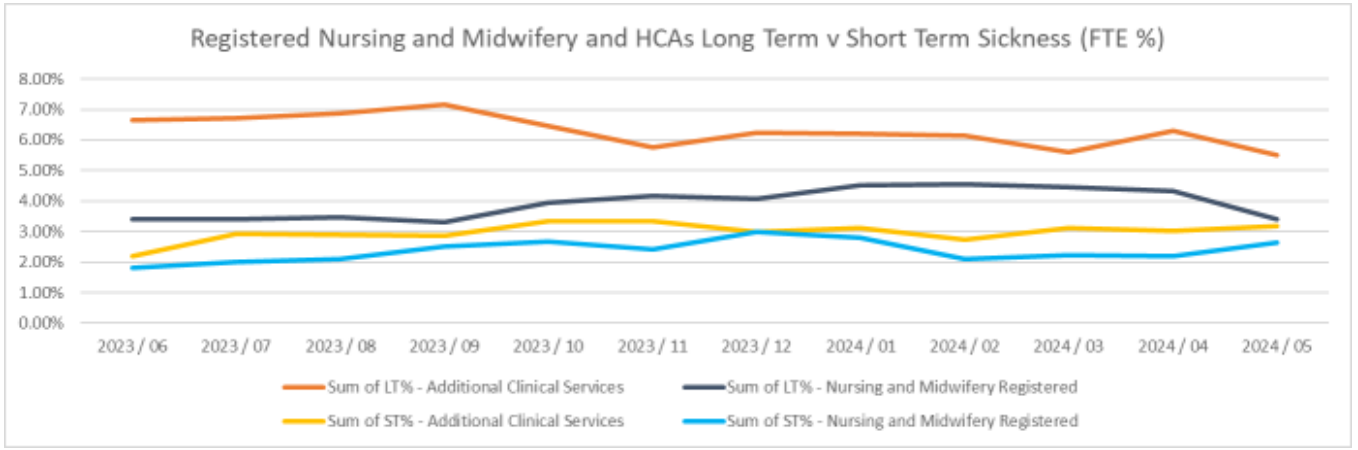
Target has been achieved again this month across the Board.

WAHT Charts on Sickness Absence and Turnover for HCSWs and Registered Nurses and Midwives

Sickness Absence	Column Labels				
Main Staff Group	SCSD	Spec Med	Surgery	Urgent Care	W&C
Additional Clinical Services	8.48%	6.66%	9.45%	9.59%	10.23%
Nursing and Midwifery Registered	7.05%	5.49%	5.83%	5.37%	5.76%
Grand Total	**7.69%**	**5.99%**	**7.31%**	**6.78%**	**6.67%**

Sum of ABS FTE	Column Labels				
Main Staff Group	SCSD	Spec Med	Surgery	Urgent Care	W&C
Available FTE	0.00%	0.00%	0.00%	0.00%	0.00%
S10 Anxiety/stress/depression/other psychiatric illnesses	8.29%	3.73%	4.99%	4.79%	6.07%
S11 Back Problems	0.87%	0.57%	0.84%	0.04%	1.05%
S12 Other musculoskeletal problems	5.13%	3.27%	1.38%	0.92%	0.63%
S13 Cold, Cough, Flu - Influenza	3.47%	3.24%	0.87%	0.81%	0.91%
S14 Asthma	0.04%	0.00%	0.12%	0.13%	0.00%
S15 Chest & respiratory problems	0.86%	1.04%	0.22%	0.85%	0.44%
S16 Headache / migraine	0.50%	0.68%	0.63%	0.56%	0.02%
S17 Benign and malignant tumours, cancers	0.03%	0.06%	0.77%	0.76%	0.34%
S18 Blood disorders	0.08%	0.03%	0.00%	0.00%	0.10%
S19 Heart, cardiac & circulatory problems	0.89%	0.47%	1.48%	0.03%	0.20%
S20 Burns, poisoning, frostbite, hypothermia	0.24%	0.00%	0.00%	0.06%	0.00%
S21 Ear, nose, throat (ENT)	0.67%	0.06%	0.35%	0.15%	0.61%
S22 Dental and oral problems	0.09%	0.10%	0.03%	0.00%	0.01%
S23 Eye problems	0.04%	0.07%	0.03%	0.06%	0.00%
S24 Endocrine / glandular problems	0.00%	0.04%	0.00%	0.00%	0.00%
S25 Gastrointestinal problems	3.47%	1.49%	2.69%	1.18%	0.74%
S26 Genitourinary & gynaecological disorders	3.13%	1.05%	0.44%	1.16%	0.51%
S27 Infectious diseases	0.46%	0.74%	0.51%	0.57%	0.09%
S28 Injury, fracture	2.49%	0.34%	0.80%	0.08%	0.55%
S29 Nervous system disorders	0.90%	0.57%	0.00%	0.00%	0.10%
S30 Pregnancy related disorders	1.24%	1.43%	0.77%	0.19%	0.26%
S31 Skin disorders	0.03%	0.14%	0.00%	0.00%	0.09%
S98 Other known causes - not elsewhere classified	1.14%	2.54%	0.77%	0.68%	0.81%
Grand Total	**34.07%**	**21.66%**	**17.70%**	**13.03%**	**13.53%**





OUR FINANCIAL PERFORMANCE

Neil Cook

Chief Finance Officer

Financial Plan 2024/25

Since the last Finance Report the System has been asked to resubmit the plan, this has led to a reduction in the full year deficit from £60.3m reported in May to £57.3m in June. The £3m movement includes £1.8m NHSE contribution towards change in accounting treatment for PFI and a further £1.2m CPIP stretch. The 2024/25 plan includes £45.1m (6% of operating expenses) of CPIP and non-recurrent system funding of £13.6m. It is important to note that the recurrent underlying position of the Trust continues to run at a greater level of deficit once non-recurrent items are removed and financial controls have therefore been extended consequently.

Income & Expenditure Performance

At the end of Month 2 we report a year to date (YTD) favourable variance of £0.1m against the revised plan. **Patient care income £3.3m favourable YTD** of which £3.3m is the offset of Non PbR drugs and devices costs. **Employee expenses £0.3m adverse YTD** of which £0.3m YTD due to additional Consultants in Urgent Care, and £0.3m of Consultant Pay award (offset by Income). Adverse variances partially offset by favourable variances on Dermatology vacancies (£0.2m) and Business Case underspends (£0.2m). **Operating expenses excluding Employee Expenses £3.0m adverse YTD** of which £3.3m Non PbR Drugs and Devices YTD which is offset by Income. Favourable variance of £0.3m due to PFI technical adjustment to UK GAAP basis noting due to timing difference therefore expect to outturn in line with full year revised plan.

Capital

The capital plan for 2024/25 has been re-submitted at £12.458m, compared to the plan submitted in May of £14.356m. The reduction for WAHT is £1.898m from the total reduction of £2.531m across the system. This reduction in CRL is due to the 2024/25 Revenue Financial Plan Limit compared to the notional fair share value which has reduced the providers CRL by 10% across the system. The impacted areas include a rephasing plan of £907k for ASR into 2025/26, slippage of £389k for Property and Works, ICT £206k and removal of the contingency funding £396k for 2024/25. The plan includes £1m of external funding for the ongoing Front Line Digitalisation Scheme (FLD) scheme, which is planned capital expenditure, £1.4m will be allocated for new lease additions and £340k for PFI replacement equipment. The Strategic schemes planned to take place in 2024/25 include Acute Service Review (ASR) £2.7m, Cath Lab £2m and LIMS £911k. Capital spend at M2 was £1,320k, which included two new lease contracts that began in April with a ROU asset value of £681k.

Cash

The Trust cash position at the end of month 2 was £1.712m. The Trust received revenue support of £4.25m in May, which was 50% of the amount that was requested. The Trust submitted a revised revenue application for June of £7.5m, of which £6m was approved and will be received in June. NHSE's CFO office advised that the reduction of £1.5m of the amount requested for June was due to finalisation of all Trusts planning submission.
The Trust has had notification from the ICB that the deficit, and therefore the cash requirement will now be funded through the ICB and the Trust will receive £7.5m in July. As a result of this there has been no application for revenue support for quarter 2 (July-August).

For 2024/25, the planned deficit is £57.3m and as noted above will be funded through the ICB. It is to be noted that the CPIP's of £45m is assumed to be cash releasing savings and is phased over the full 12 months. If the CPIP is not achieved, the Trust will need to apply for additional cash support.

To ensure that there is adequate cash to cover payroll costs, including Tax, NI and Pensions, the creditor payment runs have been reduced and this will significantly reduce the Trust BPPC %.

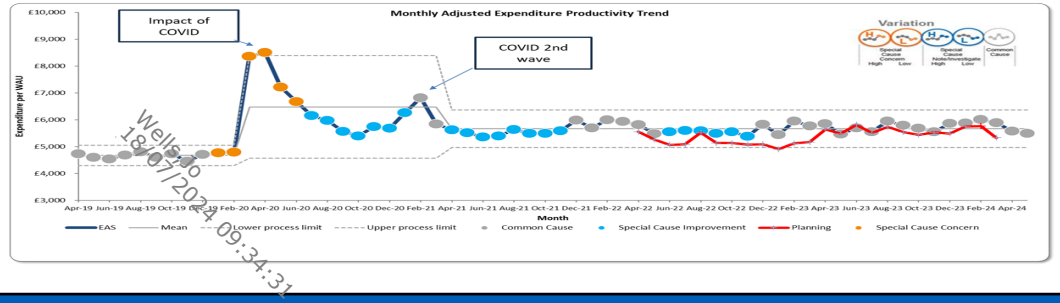
The Trust will be making an application for Capital PDC in quarter 2 of 2024/25 (previously noted as quarter 2).

BEST USE OF RESOURCES – INCOME & EXPENDITURE

We are driving this measure because

The Income and Expenditure plan reflects the Trust's operational plan, and the resources available to the Trust to achieve its objectives. Variances from the plan should be understood, and wherever possible mitigations identified to manage the financial risk and ensure effective use of resources.

Statement of comprehensive income	Year to Date Plan £'000	Actual £'000	Variance £'000
INCOME & EXPENDITURE			
Operating income from patient care activities	107,101	110,397	3,296
Other operating income	5,356	5,231	(125)
Employee expenses	(74,753)	(75,080)	(326)
Operating expenses excluding employee expenses	(45,941)	(48,908)	(2,967)
OPERATING SURPLUS / (DEFICIT)	**(8,237)**	**(8,359)**	**(122)**
FINANCE COSTS			
Finance income	308	355	47
Finance expense	(1,869)	(1,865)	4
PDC dividends payable/refundable	(934)	(937)	(3)
NET FINANCE COSTS	**(2,495)**	**(2,447)**	**48**
Other gains/(losses) including disposal of assets	0	0	0
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR	**(10,732)**	**(10,806)**	**(74)**
Add back all I&E impairments/(reversals)	0	0	0
Surplus/(deficit) before impairments and transfers	**(10,732)**	**(10,806)**	**(74)**
Remove capital donations/grants/peppercorn lease I&E impact	24	(58)	(82)
Adjust PFI revenue costs to UK GAAP basis	(1,898)	(1,607)	291
Adjusted financial performance surplus/(deficit)	**(12,606)**	**(12,471)**	**135**



Performance and Actions

At the end of Month 2 we report a year to date (YTD) favourable variance of £0.1m against the revised plan.

Patient care income £3.3m favourable YTD of which £3.3m is the offset of overspends on Non PbR items, other favourable variances include £0.3m for Consultant pay award and £0.2m over performance on elective activity. This is being partially by £0.4m timing difference on receipt of contribution towards PFI costs.

Employee expenses £0.3m adverse YTD - Included in these variances are £0.3m YTD due to additional Consultants in Urgent Care, and £0.3m of Consultant Pay award (offset by Income). Adverse variances partially offset by favourable variances on Dermatology vacancies (£0.2m) and Business Case underspends (£0.2m).

Operating expenses excluding Employee Expenses £3.0m adverse YTD - Included in these adverse variances are Non PbR Drugs £2.1m and Non PbR Devices £1.6m YTD which is offset by Income, and £0.2m insourcing in Dermatology offset by favourable pay variances. This is partially offset by £0.7m of central reserves for delivering additional activity.

Favourable variance of £0.3m due to PFI technical adjustment to UK GAAP basis is a timing difference, we expect to outturn full year in line with revised plan.

Risks

The challenge of meeting all of the requirements of 24/25 plan across operational performance, workforce and finance should not be underestimated given our underlying exit deficit position from 2023/24. There remains a significant level of risk associated with delivering the plan, for which mitigations continue to be sought.

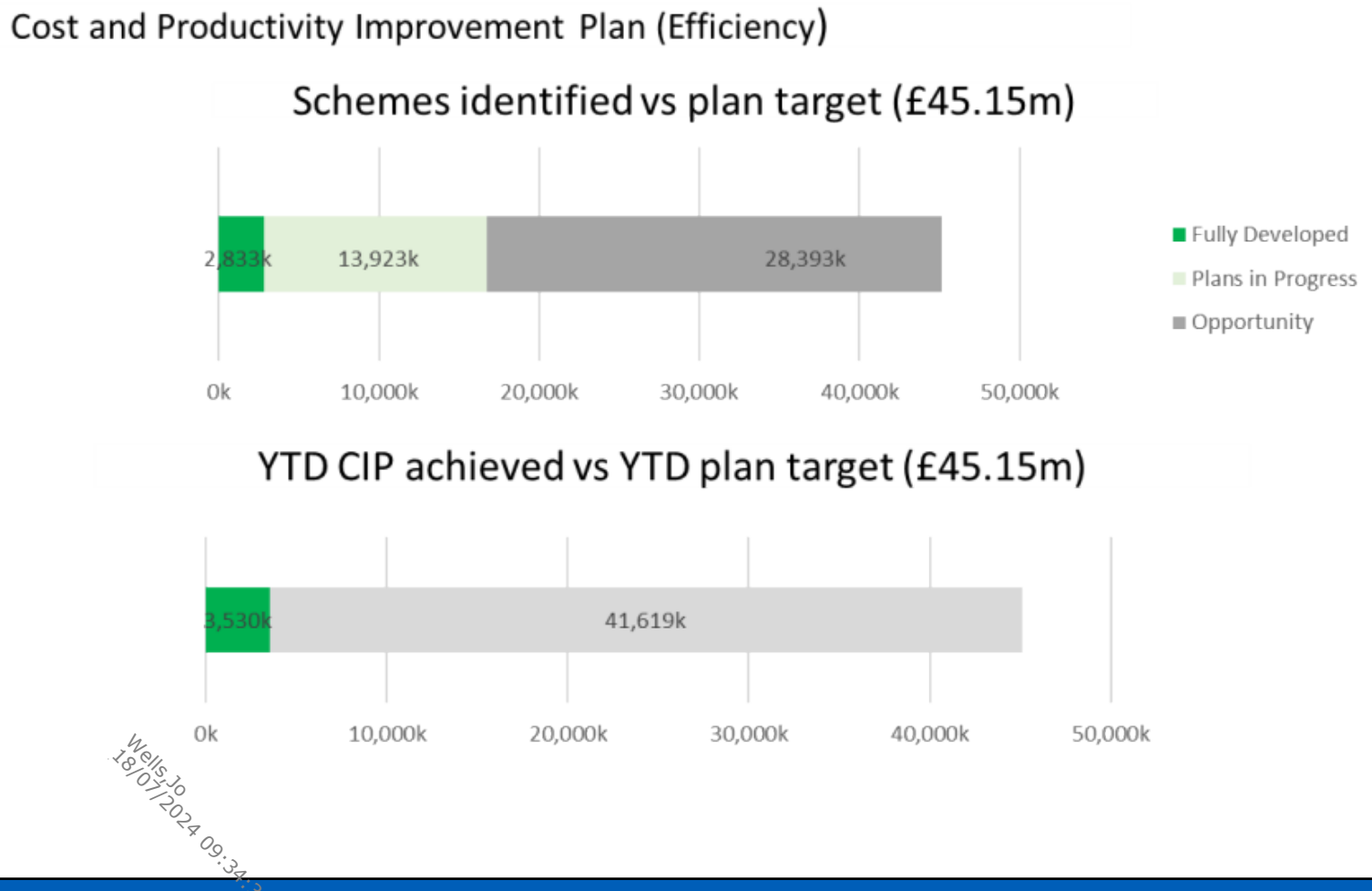
What the charts tell us

For May our Cost per WAU is 2% lower than April and the trend is continuing to reduce over the last 5 month . This means we are delivering more activity per spend than in recent months. Expenditure is 3% higher than April, so spending more but the weighted activity is 4% higher, so doing more activity. This is primarily due to a large increase in Elective Inpatient discharges during May.
We are currently working on updating the plan line following the recent resubmission of both the activity and the finance plan. An updated chart including plan line will be available for M3.

BEST USE OF RESOURCES – PRODUCTIVITY & EFFICIENCY

We are driving this measure because

If the Trust fails to identify recurrent Productivity & Efficiency Plans (PEP) and put in place sufficient resources and governance arrangements to drive delivery, then it will not achieve financial sustainability.



Performance and Actions

- The Trusts target for 24/25 as submitted to NHSE on 12th June is £45.15m
- M2 Plan figure was £2.13m
- M2 Actuals delivered £2.04m. Delivery estimates have been included for Elective productivity pending final coded activity and finalisation of evaluation methodology
- The efficiency (cost out) and productivity schemes for the Trust are still being developed and progressed through the Trust maturity levels

Detailed update contained within CPIP report to Financial Recovery Board

Risks

- Delivery of the 24/25 target is extremely challenging, but work is continuing to develop existing schemes as well as identifying further cost saving and productivity savings to ensure delivery of the 24/25 target.

What the charts tell us

M2 delivered actuals of £2.04m against a plan of £2.13m, an under delivery of £0.09m. Year to date (YTD) actuals are £3.53m compared to a Plan of £4.37m, an under delivery of £0.84m
Work is continuing to develop the CPIP schemes for 24/25 through the Trust maturity levels alongside the Divisions and Corporate functions. For 24/25, targets have been set in terms of Efficiency (cost out) and Productivity. 'Check and Challenge' style sessions are being arranged to take place fortnightly for assisting with monitoring and measuring performance to improve delivery against plan.