University Hospitals Coventry and Warwickshire NHS Trust

Resolution of Items Heard in Private
In accordance with the provisions of Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960, and the Public Bodies (Admissions to Meetings) (NHS Trusts) Order 1997, it has been resolved that the representatives of the press and other members of the public are excluded from the second part of the Trust Board meeting on the grounds that it would be prejudicial to the public interest due to the confidential nature of the business transacted. This section of the meeting has been held in private session.

PUBLIC TRUST BOARD MEETING TO BE HELD ON WEDNESDAY 31st JULY 2013 IN ROOM 20063/64, CLINICAL SCIENCES BUILDING, UNIVERSITY HOSPITAL, COVENTRY, CV2 2DX

PUBLIC AGENDA

THE PUBLIC SESSION OF THE TRUST BOARD WILL COMMENCE PROMPTLY AT 3.00PM

1	General Business	Paper	Presenter	Category
1.1	Apologies for Absence	Verbal	Mr N Stokes, Acting Chairman	N/A
1.2	Minutes of Meeting held on 26th June 2013*	Enc 1	Mr N Stokes, Acting Chairman	N/A
1.3	Actions Update	Enc 2	Mr N Stokes, Acting Chairman	N/A
1.4	Matters Arising	Verbal	Mr N Stokes, Acting Chairman	N/A
1.5	Declarations of Interest	Verbal	Mr N Stokes, Acting Chairman	N/A
1.6	Chairman's Report	Verbal	Mr N Stokes, Acting Chairman	N/A
1.7	Private Trust Board Meeting Session Report – 26th June 2013*	Enc 3	Mr N Stokes, Acting Chairman	N/A
1.8	Chief Executive's Report	Verbal	Mr A Hardy, Chief Executive Officer	N/A
1.9	Integrated Performance Report	Enc 4	Mrs G Nolan, Chief Finance Officer	Quality & Safety
1.10	Provider Management Regime	Enc 5	Mrs G Nolan, Chief Finance Officer	Governance
1.11	Audit Committee Meeting Report – 13 May 2013	Enc 6	Mr T Robinson, Non-Executive Director	Governance

2	To Deliver Excellent Patient Care and Experience	Paper	Presenter	Category
2.1	Patient Trust Assurance Process Story	Enc 7	Mrs M Pandit, Chief Medical Officer	Quality & Safety
2.2	Francis Enquiry	Enc 8	Mrs M Pandit, Chief Medical Officer	Governance
2.3	Quality Governance Committee Meeting Report – February to June 2013	Enc 9	Mr N Stokes, Acting Chairman	Governance
2.4	Major Trauma Network Peer Review	Enc 10	Mrs M Pandit, Chief Medical Officer	Quality & Safety

3	To Deliver Value for Money	Paper	Presenter	Category
3.1	Finance and Performance Meeting Report – 28 May 2013	Enc 11	Ms S Tubb, Senior Independent Director	Governance

4	To be an Employer of Choice	Paper	Presenter	Category
4.1	Foundation Trust Application Update*	Enc 12	Mr A Hardy, Chief Executive Officer	Strategy

5	To be a Research Based Healthcare Organisation	Paper	Presenter	Category
	No reports under this section			

6	To be a Leading Training and Education Centre	Paper	Presenter	Category
6.1	West Midlands South Health Innovation and Education Cluster Report	Enc 13	Mrs M Pandit, Chief Medical Officer	Strategy

7	Administrative Matters			
7.1	A Review of Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation	Enc 14	Mrs G Nolan, Chief Finance Officer	Governance
7.2	Any Other Business	Verbal	Mr N Stokes, Acting Chairman	

8	Questions from the Public up to 15 minutes			

9	Date of Next Meeting:			
	Wednesday 25 September 2013 at 1:00pm, prior to Private Board			

Please note: asterisked items (*) are for noting and, in general, do not require discussion.

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST

MINUTES OF THE PUBLIC MEETING OF THE UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST BOARD HELD ON WEDNESDAY 26th JUNE 2013 AT 1.00PM IN ROOM 20063/64, CLINICAL SCIENCES BUILDING, UNIVERSITY HOSPITAL, COVENTRY, CV2 2DX

In accordance with the provisions of Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960, and the Public Bodies (Admissions to Meetings) (NHS Trusts) Order 1997, it is resolved that the representatives of the press and other members of the public are excluded from the second part of the Trust Board meeting on the grounds that it is prejudicial to the public interest due to the confidential nature of the business about to be transacted. This section of the meeting will be held in private session.

AGENDA ITEM	DISCUSSION	ACTION
HTB 13/257 PRESENT	Mr I Crich, Chief HR Officer (IC) Mr D Eltringham, Chief Operating Officer (DE) Mr A Hardy, Chief Executive Officer (AH) Mrs G Nolan, Chief Finance Officer/Deputy Chief Executive Officer (GN) Mrs M Pandit, Chief Medical Officer (MP) Professor M Radford, Chief Nursing Officer (MR) Mr T Robinson, Non-Executive Director (TR) **Mr N Stokes, Acting Chairman (NS)** Ms S Tubb, Senior Independent Director (ST)	
HTB 13/258 IN ATTENDANCE	Mrs K Beadling, Head of Communications (KB) Miss A Johnson, Executive Assistant (Note taker) (AJ) Mr M Patel, Interim Director of Corporate Affairs (MPa)	
HTB 13/259 APOLOGIES	Professor P Winstanley, Non-Executive Director (PW)	
HTB 13/260 MINUTES OF MEETING HELD 29 MAY 2013	The Trust Board **APPROVED** the minutes of the meeting held on 29 May 2013 as a true and accurate record of the proceedings.	
HTB 13/261 ACTION MATRIX	It was noted that: HTB 13/172 – ST stated the date for completion should be July 2013 HTB 13/211 – ST stated the letter referred to is still to be circulated HTB 13/012 – MP stated that we are waiting for a new date for Board seminar.	
HTB 13/262 MATTERS ARISING	There were no matters arising.	
HTB 13/263 DECLARATIONS OF INTEREST	There were no declarations of interest.	

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST

MINUTES OF THE PUBLIC MEETING OF THE UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST BOARD HELD ON WEDNESDAY 26th JUNE 2013 AT 1.00PM IN ROOM 20063/64, CLINICAL SCIENCES BUILDING, UNIVERSITY HOSPITAL, COVENTRY, CV2 2DX

AGENDA ITEM	DISCUSSION	ACTION
HTB 13/264 CHIEF EXECUTIVE OFFICERS REPORT	AH highlighted that: - On 4 July 2013, an Extraordinary Audit Committee meeting was held, all statutory financial duties had been met and the Trust accounts for 2012/13 were approved without qualification. - On 10 June 2013, a regional breast screening quality assurance visit feedback session was held. It was noted that UHCW is seen as an national exemplar and good feedback was received.	
HTB 13/265 CHAIRMANS REPORT	NS updated the Board on the recruitment process for the new Trust Chair.	
HTB 13/266 PRIVATE TRUST BOARD MEETING SESSION REPORT – 29 MAY 2013	The Trust Board **NOTED** the report.	
HTB 13/267 INTEGRATED PERFORMANCE REPORT	GN noted that the purpose of the report is to inform the Board of the performance against the key agreed dashboard indicators for May 2013. GN acknowledged that the scorecard within the report was incorrectly dated and added that the report highlights indicators which are of concern. ST added that a "deep dive" session had been carried out on ED within the Finance and Performance Committee (F&P) and she drew out the key issues from within that session. ST also noted that it would be helpful at some stage to take stock of current performance, as that will help with planning for winter. ST also added that the HSMR numbers had been looked at and noted the falls figure which has moved over the last month. NS asked why the HSMR figure fluctuated month to month and in response, MP stated that this is most likely to be related to variable activity levels. TR added that for that reason it was important to look at the figures month by month but also on an annual basis in order to observe overall trends. ST stated that the forecast to F&P and the Board on mandatory training rates is supported by greater detail in the IPR reference metrics. It was noted that this was discussed at F&P to determine what is required in order that IC can compile an action document to cover F&P, Board and Governance. IC confirmed a further update would be provided at the next F&P meeting, then Quality Governance and then brought back to Board. NS asked what measures need to be reported from "Friends and Family Test" and it was confirmed that the detail was contained in the Board report. AH stated that overall Friends and Family Test score for May 2013 was 57. MP stated this would be reported centrally.	

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST

MINUTES OF THE PUBLIC MEETING OF THE UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST BOARD HELD ON WEDNESDAY 26th JUNE 2013 AT 1.00PM IN ROOM 20063/64, CLINICAL SCIENCES BUILDING, UNIVERSITY HOSPITAL, COVENTRY, CV2 2DX

AGENDA ITEM	DISCUSSION	ACTION
HTB 13/267 INTEGRATED PERFORMANCE REPORT	The Trust Board **CONFIRMED** their understanding of the report and the report was **NOTED.**	
HTB 13/268 PROVIDER MANAGEMENT REGIME	GN reported that there is no change in the overall position from previous months and proposed that in future the PMR report is slimmed down in order to keep it focussed. TR sought clarification on what actions would be taken if things were to change considerably and AH stated an escalation meeting would take place to cover areas of concern. The Trust Board **APPROVED** the report, **CONFIRMED** its support for Governance Declaration and **NOTED** the new monthly submissions.	
HTB 13/269 SIG REPORT	MP presented this item and noted that the purpose of the report is to provide the Trust Board with a quantitative summary of significant incidents that were opened or closed during the period January – May 2013. In response to a query from TR on Never Events, MP noted that gap analysis results will be presented at Grand Round on 6 September 2013. TR added that feedback produced at the Grand Round would be beneficial along with details of any lessons learned. ST stated that the breakdown of information was useful in terms of understanding the larger numbers and added it would also be useful if we can include in the summary detail of where there has been an increase since last year. MP stated that this report arrives at the same time as safety thermometer and the analysis is completed as one. NS added that it would be useful to know how this data compares to other similar sized acute hospitals. The Trust Board **RECEIVED** and **ACCEPTED** the report.	
HTB 13/270 MORTALITY	MP presented this item and noted that the purpose the report is to provide the Trust Board with a quantitative summary of Trust-wide mortality data for February and March 2013 and to provide an update on the status of any closed/ongoing Dr Foster mortality reports. The Trust Board **RECEIVED** and **ACCEPTED** the report.	
HTB 13/271 REMUNERATION COMMITTEE TERMS OF REFERENCE	NS noted that the purpose of the report is review/approve the terms of reference discussed at the meeting on 8 May 2013. MPa noted that the terms of reference will need further review and needs minor amendments in a small number of places to ensure consistency with best practice and national guidance. The Trust Board **AGREED** to carry this item over to the next meeting.	**MPa**

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST

MINUTES OF THE PUBLIC MEETING OF THE UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST BOARD HELD ON WEDNESDAY 26th JUNE 2013 AT 1.00PM IN ROOM 20063/64, CLINICAL SCIENCES BUILDING, UNIVERSITY HOSPITAL, COVENTRY, CV2 2DX

AGENDA ITEM	DISCUSSION	ACTION
HTB 13/272 F&P COMMITTEE MEETING REPORT – 22 APRIL 2013	ST presented this item and noted that the purpose of the report is to advise the Board of the F&P Committee meeting agenda for 22 April 2013 and of the key decisions/outcomes made by the F&P Committee. The Trust Board **REVIEWED** and **NOTED** the report.	
HTB 13/273 FOUNDATION TRUST APPLICATION UPDATE	The purpose of the report is to provide an update on the progress and timeline for the Foundation Trust (FT) status application and report on decisions made by the FT Steering Committee. AH stated that the NHS Trust Development Authority is going through a process of agreeing the timelines for NHS Trust to achieve FT status and we are awaiting feedback on this. AH stated that the December 2013 deadline has been removed and the new deadline for UHCW is June 2015. ST asked if there would be a session before September 2013 for the Board to review and digest the FT timelines for UHCW. AH confirmed that the FT membership session scheduled for 19 June 2013 had been cancelled. KB confirmed there is one FT membership event in the diary per month. The Trust Board **RECEIVED** and **ACCEPTED** the report.	
HTB 13/274 WORK PROGRAMME	The Work Programme was **NOTED** by the Trust Board.	
HTB 13/275 ANY OTHER BUSINESS	No other business was noted.	
HTB 13/276 DATE OF NEXT MEETING	The date of the next meeting is **Wednesday 31 July 2013** at **3pm** in the **Clinical Sciences Building, University Hospital, Coventry, CV2 2DX.**	
HTB 13/277 APPROVAL OF MINUTES	These minutes are approved subject to any amendments agreed at the next Trust Board meeting. **SIGNED** …….. **CHAIRMAN** **DATE** ……..	

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST
ACTIONS UPDATE: PUBLIC TRUST BOARD MEETINGS

26 June 2013

AGENDA ITEM	ACTION	LEAD	DATE TO BE COMPLETED	COMMENT
ACTIONS IN PROGRESS				
ACTIONS COMPLETE				
HTB 13/172 (24.4.13) INTEGRATED PERFORMANCE REPORT	**REQUESTED** that the Chief Executive Officer writes to all parties setting out the views of the Trust in relation to the workings of the local health economy and across areas of common concern	AH	3.6.13	Complete
HTB 13/175 (24.4.13) FRANCIS INQUIRY: TASK & FINISH GROUP UPDATE	The Chief Executive Officer confirmed that a detailed gap analysis and action plan will be presented to the Trust Board in June 2013. The Trust Board **ENDORSED** and **SUPPORTED** the actions of the Chief Executive Officer and the Executive Team and **REQUESTED** further periodic reports of not less than annual in nature.	AH AH	June 2013 June 2014	Complete – this is on the July Board agenda. Report on Francis has been added to the Board Forward Planner and a further report will be coming in September 2013.
HTB 13/211 RESEARCH AND DEVELOPMENT ANNUAL REPORT	Professor Winstanley had a copy of a congratulatory letter from Dame Sally Davis regarding the Bio-medical research. He will send a copy to Board members.	PW	June 2013	Circulated.
REPORTS SCHEDULED FOR NEXT MEETING				
HTB 13/219 ICT REPORT	Trust Board **REQUESTED** Mr Eltringham to bring back a report after talking to UHB to the September Board.	DE	September 2013	Scheduled for September Board meeting
REPORTS SCHEDULED FOR FUTURE MEETINGS				
HTB 12/410 (26.9.12) PERFORMANCE REPORT	The Board will look to have more formal periodical meetings with the CCG's to engage with them and build up good solid working relationships. The Chairman requested that Mrs Gardiner facilitate a meeting in the next 2-3 months. Mrs Gardiner advised that she will need to take guidance from the CCG's in terms of whether they yet have full Board appointments.	JG	July 2013	Exec to Exec meetings with CCG's on 24.10.12 and 21.11.12 both cancelled by CCG. CEO confirmed with CCG Accountable Officer that the CCG does not require Board to Board meetings at this time. To be reviewed in six months i.e. July 2013.

Red = outstanding
Black = in progress not yet due
Green = complete

Unless a date is specified it will be assumed that the date for completion is the 1st Monday following the next Trust Board.

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST
ACTIONS UPDATE: PUBLIC TRUST BOARD MEETINGS

26 June 2013

AGENDA ITEM	ACTION	LEAD	DATE TO BE COMPLETED	COMMENT
HTB 12/460 (31.10.12) SUSTAINABLE SPECIALTIES & FRAIL OLDER PEOPLES PROGRAMME	Dr Sabapathy suggested that this be the first item for discussion on the Board to Board agenda with the CCG's as a topic for partnership working.	JG	As above	As above
ACTIONS REFERRED TO TRUST BOARD SUB-COMMITTEES				
HTB 13/012 (30.1.13) MORTALITY REPORT	**REQUESTED** that a list be made available to the Board Seminar in March relating to the level of complaints received regarding to mortality issues for three years prior to 31st March 2013.	MP	4.3.13	Scheduled for 6.3.13; but B/S cancelled. To be rescheduled.

Red = outstanding
Black = in progress not yet due
Green = complete

Unless a date is specified it will be assumed that the date for completion is the 1st Monday following the next Trust Board.

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST

REPORT TO THE TRUST BOARD: PUBLIC

31 July 2013

Subject:	**Trust Board Meeting Session Report of 26th June 2013**
Report By:	**Nick Stokes, Acting Chairman**
Author:	**Moosa Patel, Interim Director of Corporate Affairs**
Accountable Executive Director:	**Nick Stokes, Acting Chairman**

GLOSSARY

Abbreviation	In Full

WRITTEN REPORT (provided in addition to cover sheet)? ☐ **Yes** ☒ **No**

POWERPOINT PRESENTATION? ☐ **Yes** ☒ **No**
NB Presentations need to be submitted for inclusion in Board papers

Title	
Approx. Length	

PURPOSE OF THE REPORT / PRESENTATION:

To advise the Board of the private Trust Board Session meeting agenda for 26th June 2013 and of any key decisions/outcomes made by the Trust Board.

Trust Board Session of 26th June 2013

Chairman's Report: Mr N Stokes, Acting Chair The Trust Board **NOTED** the Chairman's report.
Chief Executive's Report: Mr A Hardy, Chief Executive Officer The Trust Board **NOTED** the Chief Executive Officer's report.
Board Assurance Framework: Mrs M Pandit, Chief Medical Officer The Trust Board **NOTED** and **APPROVED** the report.
Quality Governance Committee Chairs Meeting Report and Draft Quality Governance Minutes of Meeting – 11 June 2013: Professor P Winstanley, Non-Executive Director The Trust Board **NOTED** the report.
PWC Quality Governance Framework Action Plan: Mrs M Pandit, Chief Medical Officer The Trust Board **APPROVED** the report.
Additional Colorectal Surgeon Business Case: Mr D Eltringham, Chief Operating Officer The Trust Board **APPROVED** the report.
Finance and Performance Committee Chairs Meeting Report – 24th June 2013: Ms S Tubb, Senior Independent Director The Trust Board **NOTED** the report.
External Support to the UHCW Transformation Programme: Professor M Radford, Chief Nursing Officer The Trust Board **APPROVED** the report, **SUBJECT TO** a further paper being submitted to the next Board meeting.
Draft Finance and Performance Minutes of the Meeting – 29th May 2013: Ms S Tubb, Senior Independent Director The Trust Board **NOTED** the minutes.
Finance Strategy: Mrs G Nolan, Chief Finance Officer The Trust Board **APPROVED** the strategy.
Draft Remuneration Committee Report – 8th May 2013: Mr N Stokes, Acting Chairman The Trust Board **NOTED** the report.
Procurement Strategy: Mrs G Nolan, Chief Finance Officer The Trust Board **APPROVED** the report.
Sustainability Strategy: Mr I Crich, Chief HR Officer The Trust Board **APPROVED** the report.
Healthy Travel Strategy: Mr I Crich, Chief HR Officer The Trust Board **APPROVED** the report.

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST

REPORT TO THE TRUST BOARD: PUBLIC

31 July 2013

Delivery of Foundation Trust Action Plans from External Reviews: Mr A Hardy, Chief Executive Officer The Trust Board **APPROVED** and **NOTED** the report.
Work Programme: Mr N Stokes, Acting Chairman The Trust Board **NOTED** the work programme.
Extraordinary Audit Committee Meeting Minutes: Mr N Stokes, Acting Chairman The Trust Board **NOTED** the minutes.
Late Items: Mr N Stokes, Acting Chairman The Trust Board **NOTED** the paper.

SUMMARY OF KEY RISKS:

No risks were identified.

RECOMMENDATION / DECISION REQUIRED:

For Noting.

IMPLICATIONS:

Financial:	N/A
HR / Equality & Diversity:	N/A
Governance:	N/A
Legal:	N/A

REVIEW:

Trust Standing Committee	**Date**	**Trust Standing Committee**	**Date**
Quality Governance Committee		Remuneration Committee	
Finance and Performance Committee		Executive Meeting	
Audit Committee			

DATA QUALITY:

Data/information Source:	
Data Quality Controls:	
Data Limitations:	

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST

REPORT TO THE TRUST BOARD: PUBLIC

31 July 2013

Subject:	Integrated Performance Report – Month 3 – 2012/13
Report By:	Gail Nolan, Chief Finance Officer
Author:	Jonathan Brotherton, Director of Performance and Programme Management Lynda Cockrill, Head of Performance and Programme Analytics Sarah Oakley, Head of Performance and Programme Finance
Accountable Executive Director:	Gail Nolan, Chief Finance Officer

GLOSSARY

Abbreviation	**In Full**
A&E	Accident and Emergency
ALOS	Average Length of Stay
AMU	Acute Medical Unit
CAB	Choose and Book
CIP	Cost Improvement Programme
DNA	Did Not Attend
EBITDA	Earnings Before Interest, Tax, Depreciation and Amortisation
ED	Emergency Department
FRR	Financial Risk Rating
FTE	Full Time Equivalent
HRED	Human Resources Equality and Diversity
HSMR	Hospital Standardised Mortality Ratio
KPI	Key Performance Indicator
NIHR	National Institute for Health and Research
NPS	Net Promoter Score
PMR	Provider Management Regime
PPMO	Performance and Programme Management Office
QIPP	Quality Innovation Productivity and Prevention
QPS	Quality and Patient Safety
RTT	Referral To Treatment
SHMI	Standardised Hospital-level Mortality Indicator
VTE	Venous Thromboembolism
WTE	Whole Time Equivalent
YTD	Year To Date

WRITTEN REPORT (provided in addition to cover sheet)? ☒ **Yes** ☐ **No**

POWERPOINT PRESENTATION? ☐ **Yes** ☒ **No**
NB Presentations need to be submitted for inclusion in Board papers

Title	
Approx. Length	

PURPOSE OF THE REPORT / PRESENTATION:

To inform the Board of the performance against the key agreed dashboard indicators for the month of June 2013

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST

REPORT TO THE TRUST BOARD: PUBLIC

31 July 2013

SUMMARY OF KEY ISSUES:

In this report, 18 of the 53 KPIs reported against are breaching the standard / target, this is a reduction from the previous month. Further detail is contained within the report.

The Trust has recorded **95.70%** against the A&E 4 hour wait target for June and has therefore achieved the 95% target for the first time in nine months. This is also just above the trajectory submitted to the NHS TDA (95.4%). Considerable pressures remain, however, so delivery of the emergency care improvement plan is paramount and continues in earnest.

The extended pressure on the non-elective pathway in previous months has resulted in the deterioration of a number of the KPIs linked to the elective pathway. Some of these are difficult to recover and thus a significant performance risk has arisen. Recovery plans have been devised to restore elective care access performance.

Principal performance exceptions by Domain

Excellence in patient care and experience

- There have been 3 reported Grade 3 pressure ulcers during June. Following root cause analysis (RCA), all are deemed as avoidable.
- Last minute non-clinical cancelled operations (elective) have risen following last month to **2.24%**
- Referral to Treatment non delivery was recorded across a number of specialties
- The Trust has recorded 416 minutes Total time in A&E - admitted patients (95th centile). This KPI has improved considerably in line with 4 hour performance but represents a continued breach.

Delivery of Value for Money

- The Trust is currently reporting a net deficit of £4.6m which is £0.4m better than the plan signed off by the Trust Board and submitted to the NHS Trust Development Authority.
- The forecast outturn remains a £2.5m surplus for 2013/14.

Employer of Choice

- The Trust has recorded a 54.46% Appraisal rate. This is considerably below target.
- The Trust has recorded a 60.42% Consultant appraisal rate. This is below target.
- The Trust has recorded a 62.03% attendance at mandatory training. This is below target.
- The Trust has recorded a 4.06% Sickness rate. This is above YTD plan.

Research Based Healthcare Organisation

- There are 2 additional KPIs being developed that will be included in future reports under this domain.

Leading Training and Education Centre

- At present there is a single KPI with a further 2 to follow in future months.

SUMMARY OF KEY RISKS:

- Failure to deliver and sustain the A&E target
- Recent and sustained pressure on the non-elective pathway is manifesting itself as month on month deterioration of the KPIs linked to the elective pathway
- Performance metrics around workforce are yet to show significant signs of improvement
- Development of CIPs to ensure recurrent savings needs to be accelerated which may require transformational support

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST

REPORT TO THE TRUST BOARD: PUBLIC

31 July 2013

RECOMMENDATION / DECISION REQUIRED:

- **The Board are asked to confirm their understanding of the contents of the June 2013 IPR and note the associated actions.**

IMPLICATIONS:

Financial:	CIP development and the impact of additional resources to deliver the A&E and waiting times
HR / Equality & Diversity:	Effective Management of attendance and appraisal of staff
Governance:	None
Legal:	None

REVIEW:

Trust Standing Committee	**Date**	**Trust Standing Committee**	**Date**
Quality Governance Committee		Remuneration Committee	
Finance and Performance Committee		Executive Meeting	
Audit Committee			

DATA QUALITY:

Data/information Source:	Various
Data Quality Controls:	DQ policies, PPMC and F&P
Data Limitations:	ESR Self Service roll out not yet complete.

University Hospitals Coventry and Warwickshire NHS Trust

University Hospitals Coventry and Warwickshire NHS Trust

Integrated Quality, Performance and Finance Reporting Framework

Reporting Period:
June 2013

Report Date:
25 July 2013

Contents

Executive Summary

Executive Summary

Summary of performance

Commentary

In this report the Trust has highlighted areas of compliance and underperformance. Areas which are underperforming also include an exception report and trends/benchmarking where available.

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Executive Summary

Summary of performance

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Executive Summary

Summary of performance

PMR

PMR status for June is reported as below:

PERIOD	Governance Risk Rating	Financial Risk Rating
Jul 12	Green (1.0)	Red (2.0)
Aug 12	Green (1.0)	Red (2.0)
Sep 12	Green (0.0)	Red (2.0)
Oct 12	Red (4.0)	Red (2.0)
Nov 12	Red (4.0)	Red (2.0)
Dec 12	Red (4.0)	Red (2.0)
Jan 13	Red (4.0)	Red (2.0)
Feb 13	Red (4.0)	Red (2.0)
Mar 13	Red (4.0)	Red (2.0)
Apr 13	Red (4.0)	Red (1.0)
May 13	Red (4.0)	Red (2.0)
Jun 13	Red (4.0)	Red (1.0)

Executive Summary

Trust Scorecard – June 2013

No Target or RAG rating
Achieving or exceeding target
Slightly behind target
Not achieving target
Data not currently available

Performance has improved from the previous month
Performance has deteriorated from the previous month
Performance is stable compared to previous month

High data quality assurance
Medium data quality assurance
Low data quality assurance

Trust Board Scorecard	Reporting Period									June
Domain - Excellence in patient care and experience										
Measure	Previous month	Actual	DoT	YTD Plan	Annual Target	Annual FOT	Executive Lead	Owner	Trend	DQ
Clostridium difficile (Trust acquired) - cumulative	7	11	⇩	16	57	57	Mark Radford	Karen Bond		✓
MRSA bacteremia (Trust acquired) - cumulative	0	0	⇨	0	0	0	Mark Radford	Karen Bond		✓
Eligible patients having VTE risk assessment (1 month in arrears)	95.88%	96.05%	⇧	95.00%	95.00%	95.00%	Mark Radford	Oliver Chapman		✓
Falls per 1000 occupied bed days resulting in serious harm	0.12	0.10	⇧	0.05	0.05	0.05	Mark Radford	Paul Martin		✓
HSMR (basket of 56 diagnosis groups) (3 month in arrears)	104	90	⇧	100	100	100	Meghana Pandit	Paul Martin		✓
SHMI (Quarterly) (6 month in arrears)	103.00	103.00	⇨	100	100	100	Meghana Pandit	Paul Martin		✓
Number of never events reported - cumulative	1	1	⇨	0	0	1	Meghana Pandit	Paul Martin		✓
Pressure Ulcers 3 and 4 (Trust associated)	0	3	⇩	0	0	3	Mark Radford	Karen Bond		!
Dementia case finding question (1 month in arrears)	91.50%	93.08%	⇧	90.00%	90.00%	90.00%	Meghana Pandit	Mark Radford		✓
No of Dr Foster Red mortality alerts (3 month in arrears)	0	1	⇩	0	0	1	Meghana Pandit	Paul Martin		✓
No of Dr Foster High Relative risks (3 month in arrears)	1	0	⇧	0	0	1	Meghana Pandit	Paul Martin		✓
% spending >90% of their stay on a stroke unit (1 month in arrears)	86.44%	81.48%	⇩	80.00%	80.00%	80.00%	David Eltringham	Jon Barnes		!
18 week referral to treatment time - Admitted (1 month in arrears)	91.90%	90.54%	⇩	90.00%	90.00%	90.00%	David Eltringham	Ros Kay		✓
18 week referral to treatment time - Non-admitted (1 month in arrears)	97.57%	97.53%	⇩	95.00%	95.00%	95.00%	David Eltringham	Ros Kay		✓
RTT - incomplete in 18 weeks (1 month in arrears)	95.59%	93.64%	⇩	92.00%	92.00%	92.00%	David Eltringham	Ros Kay		✓
RTT non delivery in all specialties (1 month in arrears)	14	17	⇩	0	0	0	David Eltringham	Ros Kay		✓
2 week cancer wait (GP referral to outpatient appointment - 1 month in arrears)	94.72%	96.35%	⇧	93.00%	93.00%	93.00%	David Eltringham	Jon Barnes		✓
31 day diagnosis to treatment cancer target (1 month in arrears)	100.00%	97.14%	⇩	96.00%	96.00%	96.00%	David Eltringham	Jon Barnes		✓
62 days urgent referral to treatment cancer target (1 month in arrears)	85.86%	85.19%	⇩	85.00%	85.00%	85.00%	David Eltringham	Jon Barnes		✓
A&E 4 hour wait target	92.87%	95.70%	⇧	95.00%	95.00%	95.00%	David Eltringham	Jon Barnes		✓
A&E Total time in A&E - admitted patients	498	416	⇧	240	240	240	David Eltringham	Jon Barnes		✓
A&E Total time in A&E - non-admitted patients	237	230	⇧	240	240	240	David Eltringham	Jon Barnes		✓
Breaches of the 28 day treatment guarantee following elective cancellation	13.04%	2.44%	⇧	5.00%	5.00%	5.00%	David Eltringham	Jon Barnes		✓
Delayed transfers as a percentage of admissions	4.05%	3.74%	⇧	3.50%	3.50%	3.50%	David Eltringham	Jon Barnes		!
Diagnostic waiters, 6 weeks and over	0.33%	0.37%	⇩	1.00%	1.00%	1.00%	David Eltringham	Jon Barnes		✓
DNA rates (first) (3 month in arrears)	6.59%	6.91%	⇩	7.60%	7.60%	7.60%	David Eltringham	Jon Barnes		✓
DNA rates (FU) (3 month in arrears)	7.33%	7.84%	⇩	9.40%	9.40%	9.40%	David Eltringham	Jon Barnes		✓
Last minute non-clinical cancelled ops(elective)	1.21%	2.24%	⇩	0.80%	0.80%	0.80%	David Eltringham	Jon Barnes		✓
Theatre efficiency - Main	82.50%	79.50%	⇩	85.00%	85.00%	85.00%	Meghana Pandit	Steve Parker		✓
Theatre efficiency - Rugby	86.50%	85.70%	⇩	85.00%	85.00%	85.00%	Meghana Pandit	Steve Parker		✓
Theatre efficiency - Day Surgery	66.50%	65.60%	⇩	70.00%	70.00%	70.00%	Meghana Pandit	Steve Parker		✓
Same sex accommodation standards breaches	0	0	⇨	0	0	0	David Eltringham	Gillian Arblaster		✓
Standardised ALOS (Elective) (3 month in arrears)	3.60	3.30	⇧	3.80	3.80	3.80	David Eltringham	Jon Barnes		✓
Standardised ALOS (Non-Elective) (3 month in arrears)	5.60	5.70	⇩	4.60	4.60	4.60	David Eltringham	Jon Barnes		✓
Successful Choose and Book	5.69%	11.60%	⇩	3.00%	3.00%	3.00%	David Eltringham	Jon Barnes		✓
Readmission Rate (6 month in arrears)	6.69%	6.91%	⇩	7.10%	7.10%	7.10%	David Eltringham	Jon Barnes		✓
Friends & Family Test (combined percentage coverage)	19.65	19.16	⇩	15	15	15	Meghana Pandit	Paul Martin		✓
Number of complaints registered - cumulative	74	101	⇩	120	480	480	Meghana Pandit	Paul Martin		✓

Executive Summary

Trust Scorecard – June 2013

No Target or RAG rating
Achieving or exceeding target
Slightly behind target
Not achieving target
Data not currently available

Performance has improved from the previous month
Performance has deteriorated from the previous month
Performance is stable compared to previous month

High data quality assurance
Medium data quality assurance
Low data quality assurance

Trust Board Scorecard	Reporting Period									June
Domain - Deliver value for money										
Measure	**Previous month**	**Actual**	**DoT**	**YTD Plan**	**Annual Target**	**Annual FOT**	**Executive Lead**	**Owner**	**Trend**	**DQ**
Pay expenditure (actual vs plan)	3.00%	3.00%	⇨	0.00%	0.00%	9.30%	Gail Nolan	Anthony Hobbs		✓
Non pay expenditure (actual vs plan)	-4.30%	-4.50%	⇧	0.00%	0.00%	3.60%	Gail Nolan	Anthony Hobbs		✓
CIP (actual vs plan)	279.44%	260.50%	⇩	100.00%	100.00%	51.90%	Gail Nolan	Anthony Hobbs		!
EBITDA margin	5.90%	5.60%	⇩	5.29%	9.80%	9.80%	Gail Nolan	Sarah Oakley		✓
I&E Surplus margin	-3.60%	-3.80%	⇩	-4.08%	0.48%	0.50%	Gail Nolan	Sarah Oakley		✓
Liquidity ratio (days)	1.80	4.31	⇧	3.37	7.85	8.45	Gail Nolan	Alan Jones		✓
Monitor Risk Rating	2	1	⇩	1	2	2	Gail Nolan	Sarah Oakley		✓
PMR indices	5	5	⇨	0	0	0	Gail Nolan	Sarah Oakley		✓
Total income (actual vs plan)	-2.70%	-1.40%	⇧	0.00%	0.00%	-0.30%	Gail Nolan	Anthony Hobbs		✓
Domain - Employer of Choice										
Measure	**Previous month**	**Actual**	**DoT**	**YTD Plan**	**Annual Target**	**Annual FOT**	**Executive Lead**	**Owner**	**Trend**	**DQ**
Appraisal rate	53.49%	54.46%	⇧	90.00%	90.00%	90.00%	Ian Crich	Andrew Mcmenemy		!
Consultant appraisal rate	58.24%	60.42%	⇧	90.00%	90.00%	90.00%	Ian Crich	Andrew Mcmenemy		!
Attendance at mandatory training (1 month in arrears)	65.07%	62.03%	⇩	90.00%	90.00%	90.00%	Ian Crich	Andrew Mcmenemy		!
Sickness rate	4.19%	4.06%	⇧	3.39%	3.39%	3.39%	Ian Crich	Andrew Mcmenemy		!
Domain - Leading research based health care organisation										
Measure	**Previous month**	**Actual**	**DoT**	**YTD Plan**	**Annual Target**	**Annual FOT**	**Executive Lead**	**Owner**	**Trend**	**DQ**
Number of Pts recruited into NIHR portfolio - cumulative	809	865	⇧	708	4,250	4,250	Meghana Pandit	Chris Imray		✓
Domain - Leading training and education centre										
Measure	**Previous month**	**Actual**	**DoT**	**YTD Plan**	**Annual Target**	**Annual FOT**	**Executive Lead**	**Owner**	**Trend**	**DQ**
Job evaluation survey tool (JEST) score (1 month in arrears)	3.7	3.7	⇨	3.5	3.5	3.5	Meghana Pandit	Maggie Allen		✓

Domain 1: Excellence in patient care and experience

Domain Summary – Excellence in Patient Care and Experience

Commentary

In this summary, we have outlined the overall performance for the Trust for all of the **Excellence in Patient Care and Experience** indicators. It should be noted that the Trusts' recorded **SHMI score of 103.0** hasn't changed since the previous month as it is reported quarterly. So whilst this represents a breach of the KPI there is nothing new to report this month.

The following areas are covered in more detail overleaf due to their current performance:

- **Patient falls per 1000 occupied bed days resulting in serious harm** showed a slight decrease from last month. This measure will need to remain under close scrutiny although it is intended that the target is revised in line with Regional and National benchmarks.
- There have been **3 reported Grade 3 pressure ulcers** during June. Following root cause analysis (RCA), all are deemed as avoidable.
- There has been **one** reported **Dr Foster Red Mortality Alert** for a drainage through perineal region.
- The Trust has recorded **416 minutes Total time in A&E - admitted patients (95th centile).** This KPI has improved significantly from the position last month but continues to be a breach.
- **Last minute non-clinical cancelled operations (elective)** have risen following last month to **2.24%** and is therefore still above the target.
- The **Successful Choose and Book** KPI has deteriorated since last month with performance at **11.6%,** this is significantly above the target of 3%.
- The Trust has recorded **5.7** days as the **Standardised ALOS (non elective).** This is another small increase from last month and is above the benchmarked target of 4.6 days.
- **Referral to Treatment non delivery** was recorded across a number of specialties; Oral Surgery, Neurosurgery, General Surgery, Urology, Plastic Surgery, Trauma and Orthopaedics, Gynaecology, ENT, Cardiothoracic surgery and Acute Medicine. Deterioration of this KPI is of significant concern to the wider RTT performance. A weekly risk assessment is undertaken and Groups are preparing recovery plans which are sighted by the Chief Officers.
- **Delayed transfers of care** decreased from the previous month to **3.74%** and are now only slightly above the target of 3.5%.

Domain Summary – Excellence in Patient Care and Experience

Commentary (continued)

There is one indicator in a **watching or amber** status;

• The Trust has recorded a slight deterioration in **theatre efficiency** at all three sites although main theatres and day surgery are still below the required thresholds.

The Trust has recorded **95.7%** against the **A&E 4 hour wait** target for June. This shows an improvement from last month and for the first time in nine months has achieved the 95% standard.

The Trust has recorded **230 minutes Total time in A&E – non admitted patients (95th centile)** this month and while the KPI has been improved and achieved, it remains close to the target of 240 minutes and will require continued close scrutiny.

To date in 2013/14, the target for **Clostridium Difficile** has been achieved.

Excellence in patient care – area of underperformance

Falls per 1000 occupied bed days resulting in serious harm

Commentary

This indicator reports patient falls (graded as causing major or catastrophic injury) per 1000 occupied bed days.

June's reported position shows an increase from 0.03 to 0.12 which has breached the 0.05 threshold. This represents 4 falls in this category this month. This is marginally above the average performance throughout 2012/13.

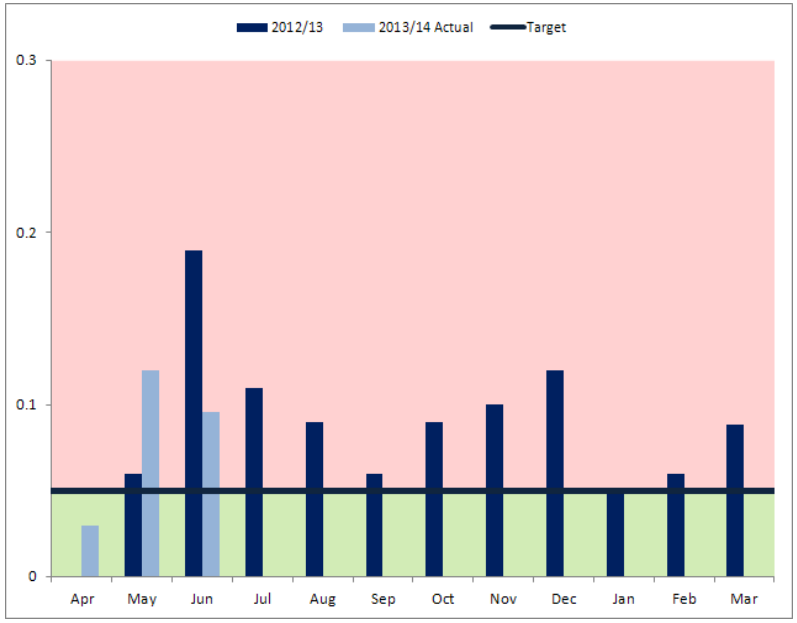
The falls action plan that is led by the Chief Nursing Officer remains active and is reviewed monthly at a Trust wide falls forum.

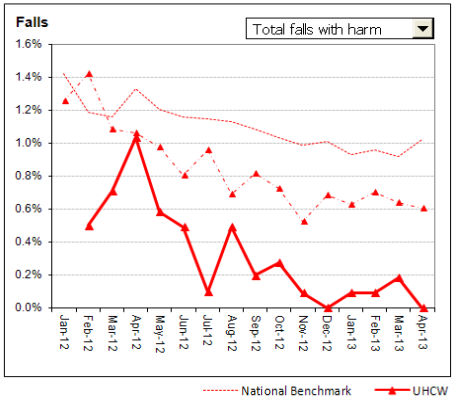
This indicator remains under close scrutiny for further deviation but performance has improved this month.

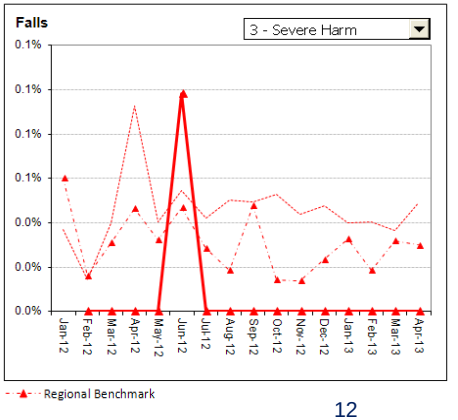
The Trust will be presenting alongside all other providers in the health economy at the 'Falls Focus Day' run by the Clinical Commissioning Groups. This day has been rescheduled to September and will be looking at best practice and improvements for preventing patient falls.

It is worth noting that the national safety thermometer shows the Trust is performing well compared to the Regional and National Benchmark for falls with harm. In light of this, the target for this indicator will be revised for future monitoring.

Overall Trust position







Source: Health and Social Care Information Centre

Excellence in patient care – area of underperformance

Pressure Ulcers 3 and 4 (Trust Associated)

Commentary

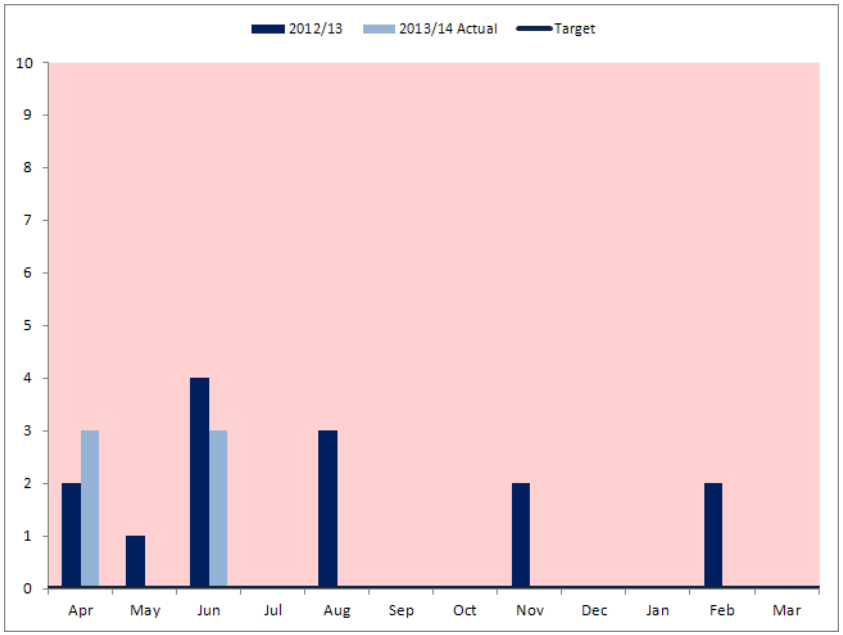
Applicable Frameworks/Contracts: Acute Contract - Quality Schedule

This indicator reports the number of incidences of grade 3 and 4 avoidable pressure ulcers acquired by in patients in the care of the organisation in the calendar month. The organisation has a target of 0. Monitoring this will encourage best practice in prevention and management for all patients at risk of developing pressure ulcers.

There have been 3 grade 3 pressure ulcers in June, following route cause analysis (RCA) all three are deemed as avoidable.

Performance meetings have been held with ward teams and actions have been put in place in respect of the avoidable pressure ulcers.

Overall Trust position



Excellence in patient care – area of underperformance

No of Dr Foster Red Mortality Alerts

Commentary

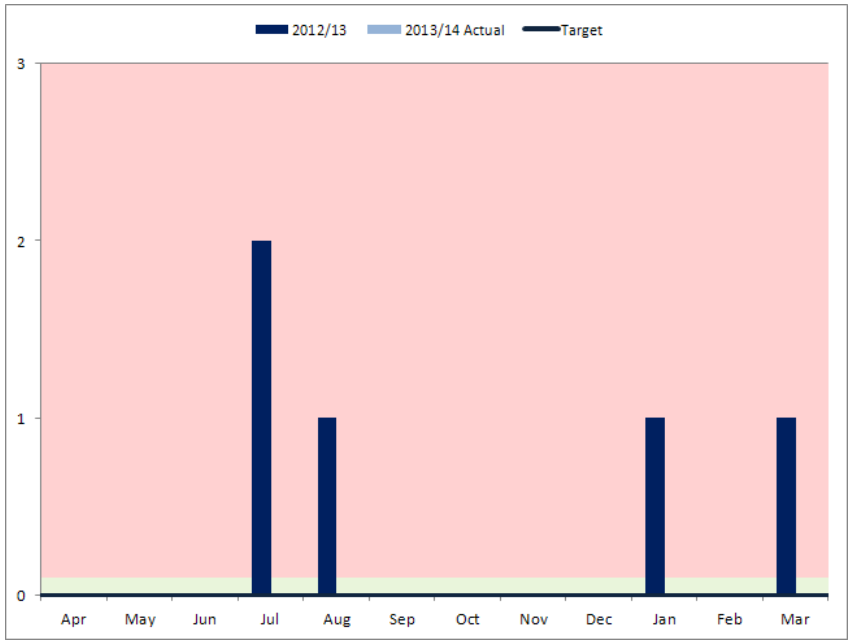
Applicable Frameworks/Contracts: Acute Contract - Quality Schedule

This indicator reports the number of Dr Foster High Relative Risk alerts per calendar month. The organisation has a target of 0. By achieving this target, the organisation can demonstrate links to quality of care and to managing its reputation as a healthcare provider.

This indicator is reported 3 months in arrears.

The Dr Foster red mortality alert that arose in March was drainage through perineal region. A clinical review is in progress and the coding review is to be conducted.

Overall Trust position



Excellence in patient experience – area of underperformance

A&E Total time in A&E - admitted patients

Commentary

Applicable Frameworks/Contracts:
NHS Performance Framework
Monitor Compliance Framework
Acute Contract - Quality Schedule

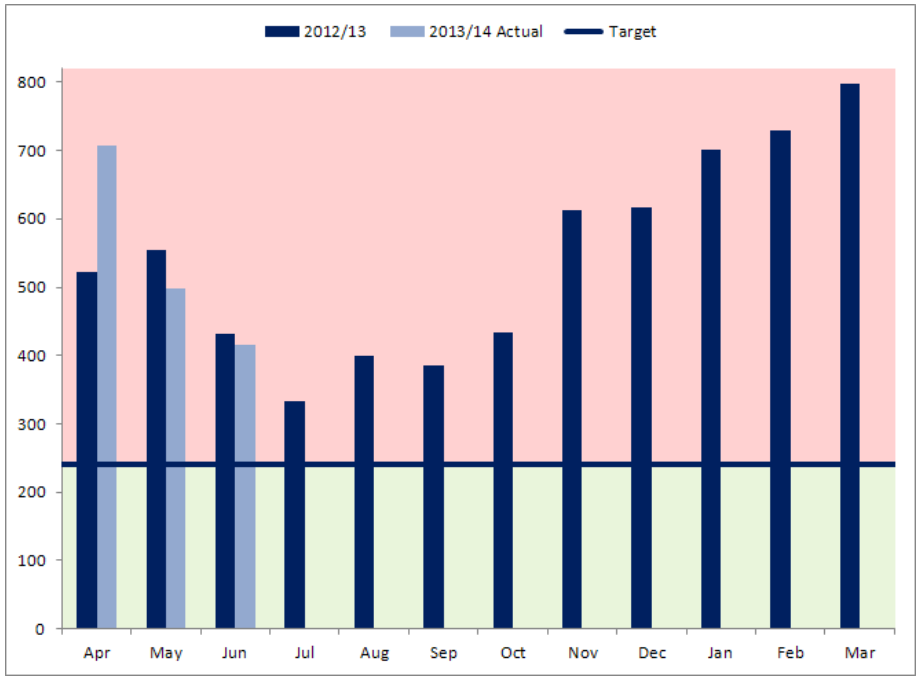
This indicator reports in minutes the length of time of the 95th percentile of admitted patients seen in A&E in a calendar month. This calculation excludes planned follow up attendances and attendances with unknown total times. The organisation's target is less than 240 minutes. By achieving this target, the organisation can demonstrate that their patient's receive fast access to treatment, which can improve outcomes and reduce anxiety for the patient.

The Trusts performance against this indicator has improved in line with overall 4 hour performance but remains significantly above target. The actions required to further improve this KPI are those attached to overall 4 hour performance, namely;

o ED recovery plan: The ED recovery plan is progressing as expected. Both the Steering Group and Recovery Board are in operation providing both drive and oversight around the various work streams

o Site Operations Team: Recruitment for the substantive site operations team is progressing well. The final round of interviews are about to be conducted with the full team in place by September.

Overall Trust position



o ED Model:

- A 'See and treat model' trial commenced on 17 June 2013 with approximately 30 patients per day being seen. This service runs daily from 12:00 to 20:00 with continuous review.
- The Rapid Assessment and Treatment model is scheduled to commence on 22 July
- Recruitment for the Emergency Nurse Practitioner service continues.

Excellence in patient experience – area of underperformance

Delayed transfers as a percentage of admissions

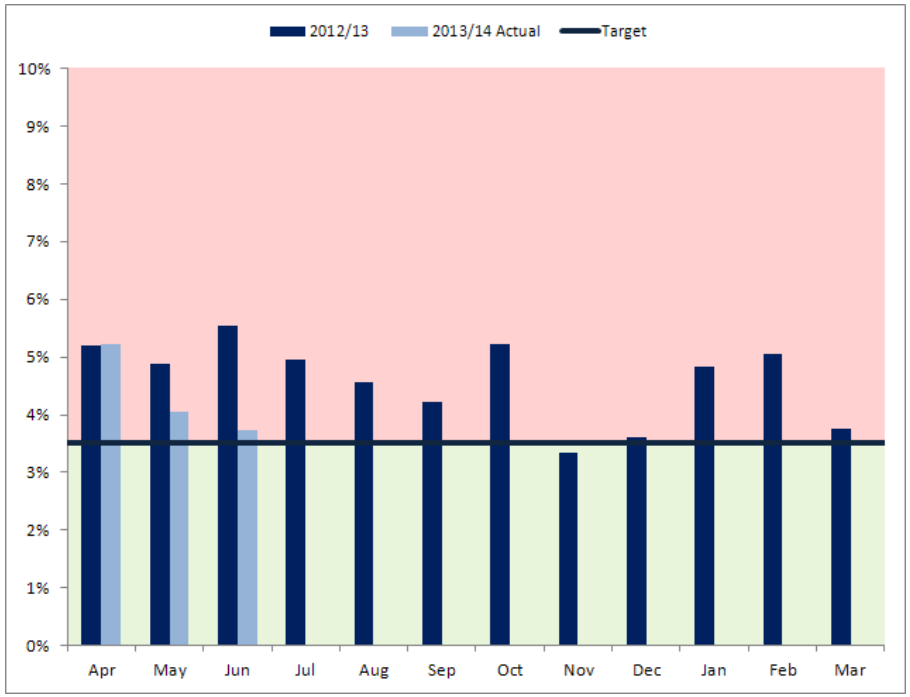
Commentary

Applicable Frameworks/Contracts:
Acute Contract - Quality Schedule

This indicator reports the percentage of Delayed Transfers of Care. This should be maintained at a minimum level. The organisation's target is less than 3.5%. By achieving this target, the organisation can demonstrate that it offers accessible and responsive services that are delivered in a timely and efficient manner.

Cross-organisational work continues at a senior level to further strengthen the whole system linkage around complex discharge. The overall Trust position shows a steady improvement and this KPI is now only marginally above the target at 3.74%

Overall Trust position



Excellence in patient experience – area of underperformance

Last minute non-clinical cancelled ops (elective)

Commentary

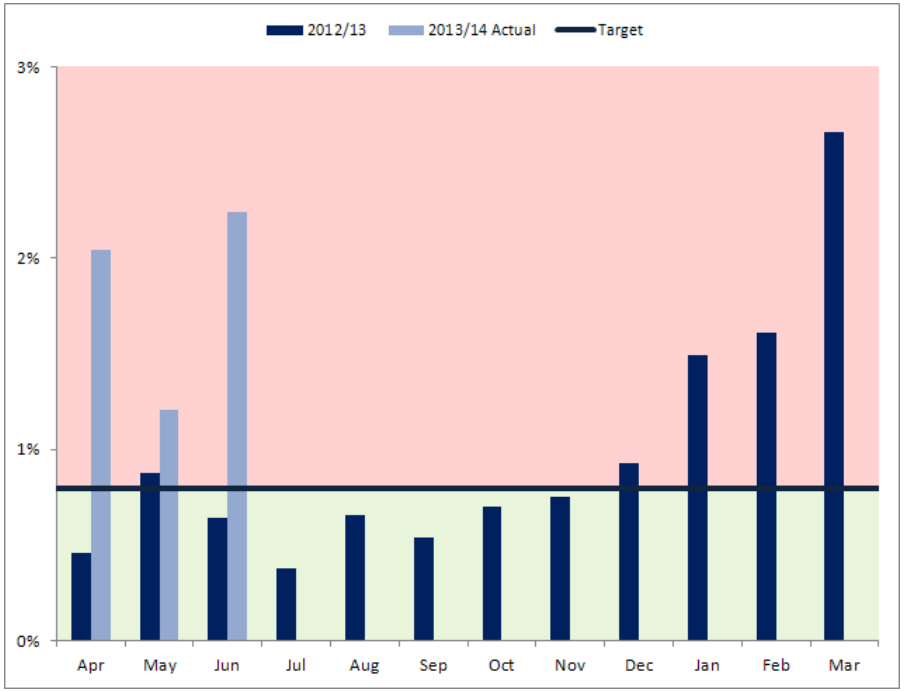
Applicable Frameworks/Contracts:
Acute Contract - Quality Schedule

This indicator reports the percentage of Elective Care operations cancelled by the Provider for non-clinical reasons either before or after patient admission per calendar month. The organisation's performance is measured against a target of less than 0.8%. By achieving this target, the organisation can demonstrate that it offers accessible and responsive services that are delivered in a timely and efficient manner, which can improve outcomes and reduce anxiety for the patient.

Last minute cancelled operations continued to improve to 1.21% (69 cases), however it remains higher than the target of 0.8%.

The primary reason for the cancellations was bed availability (sufficient to maintain ED flow & associated patient safety). With bed availability improving in June (reflected in overall ED transit time improvements) there was a greater reluctance to cancel the day before surgery in an attempt to increase elective activity. As ED / flow performance improves, on the day cancellations will also reduce back to plan.

Overall Trust position



Excellence in patient experience – area of underperformance

Standardised ALOS (Non-Elective)

Commentary

Applicable Frameworks/Contracts:
Acute Contract - Quality Schedule

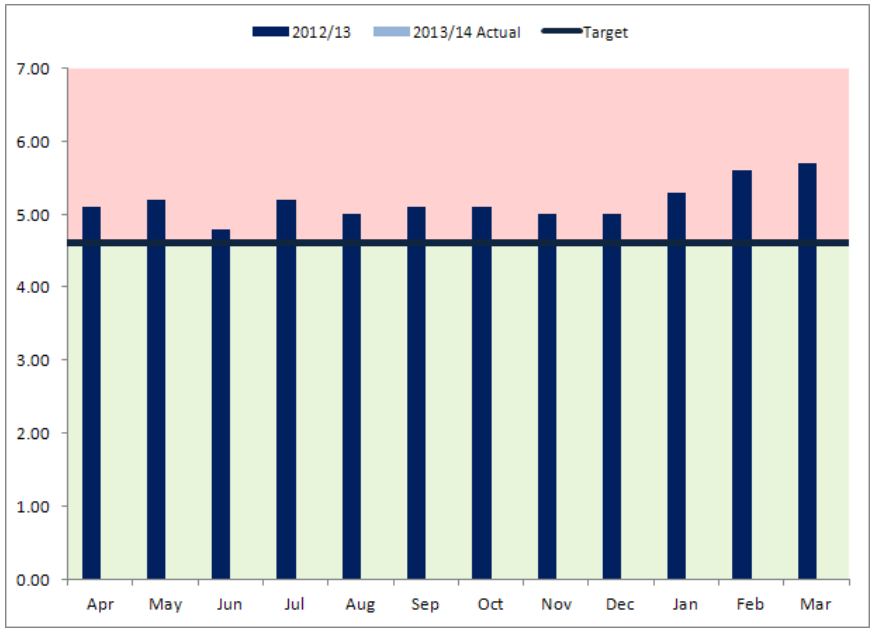
This indicator reports the average length of stay in a calendar month for non-elective patients, recorded on completion of their stay. The organisation's performance is measured against a target of 4.6. By achieving this target, the organisation can demonstrate that it offers accessible and responsive services that are delivered in a timely and efficient manner.

This indicator is reported 3 months in arrears.

This target has been set internally, based on the average performance against a benchmark group of ten other large acute/teaching hospitals in England.

Trust ALOS for non-elective patients has worsened slightly from last month and is showing a slight trend away from the target.

Overall Trust position



Excellence in patient experience – area of underperformance

Successful Choose and Book

Commentary

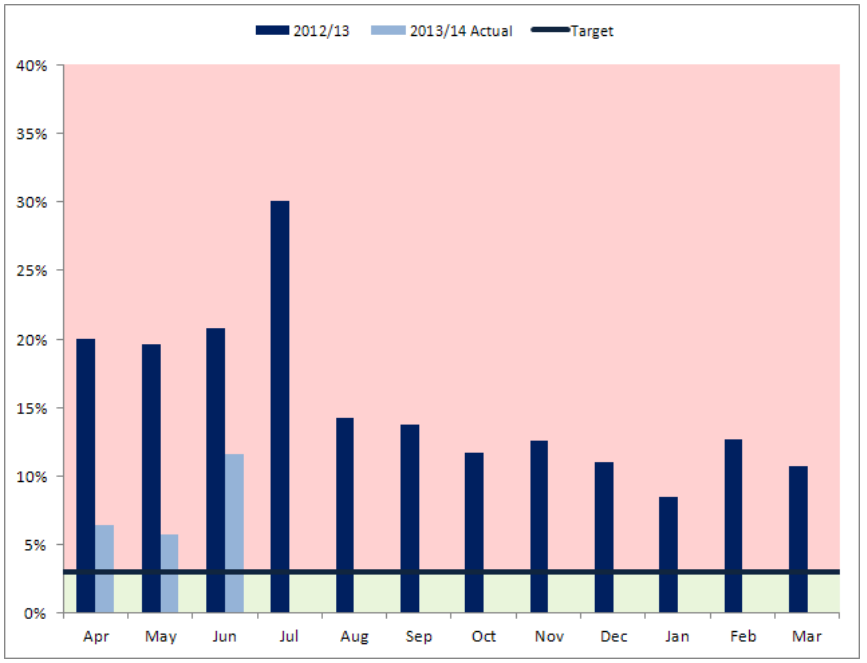
Applicable Frameworks/Contracts:
Acute Contract - Quality Schedule

This indicator reports the percentage of patients who could not book into an appointment slot. The organisation's performance is measured against a target of no more than 3%. By achieving this target, the organisation can demonstrate its commitment to offering accessible and responsive services that are delivered in a timely and effective manner.

In comparison to last year, the number of patients unable to book has continued to improve. However, the Trust is finding it a challenge to meet the target.

While some specialities have managed to bring their capacity issues under control thus preventing any issues occurring. Other specialities have sporadic capacity issues from time to time throughout the year especially at holiday times where capacity is reduced due to annual leave. However Orthopaedics continues to be the main area of concern with continuous issues with lack of outpatient capacity.

Overall Trust position



Excellence in patient care – area of underperformance

RTT non delivery in all specialties

Commentary

Applicable Frameworks/Contracts:
Acute Contract – NHS Performance Framework

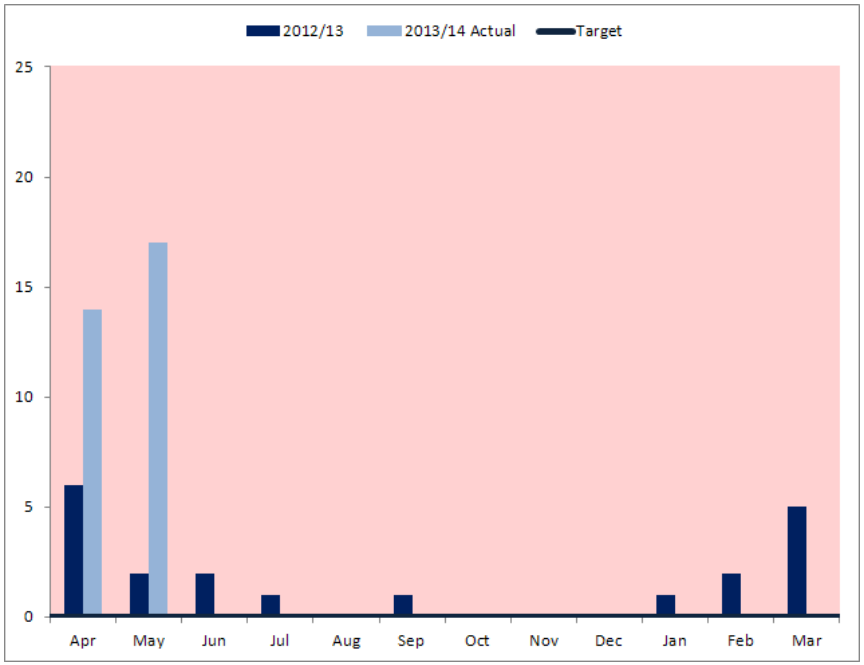
This indicator reports the number of specialties (treatment functions) where RTT standards are not delivered. The organisation's target is 0. By achieving this target the organisation can demonstrate that it offers accessible and responsive services that are delivered in a timely and efficient manner. This indicator is reported 1 month in arrears.

Referral to Treatment non delivery was recorded across a number of specialties; Oral Surgery, Neurosurgery, General Surgery, Urology, Plastic Surgery, Trauma and Orthopaedics, Gynaecology, ENT, Cardiothoracic surgery and Acute Medicine. Deterioration of this KPI is of significant concern to the wider RTT performance. A weekly risk assessment is undertaken and Groups are preparing recovery plans which are sighted by the Chief Officers.

o An 18-week recovery group had been formed to oversee and deliver the 18-week Recovery Plan.
o The Recovery Plan focuses on the following actions:

- Improving theatre efficiency
- Reducing hospital cancellations
- Undertaking additional 'out of hours' work at University Hospital and Rugby St. Cross
- Utilising Surgical Day Unit over the weekend to undertake additional work (whilst protecting the inpatient bed base)
- Working with private health care partners to undertake elective activity

Overall Trust position



Excellence in patient experience – standard reporting item

Friends and Family Test

The Friends and Family test forms a part of the Commissioning for Quality and Innovation (CQUIN) framework for 2013/14 which aims to secure improvements in quality of services and better outcomes for patients. This test intends to improve the experience of patients in line with Domain 4 of the NHS Outcomes Framework. The Friends and Family Test will provide timely, granular feedback from patients about their experience.

The Trust is required to achieve a baseline response rate of at least 15% and by Q4 a response rate that is both (a) higher than the response rate for Q1 and (b) 20% or over. A single response rate for each provider will be calculated by combining the response rates from the A&E and acute inpatient areas. The position for June is **19.16**% and therefore the target is being achieved.

A&E position

	NPS Type						
Ward	Number of Detractors	Number of Passives	Number of Promoters	Grand Total	Score	Patients Eligible to Respond	Coverage %
Accident and Emergency	138	172	596	906	50.55	5751	16

Inpatient survey Specialty Group position

	NPS Type						
Group	Number of Detractors	Number of Passives	Number of Promoters	Grand Total	Score	Patients Eligible to Respond	Coverage %
Cardiothoracic Surgery/Cardiology/Respiratory	13	20	56	89	48.31	510	17.45
Renal/Transplant	0	4	11	15	73.33	63	23.81
Emergency Department	2	2	6	10	40.00	64	15.63
Neurosciences	9	16	40	65	47.69	168	38.69
Oncology & Haematology	2	6	29	37	72.97	112	33.04
Surgery	13	57	120	190	56.32	761	24.97
Trauma & Orthopaedics	10	30	144	184	72.83	348	52.87
Women & Children	1	4	5	10	40.00	117	8.55
Ambulatory Care	3	7	19	29	55.17	252	11.51
Anaesthetics	0	0	4	4	100.00	5	80.00
Care of the Elderly	5	18	52	75	62.67	575	13.04
Unknown Specialty	1	9	24	34	67.65	0	-
Grand Total	**59**	**173**	**510**	**742**	**60.78**	**2975**	**25.30**

Excellence in patient experience – standard reporting item

Friends and Family Test – Inpatient Survey

Specialty position

Group	NPS Type: Number of Detractors	Number of Passives	Number of Promoters	Grand Total	Score	Patients Eligible to Respond	Coverage %
100 : General Surgery	5	28	60	93	59.14	368	25.27
101 : Urology	0	2	4	6	66.67	103	5.83
103 : Breast Surgery	0	0	6	6	100.00	14	42.86
104 : Colorectal Surgery	0	3	2	5	40.00	5	100.00
107 : Vascular Surgery	2	2	4	8	25.00	18	44.44
110 : Trauma & Orthopaedics	10	30	144	184	72.83	348	52.87
120 : ENT	1	5	12	18	61.11	47	38.30
130 : Ophthalmology	0	2	4	6	66.67	29	20.69
144 : Maxillo-Facial Surgery	1	2	6	9	55.56	45	20.00
150 : Neurosurgery	7	8	30	45	51.11	123	36.59
160 : Plastic Surgery	2	9	12	23	43.48	49	46.94
170 : Cardiothoracic Surgery	1	3	19	23	78.26	117	19.66
180 : Accident & Emergency	2	2	6	10	40.00	64	15.63
192 : Critical Care	0	0	4	4	100.00	5	80.00
300 : Acute Medicine	4	10	24	38	52.63	243	15.64
301 : Gastroenterology	2	6	14	22	54.55	109	20.18
302 : Endocrinology	1	2	8	11	63.64	134	8.21
303 : Clinical Haematology	0	2	11	13	84.62	41	31.71
307 : Diabetic Medicine	0	2	3	5	60.00	77	6.49
314 : Rehabilitation	0	4	7	11	63.64	5	220.00
320 : Cardiology	4	1	21	26	65.38	143	18.18
350 : Infectious Diseases	1	1	0	2	-50.00	34	5.88
361 : Nephrology	0	4	11	15	73.33	59	25.42
400 : Neurology	2	8	10	20	40.00	45	44.44
410 : Rheumatology	2	1	4	7	28.57	11	63.64
430 : Age related Medicine	1	4	21	26	76.92	328	7.93
502 : Gynaecology	1	4	2	7	14.29	89	7.87
503 : Gynaecological Oncology	0	0	3	3	100.00	28	10.71
Respiratory Medicine	7	15	16	38	23.68	216	17.59
800 : Clinical Oncology	2	4	18	24	66.67	70	34.29
999a : Unknown Specialty	1	9	24	34	67.65	8	425.00
TOTAL	**59**	**173**	**510**	**742**	**60.78**	**2975**	**25.30**

Ward position

Ward	NPS Type: Number of Detractors	Number of Passives	Number of Promoters	Grand Total	Score	Patients Eligible to Respond	Coverage %
Cardiothoracic Critical Care	0	0	0	0	0.00	1	0.0
Coronary Care Unit	0	0	8	8	100.00	55	14.5
General Critical Care	0	0	3	3	100.00	0	-
Surgery on Day of Admission	1	0	1	2	0.00	0	-
UA - Unknown Area (UHCW)	1	9	24	34	67.65	7	485.7
Ward 1	0	3	9	12	75.00	96	12.5
Ward 10	3	0	15	18	66.67	101	17.8
Ward 11	1	3	21	25	80.00	136	18.4
Ward 12/AMU	3	6	14	23	47.83	122	18.9
Ward 2/AMU Short Stay	3	4	12	19	47.37	111	17.1
Ward 20	2	6	14	22	54.55	115	19.1
Ward 21 Medicine	0	1	3	4	75.00	54	7.4
Wrd 21 Surgery	0	7	12	19	63.16	90	21.1
Ward 22 ECU	0	1	7	8	87.50	27	29.6
Ward 22 SAU	0	10	12	22	54.55	104	21.2
Ward 22a Vascular	2	1	4	7	28.57	32	21.9
Ward 23	3	5	12	20	45.00	181	11.0
Ward 3	3	2	7	12	33.33	59	20.3
Ward 30	2	6	7	15	33.33	107	14.0
Ward 31 Respiratory Medicine	5	11	10	26	19.23	153	17.0
Ward 32	4	22	44	70	57.14	193	36.3
Ward 33 Renal	1	2	3	6	33.33	56	10.7
Ward 33 Short Stay	5	10	17	32	37.50	124	25.8
Ward 33 Urology	1	3	5	9	44.44	127	7.1
Ward 34 Haematology	0	3	12	15	80.00	43	34.9
Ward 35	2	4	19	25	68.00	100	25.0
Ward 40	0	1	3	4	75.00	57	7.0
Ward 41 Stroke	0	3	5	8	62.50	38	21.1
Ward 42	2	5	6	13	30.77	37	35.1
Ward 43 Neurosurgery	6	8	23	37	45.95	99	37.4
Ward 50	0	5	10	15	66.67	61	24.6
Ward 52	5	5	20	30	50.00	107	28.0
Ward 53	0	5	7	12	58.33	78	15.4
Cedar Unit	4	17	118	139	82.01	188	73.9
Hoskyn Ward	0	1	7	8	87.50	48	16.7
Mulberry Ward	0	4	9	13	69.23	41	31.7
Oak Ward	0	0	0	0	0.00	26	0.0
UA Unknown Area (STX)	0	0	7	7	100.00	1	700.0
Grand Total	**59**	**173**	**510**	**742**	**60.78**	**2975**	**25.3**

Domain 2:
Deliver value for money

Domain Summary – Value for Money

Commentary

In this summary, we have outlined the overall performance for the Trust for all of the **Value for Money** indicators.

In June the following areas are covered in more detail:

The Trust has recorded **3.0% YTD variance in Pay expenditure against budget.**

The Trust has recorded a score of 1 **against the Monitor Financial Risk Rating**. This is on plan for this point in the year and is green-rated but it should be noted that the expectation of an applicant FT is FRR3 – no separate escalation is included.

The Trust has recorded failure against **5 out of 10 Provider Management Regime indices (PMR).** Green rated performance requires failure of no more than 1 indicator.

The Trust has recorded **-1.4% YTD variance in Total income against budget**.

Value for Money – area of underperformance

Pay expenditure (actual vs plan)

Indicator Range:			Performance			Timeframe to meet Standard	Executive Lead	
Red	Amber	Green	Plan	YTD	Forecast			
> 1%	< 1% > 0.5%	< 0.5%	**0.0%**	**3.0%**	**9.3%**	**Q4 2013/14**	CFO	COO

Commentary

This indicator reports the YTD actual pay expenditure as compared to the YTD planned expenditure (the budget position). The organisation has a target of a variance of no more than 0.5% above budget per calendar month. Reporting of this target enables the organisation to assess progress on efficiency savings.

The year to date variances are driven by:

- Operational pressures
- Vacancies being filled by agency staff
- Additional agency used to cover emergency medicine.

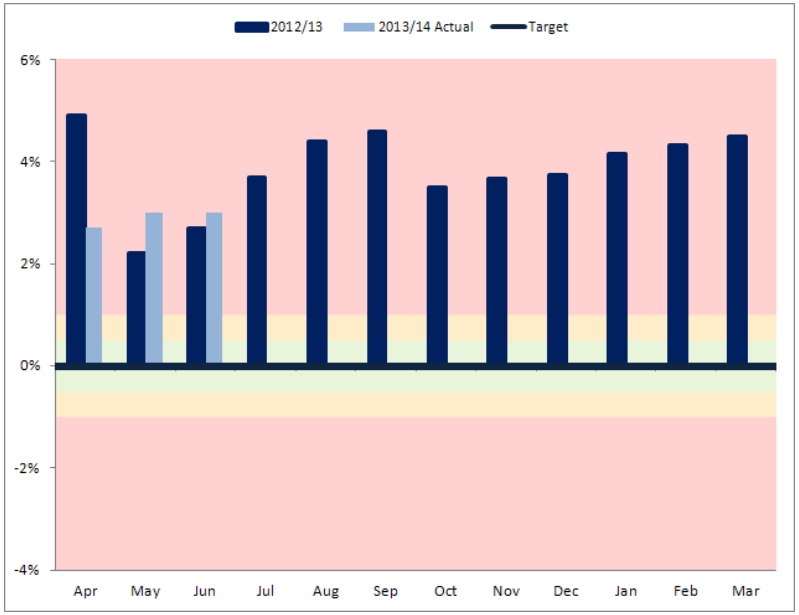
The SOCI identifies that groups have forecast an adverse variance to plan on operational expenditure of £32.4m, of which £26.3m is pay expenditure. This is driven by:

- Operational pressures
- 70% unidentified CIPS allocated to pay

The response to an increase in emergency activity is being reviewed to agree a substantive solution and reduce the use of temporary staff.

Groups are attending monthly performance meetings which continue to supporting the identification and delivery of CIP targets.

Overall Trust position



The Trust in the process of commissioning a external transformation partner to assist in CIP identification and delivery.

Value for Money – area of underperformance

PMR indices

Commentary

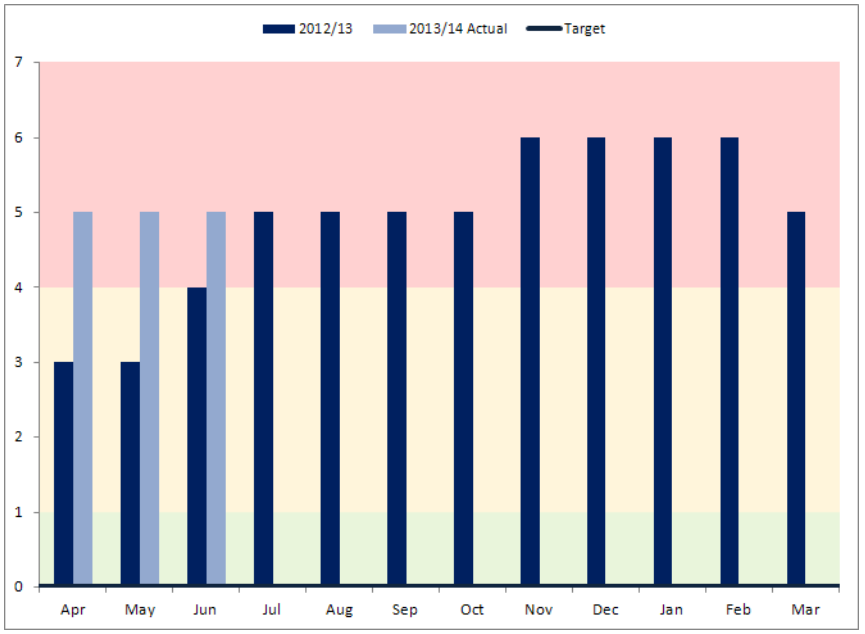
This indicator reports on the 10 indicators of forward financial risk. The organisation has a target of failing to achieve no more than one of these indicators.

The indicators that are red reflect four main areas:

- I&E performance below planned levels.
- High Debtor/Creditor balances.
- Low Cash Balances.
- Future years CIP identification

Performance for Month 3 has the same number of indicators in failure as in Month 2 of 2013/14, although the incidence has changed. EBITDA is now above plan, but the debtors measure is now failing.

Overall Trust position



Value for Money – area of underperformance

Total income (actual vs plan)

Indicator Range:			Performance			Timeframe to meet Standard	Executive Lead
Red	Amber	Green	Plan	YTD	Forecast		
> +/-1% of plan	< +/-1% > +/-0.5%	< +/-0.5%	**0.0%**	**-1.4%**	**-0.3%**	**Q4 2013/14**	CFO

Commentary

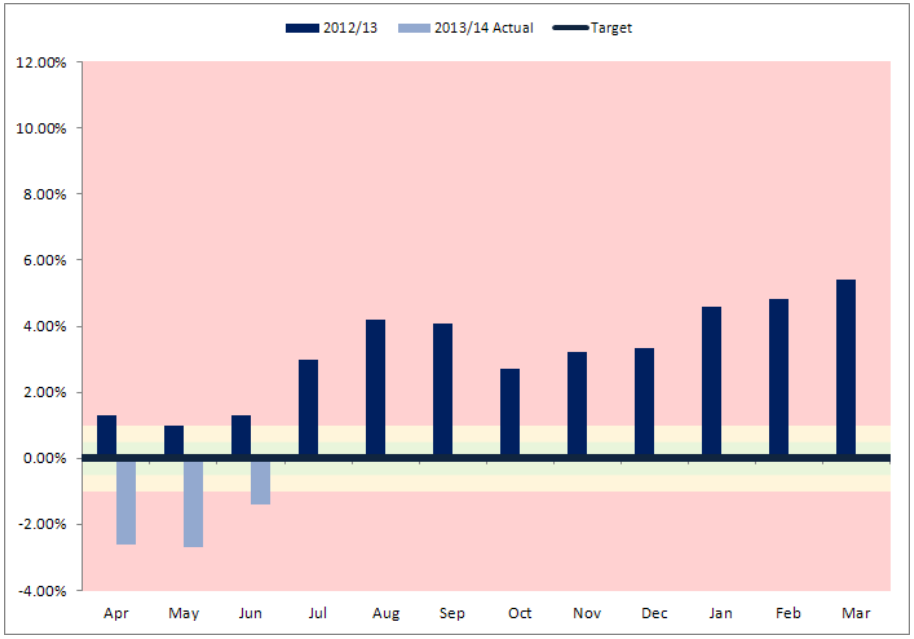
This indicator reports the YTD actual income as compared to the YTD planned income (the budget position). The organisation has a target of no more than 0.5% either side of the budget position.

The reported year to date under-performance against plan is being driven primarily by elective, daycase and critical care under-performance. Whilst the elective inpatient income position was favourable in month 3 alone, coming in at £82k over plan, the year to date position showed an underperformance of -£2.8m due largely to the "black alert" effect seen in month 1 and month 2.

The specialties where we have experienced the greatest level of income underperformance are within Trauma and Orthopaedics, Gynaecology and a combination of General Surgery, Colorectal Surgery and Upper-GI Surgery.

Critical care income is also under-performing year to date against plan (£972k) which is being driven primarily by an underperformance of neonatal critical care.

Overall Trust position



Domain 3: Employer of choice

Domain Summary – Employer of choice

Commentary

In this summary, we have outlined the overall performance for the Trust for all of the **Employer of choice** indicators. It should be noted that despite still failing the targets, three out of the four indicators have a positive direction of travel this month.
The following areas are covered in more detail overleaf:

• The Trust has recorded a **54.46% Appraisal rate**. This is considerably below YTD plan although the position has stabilised from last month.

• The Trust has recorded a **60.42% Consultant appraisal rate** which is a slight improvement from last month when first reported. Rates have improved by circa 10% over the last 12 months with more actions planned to increase further.

• The Trust has recorded a **62.03% attendance at mandatory training.** This remains consistent with performance throughout the year with the majority of teams highlighting mediocre performance.

• The Trust has recorded a **4.06% Sickness rate**. This is above YTD plan but shows a marginal improvement from the previous month and is at it's lowest rate for the last twelve months.

Employer of choice – area of underperformance

Appraisal rate

Commentary

This indicator reports all staff other than medical staff in relation to whether they have received an appraisal in the previous 12 month period. The organisation has established a target of 100% of those eligible to undertake an appraisal process. The completion of an appraisal for staff alongside clear objectives and performance development plan demonstrates a workforce that has clarity in what they should be achieving in relation to their job and aligned to the strategy, values and behaviours of the Trust.

Appraisal rates have marginally improved to 54.48% against an overall target of 90%. The monthly workforce key performance indicator report highlights the management teams of Anaesthetics, T & O, Cardiac/Respiratory, Emergency, Oncology/Haematology, Pathology and Surgery are all demonstrating rates below 50%.

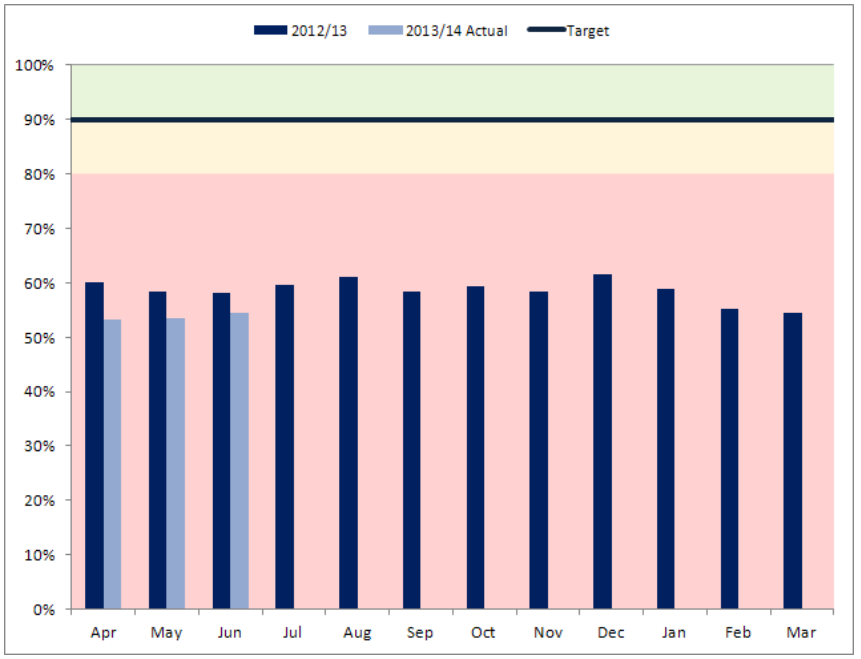
In contrast St. Cross and Clinical Support are demonstrating excellent performance with approximately 85% rates for staff appraisal.

In order to provide improved performance alongside this indicator the following actions are either in place or are planned to take place:

To review the paperwork and procedure to support the appraisal process. This has now been completed and it is expected that the new paperwork will be initiated from 1st August 2013.

- That workforce targets including appraisal rates are managed within the new performance framework and management teams held accountable.

Overall Trust position



- To establish a task and finish group to consider why appraisal rates are low and what specific interventions need to take place to improve performance. This has been established and is meeting with managers where performance is below 50% in order to find ways to improve performance.

Employer of choice – area of underperformance

Consultant appraisal rate

Commentary

This indicator reports the percentage of consultant doctors recorded as having received an appraisal within the previous 12 months. The organisation has a target of 100%. In addition, this is a contractual and professional requirement for all consultants to ensure satisfactory revalidation. In addition, consultants are required to demonstrate that they have undertaken a satisfactory appraisal in the previous 12 months as a prerequisite for an application to the clinical excellence awards.

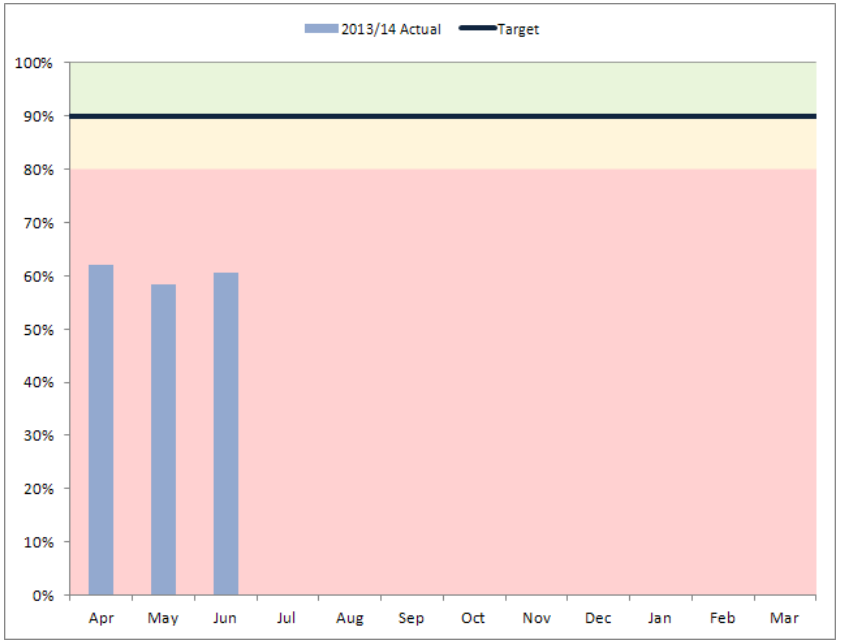
Consultant Appraisal rates have risen since last month to 60.42% reversing a long standing trend. The monthly workforce key performance indicator report highlights the management teams of Ambulatory Care, Cardiac, Surgery, Theatres and Women's & Children's are all demonstrating rates below 50%.

In addition, a recent data validation exercise has been completed regarding consultant appraisal figures that will allow for the current figure to be revised to just over 70%.

In order to provide improved performance alongside this indicator the following actions are either in place or are planned to take place:

- The Chief Medical Officer to hold Clinical Directors to account.
- To establish a task and finish group to consider why appraisal rates are low and what specific interventions need to take place to improve performance.

Overall Trust position



- The HR&ED Committee to continue to hold areas of poor performance to account and request action plans to demonstrate improved performance within an agreed trajectory.
- That workforce targets including appraisal rates are managed within the new performance framework and management teams held accountable.

Employer of choice – area of underperformance

Attendance at mandatory training

Commentary

This indicator reports the percentage of staff compliant with their mandatory training requirements that are required as part of their role on a rolling 12 month basis. The organisation has a target of 100% compliance for those eligible staff. The achievement of full compliance not only reduces our clinical and non-clinical risks regarding workforce but also enhances the skill base of our staff.

As part of the 2013-14 HR Business Plan, the target for overall Trust compliance is 80% by October 2013 and for 90% by the end of March 2014 which was ratified by the HR, Equality and Diversity Committee.

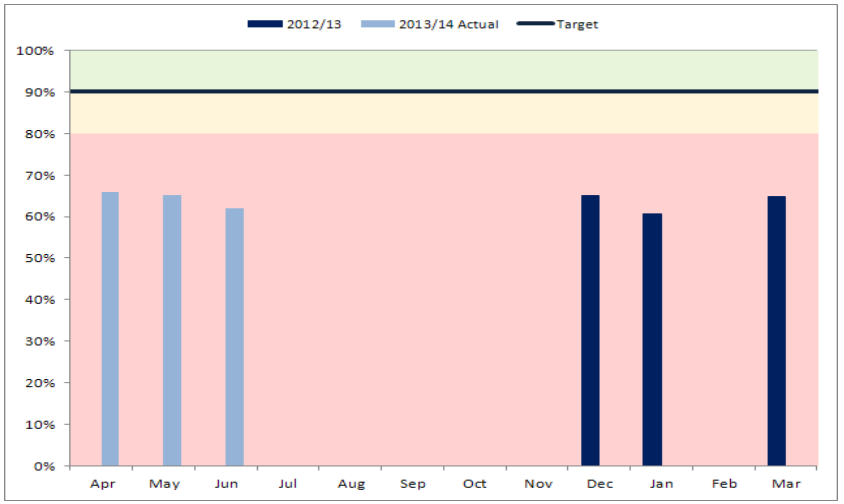
The Trust's current overall compliance is 62.03%.

There are a number of training topics that are under 50%, notably Information Governance e-learning (annual), ALS, Neonates Life Support, Advanced Paediatric Life Support and Bloods specifically NPSA obtaining venous blood.

The new Mandatory Training programme was launched on the 1st June. Communication was made with key stakeholders to explain the key changes to the programme, specifically that there would be less topics, less face to face training and that individuals are more responsible for undertaking their mandatory training via e- learning on ESR.

Essential clinical skills remain face to face and sufficient capacity has been built for the whole of 2013 until March 2014.

Overall Trust position



In response to concerns about staff competence and confidence about using e-learning, the Learning and OD Team have a rota of supported e-learning sessions.

The HR function has set up a specific working group to further improve how we can continue to contribute to improving overall compliance.

The Subject Matter Experts (SMEs) within the Trust will examine the compliance data and refocus their work in the clinical areas where compliance remains low on key topics, as well as the staff groups where this remains the case. This will be monitored by the monthly Mandatory Training Committee (MTC).

Employer of choice – area of underperformance

Sickness rate

Commentary

This indicator reports the percentage of sickness recorded in the organisation against the overall hours. The organisation has set itself a target of 3.39% as this aligns with national recommendations. The rate of absence provides an indication of the wider health of the business as it takes consideration of various factors such as motivation and the general health & well being of the workforce.

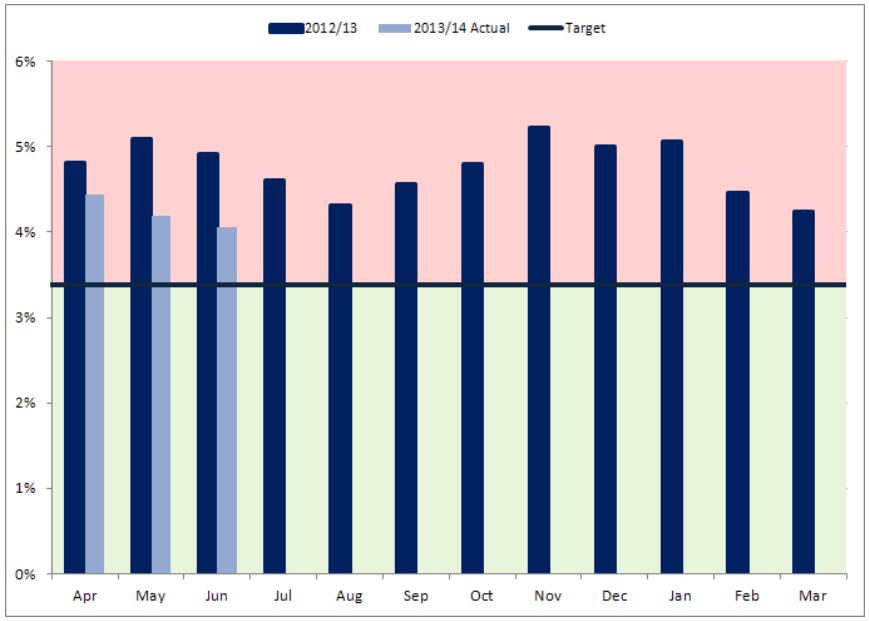
The absence rate for June 2013 is reduced again and now stands at 4.09%. We are aware of significant areas of high sickness absence with the following groups reporting sickness above 6% - Renal, Anaesthetics, Theatres and St. Cross. However, with both Renal and St. Cross are demonstrating a reduction in their sickness rates over the last 2 months.

In order to provide improved and sustained performance alongside this indicator the following actions are either in place or are planned to take place:

The HR Team are working alongside particular areas where there are high rates of sickness in order to provide interventions that can assist with lowering absence rates.

There is an absence campaign underway and also recognition of those with 100% in the previous 12 months.

Overall Trust position



Domain 4: Leading research based health organisation

Domain Summary – Leading research based health care organisation

Commentary

In this summary, we have outlined the overall performance for the Trust for all of the **Leading research based health care organisation** indicators.

The only KPI currently in this domain is the **number of patients recruited into NIHR portfolio**. This indicator has an outturn of 386, which exceeds the year to date target of 354.

Development work is underway to incorporate two further KPIs in this domain:

1. The percentage of commercially funded studies where the first patient is recruited within 70 days of receipt of the research application. This indicator will be reported for the first time in August for July's data.

2. Peer-reviewed publications from UHCW staff. This indicator will be reported in October for September's data.

As requested at the May 2013 Trust Board, additional comparative data has been provided on the next slide.

Domain Summary – Leading research based health care organisation

UHCW Research, Development and Innovation: Comparative Data, June 2013 Quality Bar 2013/14:

A comparison of UHCW NHS Trust with national picture:

Data	Raising the Bar Current Benchmark Against Vision			
Key: colour represents position of UHCW, absence of colour means information not yet available.	**Improvement – below target**	**Compliant – meets target set**	**National Leader – above mean**	**International Leader – National Exemplar**
*Trial participation (National Institute of Health Research **2011/12** data)*	Outside Top 50 Trusts in England for number of research studies open for recruitment	Within Top 50 Trusts in England for number of research studies open for recruitment	Within Top 20 Trusts in England for number of research studies open for recruitment	Within Top 10 Trusts in England for number of research studies open for recruitment
*Trial participation (**2011/12** NIHR data)*	In bottom third of Acute Teaching Trusts in England for number of patients recruited	In middle third of Acute Teaching Trusts for number of patients recruited	In Top 1/3rd of Acute Teaching Trusts for number of patients recruited	Within Top 5 Acute Teaching Trusts in England for number of patients recruited
*NIHR Research Capability Funding (DH Grant income; **2012/13** data)*	Funding less than £100K pa (67% of Trusts)	Funding £101 to £999K pa (c.25% of Trusts)	Funding over £1million pa (top 8% of Trusts)	Funding over £5million pa (top 2% of Trusts)

Local Comparison (NIHR 2011/12 data):

Trust Name	Number of Recruiting Studies	2011/12 Recruitment
UNIVERSITY HOSPITAL OF NORTH STAFFORDSHIRE	109	3427
UHCW NHS TRUST	168	3160
UNIVERSITY HOSPITALS BIRMINGHAM	174	2442

Recruitment at UHCW increased from 3160 patients in 2011/12 to 5,072 in 2012/13. National comparative data will be released early July 2013.

Domain 5:
To be a leading training & education centre

Domain Summary – Leading training & education centre

Commentary

The **Job Evaluation Survey Tool (JEST)** is run by the West Midlands Deanery and includes responses from all trainee doctors (foundation and specialty trainees). There are three key reporting dates throughout the year; April, August and December and these updates will be included within the IPR upon release. The date range reported this time is August 2012 to April 2013.
A set number of questions are included in the survey with responses ranging from 5 (excellent) to 1 (unsatisfactory). Any responses of 1 and 2 are considered low. The score represents an average of all responses. The target has been set at 3.5 to allow for future improvement. The figure included this month is **3.7** which is marginally above the target.

In this summary, we have outlined the 2 KPIs that are being scoped for inclusion in future reports to reflect the organisations realisation of this objective.

GMC Annual Survey
This survey of all trainees' is undertaken during March and April each year and results compiled by the Deanery. Information could be presented as a Trust overview and may be comparable with other Trusts. It could also be shown at specialty level for internal reporting as well as good practice identification and to highlight concerns and trends. The target would be no unsatisfactory ratings.

GMC accreditation standards
These are new standards for all teachers / trainers of junior medical staff. The standards aren't yet in force but will be by 2015. They will vary according to the specific role. UHCW are completing their initial gap analysis survey. Once complete this could be reported and updated periodically throughout the year (3 monthly at most).

In theory 100% of undergraduate trainers and 100% of post graduate trainers should meet GMC requirements. As this is a new requirement a 90% target is thought to be challenging yet realistic.

Appendix 1: Financial Statements

Month 3 – 2013/14
Statement of Comprehensive Income – Primary Statement

University Hospitals Coventry and Warwickshire NHS Trust

Statement of Comprehensive Income	2013/14 Plan £000	2013/14 Forecast Outturn £000	2013/14 Variance £000	Year To Date Plan £000	Year To Date Actual £000	Year To Date Variance £000	Month Plan £000	Month Actual £000	Month Variance £000
Income									
Contract income from activities	434,753	432,686	(2,067)	107,978	105,795	(2,183)	34,799	35,069	270
Group income from activities	13,445	13,178	(267)	3,382	3,476	94	1,130	1,193	63
Other Operating Income	66,428	67,136	708	16,588	16,883	295	5,532	5,764	232
Total Income	**514,626**	**513,000**	**(1,626)**	**127,948**	**126,154**	**(1,794)**	**41,461**	**42,026**	**565**
Operating Expenses									
Pay	(282,223)	(308,544)	(26,321)	(73,510)	(75,730)	(2,220)	(24,517)	(25,229)	(712)
Non Pay	(172,194)	(178,308)	(6,114)	(45,370)	(43,319)	2,051	(15,086)	(14,373)	713
CIP gap to target delivery	0	12,025	12,025						
Additional savings required	0	13,638	13,638						
Reserves	(9,676)	(1,479)	8,197	(2,301)	(42)	2,259	(817)	(318)	499
Total Operating Expenses	**(464,093)**	**(462,668)**	**1,425**	**(121,181)**	**(119,091)**	**2,090**	**(40,420)**	**(39,920)**	**500**
EBITDA	**50,533**	**50,332**	**(201)**	**6,767**	**7,063**	**296**	**1,041**	**2,106**	**1,065**
EBITDA Margin %	9.8%	9.8%		5.3%	5.6%		2.5%	5.0%	
Non Operating Items									
Profit / loss on asset disposals	0	8	8	0	8	8	0	0	0
Fixed Asset Impairments	0	0	0	0	0	0	0	0	0
Depreciation	(19,833)	(19,833)	0	(4,958)	(4,932)	26	(1,653)	(1,644)	9
Interest Receivable	83	85	2	21	23	2	7	4	(3)
Interest Charges	(272)	(272)	0	(68)	(68)	0	(23)	(23)	0
Financing Costs	(25,292)	(25,292)	0	(6,323)	(6,303)	20	(2,108)	(2,078)	30
PDC Dividend	(2,719)	(2,528)	191	(680)	(632)	48	(227)	(211)	16
Total Non Operating Items	**(48,033)**	**(47,832)**	**201**	**(12,008)**	**(11,904)**	**104**	**(4,004)**	**(3,952)**	**52**
Net Surplus/(Deficit)	**2,500**	**2,500**	**0**	**(5,241)**	**(4,841)**	**400**	**(2,963)**	**(1,846)**	**1,117**
	0.5%	0.5%		-4.1%	-3.8%		-7.1%	-4.4%	

Month 3 – 2013/14
Statement of Financial Position

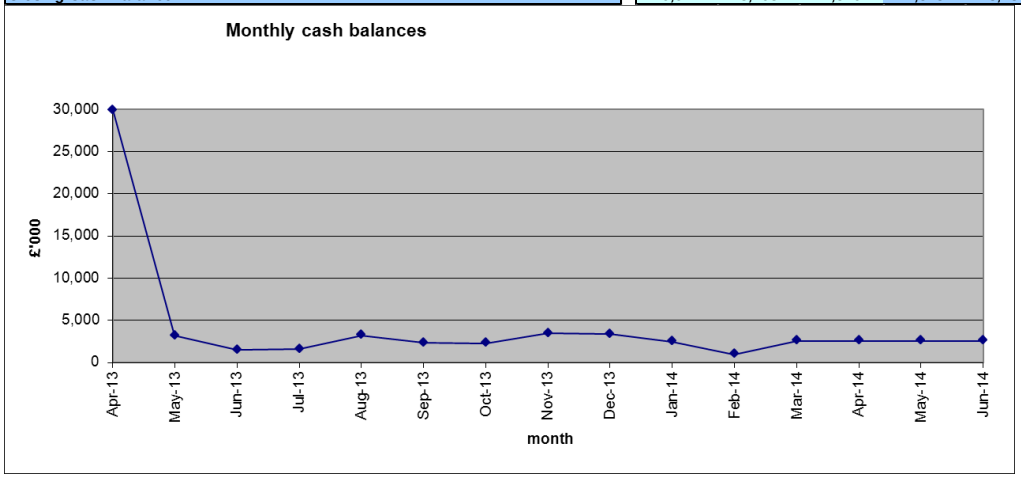
University Hospitals Coventry and Warwickshire NHS Trust

Prior Year Outturn £000	Statement of Financial Position	2013/14 Plan £000	2013/14 Forecast Outturn £000	2013/14 Variance £000	Year To Date Plan £000	Year To Date Actual £000	Year To Date Variance £000	Month Plan £000	Month Actual £000	Month Variance £000
	Non-current assets									
340,122	Property, plant and equipment	362,328	357,252	(5,076)	345,811	339,533	(6,278)	391	(284)	(675)
112	Intangible assets	112	112	0	112	113	1	0	0	0
3,515	Investment Property	3,515	3,515	0	3,515	3,515	0	0	0	0
36,902	Trade and other receivables	30,081	30,081	0	36,050	36,093	43	(914)	(764)	150
380,651	**Total non-current assets**	**396,036**	**390,960**	**(5,076)**	**385,488**	**379,254**	**(6,234)**	**(523)**	**(1,048)**	**(525)**
	Current assets									
9,864	Inventories	10,864	10,864	0	9,864	9,544	(320)	0	37	37
21,252	Trade and other receivables	18,685	18,679	(6)	17,139	20,417	3,278	(6,753)	(3,512)	3,241
3,968	Cash and cash equivalents	2,562	2,562	0	1,299	1,796	497	(5,044)	(1,402)	3,642
35,084		**32,111**	**32,105**	**(6)**	**28,302**	**31,757**	**3,455**	**(11,797)**	**(4,877)**	**6,920**
453	Non-current assets held for sale	0	0	0	223	227	4	(230)	0	230
35,537	**Total current assets**	**32,111**	**32,105**	**(6)**	**28,525**	**31,984**	**3,459**	**(12,027)**	**(4,877)**	**7,150**
416,188	**Total assets**	**428,147**	**423,065**	**(5,082)**	**414,013**	**411,238**	**(2,775)**	**(12,550)**	**(5,925)**	**6,625**
	Current liabilities									
(40,000)	Trade and other payables	(37,902)	(37,902)	0	(39,542)	(42,191)	(2,649)	9,639	4,056	(5,583)
(6,329)	Borrowings	(8,606)	(8,606)	0	(6,857)	(6,857)	0	0	0	0
0	DH Working Capital Loan	(500)	(500)	0	0	0	0	0	0	0
(1,500)	DH Capital loan	(2,160)	(2,160)	0	(1,500)	(1,500)	0	0	0	0
(5,953)	Provisions	(192)	(192)	0	(5,953)	(5,114)	839	0	5	5
(18,245)	**Net current assets/(liabilities)**	**(17,249)**	**(17,255)**	**(6)**	**(25,327)**	**(23,678)**	**1,649**	**(2,388)**	**(816)**	**1,572**
362,406	**Total assets less current liabilities**	**378,787**	**373,705**	**(5,082)**	**360,161**	**355,576**	**(4,585)**	**(2,911)**	**(1,864)**	**1,047**
	Non-current liabilities:									
	Trade and other payables									
(279,618)	Borrowings	(272,174)	(272,174)	0	(277,453)	(277,503)	(50)	40	25	(15)
0	DH Working Capital Loan	(4,500)	(4,500)	0	0	0	0	0	0	0
(8,250)	DH Capital loan	(12,695)	(12,695)	0	(8,250)	(8,250)	0	0	0	0
(2,418)	Provisions	(2,359)	(2,353)	6	(2,503)	(2,545)	(42)	(85)	0	85
72,120	**Total assets employed**	**87,059**	**81,983**	**(5,076)**	**71,955**	**67,278**	**(4,677)**	**(2,956)**	**(1,839)**	**1,117**
	Financed by taxpayers' equity:									
24,870	Public dividend capital	24,870	24,870	0	24,870	24,870	0	0	0	0
9,234	Retained earnings	16,734	11,909	(4,825)	8,993	4,567	(4,426)	(2,956)	(1,839)	1,117
38,016	Revaluation reserve	45,455	45,204	(251)	38,092	37,841	(251)	0	0	0
72,120	**Total Taxpayers' Equity**	**87,059**	**81,983**	**(5,076)**	**71,955**	**67,278**	**(4,677)**	**(2,956)**	**(1,839)**	**1,117**

Month 3 – 2013/14
Cash Flow

University Hospitals Coventry and Warwickshire NHS Trust

Cash Flow	Apr-13 £000	May-13 £000	Jun-13 £000	Jul-13 £000	Aug-13 £000	Sep-13 £000	Oct-13 £000	Nov-13 £000	Dec-13 £000	Jan-14 £000	Feb-14 £000	Mar-14 £000	Total £'000
EBITDA	**1,563**	**3,390**	**1,730**	**6,368**	**4,594**	**3,857**	**6,455**	**3,912**	**5,239**	**6,161**	**2,449**	**4,611**	**50,329**
Donated assets received credited to revenue but non-cash	0	0	0	0	0	0	0	0	0	0	0	0	0
Interest paid	(6,299)	(118)	(17)	(6,302)	(48)	(49)	(6,302)	(48)	(48)	(6,301)	(47)	(46)	(25,625)
Dividends paid	0	0	0	0	0	(1,364)	0	0	0	0	0	(1,262)	(2,626)
Increase/(Decrease) in provisions	9	(716)	(5)	(48)	(1,661)	0	(48)	0	0	(48)	(2,000)	(1,309)	(5,826)
Operating cash flows before movements in working capital	**(4,727)**	**2,556**	**1,708**	**18**	**2,885**	**2,444**	**105**	**3,864**	**5,191**	**(188)**	**402**	**1,994**	**16,252**
Movements in Working Capital	32,147	(24,452)	(1,009)	3,559	1,102	(949)	3,400	(1,325)	(4,196)	4,082	1,718	(7,619)	6,458
Net cash inflow/(outflow) from operating activities	**27,420**	**(21,896)**	**699**	**3,577**	**3,987**	**1,495**	**3,505**	**2,539**	**995**	**3,894**	**2,120**	**(5,625)**	**22,710**
Capex spend	(1,409)	(3,575)	(2,360)	(2,247)	(2,298)	(1,621)	(2,023)	(1,347)	(1,040)	(3,290)	(3,554)	(3,618)	(28,382)
Interest received	13	5	4	7	7	7	7	7	7	7	7	7	85
Cash receipt from asset sales		234		227									461
Net cash inflow/(outflow) from investing activities	**(1,396)**	**(3,336)**	**(2,356)**	**(2,013)**	**(2,291)**	**(1,614)**	**(2,016)**	**(1,340)**	**(1,033)**	**(3,283)**	**(3,547)**	**(3,611)**	**(27,836)**
CF before Financing	**26,024**	**(25,232)**	**(1,657)**	**1,564**	**1,696**	**(119)**	**1,489**	**1,199**	**(38)**	**611**	**(1,427)**	**(9,236)**	**(5,126)**
Public Dividend Capital received													
Public Dividend Capital repaid													
DH loans repaid	0	0	0	0	0	(750)	0	0	0	0	0	(750)	(1,500)
Capital Element of payments in respect of finance leases and PFI	(25)	(1,482)	(25)	(1,502)	(40)	(40)	(1,502)	(40)	(40)	(1,515)	(60)	(59)	(6,330)
Drawdown of new DH loans	0	0	0	0	0	0	0	0	0	0	0	11,605	11,605
Net cash inflow/(outflow) from financing	**(25)**	**(1,482)**	**(25)**	**(1,502)**	**(40)**	**(790)**	**(1,502)**	**(40)**	**(40)**	**(1,515)**	**(60)**	**10,796**	**3,775**
Net cash outflow/inflow	**25,999**	**(26,714)**	**(1,682)**	**62**	**1,656**	**(909)**	**(13)**	**1,159**	**(78)**	**(904)**	**(1,487)**	**1,560**	**(1,351)**
Opening Cash Balance	**3,913**	**29,912**	**3,198**	**1,516**	**1,578**	**3,234**	**2,325**	**2,312**	**3,471**	**3,393**	**2,489**	**1,002**	**3,913**
Closing Cash Balance	**29,912**	**3,198**	**1,516**	**1,578**	**3,234**	**2,325**	**2,312**	**3,471**	**3,393**	**2,489**	**1,002**	**2,562**	**2,562**



Month 3 – 2013/14
Capital Expenditure

University Hospitals Coventry and Warwickshire NHS Trust

Capital Resource Limit (CRL)	2013/14 Plan £000	2013/14 Forecast Outturn £000	2013/14 Variance fav/(adv) £000	Year To Date Plan £000	Year To Date Actual £000	Year To Date Variance fav/(adv) £000	Month Plan £000	Month Actual £000	Month Variance fav/(adv) £000
Confirmed CRL	6,952	6,952	0	2,872	2,872	0	2,872	2,872	0
Forecast CRL for PFI	14,372	14,372	0	2,470	2,470	0	644	644	0
Forecast CRL for non PFI	7,823	7,823	0	0	0	0	(1,702)	(1,702)	0
Total Forecast CRL	**29,147**	**29,147**	**0**	**5,342**	**5,342**	**0**	**1,814**	**1,814**	**0**

Capital Expenditure Programme	2013/14 Plan £000	2013/14 Forecast Outturn £000	2013/14 Variance £000	Year To Date Plan £000	Year To Date Actual £000	Year To Date Variance £000	Month Plan £000	Month Actual £000	Month Variance £000
Major Schemes									
PFI lifecycle	14,372	14,372	0	2,470	2,470	0	644	644	0
Site Infrastructure/access development	2,450	2,450	0	0	25	(25)	0	25	(25)
Critical care beds	586	375	211	0	0	0	0	0	0
Pathology Replacement Project (Net UHCW)	620	365	255	78	14	64	44	6	38
PACS Replacement Project	692	947	(255)	598	676	(78)	124	276	(152)
E'Prescribing	710	710	0	0	0	0	0	0	0
Technology Refresh - PC and peripherals including PDA's	750	750	0	85	0	85	75	(62)	137
VitalPAC Replacement scheme	940	940	0	0	0	0	0	0	0
Aggregated Other Schemes	8,480	8,691	(211)	2,341	1,160	1,181	1,157	470	687
Total Capital Expenditure	**29,600**	**29,600**	**0**	**5,572**	**4,345**	**1,227**	**2,044**	**1,359**	**685**
Less: Donated/granted Asset Purchases	0	0	0	0	0	0	0	0	0
Less: Book value of assets disposed of:	453	453	0	230	226	(4)	230	0	(230)
Net Charge against CRL	**29,147**	**29,147**	**0**	**5,342**	**4,119**	**1,223**	**1,814**	**1,359**	**455**
Under/(Over)Commitment against CRL (total)	**0**	**0**	**0**	**0**	**1,223**	**1,223**	**0**	**455**	**455**

Month 3 – 2013/14
Capital Financing

University Hospitals Coventry and Warwickshire NHS Trust

	2013/14 Plan £'000
Capital Expenditure	
Gross Capital Expenditure	29,600
Less: PFI Capital Expenditure	(14,372)
Total Non-PFI Capital Expenditure	**15,228**
Capital Financing	
Depreciation	
Gross Depreciation	19,833
Less: PFI Depreciation	(12,492)
Net Depreciation	**7,341**
Movement in Capital Payables/Receivables	
Finance Lease Repayments (non-PFI)	(484)
New Finance Leases (non-PFI)	1,218
Other Capital Payables/Receivables (non-PFI)	0
Movement in Capital Payables/Receivables	**734**
Other Funding Sources	
Grants and Donations	0
Net Book Value of Non-Current Asset Disposals	453
Other Funding Sources	**453**
Revenue Surplus	
Surplus for the Year	2,500
Less: Applied to Finance PFI	(905)
Less: Applied to Working Capital Loan Repayments	0
Less: Applied to Other Working Capital	0
Surplus Applied to Capital	**1,595**
Total Internally Generated Funds	**10,123**
External Funding	
New Public Dividend Capital (PDC)	0
New Capital Investment Loans (CIL)	6,605
Capital Investment Loan Repayments	(1,500)
Total External Funding	**5,105**
Total Capital Funding	**15,228**
Capital Surplus/(Deficit)	**0**

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST

REPORT TO TRUST BOARD: PUBLIC

31 JULY 2013

Subject:	Provider Management Regime
Report By:	Gail Nolan, Chief Finance Officer
Author:	Simon Reed, Senior Performance Manager
Accountable Executive Director:	Gail Nolan, Chief Finance Officer

GLOSSARY

Abbreviation	In Full
DH	Department of Health
UHCW	University Hospitals Coventry and Warwickshire
SHAs	Strategic Health Authorities
CCGs	Clinical Commissioning Groups
PMR	Provider Management Regime
TDA	Trust Development Authority

WRITTEN REPORT (provided in addition to cover sheet)? ☒ **Yes** ☐ **No**

POWERPOINT PRESENTATION? ☐ **Yes** ☒ **No**
NB Presentations need to be submitted for inclusion in Board papers

Title	
Approx. Length	

PURPOSE OF THE REPORT / PRESENTATION:

UHCW is required by the TDA to submit the PMR and a self-certification for Monitor compliance (Appendix A) and the second self-certification for Board statements (Appendix B) each month. The purpose of this return is to highlight areas in exception in these returns and give assurance of respective remedial actions to recover performance.

SUMMARY OF KEY ISSUES:

Based on the data provided by the relevant leads the Trust risk ratings are as detailed below:

PERIOD	Governance Risk Rating	Financial Risk Rating
JUL-12	Green (1.0)	Red (2.0)
AUG-12	Green (1.0)	Red (2.0)
SEP-12	Green (0.0)	Red (2.0)
OCT-12	Red (4.0)	Red (2.0)
NOV-12	Red (4.0)	Red (2.0)
DEC-12	Red (4.0)	Red (2.0)
JAN-13	Red (4.0)	Red (2.0)
FEB-13	Red (4.0)	Red (2.0)
MAR-13	Red (4.0)	Red (2.0)
APR-13	Red (4.0)	Red (1.0)
MAY-13	Red (4.0)	Red (2.0)
JUN-13	Red (4.0)	Red (2.0)

The Governance Risk Rating of Red (4.0) for June 2013 is because of the continuation of the application of the overriding rule by the TDA which was first applied by the then SHA in January 2013. This automatically gave an overall weighting of 4 and was retrospectively applied back to October 2012.

Appendix C is UHCW's proposed submission to the TDA at the end of July 2013.

Specified areas of insufficient assurance and associated actions are:

- **From point of referral to treatment in aggregate (RTT) – admitted:**

  - An 18-week recovery group had been formed to oversee and deliver the 18-week Recovery Plan.
  - The Recovery Plan focuses on the following actions:
    - Improving theatre efficiency
    - Reducing hospital cancellations
    - Undertaking additional 'out of hours' work at University Hospital and Rugby St. Cross
    - Utilising Surgical Day Unit over the weekend to undertake additional work (whilst protecting the inpatient bed base)
    - Working with private health care partners to undertake elective activity
- **A&E - maximum waiting time of four hours from arrival to admission/transfer/discharge:**
  - ED recovery plan: The ED recovery plan is progressing as expected. Both the Steering Group and Recovery Board are in operation providing both drive and oversight around the various workstreams
  - Site Operations Team: Recruitment for the substantive site operations team is progressing well. The final round of interviews are about to be conducted with the full team in place by September.
  - ED Model:
    - A 'See and treat model' trial commenced on 17 June 2013 with approximately 30 patients per day being seen. This service runs daily from 12:00 to 20:00 with continuous review.
    - The Rapid Assessment and Treatment model is scheduled to commence on 22 July
    - Recruitment for the Emergency Nurse Practitioner service continues.
- **Financial Risk Rating (FRR)** - The governance declaration is based on the year to date FRR. The Trust has recorded an FRR 1 for the month three position (which is the same as the financial plan submitted to the TDA), driven by poor liquidity and a low surplus margin. This also results in the Trust being unable to self certify against Board Statement 4 (that the Trust will continue to maintain a financial risk rating of at least 3 over the next 12 months).
- **Board Statement 4** asks the Board to confirm that the Trust will maintain a financial risk rating of at least 3 over the next 12 months. The 2013/14 financial plan is currently forecast to have a financial risk rating (FRR) of 2. This is due to the liquidity metric being less than 10 days. The route to improving liquidity is to target increasing revenue surpluses.

It is noted that if the Board does not self certify against Board Statement 4, UHCW could be deemed to be in escalation by the TDA.

SUMMARY OF KEY RISKS:

- **The Governance Risk Rating and Financial Risk Rating are showing as Red**
- **The overriding rule against the 95%, 4-hour A&E target has been applied for October, November and December 2012 and January, February, March, April, May and June 2013**
- **In line with the current 2013/14 financial plan, the Board does not self-certify against Board Statement 4.**

RECOMMENDATION / DECISION REQUIRED:

- Trust Board to approve the Provider Manager Regime return based on June 2013 data for onward submission to the TDA (Appendix C) and Appendices A and B. (In previous months Appendices A and B would have been submitted to the TDA prior to Trust Board. However the TDA have confirmed both these submissions will be required on the last working day of the month in line with the PMR submission)
- Trust Board to confirm its support for Governance Declaration 2 (for insufficient assurance that all targets are being met) in relation to the Financial Risk Rating, A&E and admitted 18-week performance.
- It is recommended that, in line with the current 2013/14 financial plan, the Board does not self-certify against Board Statement 4.

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST

REPORT TO TRUST BOARD: PUBLIC

31 JULY 2013

IMPLICATIONS:

Financial:	N/A
HR / Equality & Diversity:	N/A
Governance:	Performance against the PMR submission will impact on the Trust's ability to move forward with its Foundation Trust application
Legal:	N/A

REVIEW:

Trust Standing Committee	**Date**	**Trust Standing Committee**	**Date**
Quality Governance Committee		Remuneration Committee	
Finance and Performance Committee		Executive Meeting	
Audit Committee			

DATA QUALITY:

Data/information Source:	
Data Quality Controls:	
Data Limitations:	

SELF-CERTIFICATION RETURNS
Organisation Name:
University Hospitals Coventry & Warwickshire NHS Trust
Monitoring Period:
June 2013
NHS Trust Over-sight self certification template

Returns to XXX by the last working day of each month

NHS Trust Governance Declarations : 2013/14 In-Year Reporting

Name of Organisation:	University Hospitals Coventry & Warwickshire NHS Trust	Period:	June 2013

Organisational risk rating

Each organisation is required to calculate their risk score and RAG rate their current performance, in addition to providing comment with regard to any contractual issues and compliance with CQC essential standards:

Key Area for rating / comment by Provider	Score / RAG rating*
Governance Risk Rating (RAG as per SOM guidance)	R
Normalised YTD Financial Risk Rating (Assign number as per SOM guidance)	1

*** Please type in R, AR, AG or G and assign a number for the FRR**

Governance Declarations

Declaration 1 or declaration 2 reflects whether the Board believes the Trust is currently performing at a level compatible with FT authorisation.

Supporting detail is required where compliance cannot be confirmed.

Please complete sign **one** of the two declarations below. If you sign declaration 2, provide supporting detail using the form below. Signature may be either hand written or electronic, you are required to print your name.

Governance declaration 1

The Board is sufficiently assured in its ability to declare conformity with **all** of the Clinical Quality, Finance and Governance elements of the Board Statements.

Signed by:		Print Name:	
on behalf of the Trust Board	Acting in capacity as:		
Signed by:		Print Name:	
on behalf of the Trust Board	Acting in capacity as:		

Governance declaration 2

At the current time, the board is yet to gain sufficient assurance to declare conformity with all of the Clinical Quality, Finance and Governance elements of the Board Statements.

Signed by :		Print Name :	Andrew Hardy
on behalf of the Trust Board	Acting in capacity as:		Chief Executive Officer
Signed by :		Print Name :	Nick Stokes
on behalf of the Trust Board	Acting in capacity as:		Deputy Chairman

If Declaration 2 has been signed:

For each target/standard, where the board is declaring insufficient assurance please state the reason for being unable to sign the declaration, and explain briefly what steps are being taken to resolve the issue. Please provide an appropriate level of detail.

Target/Standard:	**A&E: total time in A&E**
The Issue :	**Continuing pressures with a rise in both volume and acuity of medical admissions**
Action :	**o ED recovery plan: The ED recovery plan is progressing as expected. Both the Steering Group and Recovery Board are in operation providing both drive and oversight around the various workstreams** **o Site Operations Team: Recruitment for the substantive site operations team is progressing well. The final round of interviews are about to be conducted with the full team in place by September.** **o ED Model:** **□ A 'See and treat model' trial commenced on 17 June 2013 with approximately 30 patients per day being seen. This service runs daily from 12:00 to 20:00 with continuous review.** **□ The RAT model is scheduled to commence on 22 July** **□ Recruitment for the ENP service continues.**

Target/Standard:	**From point of referral to treatment in aggregate (RTT) – admitted**
The Issue :	**This position was driven by restricted patient flow and significant pressures on emergency pathways, this led**
Action :	**o An 18-week recovery group had been formed to oversee and deliver the 18-week Recovery Plan.** **o The Recovery Plan focuses on the following actions:** **□ Improving theatre efficiency** **□ Reducing 'non-patient' cancellations** **□ Undertaking additional 'out of hours' work at UH and STX** **□ Utilising SDU over the weekend to undertake additional work (whilst protecting the inpatient bed base)** **□ Working with private health care partners to undertake elective activity**

Target/Standard:	**Financial Risk Rating**
The Issue :	**The Trust is reporting an FRR of 1 based on the year-to-date position**
Action :	**The governance declaration is based on the year to date FRR.** **The Trust has recorded an FRR 1 for the month three position (which is the same as the financial plan submitted to the TDA), driven by poor liquidity and a low surplus margin. This also results in the Trust being unable to self certify against Board Statement 4 (that the Trust will continue to maintain a financial risk rating of at least 3 over the next 12 months).**

Target/Standard:	
The Issue :	
Action :	

Target/Standard:	
The Issue :	
Action :	

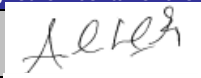
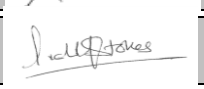
Board Statements

ity Hospitals Coventry & Warwickshire NH

June 2013

For each statement, the Board is asked to confirm the following:

	For CLINICAL QUALITY, that:	Response
1	The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the SOM's Oversight Regime (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.	✓
2	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.	✓
3	The board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.	✓
	For FINANCE, that:	**Response**
4	The board anticipates that the trust will continue to maintain a financial risk rating of at least 3 over the next 12 months.	✗
5	The board is satisfied that the trust shall at all times remain a going concern, as defined by relevant accounting standards in force from time to time.	✓
	For GOVERNANCE, that:	**Response**
6	The board will ensure that the trust at all times has regard to the NHS Constitution.	✓
7	All current key risks have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues – in a timely manner	✓
8	The board has considered all likely future risks and has reviewed appropriate evidence regarding the level of severity, likelihood of occurrence and the plans for mitigation of these risks.	✓
9	The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.	✓
10	An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).	✓
11	The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) as set out in the Governance Risk Rating; and a commitment to comply with all commissioned targets going forward.	✓
12	The trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.	✓
13	The board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies, and that any elections to the shadow board of governors are held in accordance with the election rules.	✓
14	The board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.	✓
15	The board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual plan; and the management structure in place is adequate to deliver the annual plan.	✓

	Signed on behalf of the Trust:	*Print name*	*Date*
CEO		**Andrew Hardy**	**31/07/2013**
Chair		**Nick Stokes**	**31/07/2013**

QUALITY

Information to inform the discussion meeting

University Hospitals Coventry & Warwickshire NHS Trust

Insert Performance in Month

Refresh Data for new Month

	Criteria	Unit	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Board Action
1	SHMI - latest data	Score	106.1	106.1	106.1	107.4	107.4	107.4	103.4	103.4	103.4	103.0	103.0	103.0	The SHMI is produced and published quarterly by the NHS IC. 103.3 relates to published data in April. SHMI's first publication was end of October 2011
2	Venous Thromboembolism (VTE) Screening	%	93.1	93.2	92.6	93	93.68	93.66	93.87	95.88	95.73	95.88	96.05	95.53	
3a	Elective MRSA Screening	%	135.22	136.62	137.37	137.6	140.8	129.96	131.39	122.37	125.6	120.2	114.67	121.04	1530 tests were undertaken on patients needing screening out of the 1250 total number of admissions.
3b	Non Elective MRSA Screening	%	70.3	71.1	76.2	70.3	72	69.42	77.21	70.22	68.12	66.69	69.58	65.18	
4	Single Sex Accommodation Breaches	Number	0	0	0	0	0	0	0	0	0	0	0	0	
5	Open Serious Incidents Requiring Investigation (SIRI)	Number	24 6	19 7	21 7	21 5	22 7	28 1	22 2	36 8	30 4	25 2	29 4	26 2	Open SIRIs Number that were over the 45 day target on the last day of
6	"Never Events" occurring in month	Number	0	0	0	0	1	1	0	0	1	0	1	0	Never events - 1 wrong implant/prosthesis
7	CQC Conditions or Warning Notices	Number	0	0	0	0	0	0	0	0	0	0	0	0	compliant with all CQC Essential standards; no warning notices issued
8	Open Central Alert System (CAS) Alerts	Number	11	9 2	8 2	8 1	7 2	5 2	3 2	9 0	9 3	8 4	14 5	14 4	14 open CAS alerts. 4 outstanding
9	RED rated areas on your maternity dashboard?	Number	2	3	2	4	3	3	3	3	3	1	0	3	C/S Rate in Month 26.90% Smoking at Delivery - 12.68% 3rd and 4th degree tears - 17
10	Falls resulting in severe injury or death	Number	4	1	2	3	2	4	1	2	3	1	4	4	interpreted as those falls incidents graded as 'major' or 'catastrophic'
11	Grade 3 or 4 pressure ulcers	Number	0	3	0	0	2	0	1	1	0	3	0	3	
12	100% compliance with WHO surgical checklist	Y/N	N	N	N	N	N	N	N	N	N	Y	Y	N	Dec-11 94.6%, Jan-12 94.8%, Feb-12 94.4%, Mar-12 96.4%, Apr-12 97.7%, May-12 98.4%, Jun-12 98.9%, Jul-12 99.2%, Aug-12 99.1%, Sep-12 99.6%, Oct 99.2%, Nov 99.5%, Dec 99.7%, Jan 99.4%, Feb 99.7%, Mar 99.7%, Apr 99.7%, May-13 100% (99.97%), June 99.34%
13	Formal complaints received	Number	48	45	47	40	37	36	38	40	38	39	35	27	
14	Agency as a % of Employee Benefit Expenditure	%	3.39	4.1	2.84	4.23	3.7	3.17	4	3.86	5.17	5.51	6.28	6.44	Historic and current information changed to reflect the different definition. Agency costs ONLY as a % of Employee Benefit Costs - previously Agency & Bank as a % of Turnover
15	Sickness absence rate	%	4.62	4.32	4.56	4.79	5.23	5.00	5.06	4.46	4.24	4.43	4.19	2.87	
16	Consultants which, at their last appraisal, had fully completed their previous years PDP	%	46.23	52.98	55.62	57.49	59.94	63.93	64.35	65.41	63.45	62.06	58.24	54.65	The figure provided here is based on the number of Consultants whom have completed an appraisal within the previous rolling 12 months as extracted from ESR. Part of the appraisal process incorporates a discussion on the previous year's objectives and PDP

FINANCIAL RISK RATING

University Hospitals Coventry & Warwickshire NHS Trust

			Risk Ratings					Insert the Score (1-5) Achieved for each Criteria Per Month				
								Reported Position		Normalised Position*		
Criteria	Indicator	Weight	5	4	3	2	1	Year to Date	Forecast Outturn	Year to Date	Forecast Outturn	Board Action
Underlying performance	**EBITDA margin %**	25%	11	9	5	1	<1	3	4	3	4	
Achievement of plan	**EBITDA achieved %**	10%	100	85	70	50	<50	5	4	5	4	
Financial efficiency	**Net return after financing %**	20%	>3	2	-0.5	-5	<-5	1	3	1	3	
	I&E surplus margin %	20%	3	2	1	-2	<-2	1	2	1	2	
Liquidity	**Liquid ratio days**	25%	60	25	15	10	<10	1	1	1	1	
Weighted Average		**100%**						**1.9**	**2.7**	**1.9**	**2.7**	
Overriding rules								1	2	1	2	
Overall rating								**1**	**2**	**1**	**2**	

Overriding Rules :

Max Rating	Rule							
3	Plan not submitted on time	No						
3	Plan not submitted complete and correct	No						
2	PDC dividend not paid in full	No						
2	Unplanned breach of the PBC	No						
2	One Financial Criterion at "1"			2		2		
3	One Financial Criterion at "2"							
1	Two Financial Criteria at "1"		1		1			
2	Two Financial Criteria at "2"							

* Trust should detail the normalising adjustments made to calculate this rating within the comments box.

FINANCIAL RISK TRIGGERS

University Hospitals Coventry & Warwickshire NHS Trust

Insert "Yes" / "No" Assessment for the Month

Refresh Triggers for New Quarter

	Criteria	Historic Data			Current Data				Board Action
		Qtr to Sep-12	Qtr to Dec-12	Qtr to Mar-13	Apr-13	May-13	Jun-13	Qtr to Jun-13	
1	Unplanned decrease in EBITDA margin in two consecutive quarters	Yes	Yes	Yes	No	Yes	No	No	EBITDA performance is above plan for M3 of 2013/14
2	Quarterly self-certification by trust that the normalised financial risk rating (FRR) may be less than 3 in the next 12 months	Yes	Yes	Yes	Yes	Yes	Yes	Yes	The FRR is forecast to be less than 3 for 2013/14 given the poor liquidity position
3	Working capital facility (WCF) agreement includes default clause	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
4	Debtors > 90 days past due account for more than 5% of total debtor balances	Yes	Yes	Yes	No	No	Yes	Yes	Action - Continued focus on debt recovery
5	Creditors > 90 days past due account for more than 5% of total creditor balances	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Issues around large intra-NHS balances
6	Two or more changes in Finance Director in a twelve month period	No	No	No	No	No	No	No	
7	Interim Finance Director in place over more than one quarter end	No	No	No	No	No	No	No	
8	Quarter end cash balance <10 days of operating expenses	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Improvement requires ongoing increases in liquidity - M3 2013/14 position also <10 days of operating expenditure
9	Capital expenditure < 75% of plan for the year to date	No	No	No	Yes	No	No	No	
10	Yet to identify two years of detailed CIP schemes		Yes	Yes	Yes	Yes	Yes	Yes	Development of 2 years of CIP schemes is progressing but not yet complete

GOVERNANCE RISK RATINGS

University Hospitals Coventry & Warwickshire NHS Trust

Insert YES, NO or N/A (as appropriate)

Refresh GRR for New Quarter

See 'Notes' for further detail of each of the below indicators

Area	Ref	Indicator	Sub Sections	Thresh-old	Weight-ing	Historic Data: Qtr to Sep-12	Historic Data: Qtr to Dec-12	Historic Data: Qtr to Mar-13	Current Data: Apr-13	Current Data: May-13	Current Data: Jun-13	Current Data: Qtr to Jun-13	Board Action
Effectiveness	1a	Data completeness: Community services comprising:	Referral to treatment information	50%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
			Referral information	50%									
			Treatment activity information	50%									
	1b	Data completeness, community services: *(may be introduced later)*	Patient identifier information	50%		N/a	N/a	N/a	N/a	N/a	N/a	N/a	
			Patients dying at home / care home	50%		N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	1c	Data completeness: identifiers MHMDS		97%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	1c	Data completeness: outcomes for patients on CPA		50%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
Patient Experience	2a	From point of referral to treatment in aggregate (RTT) – admitted	Maximum time of 18 weeks	90%	1.0	Yes	Yes	Yes	Yes	Yes	No	Yes	During June 2013, 3,005 patients out of 3,356 were treated within 18-weeks (89.54%). This position was driven by restricted patient flow and significant pressures on emergency pathways, this led to high numbers of planned and unplanned cancellations for a protracted period in turn leading to a significant rise in the waiting list backlog ACTIONS: o An 18-week recovery group had been formed to oversee and deliver the 18-week Recovery Plan. o The Recovery Plan focuses on the following actions: □ Improving theatre efficiency □ Reducing hospital cancellations □ Undertaking additional 'out of hours' work at University Hospital and Rugby St. Cross □ Utilising Surgical Day Unit over the weekend to undertake additional work (whilst protecting the inpatient bed base) □ Working with private health care partners to undertake elective activity
	2b	From point of referral to treatment in aggregate (RTT) – non-admitted	Maximum time of 18 weeks	95%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	2c	From point of referral to treatment in aggregate (RTT) – patients on an incomplete pathway	Maximum time of 18 weeks	92%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	2d	Certification against compliance with requirements regarding access to healthcare for people with a learning disability		N/A	0.5	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
Quality	3a	All cancers: 31-day wait for second or subsequent treatment, comprising:	Surgery	94%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
			Anti cancer drug treatments	98%									
			Radiotherapy	94%									
	3b	All cancers: 62-day wait for first treatment:	From urgent GP referral for suspected cancer	85%	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
			From NHS Cancer Screening Service referral	90%									
	3c	All Cancers: 31-day wait from diagnosis to first treatment		96%	0.5	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
	3d	Cancer: 2 week wait from referral to date first seen, comprising:	all urgent referrals	93%	0.5	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
			for symptomatic breast patients (cancer not initially suspected)	93%									
	3e	A&E: From arrival to admission/transfer/discharge	Maximum waiting time of four hours	95%	1.0	Yes	No	No	No	No	Yes	No	During June 2013, 582 patients out of 13,419 attendances at A&E were seen outside of 4 hours. This means that UHCW's performance was at 95.66% so above the minimum performance threshold of 95% for June & slightly ahead of the recovery trajectory agreed with the TDA (95.4%). For Q1, 4,359 patients out of 44,119 attendances at A&E were seen outside of 4 hours, giving a performance of 90.12%, 4.88% below the 95% target. ACTIONS: o ED recovery plan: The ED recovery plan is progressing as expected. Both the Steering Group and Recovery Board are in operation providing both drive and oversight around the various workstreams o Site Operations Team: Recruitment for the substantive site operations team is progressing well. The final round of interviews are about to be conducted with the full team in place by September. o ED Model: □ A 'See and treat model' trial commenced on 17 June 2013 with approximately 30 patients per day being seen. This service runs daily from 12:00 to 20:00 with continuous review. □ The Rapid Asssessment and Treatment model is scheduled to commence on 22 July □ Recruitment for the Emergency Nurse Practitioner service continues.
	3f	Care Programme Approach (CPA) patients, comprising:	Receiving follow-up contact within 7 days of discharge	95%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
			Having formal review within 12 months	95%									
	3g	Minimising mental health delayed transfers of care		≤7.5%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	3h	Admissions to inpatients services had access to Crisis Resolution/Home Treatment teams		95%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	3i	Meeting commitment to serve new psychosis cases by early intervention teams		95%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	3j	Category A call –emergency response within 8 minutes	Red 1	80%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
			Red 2	75%	0.5	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
	3k	Category A call – ambulance vehicle arrives within 19 minutes		95%	1.0	N/a	N/a	N/a	N/a	N/a	N/a	N/a	
Safety	4a	Clostridium Difficile	Is the Trust below the de minimus	*12*	1.0	No	No	No	Yes	Yes	Yes	Yes	
			Is the Trust below the YTD ceiling	*Enter contractual ceiling*		Yes	Yes	No	Yes	Yes	Yes	Yes	Year to date to June 2013 there have been 11 c-diff infections in UHCW against a target of 16. The SHA have confirmed the spreadsheet is applying a weighting of 1 for this metric where Trusts are exceeding the de minimus.
	4b	MRSA	Is the Trust below the de minimus	*6*	1.0	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
			Is the Trust below the YTD ceiling	*Enter contractual ceiling*		Yes	Yes	Yes	Yes	Yes	Yes	Yes	No MRSA to June 2013
		CQC Registration											
	A	Non-Compliance with CQC Essential Standards resulting in a Major Impact on Patients		0	2.0	No	No	No	No	No	No	No	
	B	Non-Compliance with CQC Essential Standards resulting in Enforcement Action		0	4.0	No	No	No	No	No	No	No	
	C	NHS Litigation Authority – Failure to maintain, or certify a minimum published CNST level of 1.0 or have in place appropriate alternative arrangements		0	2.0	No	No	No	No	No	No	No	
			TOTAL			**1.0**	**2.0**	**2.0**	**1.0**	**1.0**	**1.0**	**1.0**	
						AG	AR	AR	AG	AG	AG	AG	

RAG RATING :

GREEN	= Score less than 1
AMBER/GREEN	= Score greater than or equal to 1, but less than 2
AMBER / RED	= Score greater than or equal to 2, but less than 4
RED	= Score greater than or equal to 4

GOVERNANCE RISK RATINGS

University Hospitals Coventry & Warwickshire NHS Trust

See 'Notes' for further detail of each of the below indicators

Insert YES, NO or N/A (as appropriate)

Refresh GRR for New Quarter

			Historic Data			Current Data				
Overriding Rules - Nature and Duration of Override at SHA's Discretion										
i)	Meeting the MRSA Objective	Greater than six cases in the year to date, and breaches the cumulative year-to-date trajectory for three successive quarters								
ii)	Meeting the C-Diff Objective	Greater than 12 cases in the year to date, and either: Breaches the cumulative year-to-date trajectory for three successive quarters Reports important or signficant outbreaks of C.difficile, as defined by the Health Protection Agency.								
iii)	RTT Waiting Times	Breaches: The admitted patients 18 weeks waiting time measure for a third successive quarter The non-admitted patients 18 weeks waiting time measure for a third successive quarter The incomplete pathway 18 weeks waiting time measure for a third successive quarter								
iv)	A&E Clinical Quality Indicator	Fails to meet the A&E target twice in any two quarters over a 12-month period and fails the indicator in a quarter during the subsequent nine-month period or the full year.		Yes	Yes	Yes	Yes	Yes	Yes	UHCW did not achieve the 95%, 4-hour A&E target in Q3 2012/13. The target was not achieved in Q4 2012/13. UHCW has therefore failed to meet the A&E target twice in any two quarters over the last 12 months. UHCW did not achieve the target in October, November, December 2012 or January, February, March, April, May and June 2013. The SHA advised UHCW in January 2013 that the overriding rule will be applied retrospectively from October 2012 because this target has been failed in the subsequent nine-month period
v)	Cancer Wait Times	Breaches either: the 31-day cancer waiting time target for a third successive quarter the 62-day cancer waiting time target for a third successive quarter								
vi)	Ambulance Response Times	Breaches either: the category A 8-minute response time target for a third successive quarter the category A 19-minute response time target for a third successive quarter either Red 1 or Red 2 targets for a third successive quarter								
vii)	Community Services data completeness	Fails to maintain the threshold for data completeness for: referral to treatment information for a third successive quarter; service referral information for a third successive quarter, or; treatment activity information for a third successive quarter								
viii)	Any other Indicator weighted 1.0	Breaches the indicator for three successive quarters.								
		Adjusted Governance Risk Rating	**1.0**	**4.0**	**4.0**	**4.0**	**4.0**	**4.0**	**4.0**	
			AG	R	R	R	R	R	R	

CONTRACTUAL DATA

University Hospitals Coventry & Warwickshire NHS Trust

Information to inform the discussion meeting

Insert "Yes" / "No" Assessment for the Month

Refresh Data for new Quarter

	Criteria	Historic Data			Current Data				Board Action
		Qtr to Sep-12	Qtr to Dec-12	Qtr to Mar-13	Apr-13	May-13	Jun-13	Qtr to Jun-13	
1	Are the prior year contracts* closed?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
2	Are all current year contracts* agreed and signed?	Yes	Yes	Yes	No	Yes	Yes	Yes	
3	Has the Trust received income support outside of the NHS standard contract e.g. transformational support?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
4	Are both the NHS Trust and commissioner fulfilling the terms of the contract?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	
5	Are there any disputes over the terms of the contract?	No	No	No	No	No	No	No	
6	Might the dispute require third party intervention or arbitration?	No	No	No	No	No	No	No	
7	Are the parties already in arbitration?	No	No	No	No	No	No	No	
8	Have any performance notices been issued?	Yes	Yes	Yes	No	No	Yes	Yes	The Trust has currently been issued with performance notices around: A&E 4 hr performance 18 weeks RTT Ambulance Turnaround times Cancelled Operations
9	Have any penalties been applied?	Yes	No	No	No	No	Yes	Yes	Penalties have been applied for: 18 weeks RTT Ambulance Turnaround times Cancelled Operations

*All contracts which represent more than 25% of the Trust's operating revenue.

TFA Progress

Jul-13

University Hospitals Coventry & Warwickshire NHS Trust

Select the Performance from the drop-down list

	TFA Milestone (All including those delivered)	Milestone Date	Due or Delivered Milestones	Future Milestones	Board Action
1	SHA Interviews with the board, SHA initial meeting with the commissioners	Mar-12	Fully achieved in time		Completed
2	SHA/UHCW discussion of IBP/LTFM & PMR escalation meeting	Mar-12	Fully achieved in time		Completed
3	Self-assessment completion of BGAF	Mar-12	Fully achieved in time		Completed.
4	Submit 1st draft of IBP/LTFM and authorization for HDD1 refresh	Nov-12	Fully achieved in time		Completed
5	Trust complete self-assessment against quality dashboard and submit to the SHA	Mar-13		Risk to delivery within timescale	Revised timeline submitted to SHA 25th January 2013.
6	HDD1	Jan-13	Fully achieved in time	On track to deliver	Final report received and actions incorporated into plan.
7	Submit high quality draft of IBP/LTFM to SHA	Jan-13	Not fully achieved	Risk to delivery within timescale	Revised timeline submitted to SHA 25th January 2013
8	Final Draft of the IBP/LTFM to the SHA	Feb-13	Not fully achieved	Risk to delivery within timescale	Revised timeline submitted to SHA 25th January 2013
9	CQC Opinion received by SHA (SHA action)	Mar-13	Not fully achieved	Risk to delivery within timescale	This is an SHA action - revised timeline submitted to SHA on 25th January 2013
10	HDD 2	Mar-13	Not fully achieved	Risk to delivery within timescale	Delayed due to new timeline
11	Implement recommendations from HDD1	Sep-13		On track to deliver	Revised timeline submitted to SHA 25th Janaury 2013 - detailed timeline provided to TDA 20th June
12	IBP to Board for review	Sep-13		On track to deliver	
13	HDD1 Reassessment	Dec-13		On track to deliver	Advised by SHA requirement to reassess HDD1 due to changes in service strategy model and replacement of Chair/NEDS
14	FT Readiness review NTDA/UHCW including PMR escalation meeting	Jan-14		On track to deliver	
15	Complete QGAF assessment	Mar-14		On track to deliver	
16	Board seminar BGAF, ICTstrategy, IBP and LTFM prior to submission to NTDA	Mar-14		On track to deliver	
17	Final IBP LTFM and supporting appendices to NTDA	Mar-14		On track to deliver	
18	BGAF external validation and CQC opinion	Apr-14		On track to deliver	
19	Formal 12 weeks public consultation	Jun-14		On track to deliver	Advised by NTDA that formal consultation required
20	HDD2 assessment	Dec-14		On track to deliver	
21	Board seminar on HDD2, financial plans and risks and BGAF	Mar-15		On track to deliver	
22	CCG letter of support	Mar-15		On track to deliver	
23	NTDA interview with HDD 2 lead and review of self certifications	Apr-15		On track to deliver	
24	Board seminar on final IBP HDD and BGAF	Apr-15		On track to deliver	
25	Completed IBP/LTFM to NTDA	Apr-15		On track to deliver	
26	NTDA/UHCW Board to Board (Full Voting Board), includes review of PMR	May-15		On track to deliver	
27	Submit FT application to the DH	Jun-15		On track to deliver	
28					
29					
30					
31					
32					
33					
34					
35					
36					
37					
38					
39					
40					

Notes

Ref	Indicator	Details
Thresholds	The SHA will not utilise a general rounding principle when considering compliance with these targets and standards, e.g. a performance of 94.5% will be considered as failing to achieve a 95% target. However, exceptional cases may be considered on an individual basis, taking into account issues such as low activity or thresholds that have little or no tolerance against the target, e.g. those set between 99-100%.	
1a	Data Completeness: Community Services	Data completeness levels for trusts commissioned to provide community services, using Community Information Data Set (CIDS) definitions, to consist of: - Referral to treatment times – consultant-led treatment in hospitals and Allied Healthcare Professional-led treatments in the community; - Community treatment activity – referrals; and - Community treatment activity – care contact activity. While failure against any threshold will score 1.0, the overall impact will be capped at 1.0. Failure of the same measure for three quarters will result in a red-rating. **Numerator:** all data in the denominator actually captured by the trust electronically (not solely CIDS-specified systems). **Denominator:** all activity data required by CIDS.
1b	Data Completeness Community Services (further data):	The inclusion of this data collection in addition to Monitor's indicators (until the Compliance Framework is changed) is in order for the SHA to track the Trust's action plan to produce such data. This data excludes a weighting, and therefore does not currently impact on the Trust's governance risk rating.
1c	Mental Health MDS	Patient identity data completeness metrics (from MHMDS) to consist of: - NHS number; - Date of birth; - Postcode (normal residence); - Current gender; - Registered General Medical Practice organisation code; and - Commissioner organisation code. **Numerator:** count of valid entries for each data item above. (For details of how data items are classified as VALID please refer to the data quality constructions available on the Information Centre's website: www.ic.nhs.uk/services/mhmds/dq) **Denominator:** total number of entries.
1d	Mental Health: CPA	**Outcomes for patients on Care Programme Approach:** • Employment status: **Numerator:** the number of adults in the denominator whose employment status is known at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting, in a financial year. Include only those whose assessments or reviews were carried out during the reference period. The reference period is the last 12 months working back from the end of the reported month. **Denominator:** the total number of adults (aged 18-69) who have received secondary mental health services and who were on the CPA at any point during the reported month. • Accommodation status: **Numerator:** the number of adults in the denominator whose accommodation status (i.e. settled or non-settled accommodation) is known at the time of their most recent assessment, formal review or other multi-disciplinary care planning meeting. Include only those whose assessments or reviews were carried out during the reference period. The reference period is the last 12 months working back from the end of the reported month. **Denominator:** the total number of adults (aged 18-69) who have received secondary mental health services and who were on the CPA at any point during the reported month. • Having a Health of the Nation Outcome Scales (HoNOS) assessment in the past 12 months: **Numerator:** The number of adults in the denominator who have had at least one HoNOS assessment in the past 12 months. **Denominator:** The total number of adults who have received secondary mental health services and who were on the CPA during the reference period.
2a-c	RTT	Performance is measured on an aggregate (rather than specialty) basis and trusts are required to meet the threshold on a monthly basis. Consequently, any failure in one month is considered to be a quarterly failure. Failure in any month of a quarter following two quarters' failure of the same measure represents a third successive quarter failure and should be reported via the exception reporting process. Will apply to consultant-led admitted, non-admitted and incomplete pathways provided. While failure against any threshold will score 1.0, the overall impact will be capped at 2.0. The measures apply to acute patients whether in an acute or community setting. Where a trust with existing acute facilities acquires a community hospital, performance will be assessed on a combined basis. The SHA will take account of breaches of the referral to treatment target in 2011/12 when considering consecutive failures of the referral to treatment target in 2012/13. For example, if a trust fails the 2011/12 admitted patients target at quarter 4 and the 2012/13 admitted patients target in quarters 1 and 2, it will be considered to have breached for three quarters in a row.
2d	Learning Disabilities: Access to healthcare	Meeting the six criteria for meeting the needs of people with a learning disability, based on recommendations set out in Healthcare for All (DH, 2008): a) Does the trust have a mechanism in place to identify and flag patients with learning disabilities and protocols that ensure that pathways of care are reasonably adjusted to meet the health needs of these patients? b) Does the trust provide readily available and comprehensible information to patients with learning disabilities about the following criteria: - treatment options; - complaints procedures; and - appointments? c) Does the trust have protocols in place to provide suitable support for family carers who support patients with learning disabilities? d) Does the trust have protocols in place to routinely include training on providing healthcare to patients with learning disabilities for all staff? e) Does the trust have protocols in place to encourage representation of people with learning disabilities and their family carers? f) Does the trust have protocols in place to regularly audit its practices for patients with learning disabilities and to demonstrate the findings in routine public reports? Note: trust boards are required to certify that their trusts meet requirements a) to f) above at the annual plan stage and in each month. Failure to do so will result in the application of the service performance score for this indicator.
3a	Cancer: 31 day wait	31-day wait: measured from cancer treatment period start date to treatment start date. Failure against any threshold represents a failure against the overall target. The target will not apply to trusts having five cases or less in a quarter. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter.. Will apply to any community providers providing the specific cancer treatment pathways
3b	Cancer: 62 day wait	62-day wait: measured from day of receipt of referral to treatment start date. This includes referrals from screening service and other consultants. Failure against either threshold represents a failure against the overall target. The target will not apply to trusts having five cases or less in a quarter. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter. Will apply to any community providers providing the specific cancer treatment pathways. National guidance states that for patients referred from one provider to another, breaches of this target are automatically shared and treated on a 50:50 basis. These breaches may be reallocated in full back to the referring organisation(s) provided the SHA receive evidence of written agreement to do so between the relevant providers (signed by both Chief Executives) in place at the time the trust makes its monthly declaration to the SHA. In the absence of any locally-agreed contractual arrangements, the SHA encourages trusts to work with other providers to reach a local system-wide agreement on the allocation of cancer target breaches to ensure that patients are treated in a timely manner. Once an agreement of this nature has been reached, the SHA will consider applying the terms of the agreement to trusts party to the arrangement.
3c	Cancer	Measured from decision to treat to first definitive treatment. The target will not apply to trusts having five cases or fewer in a quarter. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter. Will apply to any community providers providing the specific cancer treatment pathways.

Notes

Ref	Indicator	Details
3d	Cancer	Measured from day of receipt of referral – existing standard (includes referrals from general dental practitioners and any primary care professional).Failure against either threshold represents a failure against the overall target. The target will not apply to trusts having five cases or fewer in a quarter. The SHA will not score trusts failing individual cancer thresholds but only reporting a single patient breach over the quarter. Will apply to any community providers providing the specific cancer treatment pathways. Specific guidance and documentation concerning cancer waiting targets can be found at: http://nww.connectingforhealth.nhs.uk/nhais/cancerwaiting/documentation
3e	A&E	Waiting time is assessed on a site basis: no activity from off-site partner organisations should be included. The 4-hour waiting time indicator will apply to minor injury units/walk in centres.
3f	Mental	7-day follow up: **Numerator**: the number of people under adult mental illness specialties on CPA who were followed up (either by face-to-face contact or by phone discussion) within seven days of discharge from psychiatric inpatient care. **Denominator:** the total number of people under adult mental illness specialties on CPA who were discharged from psychiatric inpatient care. All patients discharged to their place of residence, care home, residential accommodation, or to non-psychiatric care must be followed up within seven days of discharge. Where a patient has been transferred to prison, contact should be made via the prison in-reach team. Exemptions from both the numerator and the denominator of the indicator include: - patients who die within seven days of discharge; - where legal precedence has forced the removal of a patient from the country; or - patients discharged to another NHS psychiatric inpatient ward. For 12 month review (from Mental Health Minimum Data Set): **Numerator:** the number of adults in the denominator who have had at least one formal review in the last 12 months. **Denominator:** the total number of adults who have received secondary mental health services during the reporting period (month) who had spent at least 12 months on CPA (by the end of the reporting period OR when their time on CPA ended). For full details of the changes to the CPA process, please see the implementation guidance Refocusing the Care Programme Approach on the Department of Health's website.
3g	Mental Health: DTOC	**Numerator:** the number of non-acute patients (aged 18 and over on admission) per day under consultant and non-consultant-led care whose transfer of care was delayed during the month. For example, one patient delayed for five days counts as five. **Denominator:** the total number of occupied bed days (consultant-led and non-consultant-led) during the month. Delayed transfers of care attributable to social care services are included.
3h	Mental Health: I/P and CRHT	This indicator applies only to admissions to the foundation trust's mental health psychiatric inpatient care. The following cases can be excluded: - planned admissions for psychiatric care from specialist units; - internal transfers of service users between wards in a trust and transfers from other trusts; - patients recalled on Community Treatment Orders; or - patients on leave under Section 17 of the Mental Health Act 1983. The indicator applies to users of working age (16-65) only, unless otherwise contracted. An admission has been gate-kept by a crisis resolution team if they have assessed the service user before admission and if they were involved in the decision-making process, which resulted in admission. For full details of the features of gate-keeping, please see Guidance Statement on Fidelity and Best Practice for Crisis Services on the Department of Health's website. As set out in this guidance, the crisis resolution home treatment team should: a) provide a mobile 24 hour, seven days a week response to requests for assessments; b) be actively involved in all requests for admission: for the avoidance of doubt, 'actively involved' requires face-to-face contact unless it can be demonstrated that face-to-face contact was not appropriate or possible. For each case where face-to-face contact is deemed inappropriate, a declaration that the face-to-face contact was not the most appropriate action from a clinical perspective will be required; c) be notified of all pending Mental Health Act assessments; d) be assessing all these cases before admission happens; and e) be central to the decision making process in conjunction with the rest of the multidisciplinary team.
3i	Mental Health	Monthly performance against commissioner contract. Threshold represents a minimum level of performance against contract performance, rounded down.
3j-k	Ambulance Cat A	For patients with immediately life-threatening conditions. The Operating Framework for 2012-13 requires all Ambulance Trusts to reach 75 per cent of urgent cases, Category A patients, within 8 minutes. From 1 June 2012, Category A cases will be split into Red 1 and Red 2 calls: • Red 1 calls are patients who are suffering cardiac arrest, are unconscious or who have stopped breathing. • Red 2 calls are serious cases, but are not ones where up to 60 additional seconds will affect a patient's outcome, for example diabetic episodes and fits. Ambulance Trusts will be required to improve their performance to show they can reach 80 per cent of Red 1 calls within 8 minutes by April 2013.
4a	C.Diff	Will apply to any inpatient facility with a centrally set C. difficile objective. Where a trust with existing acute facilities acquires a community hospital, the combined objective will be an aggregate of the two organisations' separate objectives. Both avoidable and unavoidable cases of C. difficile will be taken into account for regulatory purposes. Where there is no objective (i.e. if a mental health trust without a C. difficile objective acquires a community provider without an allocated C. difficile objective) we will not apply a C. difficile score to the trust's governance risk rating. Monitor's annual de minimis limit for cases of C. difficile is set at 12. However, Monitor may consider scoring cases of <12 if the Health Protection Agency indicates multiple outbreaks. Where the number of cases is less than or equal to the de minimis limit, no formal regulatory action (including scoring in the governance risk rating) will be taken. If a trust exceeds the de minimis limit, but remains within the in-year trajectory for the national objective, no score will be applied. If a trust exceeds both the de minimis limit and the in-year trajectory for the national objective, a score will apply. If a trust exceeds its national objective above the de minimis limit, the SHA will apply a red rating and consider the trust for escalation. If the Health Protection Agency indicates that the C. difficile target is exceeded due to multiple outbreaks, while still below the de minimis, the SHA may apply a score.
4b	MRSA	Will apply to any inpatient facility with a centrally set MRSA objective. Where a trust with existing acute facilities acquires a community hospital, the combined objective will be an aggregate of the two organisations' separate objectives. Those trusts that are not in the best performing quartile for MRSA should deliver performance that is at least in line with the MRSA objective target figures calculated for them by the Department of Health. We expect those trusts without a centrally calculated MRSA objective as a result of being in the best performing quartile to agree an MRSA target for 2012/13 that at least maintains existing performance. Where there is no objective (i.e. if a mental health trust without an MRSA objective acquires a community provider without an allocated MRSA objective) we will not apply an MRSA score to the trust's governance risk rating. Monitor's annual de minimis limit for cases of MRSA is set at 6. Where the number of cases is less than or equal to the de minimis limit, no formal regulatory action (including scoring in the governance risk rating) will be taken. If a trust exceeds the de minimis limit, but remains within the in-year trajectory for the national objective, no score will be applied. If a trust exceeds both the de minimis limit and the in-year trajectory for the national objective, a score will apply. If a trust exceeds its national objective above the de minimis limit, the SHA will apply a red rating and consider the trust for escalation

NHS TRUST DEVELOPMENT AUTHORITY

OVERSIGHT: Monthly self-certification requirements - Board Statements

Monthly Data.

CONTACT INFORMATION:

Enter Your Name: Lynda Cockrill

Enter Your Email Address: lynda.cockrill@uhcw.nhs.uk

Full Telephone Number: 02476 968405 Tel Extension: 28405

SELF-CERTIFICATION DETAILS:

Select Your Trust: University Hospitals Coventry And Warwickshire NHS Trust

Submission Date: 31/07/2013 Reporting Year: 2013/14

Select the Month

- April
- May
- June
- July
- August
- September
- October
- November
- December
- January
- February
- March

BOARD STATEMENTS:

CLINICAL QUALITY
FINANCE
GOVERNANCE

The NHS TDA's role is to ensure, on behalf of the Secretary of State, that aspirant FTs are ready to proceed for assessment by Monitor. As such, the processes outlined here replace those previously undertaken by both SHAs and the Department of Health.

In line with the recommendations of the Mid Staffordshire Public Inquiry, the achievement of FT status will only be possible for NHS Trusts that are delivering the key fundamentals of clinical quality, good patient experience, and national and local standards and targets, within the available financial envelope.

BOARD STATEMENTS:

For CLINICAL QUALITY, that

1. The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to the TDA's oversight model (supported by Care Quality Commission information, its own information on serious incidents, patterns of complaints, and including any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.

1. CLINICAL QUALITY Indicate compliance.	Yes
Timescale for compliance:	
RESPONSE:	
Comment where non-compliant or at risk of non-compliance	

BOARD STATEMENTS:

For CLINICAL QUALITY, that

2. The board is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.

2. CLINICAL QUALITY
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For CLINICAL QUALITY, that

3. The board is satisfied that processes and procedures are in place to ensure all medical practitioners providing care on behalf of the trust have met the relevant registration and revalidation requirements.

3. CLINICAL QUALITY
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For FINANCE, that

4. The board is satisfied that the trust shall at all times remain a going concern, as defined by the most up to date accounting standards in force from time to time.

4. FINANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

5. The board will ensure that the trust remains at all times compliant with the NTDA accountability framework and shows regard to the NHS Constitution at all times.

5. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

6. All current key risks to compliance with the NTDA's Accountability Framework have been identified (raised either internally or by external audit and assessment bodies) and addressed – or there are appropriate action plans in place to address the issues in a timely manner.

6. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

7. The board has considered all likely future risks to compliance with the NTDA Accountability Framework and has reviewed appropriate evidence regarding the level of severity, likelihood of a breach occurring and the plans for mitigation of these risks to ensure continued compliance.

7. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

8. The necessary planning, performance management and corporate and clinical risk management processes and mitigation plans are in place to deliver the annual operating plan, including that all audit committee recommendations accepted by the board are implemented satisfactorily.

8. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

9. An Annual Governance Statement is in place, and the trust is compliant with the risk management and assurance framework requirements that support the Statement pursuant to the most up to date guidance from HM Treasury (www.hm-treasury.gov.uk).

9. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

10. The Board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets as set out in the NTDA oversight model; and a commitment to comply with all known targets going forward.

10. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

11. The trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.

11. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

12. The board will ensure that the trust will at all times operate effectively. This includes maintaining its register of interests, ensuring that there are no material conflicts of interest in the board of directors; and that all board positions are filled, or plans are in place to fill any vacancies.

12. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

13. The board is satisfied that all executive and non-executive directors have the appropriate qualifications, experience and skills to discharge their functions effectively, including setting strategy, monitoring and managing performance and risks, and ensuring management capacity and capability.

13. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

BOARD STATEMENTS:

For GOVERNANCE, that

14. The board is satisfied that: the management team has the capacity, capability and experience necessary to deliver the annual operating plan; and the management structure in place is adequate to deliver the annual operating plan.

14. GOVERNANCE
Indicate compliance.

Yes

Timescale for compliance:

RESPONSE:

Comment where non-compliant or at risk of non-compliance

Submit

NHS TRUST DEVELOPMENT AUTHORITY

OVERSIGHT: Monthly self-certification requirements - Compliance Monitor

Monthly Data.

CONTACT INFORMATION:

Enter Your Name: Lynda Cockrill

Enter Your Email Address: lynda.cockrill@uhcw.nhs.uk

Full Telephone Number: 02476 968405 Tel Extension: 28405

SELF-CERTIFICATION DETAILS:

Select Your Trust: University Hospitals Coventry And Warwickshire NHS Trust

Submission Date: 31/07/2013 Reporting Year: 2013/14

Select the Month

- April
- May
- June
- July
- August
- September
- October
- November
- December
- January
- February
- March

COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

1. **Condition G4** – Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions).
2. **Condition G5** – Having regard to monitor Guidance.
3. **Condition G7** – Registration with the Care Quality Commission.
4. **Condition G8** – Patient eligibility and selection criteria.

5. **Condition P1** – Recording of information.
6. **Condition P2** – Provision of information.
7. **Condition P3** – Assurance report on submissions to Monitor.
8. **Condition P4** – Compliance with the National Tariff.
9. **Condition P5** – Constructive engagement concerning local tariff modifications.

10. **Condition C1** – The right of patients to make choices.
11. **Condition C2** – Competition oversight.

12. **Condition IC1** – Provision of integrated care.

Further guidance can be found in Monitor's response to the statutory consultation on the new NHS provider licence: The new NHS Provider Licence

COMPLIANCE WITH MONITOR LICENCE REQUIREMENTS FOR NHS TRUSTS:

		Comment where non-compliant or at risk of non-compliance
1. Condition G4 Fit and proper persons as Governors and Directors.	Yes	
Timescale for compliance:		
2. Condition G5 Having regard to monitor Guidance.	Yes	
Timescale for compliance:		
3. Condition G7 Registration with the Care Quality Commission.	Yes	
Timescale for compliance:		
		Comment where non-compliant or at risk of non-compliance
4. Condition G8 Patient eligibility and selection criteria.	Yes	
Timescale for compliance:		

		Comment where non-compliant or at risk of non-compliance
5. Condition P1 Recording of information.	Yes	
		Timescale for compliance:
6. Condition P2 Provision of information.	Yes	
		Timescale for compliance:
7. Condition P3 Assurance report on submissions to Monitor.	Yes	
		Timescale for compliance:
8. Condition P4 Compliance with the National Tariff.	Yes	
		Timescale for compliance:

		Comment where non-compliant or at risk of non-compliance
9. Condition P5 Constructive engagement concerning local tariff modifications.	Yes	
		Timescale for compliance:

Comment where non-compliant or at risk of non-compliance

10. Condition C1
The right of patients to make choices.

Yes

Timescale for compliance:

11. Condition C2
Competition oversight.

Yes

Timescale for compliance:

12. Condition IC1
Provision of integrated care.

Yes

Timescale for compliance:

Submit

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST

REPORT TO THE TRUST BOARD: PUBLIC

31 July 2013

Subject:	Audit Committee Meeting Report – 13 May 2013
Report By:	Mr T Robinson, Non-Executive Director
Author:	Mrs G Nolan, Chief Finance Officer
Accountable Executive Director:	Mrs G Nolan, Chief Finance Officer

GLOSSARY

Abbreviation	In Full

WRITTEN REPORT (provided in addition to cover sheet)? ☐ **Yes** ☒ **No**

POWERPOINT PRESENTATION? ☐ **Yes** ☒ **No**
NB Presentations need to be submitted for inclusion in Board papers

Title	
Approx. Length	

PURPOSE OF THE REPORT / PRESENTATION:

To advise the Board of the Audit Committee meeting agenda for 13 May 2013 and of any key issues or decisions arising from the meeting.

SUMMARY OF KEY ISSUES:

ACTIONS FROM PREVIOUS MEETING/ACTION MATRIX – SECURITY REVIEW UPDATE
An update on progress made in regard to the access control review was presented. A new procedure for the management, issue and cancellation of identification swipe cards (ID cards) has been approved by the Corporate Business Records Committee. Confidence was expressed that there is a robust system in place but a review will be undertaken in 6 months to test the new process. The Committee noted the report and agreed to receive a further update in September 2013.

ACTIONS FROM PREVIOUS MEETING/ACTION MATRIX – INTERNAL AUDIT REPORT 13/WA/27 SECURITY REVIEW FOLLOW UP
The follow up audit report was presented. It was noted that progress has been made in actioning the recommendations but the action plan had not been fully implemented. A further review will take place in September, with a report being submitted to a future meeting of the Committee.

ACTIONS FROM PREVIOUS MEETING/ACTION MATRIX – INTERNAL AUDIT REPORT 13/WA/07 NON PURCHASE ORDER INVOICES
The Committee were updated on actions being taken to review non-purchase order payments. A number of key tasks will be undertaken over the coming months a follow up report will be submitted for discussion at the November meeting.

ACTIONS DEFERRED FROM PREVIOUS MEETINGS/ACTION MATRIX – TRUST PROPERTY AND LEASE REGISTER
The Committee were advised that in the future reports will be considered by the Trust's PFI and Development Committee following the review of the terms of reference. The report set out details of properties held by the Trust and includes notes on the current position and work in progress. The Committee received the update an noted the current position in relation to property issues for the Trust.

OVERALL GOVERNANCE ARRANGEMENTS – REVIEW OF CLINICAL AUDIT WORK PLAN
The Committee were presented with an overview of the clinical audits in which the Trust will be participating during 2013/14. This Programme includes mandatory audits, national audits, and local audits. The report also included the project status of the audits and is broke down by specialty. The Committee agreed the Clinical Audit Work Plan for 2013/14.

ANNUAL ACCOUNTS – ANNUAL GOVERNANCE STATEMENT
The first draft of the Annual Governance Statement was presented to the Committee. The format was similar to that presented in previous years. The Committee reviewed the draft Annual Governance Statement and subject minor amendments considered that it met the requirements set out in the Department of Health

Guidance and should be presented to the Trust Board and signed by the Chief Executive Officer.

ANNUAL ACCOUNTS – GOING CONCERN REVIEW

An assessment as at 31 March 2013 was provided as to whether the Trust's annual accounts for 2012/13 can be prepared on a going concern basis. The assessment was carried out using the Audit Commission's criteria which has been the case for a number of years. The Committee considered the draft assessment and agreed that it is appropriate for the accounts to be prepared on an on going concern basis.

ANNUAL ACCOUNTS – ANNUAL ACCOUNTS PROGRESS REPORT

Mr Jones updated the Committee on the current position with regard to the Annual Accounts process. The Accounts have been submitted and an audit of the Accounts has commenced, with no issues being raised at the time of the Audit Committee meeting.

INTERNAL AUDIT – ANNUAL REPORT 2012/13 AND HEAD OF INTERNAL AUDIT OPINION

The Annual Report for 2012/13 was presented to the Committee. The report also provided the Head of Internal Audit's opinion. The report summarised the activities of Internal Audit for the period 1 April 2012 to 31 March 2013 and highlights that the overall opinion is that significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives and that controls are generally being applied consistently. The Committee received the Annual Report for 2012/13 and acknowledged the Head of Internal Audit's Opinion.

INTERNAL AUDIT REPORTS

A number of internal audit reports were presented as follows:

- Private Patient Income
- Risk Management
- Payroll (incorporating Self Service)
- Information Governance Toolkit Year End Review
- Security Policy Review
- Clinical Audit Follow Up
- Car Parking Review
- Audit Committee Checklist Survey

EXTERNAL AUDIT PROGRESS REPORT

An update on the work of External Audit since the last meeting of the Audit Committee was presented. The Committee noted the report.

REVIEW/APPROVAL FUNCTIONS – REVIEW OF REGISTER OF INTERESTS

The report provided an update on the information current held on the Register of Interests/Declaration of Gifts. The Committee noted the contents of the report..

OVERALL GOVERNANCE ARRANGEMENTS – BOARD ASSURANCE FRAMEWORK

A report was presented which summarised the process for targeted reviews of the Board Assurance Framework, taking into consideration the role of the three sub committees of the Trust Board. The report was received by the Audit Committee which endorsed the need for quality and financial impact assessments in support of the detailed reviews to be carried by the Quality Governance Committee and the Finance and Performance Committee. These reviews will, in turn, be used to provide further assurance to the Audit Committee as required. The next meeting of the Audit Committee will consider the detailed End of Year BAF Report.

ADMINISTRATIVE MATTERS – REVIEW OF BOARD COMMITTEES' ANNUAL REPORTS – FINANCE AND PERFORMANCE COMMITTEE

As part of the Audit Committee's responsibility to review the Trust's overall governance arrangements, the Annual Report of the Finance and Performance Committee was presented for consideration. The Committee reviewed the Annual Report for 2012/13 and also the development proposals for 2013/14.

SUMMARY OF KEY RISKS:

No key risks were identified.

RECOMMENDATION / DECISION REQUIRED:

The Board is asked to review and note the minutes of the Audit Committee held on 13 May 2013.

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST

REPORT TO THE TRUST BOARD: PUBLIC

31 July 2013

IMPLICATIONS:

Financial:	None identified
HR / Equality & Diversity:	None identified
Governance:	The work of the Audit Committee is in line with good governance principles and best practice.
Legal:	None identified.

REVIEW:

Trust Standing Committee	**Date**	**Trust Standing Committee**	**Date**
Quality Governance Committee		Remuneration Committee	
Finance and Performance Committee		Executive Meeting	
Audit Committee			

DATA QUALITY:

Data/information Source:	
Data Quality Controls:	
Data Limitations:	

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST

REPORT TO THE TRUST BOARD: PUBLIC

WEDNESDAY 31st JULY 2013

Subject:	Patient Story
Report By:	Promoter Verbatim Comments from Impressions for all A&E Departments for Quarter 1: 1st April 2013 – 30th June 2013
Author:	As above Header Sheet by Julia Flay, Patient Involvement Facilitator
Accountable Executive Director:	Meghana Pandit, Chief Medical Officer

GLOSSARY

Abbreviation	In Full

WRITTEN REPORT (provided in addition to cover sheet)? √☐ **Yes** ☐ **No**

POWERPOINT PRESENTATION? ☐ **Yes** ☐ **No**
NB Presentations need to be submitted for inclusion in Board papers

Title	
Approx. Length	

PURPOSE OF THE REPORT / PRESENTATION:

To appraise the Trust Board of the promoter comments received on Impressions (for Q1) for the Friends and Family Test (FFT) in the A&E Departments.

Note: The A&E FFT was implemented nationally on 1st April 2013 and currently only applies to patients over 16 who attended, and were not subsequently admitted, to type 1 and 2 A&E Departments.

At UHCW NHS Trust this means the question is asked in its Main A&E, Children's A&E, Eye Casualty and Gynaecology A&E (on Ward 23). The Minor Injuries Unit at the Hospital of St Cross is excluded.

SUMMARY OF KEY ISSUES:

This Trust has been asking its In-Patients the FFT since April 2012 as stipulated by the Midlands and East SHA, who introduced it into all its acute trusts. On 1st April 2013, FFT for In-Patients was rolled out nationally along with its introduction into type 1 and 2 A&Es across the country. For this national roll out the question and response categories were changed along with the national Patient Experience CQUIN.

The Patient Experience CQUIN for 2013/14 is based partly on increasing response rates to the FFT across both in-patients and A&E (the two areas to which the FFT currently applies) and not on its actual FFT score as was the case for the 2012/13 CQUIN.

For this year, the CQUIN stipulated that the Trust needed to achieve a baseline response rate of at least 15% in Q1 which was achieved with a response rate of 22.54%. In order to achieve the full CQUIN for the response rate aspect, the Trust has to achieve a response rate in Q4 that is both (a) higher than the response rate for Q1 and (b) 20% or over.

Due to the Trust's achievement with regard to its response rates in A&E in Q1, the Strategic Projects Team has praised us and cited us an example of best practice with regard to our trialling 3 data collection methods in A&E: post card, text and tally box.

Attached is a report which shows all of our A&E promoters' comments given on Impressions during Q1. It may be of interest to the Trust Board to note that although the actual score doesn't form part

of the CQUIN this year, the score in A&E has increased over the quarter as shown below:

April 2013 – A&E FFT Score: 22
May 2013 – A&E FFT Score: 35
June 2013 – A&E FFT Score: 51

How the Score is worked out: The response categories [to the FFT question] are classified as promoters, passives and detractors. The number of promoters are subtracted from the number of detractors, divided by the total number of responses.

N.B. General Feedback regarding A&E Departments:

It is worth noting that general feedback from all attendees at the Trust's A&E Departments for the first quarter i.e. not just patients responding to the FFT, indicate that the vast majority had a mainly good experience indicated in the breakdown below.

Main A&E: 65% of all respondents stated they had a mainly good experience

Eye Casualty: 88% of all respondents stated they had a mainly good experience

Gynaecology A&E: 85% of all respondents stated they had a mainly good experience

SUMMARY OF KEY RISKS:

The first part of the Patient Experience CQUIN has been met by achieving the requisite response rate in Q1. The response rates for both In-patients and A&E are monitored daily by the FFT Implementation Team, chaired by the Director of Governance. This daily monitoring will allow for contingency plans to be invoked should it seem likely that the required response rate in Q4 is threatened.

Note: part of the Patient Experience CQUIN for this year involves the successful implementation of the FFT into Maternity Services by October 2013 and other areas yet to be confirmed by the Strategic Projects Team (on behalf of the DoH) by the end of this financial year.

The FFT Implementation Team are on track to implement the FFT into Maternity Services by August 2013, two months prior to go live in October, allowing the Team to assess whether the data collection method identified for the Specialty (post card) will enable the response rate of 15% to be achieved.

RECOMMENDATION / DECISION REQUIRED:

The Board is asked to **NOTE** the report.

IMPLICATIONS:

Financial:	National Patient Experience CQUIN
HR / Equality & Diversity:	Francis Report National Patient Experience CQUIN Friends and Family Test
Governance:	None

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST

REPORT TO THE TRUST BOARD: PUBLIC

WEDNESDAY 31st JULY 2013

Legal:	None

REVIEW:

Trust Standing Committee	Date	Trust Standing Committee	Date
Quality Governance Committee		Remuneration Committee	
Finance and Performance Committee		Executive Meeting	
Audit Committee			

DATA QUALITY:

Data/information Source:	
Data Quality Controls:	
Data Limitations:	

Title: Reporting > Verbatim Report Shown in Date Order

Filters: Visit Type: Emergency department (A&E), FFT Type: Promoter
Date: From: 01 Apr 2013, To: 30 Jun 2013
Results:

Comments in blue: response to question – Why do you feel this way?

Comments in green: response to question – How could we improve?

ID	Date	Overall	FFT Type	Verbatim
23341	2013-06-25		Promoter	University Hospital A&E Patient
	11:08:00			We were seen within 10 minutes - very efficient
				Friendliness of some staff (not all) at reception
23228	2013-06-28		Promoter	University Hospital A&E Patient
	12:19:00			Good.
23225	2013-06-28		Promoter	University Hospital A&E Patient
	12:14:00			Parking is expensive.
23035	2013-06-14		Promoter	University Hospital Eye Casualty Patient
	12:05:00			Better parking and improve the food.
23034	2013-06-14		Promoter	University Hospital Eye Casualty Patient
	12:03:00			For an extremely busy department, the admin and medical staff were thorough, caring and polite - perfect.
22967	2013-06-10		Promoter	University Hospital A&E Patient
	12:18:00			
				Excellent experience - great staff etc.
22966	2013-06-10		Promoter	University Hospital A&E Patient
	12:16:00			Very impressed with the treatment times and waiting. Very friendly staff.
22959	2013-06-10		Promoter	University Hospital Eye Casualty Patient
	11:46:00			Got seen quick and receptionist made me welcome (Sharon Campbell).
22730	2013-05-20		Promoter	University Hospital Eye Casualty Patient
	11:33:00			Had a very good experience and was extremely happy with the service.
				Make getting in and out of the grounds easier, parking should be cheaper and cars parked in disabled spaces did not have a disabled badge.

22645	2013-05-13 13:46:00		Promoter	University Hospital	Eye Casualty	Patient
				Problem disgnosed and treated promptly.		
				Better instructions/ signs re parking.		
22613	2013-05-11 14:39:02		Promoter	University Hospital	A&E	Patient
				Spotless		
22613	2013-05-11 14:39:02		Promoter	University Hospital	A&E	Patient
				Staff attentive and confident		
22613	2013-05-11 14:39:02		Promoter	University Hospital	A&E	Patient
				Everthing exlplained		
22613	2013-05-11 14:39:02		Promoter	University Hospital	A&E	Patient
				Never left in pain		
22613	2013-05-11 14:39:02		Promoter	University Hospital	A&E	Patient
				Good information given by all staff		
22613	2013-05-11 14:39:02		Promoter	University Hospital	A&E	Patient
				Door closed when personal attention being given		
22613	2013-05-11 14:39:02		Promoter	University Hospital	A&E	Patient
				Always treated kindly		
22613	2013-05-11 14:39:02		Promoter	University Hospital	A&E	Patient
				Always asked how I wanted to be addressed		
22613	2013-05-11 14:39:02		Promoter	University Hospital	A&E	Patient
				Never had to wait for help		
22604	2013-05-10 13:35:00		Promoter	University Hospital	Gynaecology Short Stay	Patient
				Parking is a nightmare!		
				More parking for visitors and staff.		

22595	2013-05-10 12:37:00		Promoter	University Hospital	Gynaecology Short Stay	Patient
				The circumstances of admission were really awful, but all the staff were so kind and helpful.		
				More parking.		
22594	2013-05-10 12:35:00		Promoter	University Hospital	A&E	Patient
				More beds.		
22593	2013-05-10 12:33:00		Promoter	University Hospital	Eye Casualty	Patient
				Fantastic consultant; highest praise.		
22592	2013-05-10 12:29:00		Promoter	University Hospital	A&E	Patient
				Clean, modern hospital - friendly staff, kind and caring.		
				I am vacationing in the UK and I have been treated by knowledgeable and professional medical staff.		
22559	2013-05-08 16:23:00		Promoter	University Hospital	Eye Casualty	Patient
				Overall a satisfactory experience		
22542	2013-05-07 16:45:40		Promoter	University Hospital	Eye Casualty	Patient
				Current concern with Nosocomial infections~ good to see that places were kept as clean as possible		
				One hand gel dispenser empty outside dining room~ but was very busy probably more people post Bank Holiday.		
22542	2013-05-07 16:45:40		Promoter	University Hospital	Eye Casualty	Patient
				Have follow up appt. in 3weeks~ had clear & precise instructions verbal & written on administering medication.		
				Ther is always room for imrovement but don't see how on this subject. Excellent.		
22542	2013-05-07 16:45:40		Promoter	University Hospital	Eye Casualty	Patient
				From first encounter to making follow up appt. Staff very profession but friendly and approachable.		
				keep up the good work!		

22542	2013-05-07 16:45:40		Promoter	University Hospital Eye Casualty Patient Easy access to coffee & refreshments etc.,and then tasty lunch in restauranrt. Friendly staff.
22542	2013-05-07 16:45:40		Promoter	University Hospital Eye Casualty Patient Not too clear about way to Eye Casualty but asked at Endocrinolgy Unit & given clear instructions by friendly & helpful young man at desk. Receptionists, Nurses & Doctors gave very clear information. Including how long to expect to wait before seeing a Dr.
22542	2013-05-07 16:45:40		Promoter	University Hospital Eye Casualty Patient It is important to feel reassured~felt confident with examinations, diagnosis & treatment~ and medical advice.
22542	2013-05-07 16:45:40		Promoter	University Hospital Eye Casualty Patient Not too sure at first where to go~ however all quite easy once we understood the system Perhaps clear signs or 'You are here' Maps?
22542	2013-05-07 16:45:40		Promoter	University Hospital Eye Casualty Patient
				Very impressed with young Dr. & then with the Consultant who confirmed her opinions.
22542	2013-05-07 16:45:40		Promoter	University Hospital Eye Casualty Patient This is so important. Quiet examination rooms~ no personal questions asked in public areas.
22542	2013-05-07 16:45:40		Promoter	University Hospital Eye Casualty Patient Again, this is what we should expect from NHS staff & it should come naturally. Everyone seemed engaged & willing to help. Thank you.
22542	2013-05-07 16:45:40		Promoter	University Hospital Eye Casualty Patient The politeness was not forced or false. This is how human beings should treat each other.
22542	2013-05-07 16:45:40		Promoter	University Hospital Eye Casualty Patient There was possibly a heavier workload today, but was in and out of Eye Casualty in 2hours
22542	2013-05-07		Promoter	University Hospital Eye Casualty Patient

	16:45:40			System was good, was given a pager & went to have lunch~ and was warned it would be at least one hour. May be I could have requested an outside prescription to avoid long wait & blocking a car park space & avoided incurring the 5 hour tariff. Perhaps have a Pharmacy or smaller pharmacies dedicated to either A & E or OPD department.		
22526	2013-05-03 15:02:11		Promoter	University Hospital	A&E	Patient
				very clean and tidy		
22526	2013-05-03 15:02:11		Promoter	University Hospital	A&E	Patient
				made sure i was ready and fit to go		
22526	2013-05-03 15:02:11		Promoter	University Hospital	A&E	Patient
				felt well looked after		
22526	2013-05-03 15:02:11		Promoter	University Hospital	A&E	Patient
				food and drink was very good		
22526	2013-05-03 15:02:11		Promoter	University Hospital	A&E	Patient
				medical care was 1st class		
22526	2013-05-03 15:02:11		Promoter	University Hospital	A&E	Patient
				a1		
22526	2013-05-03 15:02:11		Promoter	University Hospital	A&E	Patient
				a1		
22526	2013-05-03 15:02:11		Promoter	University Hospital	A&E	Patient
				a1		
22526	2013-05-03 15:02:11		Promoter	University Hospital	A&E	Patient
				a1		
22526	2013-05-03 15:02:11		Promoter	University Hospital	A&E	Patient
				a1		
22525	2013-05-03 14:58:00		Promoter	University Hospital	Eye Casualty	Patient
				Good level of care.		

22523	2013-05-03 14:49:00		Promoter	University Hospital	Eye Casualty	Patient
				I found everything imprressive.		
22473	2013-05-03 11:41:00		Promoter	University Hospital	A&E	Patient
				Parking is too expensive.		
22416	2013-04-29 13:06:00		Promoter	University Hospital	Eye Casualty	Patient
				Coffee machine in outpatients.		
22413	2013-04-29 13:00:00		Promoter	University Hospital	Eye Casualty	Patient
				Lovely nurses and doctors; a credit to you.		
				More parking spaces and its very expensive.		
22411	2013-04-29 12:57:00		Promoter	University Hospital	Eye Casualty	Patient
				Staff were very polite, helpful, caring and very knowledgeable.		
22410	2013-04-29 12:52:00		Promoter	University Hospital	Eye Casualty	Patient
				Because staff treated me very well.		
22408	2013-04-29 12:50:00		Promoter	University Hospital	Eye Casualty	Patient
				Not enough parking spaces or wheelchairs.		
22356	2013-04-26 11:15:00		Promoter	University Hospital	A&E	Patient
				Very caring, helpful and knowledgeable doctors; thank you.		
22353	2013-04-26 11:13:00		Promoter	University Hospital	A&E	Patient
				Very pleased - seen very quickly.		
22350	2013-04-26 11:09:00		Promoter	University Hospital	A&E	Patient
				Smiling and friendly.		
22281	2013-04-22 11:43:00		Promoter	University Hospital	Eye Casualty	Patient
				Helpful and prompt attention.		
				By promoting an idea of waiting time and position in queue.		
22220	2013-04-19 11:22:00		Promoter	University Hospital	Eye Casualty	Patient
				Good care - just found the place a bit overwhelming.		

				If possible increase capacity, and the standard of the information sheets on regular conditions.		
22219	2013-04-19 11:21:00		Promoter	University Hospital	Eye Casualty	Patient
				Waiting times.		
22217	2013-04-19 11:16:00		Promoter	University Hospital	A&E	Patient
				Always a long wait at A&E but ok about it.		
				Difficult to see how - care was very good.		
22186	2013-04-15 13:31 :00		Promoter	University Hospital	Eye Casualty	Patient
				I have every confidence of expertise in this field.		
22183	2013-04-15 13:26:00		Promoter	University Hospital	Eye Casualty	Patient
				I am a regular patient at the Eye Clinic.		
22181	2013-04-15 13:21:00		Promoter	University Hospital	A&E	Patient
				Staff inspire confidence with their caring approach.		
				Only by reducing waiting times.		
22175	2013-04-15 12:49:00		Promoter	University Hospital	Eye Casualty	Patient
				We like the staff - they are very helpful.		
				Less waiting time.		
22173	2013-04-15 12:48:00		Promoter	University Hospital	Eye Casualty	Patient
				Well looked after.		
22165	2013-04-15 12:39:00		Promoter	University Hospital	Eye Casualty	Patient
				Quick and efficient.		
				Bigger car parking.		
22160	2013-04-15 12:31:00		Promoter	University Hospital	Eye Casualty	Patient
				First time visit - excellent.		
22083	2013-04-12 12:55:00		Promoter	University Hospital	A&E	Patient
				Staff reassuring.		
				Discharge felt a bit rushed.		
22080	2013-04-12		Promoter	University Hospital	A&E	Patient

	12:49:00			Food could be better.
22078	2013-04-12 12:44:00		Promoter	University Hospital A&E Patient Good, friendly treatment.
22076	2013-04-12 12:36:00		Promoter	University Hospital A&E Patient Excellent service under pressure. More staff and more beds are needed - all the things the staff cannot influence.
22073	2013-04-12 12:31 :00		Promoter	University Hospital A&E Patient Less charges for parking and more food for out of hours.
22072	2013-04-12 12:29:00		Promoter	University Hospital A&E Patient No access to food or drink. No lift to ground floor.
22071	2013-04-12 12:27:00		Promoter	University Hospital A&E Patient Nurse was brilliant (Bank Nurse Heather Elson)
22006	2013-04-04 16:13:00		Promoter	University Hospital A&E Patient Very clean cleaners cleaning constantly all day Stop cleaner entering rooms when people are been seen by health professionals
22006	2013-04-04 16:13:00		Promoter	University Hospital A&E Patient The hca were fantastic offered food and drink on many occasions Nothing felt the standards was ok
22006	2013-04-04 16:13:00		Promoter	University Hospital A&E Patient Was not given any written information but verbally communication was excellent
				N/a
22006	2013-04-04 16:13:00		Promoter	University Hospital A&E Patient Staff were excellent with privacy & dignity No change needed
22006	2013-04-04 16:13:00		Promoter	University Hospital A&E Patient Staff were always compassionate kind understanding No change needed

22006	2013-04-04 16:13:00		Promoter	University Hospital	A&E	Patient
				Politeness and respect goes along way and the medical staff nurses doctors and hca were brilliant		
				No change needed		

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST

REPORT TO THE TRUST BOARD: PUBLIC

28 July 2013

Subject:	**Francis Inquiry – Trust Assurance Process**
Report By:	**Meghana Pandit, Chief Medical Officer**
Author:	**Paul Martin, Director of Governance**
Accountable Executive Director:	**Meghana Pandit, Chief Medical Officer**

GLOSSARY

Abbreviation	In Full
T+F	Task and Finish Group

WRITTEN REPORT (provided in addition to cover sheet)? ☒ **Yes** ☐ **No**

POWERPOINT PRESENTATION? ☐ **Yes** ☒ **No**
NB Presentations need to be submitted for inclusion in Board papers

Title	
Approx. Length	

PURPOSE OF THE REPORT / PRESENTATION:

1. To update the public on progress in implementing the Assurance process in response to the Francis Inquiry Report (published on 6 February 2013).
2. To share analysis of Francis' recommendations, the degree of assurance available, and proposed actions arising therefrom.
3. To consider and approve a process that will provide full assurance of compliance with the recommendations of the Francis Inquiry

SUMMARY OF KEY ISSUES:

- The Report instigates a significant cultural shift with new expectations for Trusts
- The gap analysis shows therefore that UHCW has areas of non-compliance with the recommendations of the Francis Report. Red ratings (no assurance) do not imply an immediate risk to patient safety.
- To fully comply with the recommendations requires continuing action at Corporate and Clinical Speciality levels.
- Listening to and acting upon the patient's experience is central to meeting the recommendations
- Patients must be actively involved with all aspects of change arising from the Report
- The programme of change should take account of all those national initiatives that will develop and complement Francis' recommendations
- The Trust response to Francis should be aligned and integrated with other Change processes either already underway or projected

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST

REPORT TO THE TRUST BOARD: PUBLIC

28 July 2013

SUMMARY OF KEY RISKS:

- Failure to demonstrate full Board engagement through the response to Francis will have a negative impact on reputation in general and the Foundation Trust aspiration in particular
- Failure to make changes consistent with Francis' recommendations will have a negative impact on the Trust's public reputation
- Failure to meet some recommendations is likely to result in financial penalties
- Failure to integrate and align change processes will result in duplication, gaps, waste and ineffective outcomes
- Change will not be sustained unless the process allows for cultural change to be embedded in everyday practice

RECOMMENDATION / DECISION REQUIRED:

The Trust Board are asked to approve the report and schedule a further update discussion for September 2013.

IMPLICATIONS:

Financial:	There are potential implications for Nurse Staffing costs, information and intelligence analysis and complaints management; Recommendations from Francis are likely to be incorporated into national and local KPIs, and into CQUINs with financial penalties for non-compliance.
HR / Equality & Diversity:	The Report will have an impact on recruitment and training of all staff; there may be specific requirements for additional resources in nursing, data gathering and analysis and complaints management.
Governance:	The Trust's future strategic and operational direction and planning must reflect relevant learning from this review. National strategy and policy will also be significantly influenced by the Report. Patients and commissioners will be more closely engaged in many Trust Governance processes A nominated Board member will be required to hold accountability for Information
Legal:	Named Board members will be held legally accountable for Quality and Patient Safety; there will be legal accountability for the accuracy and honesty of information shared with public, commissioners and regulators

REVIEW:

Trust Standing Committee	**Date**	**Trust Standing Committee**	**Date**
Quality Governance Committee		Remuneration Committee	
Finance and Performance Committee		Executive Meeting	
Audit Committee			

DATA QUALITY:

Data/information Source:	
Data Quality Controls:	
Data Limitations:	

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST

REPORT TO THE TRUST BOARD: PUBLIC

28 July 2013

Response to the Francis Inquiry: Gap analysis and next steps

Report for the Trust Board - 28 July 2013

1 Introduction

At their meeting on 3 July 2013, Chief Officers reviewed the timetable and structure for responding to the recommendations arising from the Report of the Francis Inquiry.

This paper provides an update with the identification of areas where we are as yet unable to provide full assurance that the Trust meets the requirements of the Francis recommendations, and proposes next steps in taking appropriate remedial action.

Although many of the Francis Report's recommendations are not directly relevant to the Trust, they will help shape the context in which the Trust provides services. For those recommendations that are relevant, Executive and Corporate leads have assessed the level of assurance available to ensure the Trust adopts both the ethos and the specific requirements to meet each recommendation. (Appendix 1)

Of 290 recommendations 81 were considered to be of direct relevance to the Trust. Of these

- 7 are deemed to have no assurance (red)
- 20 are deemed to have limited assurance (serious impact)
- 31 are deemed to have limited assurance (impact not serious)
- 23 are deemed to have full assurance

The full table of 81 recommendations is attached for reference, sorted by theme and level of assurance.

A red (no assurance) rating does not necessarily imply an immediate risk to patient safety.

2 Summary of Gap analysis

The recommendations have been grouped into three broad themes (although there is overlap as many of the recommendations address a range of organisational and individual behaviours and practice):

- **Issues of culture, communications and relationships** – between staff, between clinicians and management and between staff, patients and carers. Listening to and acting upon the Patients voice is at the heart of the Francis report and the Board will be expected to demonstrate how they achieve this.
- **The collection, analysis and dissemination of data** in ways that optimise learning and change where appropriate and provide assurance to regulators, commissioners and public.
- **Redesign of the complaints process** to encompass individual restitution where appropriate and the sharing of content and outcome with commissioners and regulators in a way that facilitates the identification of potentially dysfunctional patterns. Any such system should provide independent assurance that complaints management is open, fair and thorough.

Each of these themes will be influenced by national processes arising from the Francis Report. The detail required to operationalise many of the recommendations will be subject to emergent national guidance. Some recommendations also require further definition. Whilst initiating a programme of change we also need to avoid making significant change to systems and processes in advance of anticipated national guidance, unless there is a concern regarding patient safety.

- The Clwyd/Hart report on NHS complaints systems is due to be delivered to the Secretary of State in July. It is likely to embrace the Patients Association (PA) approach to complaints management but is also likely to make a wider range of recommendations than those from the PA
- The Keogh Mortality Review has now been published. The intelligence gathering process used by Keogh is likely to act as a model for future comprehensive inspections by CQC. There is a strong emphasis on improving the quality and accountability of leadership, involving patients and communities in the planning, delivery and regulation of care, timeliness and transparency of data and implications for nurse staffing.
- The Cavendish Review (July 2013) has also reported; it recommends changes to the recruitment, training and development of Health Care Assistants consistent with the principles of Francis.
- The Berwick Review of patient safety, with an emphasis on staff engagement
- The CQC consultation on its strategy for regulation, encompassing a review of the scope and process of Inspection. The new Inspection regime will be implemented from October 2013 with larger groups (perhaps 15-20) staying on site for up to 15 days.
- The NTDA is developing its own strategic thinking about quality improvement and performance, adopting a range of KPIs
- Significant changes to the Quality Account can be expected for 2014/15; Guidance should be available later this year.
- The DH Consultation *Strengthening corporate accountability in health and social care* will inform their detailed response to Francis; this is expected in the autumn

3. Implications for Corporate Governance and Board Directors

- Recommendation 79 requires Directors to be 'fit and proper persons' who can demonstrate compliance with a prescribed code of conduct
- Recommendation 84 requires that a report be made to the appropriate regulatory bodies should an executive or non-executive member have their contract or appointment terminated on 'fit and proper person' grounds
- Recommendation 86 requires trusts to provide for the training and continued development of Directors
- Recommendations 173 to 179 collectively require a duty of openness and candour in sharing information with patients, carers, staff and public. Statements made to regulators must be 'completely truthful', and not mislead by omission.
- Recommendation 204 requires Boards to include at least one registered nurse as an executive director and to consider recruiting nurses as NEDs
- Recommendation 245 requires Boards to nominate an executive lead for Information

4. Key risks summary (recorded as RED – No Assurance on spreadsheet)

Cultural change

- Recruitment should explicitly assess candidates values, attitudes and behaviours towards the well-being of patients (recommendation 191)
- Informing patients of the role and function of the Nursing and Midwifery Council (230)
- Demonstrating the duty to be honest, open and truthful (173)
- Full disclosure of circumstances leading to death or serious harm, and support for those affected (174)
- Demonstrate that full and truthful answers be given to a patient asking reasonable questions about past, present or intended treatment (175)

Information

- Publish and review a speciality level statistical dataset on efficacy of treatment (264)
- Such statistics to be available online and shared with others such as the CQC (267)

Complaints management

- Facilitate access to expert advice for clients and their Independent advocates (117)
- Anonymised summaries of upheld complaints to be published on website (where patient consents); in all cases summaries should be shared confidentially with Commissioners and the CQC (118)

5. Next Steps

The key principles should be:

- Use existing processes as much as practicable. Identify where additional capacity may be required before creating new groups.
- Ensure that all stakeholders and partner organisations are engaged in the design and implementation of change arising from the process.
- The active engagement of patients in all aspects of the programme
- Build in a process of reflection and review – we are unlikely to get to the best solutions at once.
- Keep abreast of national and regional initiatives; learn from others.

Implementation structure:

1. Oversight will be the responsibility of a Task and Finish Group chaired by the Director of Governance (and reporting to COG). Membership should reflect the nature of the task and the ethos of partnership and engagement. The Group will

    - Define workstreams under the three themes (Culture, Information, Complaints), identify participants and agree timescales.
    - Maintain an overview of implementation, identifying and resolving delays and ensuring coherence across change processes.

- Scope the implications of national initiatives (Keogh, Cavendish, Hart/Clwyd and Berwick) and incorporate into the programme as appropriate.
- Provide monthly progress reports to COG

2. The Task and Finish Group will liaise with the TTWC team, ICT and the PPMO to ensure integration and alignment across the Trust. It will promote practical assistance to support change.

3. A major review of Complaints Management is proposed for the autumn.

Timescale:

Date	**Action**
End July	T+F Group established and workstreams identified
mid august	Detailed action planning in place for each workstream; implementation phase begins
September	Board update
October	Initiate review of complaints management
November	Board update

The team will draw on the experience of implementing the 'Patients First' agenda in 2003/04 and collaborate with and learn from other Trusts in identifying solutions.

There will be a further report to the September Board.

Peter Short
Compliance Manager
16 July 2013

It is recommended that:

• All commissioning, service provision regulatory and ancillary organisations in healthcare should consider the findings and recommendations of this report and decide how to apply them to their own work;
• Each such organisation should announce at the earliest practicable time its decision on the extent to which it accepts the recommendations and what it intends to do to implement those accepted, and thereafter, on a regular basis but not less than once a year, publish in a report information regarding its progress in relation to its planned actions.

Rec. no.	Theme	Recommendation	Executive Lead(s)	Corporate Lead(s)	Evidence held for Trust Assurance	Gaps	Assurance Rating (Red / Amber / Yellow / Green)
Theme 1: Cultural change - values, behaviours and relationships							
191	Nursing	Healthcare employers recruiting nursing staff, whether qualified or unqualified, should assess candidates' values, attitudes and behaviours towards the well-being of patients and their basic care needs, and care providers should be required to do so by commissioning and regulatory requirements.	CNO	Gillian Arblaster		Current recruitment process does not formally assess values, atrtitudes and behaviour based selection process for nursing staff to review current process and look to organisations that undertake values based recruitment	No Assurance
230	Professional regulation of fitness to practise	The profile of the Nursing and Midwifery Council needs to be raised with the public, who are the prime and most valuable source of information about the conduct of nurses. All patients should be informed, by those providing treatment or care, of the existence and role of the Nursing and Midwifery Council, together with contact details. The Nursing and Midwifery Council itself needs to undertake more by way of public promotion of its functions.	CNO	Karen Bond		to include in patient information, web site , bedside folders and patient notice boards	No Assurance

Rec. no.	Theme	Recommendation	Executive Lead(s)	Corporate Lead(s)	Evidence held for Trust Assurance	Gaps	Assurance Rating (Red / Amber / Yellow / Green)
280	1.3 Coroners and inquests	Both the bereaved family and the certifying doctor should be asked whether they have any concerns about the death or the circumstances surrounding it, and guidance should be given to hospital staff encouraging them to raise any concerns they may have with the independent medical examiner.	CMO	Andy Phillips / Mike Iredale	Not aware of any process or guidance where bereaved families are proactively asked about concerns. Consultants have the opportunity to highlight issues through the mortality review process. The mortality review process is not routinely available to junior medical staff, or to nursing staff, however they are able to raise a CAE if concerned.	Need to review process of communication with bereaved families + process whereby staff can raise concerns around how much encouragement there should be. Guidance will need to be issued and practice audited.	No Assurance
173	Openness, transparency and candour	Every healthcare organisation and everyone working for them must be honest, open and truthful in all their dealings with patients and the public, and organisational and personal interests must never be allowed to outweigh the duty to be honest, open and truthful.	CEO	COG (for discussion)	Nolan principles compliance Statements of Professional Ethics feedback from staff and patient surveys, includin FFT and Impressions	integrate revised NHS constitution, Nolan principles, Board Code of Conduct and statements of professional ethics. Patient information and Impressions should reflect language and assumptions of Francis.	Some Assurance (Serious Impact)
174	Openness, transparency and candour	Where death or serious harm has been or may have been caused to a patient by an act or omission of the organisation or its staff, the patient (or any lawfully entitled personal representative or other authorised person) should be informed of the incident, given full disclosure of the surrounding circumstances and be offered an appropriate level of support, whether or not the patient or representative has asked for this information.	CMO	Andy Phillips	Duty of Candour to be included in performance indicators 2013/14 and monitored quarterly via the Clinical Quality Review Group. The Trusts *Being Open* policy complies with the NPSA requirements. A revised policy will require staff to apologise and explain what happened in an open, honest way and as soon as possible following an incident. All staff must adhere to the policy. The Trust's proforma for recording Root Cause Analysis reports requires that details of patient/ family involvement and briefing of serious untoward incidents are included in the report which is reviewed by the Trust's Serious Incident Group.	Revised *Being Open* policy not yet approved. Evaluate whether CQUIN for Duty of Candour is sufficient assurance of compliance non-compliance should be considered as if it were a 'never event'?	Some Assurance (Serious Impact)

Rec. no.	Theme	Recommendation	Executive Lead(s)	Corporate Lead(s)	Evidence held for Trust Assurance	Gaps	Assurance Rating (Red / Amber / Yellow / Green)
175	Openness, transparency and candour	Full and truthful answers must be given to any question reasonably asked about his or her past or intended treatment by a patient (or, if deceased, to any lawfully entitled personal representative).	CMO	Andy Phillips	Being open policy complies with the NPSA requirements.Duty of Candour to be included in performance indicators 2013/14 (monitored via the Clinical Quality Review Group).	no agreement presently on how to evaluate or audit against this recommendation Revised Being Open policy relaunch requires confirmation	Some Assurance (Serious Impact)
176	Openness, transparency and candour	Any statement made to a regulator or a commissioner in the course of its statutory duties must be completely truthful and not misleading by omission.	CHRO	CHRO (until Dir of Service Improvement in place).	All employees bound by relevant Codes of Conduct and for Board Directors by the Nolan Principles	Specifics not directly covered in Trust Values	Some Assurance (Serious Impact)
178	Openness, transparency and candour	The NHS Constitution should be revised to reflect the changes recommended with regard to a duty of openness, transparency and candour, and all organisations should review their contracts of employment, policies and guidance to ensure that, where relevant, they expressly include and are consistent with above principles and these recommendations.	CHRO	Andrew McMenemy	The Trust values encompass the requirements of the NHS Constitution.	Current employee contracts, policies and guidance do not expressly cover these duties	Some Assurance (Serious Impact)

Rec. no.	Theme	Recommendation	Executive Lead(s)	Corporate Lead(s)	Evidence held for Trust Assurance	Gaps	Assurance Rating (Red / Amber / Yellow / Green)
198	Nursing	Healthcare providers should be encouraged by incentives to develop and deploy reliable and transparent measures of the cultural health of front-line nursing workplaces and teams, which build on the experience and feedback of nursing staff using a robust methodology, such as the "cultural barometer".	CNO	Claire Bonniger		Currently not used	Some Assurance (Serious Impact)
238	Caring for the elderly	Regular interaction and engagement between nurses and patients and those close to them should be systematised through regular ward rounds: • All staff need to be enabled to interact constructively, in a helpful and friendly fashion, with patients and visitors. • Where possible, wards should have areas where more mobile patients and their visitors can meet in relative privacy and comfort without disturbing other patients. • The NHS should develop a greater willingness to communicate by email with relatives. • The currently common practice of summary discharge letters followed up some time later with more substantive ones should be reconsidered. • Information about an older patient's condition, progress and care and discharge plans should be available and shared with that patient and, where appropriate, those close to them, who must be included in the therapeutic partnership to which all patients are entitled.C9	CMO / CNO	Nick Balcombe / Karen Bond	dayrooms available on some wards for patient to access Dementia Lounge	Audit practice in relation to ward rounds and who is involved project to commence looking at communication and information giving to patients by nurses	Some Assurance (Serious Impact)

Rec. no.	Theme	Recommendation	Executive Lead(s)	Corporate Lead(s)	Evidence held for Trust Assurance	Gaps	Assurance Rating (Red / Amber / Yellow / Green)
239	Caring for the elderly	The care offered by a hospital should not end merely because the patient has surrendered a bed – it should never be acceptable for patients to be discharged in the middle of the night, still less so at any time without absolute assurance that a patient in need of care will receive it on arrival at the planned destination. Discharge areas in hospital need to be properly staffed and provide continued care to the patient.	CMO / CNO	Nick Balcombe / Michelle Linnane	Trust policy dictates that inpatients will not be discharged any later than 20.00hrs. Review of patient discharge time from the Patient information system is carried out on a regular basis to ensure compliance with the discharge standard and CAE's are encouraged to be raised. The integrated Discharge team are planning for discharge for all patients from the point of admission and will identify / secure and document any requirement as part of support to safe discharge. The Discharge Lounge provides a safe level of patient support and care and assessment of patient throughput / workload are regularly reveiwed .	whole system approach to discharge required (QV patient flow/discharge action plan)	Some Assurance (Serious Impact)
279	Coroners and inquests	So far as is practicable, the responsibility for certifying the cause of death should be undertaken and fulfilled by the consultant, or another senior and fully qualified clinician in charge of a patient's case or treatment.	CMO	Andy Phillips / Mike Iredale	Routine practice is for junior medical staff to complete death certificates. There is an instruction (? If trust wide) that in all cases the certifying doctor should discuss the case and death certifictae entry with the responsible consultant.	No information / data on how often consultants are involved in discussion around death certificate entires. Need to review process, issue guidance and then audit practice.	Some Assurance (Serious Impact)

Rec. no.	Theme	Recommendation	Executive Lead(s)	Corporate Lead(s)	Evidence held for Trust Assurance	Gaps	Assurance Rating (Red / Amber / Yellow / Green)
3	Putting the patient first	The NHS Constitution should be the first reference point for all NHS patients and staff and should set out the system's common values, as well as the respective rights, legitimate expectations and obligations of patients.	CEO	Dan Ibeziako / Sarah Phipps	The NHS Constitution is highlighted on every page the external UHCW website. It also has a section within the Trust Intranet. The Constitution also receives its own section during Trust induction, which includes playing of the NHS Constitution film and new members of staff are encouraged to look for the full document on the intranet. Hard copies are available at the Health Information Centre. And further information is provided to members of the public via the Trust information plasma screens. It is also captured within the performance monitoring framework and the core standards.	Staff could possibly be reminded about the importance of NHS Constitution. Patient leaflets/bedside information could also include NHS Constitution There is a need to review the strategy and make the link to the NHS Constitution more explicit.	Some Assurance (Impact NOT serious)
4	Putting the patient first	The core values expressed in the NHS Constitution should be given priority of place and the overriding value should be that patients are put first, and everything done by the NHS and everyone associated with it should be informed by this ethos.	CEO	Dan Ibeziako / Sarah Phipps	The Trust values and mission puts patient centred care at the heart of our work. The performance framework monitors delivery against values and mission. In addition the Trust seeks out feedback from our patients to better understand their experiences of care. As part of this process the Trust produces reports and allows staff to access that information and thereby act upon it.	Trust staff have access to the "verbatim" comments made by patients on the Impressions site however there is no formal process of staff acknowleding comments and feeding back responses to patients this is in contrast to say complaints where this process is more clearly defined. Similarly for other 'non complaint' feedback e.g. to Choices, consideration needs to be given to processes for capturing and addressing issues	Some Assurance (Impact NOT serious)
7	Putting the patient first	All NHS staff should be required to enter into an express commitment to abide by the NHS values and the Constitution, both of which should be incorporated into the contracts of employment.	CHRO	CHRO (until Dir of Service Improvement in place).	The Trust values encompass the requirements of the NHS Constitution. New staff are required to abide by Trust values.	Current employee contracts, policies and guidance do not expressly cover these duties.	Some Assurance (Impact NOT serious)

Rec. no.	Theme	Recommendation	Executive Lead(s)	Corporate Lead(s)	Evidence held for Trust Assurance	Gaps	Assurance Rating (Red / Amber / Yellow / Green)
8	Putting the patient first	Contractors providing outsourced services should also be required to abide by these requirements and to ensure that staff employed by them for these purposes do so as well. These requirements could be included in the terms on which providers are commissioned to provide services.	CHRO	Lincoln Dawkin	Project Agreement stipulates and includes monitoring of contractors providing Hard and Soft FM service Lliason Committee monitors contract Project Co monitor the performance of the providers Soft services below supervisor staff are employed under Trust T&Cs	Confirm if all the contractors are employed on the basis that their contracts are formally compliant and their contracts of employment stipulate these. Confirm via Project Co that all Pfi partners contracts espouse these values.	Some Assurance (Impact NOT serious)
11	Fundamental standards of behaviour	Healthcare professionals should be prepared to contribute to the development of, and comply with, standard procedures in the areas in which they work. Their managers need to ensure that their employees comply with these requirements. Staff members affected by professional disagreements about procedures must be required to take the necessary corrective action, working with their medical or nursing director or line manager within the trust, with external support where necessary. Professional bodies should work on devising evidence-based standard procedures for as many interventions and pathways as possible.	CMO / CNO	Andy Phillips / Karen Bond	clinical guidelines, protocols, scope of practice documents formal process for development, approval of all nursing, midwifery documents	PDPs should demonstrtae involvement in developing procedures	Some Assurance (Impact NOT serious)

Rec. no.	Theme	Recommendation	Executive Lead(s)	Corporate Lead(s)	Evidence held for Trust Assurance	Gaps	Assurance Rating (Red / Amber / Yellow / Green)
12	Fundamental standards of behaviour	Reporting of incidents of concern relevant to patient safety, compliance with fundamental standards or some higher requirement of the employer needs to be not only encouraged but insisted upon. Staff are entitled to receive feedback in relation to any report they make, including information about any action taken or reasons for not acting.	CMO	Yvonne Gatley / Dipak Chauhan	Datix incident reporting system Incident Management Policy (including SIRI Policy) RCA & Investigation Procedure Weekly SIG meeting Discussion at Health & Safety Committee / Patient Safety Committee Whistle Blowing Policy Being Open Policy Learning from SIs and incidents is shared via relevant governing committees and through investigation locally Datix provides individual feedback to reporters of CAEs For serious incidents, staff are invited to attend and contribute to the RCA. The resulting report is shared with all relevant staff. Each specialty receives a quarterly (at least) QIPS report which details trends in incidents, complaints, claims, etc.	Generally the patient safety aspects of reporting are bench marked via the NPSA's NRLS. UHCW is consistently a high reporter of incidents compared to its peers. The BENCHMARKING of non clinical incidents is not very clear as ANECDOTALLY the reporting is generally considered to below. Carry out a benchmarking exercise to validate existing data and to corroborate the data regarding non clinical incidents and RIDDORs.	Some Assurance (Impact NOT serious)

Rec. no.	Theme	Recommendation	Executive Lead(s)	Corporate Lead(s)	Evidence held for Trust Assurance	Gaps	Assurance Rating (Red / Amber / Yellow / Green)
37	Responsibility for, and effectiveness of, healthcare standards	Trust Boards should provide, through quality accounts, and in a nationally consistent format, full and accurate information about their compliance with each standard which applies to them. To the extent that it is not practical in a written report to set out detail, this should be made available via each trust's website. Reports should no longer be confined to reports on achievements as opposed to a fair representation of areas where compliance has not been achieved. A full account should be given as to the methods used to produce the information. To make or be party to a wilfully or recklessly false statement as to compliance with safety or essential standards in the required quality account should be made a criminal offence.	CMO	Peter Short	Named lead; Named author; Progress reports to QGC; Scrutiny by and feedback from OCS, CCG and Healthwatch; Content consistency check by external auditors; Audit of Indicators by external auditors; QA published on NHS Choices and Trust website; QA signposts UHCW, CQC and NHS Choices website to provide detail information on quality performance; QA signposts Clinical Audit and CQUIN supplements to provide further detail	Updated template to be available to identify required information and ensure format complies with Regulations; Raise awareness of QA as an integrative process - create a 'Quality Accounting Network' - QA format to align with Trust's 5 quality domains	Some Assurance (Impact NOT serious)
79	Responsibility for, and effectiveness of, regulating healthcare systems governance – Monitor's healthcare systems regulatory functions	There should be a requirement that all directors of all bodies registered by the Care Quality Commission as well as Monitor for foundation trusts are, and remain, fit and proper persons for the role. Such a test should include a requirement to comply with a prescribed code of conduct for directors.	CEO	Moosa Patel	clinical guidelines, protocols, scope of practice documents formal process for development, approval of all nursing, midwifery documents	Code of conduct for directors; fit and proper persons test for new appointments	Some Assurance (Impact NOT serious)

Rec. no.	Theme	Recommendation	Executive Lead(s)	Corporate Lead(s)	Evidence held for Trust Assurance	Gaps	Assurance Rating (Red / Amber / Yellow / Green)
84	Responsibility for, and effectiveness of, regulating healthcare systems governance – Monitor's healthcare systems regulatory functions	Where the contract of employment or appointment of an executive or non-executive director is terminated in circumstances in which there are reasonable grounds for believing that he or she is not a fit and proper person to hold such a post, licensed bodies should be obliged by the terms of their licence to report the matter to Monitor, the Care Quality Commission and the NHS Trust Development Authority.	CHRO	Moosa Patel (until Dir of Corporate Affairs in place)	Cross ref to 79.	Add into Remuneration Committee TOR	Some Assurance (Impact NOT serious)
86	Responsibility for, and effectiveness of, regulating healthcare systems governance – Monitor's healthcare systems regulatory functions	A requirement should be imposed on foundation trusts to have in place an adequate programme for the training and continued development of directors.	CHRO	Janet White / Christine Emerton	Board development programme in place for NEDs and Executive Directors. Board visibility programme commences June 2013.360degree feedback completed.Bespoke internal 6mth tripartite leadership programme completed Dec 2012.Organistional Improvement programme being developed to address Francis leadership and management development recommendations.	No coherent approach to co-ordinating leadership training and development in PDPs. No database of individuals currently /previously completed West Midlands Aspiring Directors Programme and PDP compliance low	Some Assurance (Impact NOT serious)
178	Openness, transparency and candour	The NHS Constitution should be revised to reflect the changes recommended with regard to a duty of openness, transparency and candour, and all organisations should review their contracts of employment, policies and guidance to ensure that, where relevant, they expressly include and are consistent with above principles and these recommendations.	CHRO	Andrew McMenemy	Contracts of employment do not currently comply	Contracts of employment do not currently comply	Some Assurance (Impact NOT serious)

Rec. no.	Theme	Recommendation	Executive Lead(s)	Corporate Lead(s)	Evidence held for Trust Assurance	Gaps	Assurance Rating (Red / Amber / Yellow / Green)
179	Openness, transparency and candour	"Gagging clauses" or non disparagement clauses should be prohibited in the policies and contracts of all healthcare organisations, regulators and commissioners; insofar as they seek, or appear, to limit bona fide disclosure in relation to public interest issues of patient safety and care.	CHRO	Andrew McMenemy	Cotracts of employment, employee policies and compromise agreements to be checked for wording that may resember what is described as a "gagging clause"	There may be wording that could be construed as preventing disclosure in relation to patient sfatey or care. However, we believe that these gaps have already been addressed for new contracts	Some Assurance (Impact NOT serious)
180	Openness, transparency and candour	Guidance and policies should be reviewed to ensure that they will lead to compliance with Being Open, the guidance published by the National Patient Safety Agency.	CMO	Yvonne Gatley	Being Open Policy complies with the NPSA requirements. Duty of Candour to be included in performance indicators 2013/14 (monitored via the Clinical Quality Review Group).	Policy needs to be reviewed in light of Duty of Candour requirements.	Some Assurance (Impact NOT serious)
194	Nursing	As part of a mandatory annual performance appraisal, each Nurse, regardless of workplace setting, should be required to demonstrate in their annual learning portfolio an up-to-date knowledge of nursing practice and its implementation. Alongside developmental requirements, this should contain documented evidence of recognised training undertaken, including wider relevant learning. It should also demonstrate commitment, compassion and caring for patients,	CNO	Gillian Arblaster	Current appraisal documentation works through KSF domains which addresses nusing practice and evidence to demonstrate	PDR process not specifically capture care, commpassion and feedbck from patients;	Some Assurance (Impact NOT serious)

Rec. no.	Theme	Recommendation	Executive Lead(s)	Corporate Lead(s)	Evidence held for Trust Assurance	Gaps	Assurance Rating (Red / Amber / Yellow / Green)
195	Nursing	Ward nurse managers should operate in a supervisory capacity, and not be office-bound or expected to double up, except in emergencies as part of the nursing provision on the ward. They should know about the care plans relating to every patient on his or her ward. They should make themselves visible to patients and staff alike, and be available to discuss concerns with all, including relatives. Critically, they should work alongside staff as a role model and mentor, developing clinical competencies and leadership skills within the team. As a corollary, they would monitor performance and deliver training and/or feedback as appropriate, including a robust annual appraisal.	CNO	Claire Bonniger	Staff impressions and annual Staff Survry (CQC) ask about leadership; PDPs should reflect leadership practice.	Not all managers have supernumary status . A level of time is allocated for this purpose including clinical work alongside ward teams. Decision to implement supernumary status-costing and action plan recruitment to backfill review roles and responsibilities and Job descriptions and objectives for ward managers. Patient impressions survey does not ask about ward leader visibility	Some Assurance (Impact NOT serious)
197	Nursing	Training and continuing professional development for nurses should include leadership training at every level from student to director. A resource for nurse leadership training should be made available for all NHS healthcare provider organisations that should be required under commissioning arrangements by those buying healthcare services to arrange such training for appropriate staff.	CNO	Gillian Arblaster	Leadership Development Programmes for bands-5 to 7 clinical staff (Inhouse) Attendance aspiring Directors Programme Executive Directors Development Programme leadership/management programme for CD, Group Managers and Modern Matrons Leadership Forum NHS Leadership Academy	Framework for leadership development for all levels of staff and skills completencies each level and signpost how obtain	Some Assurance (Impact NOT serious)
199	Nursing	Each patient should be allocated for each shift a named key nurse responsible for coordinating the provision of the care needs for each allocated patient. The named key nurse on duty should, whenever possible, be present at every interaction between a doctor and an allocated patient.	CNO	Karen Bond	patient impressions; annual inpatient survey	no evidence that nurse goes with doctor for each interaction with patient	Some Assurance (Impact NOT serious)

Rec. no.	Theme	Recommendation	Executive Lead(s)	Corporate Lead(s)	Evidence held for Trust Assurance	Gaps	Assurance Rating (Red / Amber / Yellow / Green)
207	Nursing	There should be a uniform description of healthcare support workers, with the relationship with currently registered nurses made clear by the title.	CNO	Gillian Arblaster	identified job descriptions		Some Assurance (Impact NOT serious)
208	Nursing	Commissioning arrangements should require provider organisations to ensure by means of identity labels and uniforms that a healthcare support worker is easily distinguishable from that of a registered nurse.	CNO	Gillian Arblaster	Posters some ward HCSW uniform	name badges as identification badges not clearly visible to patients. Posters not on all wards not included patient handbook or on intranet	Some Assurance (Impact NOT serious)
236	Caring for the elderly	Hospitals should review whether to reinstate the practice of identifying a senior clinician who is in charge of a patient's case, so that patients and their supporters are clear who is in overall charge of a patient's care.	CMO	Mike Iredale	All in-patients are under a named clinician. Medical Outliers are under locum staff at present & consultant may change depending in part on cover arrangements. .	There is a degree of inaccuracy in trust systems keeping up to date recording this information	Some Assurance (Impact NOT serious)
237	Caring for the elderly	There needs to be effective teamwork between all the different disciplines and services that together provide the collective care often required by an elderly patient; the contribution of cleaners, maintenance staff, and catering staff also needs to be recognised and valued.	CMO / CNO / COO	Nick Balcombe / Michelle Linanne	Each ward / department ensures a co-ordinated approach to patient care through a Multidisciplanary approach to care, which involves a wide range of interventions and asessments. Ranging from; Documented morning Board reviews followed by a ward round, individual patient assessment against established tools to assess Falls risk, Dementia, nutrition, occupational and physiotherapy review. Regular fortnightly meetings take place between portering, catering and cleaning support to raise isues of demand or concern with regard to their part of patient support.	effective teamwork essential in all specialities	Some Assurance (Impact NOT serious)

Rec. no.	Theme	Recommendation	Executive Lead(s)	Corporate Lead(s)	Evidence held for Trust Assurance	Gaps	Assurance Rating (Red / Amber / Yellow / Green)
256	patient flow and discharge	A proactive system for following up patients shortly after discharge would not only be good "customer service", it would probably provide a wider range of responses and feedback on their care.	CMO	Julia Flay	FFT - all in-patients and A&E attendees are given the opportunity to feedback on services as at May 2013	FFT roll out by end of March 2014: Maternity Services by October 2013, Out-patients likely by end of March 2014	Some Assurance (Impact NOT serious)

Rec. no.	Theme	Recommendation	Executive Lead(s)	Corporate Lead(s)	Evidence held for Trust Assurance	Gaps	Assurance Rating (Red / Amber / Yellow / Green)
155	Medical training and education	The General Medical Council should set out a standard requirement for routine visits to each local education provider, and programme in accordance with the following principles: • The Postgraduate Dean should be responsible for managing the process at the level of the Local Educational Training Board, as part of overall deanery functions. • The Royal Colleges should be enlisted to support such visits and to provide the relevant specialist expertise where required. • There should be lay or patient representation on visits to ensure that patient interests are maintained as the priority. • Such visits should be informed by all other sources of information and, if relevant, coordinated with the work of the Care Quality Commission and other forms of review. The Department of Health should provide appropriate resources to ensure that an effective programme of monitoring training by visits can be carried out. All healthcare organisations must be required to release healthcare professionals to support the visits programme. It should also be recognised that the benefits in professional development and dissemination of good practice are of significant value.	CMO	Maggie Allen	HEEWM ('the Deanery') have a programme of visits(both regular programme reviews and 'triggered' visits) to all specialities and all levels of training. UHCW is entirely cooperative with these vists and their requirements including release of staff (trainees, supervisors, Trusteducational leads) from duties to attend. Records of attendees are retained by HEEWM		Full Assurance

Rec. no.	Theme	Recommendation	Executive Lead(s)	Corporate Lead(s)	Evidence held for Trust Assurance	Gaps	Assurance Rating (Red / Amber / Yellow / Green)
157	Medical training and education	The General Medical Council should set out a clear statement of what matters; deaneries are required to report to the General Medical Council either routinely or as they arise. Reports should include a description of all relevant activity and findings and not be limited to exceptional matters of perceived non-compliance with standards. Without a compelling and recorded reason, no professional in a training organisation interviewed by a regulator in the course of an investigation should be bound by a requirement of confidentiality not to report the existence of an investigation, and the concerns raised by or to the investigation with his own organisation.	CMO	Maggie Allen	UHCW reports concerns or investigations which involve trainees ar training direct to the Deanery and would request advice where a matter might require a direct reporting to the GMC. All regulatory bodies have unrestricted access to communicate with members of staff as they require. This will be made explicitic to staff involved in any such investigation		Full Assurance
160	Medical training and education	Proactive steps need to be taken to encourage openness on the part of trainees and to protect them from any adverse consequences in relation to raising concerns.	CMO	Maggie Allen	Trainees are actively encouraged to escalate concerns through specific discussion at induction, and at appraisal. There are regular (minuted) Junior Doctors Forums; here trainees are asked for any concerns. They are also encouraged to report to the GMC survey. Where ongoing concerns are recognised senior members of the education team will follow through and report to Patient Safety Committee and upwards within the Trust		Full Assurance
177	Openness, transparency and candour	Any public statement made by a healthcare organisation about its performance must be truthful and not misleading by omission.	CEO	Dan Ibeziako	All public statements (media enquiries, annual report etc) issued by communications are approved and signed off by a member of the executive team. The same applies to FOI responses and responses to complaints		Full Assurance

Rec. no.	Theme	Recommendation	Executive Lead(s)	Corporate Lead(s)	Evidence held for Trust Assurance	Gaps	Assurance Rating (Red / Amber / Yellow / Green)
185	Nursing	There should be an increased focus in nurse training, education and professional development on the practical requirements of delivering compassionate care in addition to the theory. A system which ensures the delivery of proper standards of nursing requires: • Selection of recruits to the profession who evidence the: – Possession of the appropriate values, attitudes and behaviours; – Ability and motivation to enable them to put the welfare of others above their own interests; – Drive to maintain, develop and improve their own standards and abilities; – Intellectual achievements to enable them to acquire through training the necessary technical skills;	CNO	Gillian Arblaster	Coventry University have had approval of a new nursing curriculum which is a value based developmental curriculum and builds competency and behaviour elements of nursing, nursing practice and professionalism Selection of new recruits onto the existing programme is already a valued based selection incorporating caring and compassion	there is not currently a national nursing curriculum but alll curriculum have to fulfil the NMC standards for practice	Full Assurance
186	Nursing	Nursing training should be reviewed so that sufficient practical elements are incorporated to ensure that a consistent standard is achieved by all trainees throughout the country. This requires national standards.	CNO	Gillian Arblaster	Coventry University have had approval of a new nursing curriculum which is a value based developmental curriculum and builds competency and behaviour elements of nursing, nursing practice and professionalism Selection of new recruits onto the existing programme is already a valued based selection incorporating caring and compassion		Full Assurance
202	Nursing	Recognition of the importance of nursing representation at provider level should be given by ensuring that adequate time is allowed for staff to undertake this role, and employers and unions must regularly review the adequacy of the arrangements in this regard.	CNO	Karen Bond	Chief Nurse at Board Level Senior nurse representation on committees feeding into Board		Full Assurance

Rec. no.	Theme	Recommendation	Executive Lead(s)	Corporate Lead(s)	Evidence held for Trust Assurance	Gaps	Assurance Rating (Red / Amber / Yellow / Green)
204	Nursing	All healthcare providers and commissioning organisations should be required to have at least one executive director who is a registered nurse, and should be encouraged to consider recruiting nurses as non-executive directors.	CEO	Moosa Patel	CNO job decsription		Full Assurance
231	Professional regulation of fitness to practise	It is essential that, so far as practicable, Nursing and Midwifery Council procedures do not obstruct the progress of internal disciplinary action in providers. In most cases it should be possible, through cooperation, to allow both to proceed in parallel. This may require a review of employment disciplinary procedures, to make it clear that the employer is entitled to proceed even if there are pending Nursing and Midwifery Council proceedings.	CNO	Claire Bonniger	Disciplinary Policy HR Cases		Full Assurance

Rec. no.	Theme	Recommendation	Executive Lead(s)	Corporate Lead(s)	Evidence held for Trust Assurance	Gaps	Assurance Rating (Red / Amber / Yellow / Green)
240	Caring for the elderly	All staff and visitors need to be reminded to comply with hygiene requirements. Any member of staff, however junior, should be encouraged to remind anyone, however senior, of these.	CNO	Kate Prevc	Auditable proceses inplace via IPCT, Performance team and Project co. All disseminated and addressed at the bi weekly operational cleaning meeting. Daily walkabout checks from performance team,IPCT and service provider a process for immediate rectification via help desk. This is also fully auditable.		Full Assurance
241	Caring for the elderly	The arrangements and best practice for providing food and drink to elderly patients require constant review, monitoring and implementation.	CNO	Michelle Linanne	good practice guidelines Essence of Care Benchmarking monthly nutriotion walkarounds Education and training		Full Assurance
243	Caring for the elderly	The recording of routine observations on the ward should, where possible, be done automatically as they are taken, with results being immediately accessible to all staff electronically in a form enabling progress to be monitored and interpreted	CNO	Karen Bond	Vital pac Performance pack		Full Assurance
263	Information	It must be recognised to be the professional duty of all healthcare professionals to collaborate in the provision of information required for such statistics on the efficacy of treatment in specialties.	CMO / CNO / CFO	Karen Bond / Jonathan Brotherton	Staff have willingly collaborated in providing information to support KPI/CQUIN measures e.g. VTE, dementia etc where required to do so.	Check that all Medical, Nursing and AHP staff have notification of such requirements in commencement of employment in the Trust.	Full Assurance
Theme 2: Data, Information, Knowledge							

Rec. no.	Theme	Recommendation	Executive Lead(s)	Corporate Lead(s)	Evidence held for Trust Assurance	Gaps	Assurance Rating (Red / Amber / Yellow / Green)
264	2.1 Efficacy statistics - speciality level	In the case of each specialty, a programme of development for statistics on the efficacy of treatment should be prepared, published, and subjected to regular review.	CFO	Jonathan Brotherton	New software has recently been procured to help in higher level of statistical testing.	There is a need to determine what outcomes drive efficacy of treatment and how these can be measured before statistical testing can commence.	No Assurance
267	2.1 Efficacy statistics - speciality level	All such statistics should be made available online and accessible through provider websites, as well as other gateways such as the Care Quality Commission.	CFO	Jonathan Brotherton	Following the establishement of the programmes identified in indicator 264, these statistics can be made available and accessible via appropriate forums e.g.the internet/annual plan	There is a need to determine what outcomes drive efficacy of treatment and how these can be measured before statistical testing can commence. Appropriate gateways for dissemination of statistics need to be identified.	No Assurance
143	2.2 system-wide review of quality of care assurance process	Metrics need to be established which are relevant to the quality of care and patient safety across the service, to allow norms to be established so that outliers or progression to poor performance can be identified and accepted as needing to be fixed.	CFO	Jonathan Brotherton	Internal process include some benchmarking e.g. targets for Dr Foster indicators, A&E benchmarking from the TDA. More is forthcoming as the PPMO team becomes resourced fully. The commissioners are to determine what/how UHCW should be benchmarking in the health economy.	Assurance required from commissioners following discussion at CQRG that evidence is sufficient, convincing and demonstrate standards are being complied with.	Some Assurance (Serious Impact)

Rec. no.	Theme	Recommendation	Executive Lead(s)	Corporate Lead(s)	Evidence held for Trust Assurance	Gaps	Assurance Rating (Red / Amber / Yellow / Green)
269	2.3 sharing information on quality of care	The only practical way of ensuring reasonable accuracy is vigilant auditing at local level of the data put into the system. This is important work, which must be continued and where possible improved.	CFO	Jonathan Brotherton	Audits are undertaken on a monthly basis to determine data quality of the Trust PAS, iPM. Clinical coding audits are also undertaken monthly and the Trust holds a monthly data quality committee.		Some Assurance (Serious Impact)

Rec. no.	Theme	Recommendation	Executive Lead(s)	Corporate Lead(s)	Evidence held for Trust Assurance	Gaps	Assurance Rating (Red / Amber / Yellow / Green)
262	2.3 sharing information on quality of care	All healthcare provider organisations, in conjunction with their healthcare professionals, should develop and maintain systems which give them: • Effective real-time information on the performance of each of their services against patient safety and minimum quality standards; • Effective real-time information of the performance of each of their consultants and specialist teams in relation to mortality, morbidity, outcome and patient satisfaction. In doing so, they should have regard, in relation to each service, to best practice for information management of that service as evidenced by recommendations of the Information Centre, and recommendations of specialist organisations such as the medical Royal Colleges. The information derived from such systems should, to the extent practicable, be published and in any event made available in full to commissioners and regulators, on request, and with appropriate explanation, and to the extent that is relevant to individual patients, to assist in choice of treatment.	CMO / CNO / CFO / COO	Karen Bond / Jonathan Brotherton	The A&E daily dashboards provide as close to real time reporting as possible at the current time. This is however of limited distribution.	A structured approach needs to be taken to develop reporting of mortality, morbidity, outcome and patient satisfaction as currently no real time reporting mechanisms are available to be put in place to deliver this due to utilisation of the Dr Foster tool which is considerably behind current month reporting timescales.	Some Assurance (Serious Impact)

Rec. no.	Theme	Recommendation	Executive Lead(s)	Corporate Lead(s)	Evidence held for Trust Assurance	Gaps	Assurance Rating (Red / Amber / Yellow / Green)
88	Responsibility for, and effectiveness of, regulating healthcare systems governance – Health and Safety Executive functions in healthcare settings	The information contained in reports for the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations should be made available to healthcare regulators through the serious untoward incident system in order to provide a check on the consistency of trusts' practice in reporting fatalities and other serious incidents.	CHRO	Lincoln Dawkin	Trust Policy on HS includes RIDDOR reporting Riddors discussed at Trust HSC meeting Riddors are discussed by exception at SIG H&S audits introduced program of audits for compliance has been developed. Risk Assessments in place and Risk Management Policy/Strategy are in place internal audit of Risk management Inspections and audits are reported on at the HSC	Update H&S policy and ensure that TB sign off this and to include more clearly the reporting of RIDDOR at SIG and PSC. Ascertain that Riddors relating to clinical circumstances are picked up at PSC and speciality QuIPPS. Only a proportion of departments are audited for compliance in regard to H&S audits/inpsction.	Some Assurance (Serious Impact)
89	Responsibility for, and effectiveness of, regulating healthcare systems governance – Health and Safety Executive functions in healthcare settings	Reports on serious untoward incidents involving death of or serious injury to patients or employees should be shared with the Health and Safety Executive.	CMO / CHRO	Yvonne Gatley / Lincoln Dawkin	All RIDDOR reportable incidents are reported via Risk management and discussed at the Trust HSC. They are also discussed by exception at the SIG if the incident is a SIRI. Trust Risk Manager attends SG meetings.	Update H&S policy and ensure that TB sign off Need to identify which incidents are included in this recommendation and then ensure systems are robust	Some Assurance (Serious Impact)
139	2.2 system-wide review of quality of care assurance process	The first priority for any organisation charged with responsibility for performance management of a healthcare provider should be ensuring that fundamental patient safety and quality standards are being met. Such an organisation must require convincing evidence to be available before accepting that such standards are being complied with.	CFO	Jonathan Brotherton	Performance Management Framework KPIs are shared via CQRG, CPPM, the IPR which goes to public Trust Board, PMR returns to the TDA and the CQC Unannounced visits/observations incorporated in the Acute Service Provider contracts (TBC)	Assurance required from commissioners following discussion at CQRG that evidence is sufficient, convincing and demonstrate standards are being complied with.	Some Assurance (Serious Impact)

Rec. no.	Theme	Recommendation	Executive Lead(s)	Corporate Lead(s)	Evidence held for Trust Assurance	Gaps	Assurance Rating (Red / Amber / Yellow / Green)
140	2.2 system-wide review of quality of care assurance process	Where concerns are raised that such standards are not being complied with, a performance management organisation should share, wherever possible, all relevant information with the relevant regulator, including information about its judgement as to the safety of patients of the healthcare provider.	CFO	Jonathan Brotherton	Terms of reference for the CQRG meeting. Performance shared via the PMR to the TDA and other meeting forums	Assurance required from commissioners following discussion at CQRG that evidence is sufficient, convincing and demonstrate standards are being complied with.	Some Assurance (Impact NOT serious)
142	2.2 system-wide review of quality of care assurance process	For an organisation to be effective in performance management, there must exist unambiguous lines of referral and information flows, so that the performance manager is not in ignorance of the reality.	CFO	Jonathan Brotherton	Internal processes identify designated leads on spreadsheets of KPIs when targets and/or monitoring is being set up e.g. CQRG, CPPM, CQUIN. For the IPR, these are listed on the dashboard. Leads/information flow contacts have not been identified in these sources for CCGs/SCTs	Assurance required from commissioners following discussion at CQRG that evidence is sufficient, convincing and demonstrate standards are being complied with.	Some Assurance (Impact NOT serious)

Rec. no.	Theme	Recommendation	Executive Lead(s)	Corporate Lead(s)	Evidence held for Trust Assurance	Gaps	Assurance Rating (Red / Amber / Yellow / Green)
244	2.3 sharing information on quality of care	There is a need for all to accept common information practices, and to feed performance information into shared databases for monitoring purposes. The following principles should be applied in considering the introduction of electronic patient information systems: • Patients need to be granted user friendly, real time and retrospective access to read their records, and a facility to enter comments. They should be enabled to have a copy of records in a form useable by them, if they wish to have one. If possible, the summary care record should be made accessible in this way. • Systems should be designed to include prompts and defaults where these will contribute to safe and effective care, and to accurate recording of information on first entry. • Systems should include a facility to alert supervisors where actions which might be expected have not occurred, or where likely inaccuracies have been entered. • Systems should, where practicable and proportionate, be capable of collecting performance management and audit information automatically, appropriately anonymised direct from entries, to avoid unnecessary duplication of input. • Systems must be designed by healthcare professionals in partnership with patient groups to secure maximum professional and patient engagement in ensuring accuracy, utility and relevance, both to the needs of the individual patients and collective professional, managerial and regulatory requirements. Systems must be capable of reflecting changing needs and local requirements over and above	CMO / CNO / COO	Robin Arnold / Jonathan Brotherton / Julia Flay	See supplementary information sheet.	See supplementary information sheet.	Some Assurance (Impact NOT serious)

Rec. no.	Theme	Recommendation	Executive Lead(s)	Corporate Lead(s)	Evidence held for Trust Assurance	Gaps	Assurance Rating (Red / Amber / Yellow / Green)
252	Information	It is important that the appropriate steps are taken to enable properly anonymised data to be used for managerial and regulatory purposes.	CFO	Jonathan Brotherton	Data Protection Policy (draft to be approved at IGC following final amendments) IG Training records Reporting only includes count or use of hospital PID where individual records are listed. Personal details only shared where necessary to aid care of the patient.	Approve Data Protection Policy at IGC	Some Assurance (Impact NOT serious)
256	Information	A proactive system for following up patients shortly after discharge would not only be good "customer service", it would probably provide a wider range of responses and feedback on their care.	CMO	Julia Flay	FFT - all in-patients and A&E attendees are given the opportunity to feedback on services as at May 2013	FFT roll out by end of March 2014: Maternity Services by October 2013, Out-patients likely by end of March 2014	Some Assurance (Impact NOT serious)
246	2.4 Quality accounting	Department of Health/the NHS Commissioning Board/regulators should ensure that provider organisations publish in their annual quality accounts information in a common form to enable comparisons to be made between organisations, to include a minimum of prescribed information about their compliance with fundamental and other standards, their proposals for the rectification of any non-compliance and statistics on mortality and other outcomes. Quality accounts should be required to contain the observations of commissioners, overview and scrutiny committees, and Local Healthwatch.	CMO	Paul Martin	The Trust complies fully with DoH guidance for the production of Quality Accounts.	N/A	Some Assurance (Impact NOT serious)

Rec. no.	Theme	Recommendation	Executive Lead(s)	Corporate Lead(s)	Evidence held for Trust Assurance	Gaps	Assurance Rating (Red / Amber / Yellow / Green)
247	2.4 Quality accounting	Healthcare providers should be required to lodge their quality accounts with all organisations commissioning services from them, Local Healthwatch, and all systems regulators.	CMO	Paul Martin	The Trust complies fully with DoH guidance for the production of Quality Accounts. The Trust also consults with local commissioners and stakeholders in their production and distribution.	N/A	Some Assurance (Impact NOT serious)
248	2.4 Quality accounting	Healthcare providers should be required to have their quality accounts independently audited. Auditors should be given a wider remit enabling them to use their professional judgement in examining the reliability of all statements in the accounts.	CMO	Paul Martin	The Trust's Quality Account is independently audited by PWC, as per national guidance.	N/A	Some Assurance (Impact NOT serious)
249	2.4 Quality accounting	Each quality account should be accompanied by a declaration signed by all directors in office at the date of the account certifying that they believe the contents of the account to be true, or alternatively a statement of explanation as to the reason any such director is unable or has refused to sign such a declaration.	CMO	Paul Martin	The Trust's Quality Account has a supporting declaration signed by relevant Directors.	N/A	Full Assurance
255	2.3 sharing information on quality of care	Results and analysis of patient feedback including qualitative information need to be made available to all stakeholders in as near “real time” as possible, even if later adjustments have to be	CMO	Julia Flay	Evidence held on Impressions		Full Assurance

Rec. no.	Theme	Recommendation	Executive Lead(s)	Corporate Lead(s)	Evidence held for Trust Assurance	Gaps	Assurance Rating (Red / Amber / Yellow / Green)
268	2.3 sharing information on quality of care	Resources must be allocated to and by provider organisations to enable the relevant data to be collected and forwarded to the relevant central registry.	CFO	Jonathan Brotherton	The Trust has nominated leads/resources to ensure all data required to be submitted to the relevant central registry is complied with. E.g. the TARN co-ordinator, SUS data leads.		Full Assurance
273	2.3 sharing information on quality of care	The terms of authorisation, licensing and registration and any relevant guidance should oblige healthcare providers to provide all relevant information to enable the coroner to perform his function, unless a director is personally satisfied that withholding the information is justified in the public interest.	CEO	Julie Midgley	Where there are cases of concern these are reported to SIG which undertakes an RCA. The report always being disclosed in advance of any Inquestto the Coroner and the family		Full Assurance
Theme 3: Complaints							
117	Effective complaints handling	A facility should be available to Independent Complaints Advocacy Services advocates and their clients for access to expert advice in complicated cases.	CMO	Sharon Wyman		This represents a new function and would need to be scoped.	No Assurance
118	Effective complaints handling	Subject to anonymisation, a summary of each upheld complaint relating to patient care, in terms agreed with the complainant, and the trust's response should be published on its website. In any case where the complainant or, if different, the patient, refuses to agree, or for some other reason publication of an upheld, clinically related complaint is not possible, the summary should be shared confidentially with the Commissioner and the Care Quality Commission.	CMO	Sharon Wyman		This is a new concept and would need further consideration.	No Assurance

Rec. no.	Theme	Recommendation	Executive Lead(s)	Corporate Lead(s)	Evidence held for Trust Assurance	Gaps	Assurance Rating (Red / Amber / Yellow / Green)
112	Effective complaints handling	Patient feedback which is not in the form of a complaint but which suggests cause for concern should be the subject of investigation and response of the same quality as a formal complaint, whether or not the informant has indicated a desire to have the matter dealt with as such.	CMO	Sharon Wyman / Julia Flay	Complaints documentation. PALS database. Patient Feedback system only partial evidence.	potential impact for resource allocation	Some Assurance (Serious Impact)
109	Effective complaints handling	Methods of registering a comment or complaint must be readily accessible and easily understood. Multiple gateways need to be provided to patients, both during their treatment and after its conclusion, although all such methods should trigger a uniform process, generally led by the provider trust.	CMO	Sharon Wyman	Impressions and complaints processes (leaflets / websites). Flagged as some assurance as patients still raise lack if information in patient surveys.	Requires further consideration..	Some Assurance (Serious Impact)
113	Effective complaints handling	The recommendations and standards suggested in the Patients Association's peer review into complaints at the Mid Staffordshire NHS Foundation Trust should be reviewed and implemented in the NHS.	CMO	Sharon Wyman	Complaints files. There are some gaps in the recommendations of the PA's peer review recommendationswhich need to be further considered.	There are some gaps in the recommendations of the PA's peer review recommendationswhich need to be further considered.	Some Assurance (Serious Impact)
119	Effective complaints handling	Overview and scrutiny committees and Local Healthwatch should have access to detailed information about complaints, although respect needs to be paid in this instance to the requirement of patient confidentiality.	CMO	Sharon Wyman	Complaints reports. Agree with Heatlwatch required	Requirements from Healthwatch would be needed.	Some Assurance (Serious Impact)
120	Effective complaints handling	Commissioners should require access to all complaints information as and when complaints are made, and should receive complaints and their outcomes on as near a real-time basis as possible. This means commissioners should be required by the NHS Commissioning Board to undertake the support and oversight role of GPs in this area, and be given the resources to do so.	CMO	Sharon Wyman	Complaints reports. Outcomes not currently provided for all complaint.	Outcomes not currently provided for all complaint.	Some Assurance (Serious Impact)

Rec. no.	Theme	Recommendation	Executive Lead(s)	Corporate Lead(s)	Evidence held for Trust Assurance	Gaps	Assurance Rating (Red / Amber / Yellow / Green)
122	Effective complaints handling	Large-scale failures of clinical service are likely to have in common a need for: • Provision of prompt advice, counselling and support to very distressed and anxious members of the public; • Swift identification of persons of independence, authority and expertise to lead investigations and reviews; • A procedure for the recruitment of clinical and other experts to review cases; • A communications strategy to inform and reassure the public of the processes being adopted; • Clear lines of responsibility and accountability for the setting up and oversight of such reviews. Such events are of sufficient rarity and importance, and requiring of coordination of the activities of multiple organisations, that the primary responsibility should reside in the National Quality Board.	CMO	Yvonne Gatley / Sharon Wyman	Complaints investigation and Route Cause Analysis/SIG.	No provision for Counselling and Bereavement services.	Some Assurance (Impact NOT serious)
40	Responsibility for, and effectiveness of, healthcare standards	It is important that greater attention is paid to the narrative contained in, for instance, complaints data, as well as to the numbers.	CMO	Sharon Wyman	Complaints files and Specialty reporting.		Full Assurance
110	Effective complaints handling	Actual or intended litigation should not be a barrier to the processing or investigation of a complaint at any level. It may be prudent for parties in actual or potential litigation to agree to a stay of proceedings pending the outcome of the complaint, but the duties of the system to respond to complaints should be regarded as entirely separate from the considerations of litigation.	CMO	Sharon Wyman	Complaints process runs alongside Trust litigation processes, unless it is deemed to prejudice the outcome.		Full Assurance

Rec. no.	Theme	Recommendation	Executive Lead(s)	Corporate Lead(s)	Evidence held for Trust Assurance	Gaps	Assurance Rating (Red / Amber / Yellow / Green)
111	Effective complaints handling	Provider organisations must constantly promote to the public their desire to receive and learn from comments and complaints; constant encouragement should be given to patients and other service users, individually and collectively, to share their comments and criticisms with the organisation.	CMO	Sharon Wyman / Julia Flay	Complaints leaflets and PALs information distributed around Trust and on website. Advertisement of Impressions around Trust.		Full Assurance
114	Effective complaints handling	Comments or complaints which describe events amounting to an adverse or serious untoward incident should trigger an investigation.	CMO	Sharon Wyman	Complaints documentation and CAE information.		Full Assurance
115	Effective complaints handling	Arms-length independent investigation of a complaint should be initiated by the provider trust where any one of the following apply: • A complaint amounts to an allegation of a serious untoward incident; • Subject matter involving clinically related issues is not capable of resolution without an expert clinical opinion; • A complaint raises substantive issues of professional misconduct or the performance of senior managers; • A complaint involves issues about the nature and extent of the services commissioned.	CMO	Sharon Wyman	Complaints documentation and CAE information.		Full Assurance
116	Effective complaints handling	Where meetings are held between complainants and trust representatives or investigators as part of the complaints process, advocates and advice should be readily available to all complainants who want those forms of support.	CMO	Sharon Wyman	Complaints documentation. ICAS information.		Full Assurance

Full Assurance

Some Assurance (Impact NOT serious)

Some Assurance (Serious Impact)

No Assurance

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST
REPORT TO THE TRUST BOARD: PUBLIC
31 JULY 2013

Subject:	Quality Governance Committee Meeting Report: February – June 2013
Report By:	Peter Winstanley, Non-Executive Director
Author:	Paul Martin, Director of Clinical Governance
Accountable Executive Director:	Meghana Pandit, Chief Medical Officer

GLOSSARY

Abbreviation	In Full
HRED	Human Resources Equality & Diversity
TER	Training, Education and Research
IT	Information Technology
QARC	Quality Assurance Reference Centre
R&D	Research & Development
CQC	Care Quality Commission
QRP	Quality Risk Profile
HSMR	Hospital Standardised Mortality Ratio
SHMI	Summary Hospital-level Mortality Indicator
SUI	Serious Untoward Incident

WRITTEN REPORT (provided in addition to cover sheet)? ☐ **Yes** ☒ **No**
POWERPOINT PRESENTATION? ☐ **Yes** ☒ **No**
NB Presentations need to be submitted for inclusion in Board papers

Title	
Approx. Length	

PURPOSE OF THE REPORT / PRESENTATION:

To advise Trust Board of the details of the Quality Governance Committee meetings during 2013 to date.

SUMMARY OF KEY ISSUES:

- **February 2013** meeting was not quorate, issues and key points as follows:-
  - **HRED** – The meeting were informed that a plan of action has been devised to help areas improve performance, particularly regarding high levels of sickness absence.
  - **TER** – the Committee were advised that the Consultant Mentoring Report has now been approved.
  - **Patient Experience Committee** – the Trust have been chosen for the pilot Patient Revolution Pathfinder aimed at improving patient and customer services experience. Trials are to complete at the end of March. The Committee were assured that there were no implications towards the Trust from the Francis report
  - **Patient Safety Committee** – Focus was brought to the Major Trauma Governance Committee; Educational Training; and Serious Incidents Report. Staffing levels regarding junior doctors should improve with a change in the current funding process. Action is being taken to address senior personnel being present during ward rounds. Efforts are currently being made to improve the level of communication with friends and relatives of patients. All requested actions from the Deanery visit in January of Neurosurgery have been completed.
  - **Information and IT Committee** – The scanning project is progressing well towards scanning all records rather than holding paper records and the Committee was assured of its security. Trial of the results acknowledgement modifications to Clinical Results Reporting System is underway.
  - **Risk Committee** – Corporate training risks are to be managed and reviewed at speciality level, with the overarching review being retained by the appropriate committee or group which will provide the Trust with assurance.
  - **Ad Hoc Reports** -

    Falls Report
    UHCW are substantially below local and national levels for potential falls and have seen a decline in reported falls.

    Clinical Coding Report
    An external audit recently achieved Level 3 of Governance Toolkit.

    CQC QRP.
    There were 6 new CQC risks that had been allocated to appropriate leads for review, but there are no new internal risks to report to the Committee.
    There inspection on 7 January 2013 was successful and UHCW were declared compliant in all required aspects under review.

MR advised that following publication of the Francis report, details of the Trust's QRP monitoring methods had been given to the SHA. This received positive response and acknowledged as being a robust process.

SUI Report

32 investigations were completed during the foregoing quarter.

Patient Safety Thermometer

This is the national mandatory safety monitoring tool for measuring and analysing patient care. Results have proved to be very positive.

HSMR & SHMI Report

It was queried whether the Significant Incident and Mortality reports needed to go to Trust Board and also to this Committee every month. It was decided this meeting needs to see these reports on a monthly basis, but perhaps it could be suggested that Trust Board only need to see them every 6 months as it is not productive to double up, even with such a sensitive issue.

IBP Supporting Strategies (Board Seminar 2 Jan 2013)

A verbal report was given and the Committee advised there is a meeting scheduled soon to discuss this item, after which a full report will be delivered via HRED.

Pathology Report

Report relating to Kingsmill Hospital was presented and confirmed that all recommendations are being followed.

- **March 2013 meeting** meeting was not quorate, issues and key points as follows:-
  - **TER**
    - The Committee was advised the Undergraduate Medical Education Committee meetings do not take place on a regular basis, but is used for other meeting purposes.
    - The current improvement programme for Mandatory Training is to go live on the 1 April and 1 June.
  - **Patient Safety Committee**
    - Forwarding details of initial stages of Never Events and Significant Incidents to be addressed.
    - Action plan in place to meet Medicines Management standards
    - The Dr Foster situation was discussed and found to be overall positive.
    - The CQC alert regarding the caesarean section rate was discussed and it was felt the nature of the populace in the area could account for the rise in caesarean sections being required. The leads in this work will report their findings which will then come through to this Committee.
    - All cases of pressure ulcers are fully recorded and documented.
  - **Information and IT Committee**
    - This year provisions have been adequate to cover all necessary work, however, next year could be very restricted, it was felt that this could be termed as a risk and therefore a risk-orientated programme has been put forward to review the work.
    - Progress is being made towards becoming paperless by 2018 as per the recommendation.
  - **Risk Committee**
    - Risk owners are now invited to the Risk Committee meeting. The first report related to bariatric equipment handling. A business case is in preparation to address difficulties in this regard.
    - Risk Committee are also looking at specific entries on the Risk Register each meeting and it was felt this is a very helpful development.
  - **Ad Hoc Reports**

    CQC - The Trust is currently reviewing alternative options for the implementation of more efficient software and development of the business intelligence systems.

    Friends & Family Test – A very disappointing result despite doing all things possible. Plans are in place to try different methods as from the 1 April 2013 UHCW are required to attain a 15% response rate to the Friends and Family Test in A&E and Inpatients per week. A number of changes for Impressions are planned for next year.

    Nursing Indicators – One of the main areas of complaint relates to lack of communication. The current visiting hours are seen as being contributory to these difficulties and Ward Managers have been asked to accommodate relatives and allow time to discuss any problems

Safeguarding YP&A, Child Protection report – Concerns relating to training and compliance with regard to child care, however, compliance levels are continuing to improve and figures in the next report will show a significant increase. It was felt that vulnerable adults also receive focus and the Committee were advised that attention is given to recognising signs which then form part of the main area of concern.

- **April 2013 meeting** was cancelled due to Executives attending another commitment, however, it was decided at the March meeting to hold a meeting during August in order to maintain the stipulated annual quota of 10 meetings.
- **May 2013 meeting** was not quorate, issues and key points as follows:-
  - **Patient Experience Committee**
    - Presentation recently taken place by TMI (Transform, Manage, Inspire) Management Consultancy. All key issues which will receive attention and of the necessary changes proposed action will be taken to see if they constitute a sustainable improvement for patients overall.
    - Friends and Family test is proving to be very useful and it was felt a better understanding of this system for the Clinical Directors would be helpful.
  - **Patient Safety Committee**
    - Patient Safety Committee reports for the previous two months were presented to the Committee.
    - All alerts had been investigated and all risks had been completed.
    - SUI report was presented and as a result of issues around Emergency Pathways actions have been taken to improve processes and establish better communication.
  - Information and IT Committee –
    - Amount of work needed this year and the capacity of the Trust is a potential issue.
    - Retention period for x-rays was discussed and stated this situation needs to be assessed as some records should follow a different process.
    - ICT annual report was presented and key areas are receiving attention.
  - **Risk Committee**
    - Mechanisms for communication of change needs to be improved so risks are not repeated.
    - An Operational Risk Committee will meet on a monthly basis and report in to the Risk Committee.
  - **Ad Hoc Reports**

    Coding – External audit results are very good. The audit had been of 200 case records over 5 specialties and key issues for action identified were:
    - Discrepancies between information contained in casenotes and edischarges
    - Availability of information for patients treated at BMI
    - Availability of bronchoscopy reports on electronic systems (coders are missing laterality of bronchoscopies)
    - Some departmental training issues.

    The accuracy levels are the highest ever found at audit and enabled the trust to move from Level 2 to Level 3

    QRP – 3 new risks included in the latest documentation and 7 on-going internal risks.

    CQC Inspection Report – the inspection had focused on how the Trust monitors patient transfers from short stay areas. There were no actions highlighted that affect our registration status and the CQC provider notes have been actioned.

    Education Report – there are a number of recurrent issues in key areas of Acute Medicine; Obstetrics & Gynaecology and Neurosurgery. These three keys areas are under regular review.

- **June 2013 meeting** was quorate and the agenda items were discussed. Key points:
  - **Patient Experience Committee** – the Committee approved the report and there were no further questions.
  - **Patient Safety Committee** –
    - falls are a significant factor in patient safety and confirmed there is an action plan in progress.
    - Phlebotomy sample rejection was discussed and the Committee were assured there is a robust policy in place to safeguard against problems in this regard.
    - Mortality information was presented and UHCW is comparable with many Trusts. However the best

performing Trusts have more favourable figures. It was felt the reasons for this need further discussion at Board in order to facilitate UHCW attain equitable levels.
- Never Events key point is the reporting process of such incidents to ensure they are reported and investigated without delay and remedial action can be taken swiftly.

- **Risk Committee** –
  - mandatory training for the use of the defibrillator was discussed and serious concern was expressed about the persistently low proportions of staff who have completed mandatory training. It was felt this matter should be discussed at Board, led by the Directors of HR and of Medicine.
  - Risk Register was presented and the Committee discussed the various items.
- **Ad Hoc Reports** -

  HR Strategy & Workforce Report was presented and discussed by the Committee.
  Make Every Contact Count Report was presented and discussion took place regarding the benefits served by this and the best method of organisation. The Committee asked for Board discussion.
  Quality Account was presented and it was confirmed that a draft report had been sent to Trust Board.
  Complaints Annual Report was presented and it was confirmed that a report will still be required for the July meeting regarding the Complaints process.
  Medicines Report was presented and the Committee were advised that the implementation of walkarounds has been very helpful and informative regarding medicine management. It was also Introduction of electronic locks on medicine cupboards has been a very positive innovation.
  QRP (Quality Risk Profile) was presented and discussed. The report is meticulously surveyed by the Chief Officers' Group.
  Mental Health Visit Report was presented and the Committee were advised that this was a very positive visit. There were 10 actions identified and these have all be allocated for attention.
  Clinical Negligence Report was presented. There are currently 378 negligence claims against the Trust with an increase of 65 in the past 3 months, however, the UHCW figure is still low against comparators.
  Infection Prevention and Control – the meeting was advised there had been an influenza outbreak thus needed to improve the uptake of vaccine amongst staff. It was also found that offering vaccine to patients at haemodialysis sessions resulted in a 100% uptake. Cleaning and the dangers of cross infection in relation to C Diff were discussed. The 4 hour wait target also needs to be met, contamination is key to this problem and investigations are being carried out into other cleaning methods which do not take so long to complete. Mandatory training to be considered for the infection control and venous access teams relating to cannula insertion and care in order to improve prevention of MSSA bacteraemia, which is seen to be the main source of infection. To be summarised for the next Board meeting.
  Patient Safety Thermometer Report was presented and the Committee was advised that this is a very useful tool which helps with comparative data.

SUMMARY OF KEY RISKS:

Identified within individual reports

RECOMMENDATION / DECISION REQUIRED:

For consideration by the Board

IMPLICATIONS:

Financial:	None Highlighted
HR / Equality & Diversity:	None highlighted
Governance:	None
Legal:	None

REVIEW:

Trust Standing Committee	**Date**	**Trust Standing Committee**	**Date**
Quality Governance Committee		Remuneration Committee	
Finance and Performance Committee		Executive Meeting	
Audit Committee			

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST
REPORT TO THE TRUST BOARD: PUBLIC
31 JULY 2013

DATA QUALITY:

Data/information Source:	
Data Quality Controls:	
Data Limitations:	

University Hospitals Coventry and Warwickshire NHS Trust

Meeting:	**QUALITY GOVERNANCE COMMITTEE**
Date/Time:	Tuesday 11 June 2013
Venue:	Clinical Sciences Building
Present:	Peter Winstanley – Non-Executive Director (PW) Andy Hardy – Chief Executive Officer (AH) Andrew Phillips – Divisional Medical Director Diagnostic & Support (AP) Karen Bond – Associate Director of Nursing (KB) Mark Radford – Chief Nurse (MR) Meghana Pandit – Chief Medical Officer (MP) David Eltringham – Chief Operating Office (DE)
Attendees:	Andrew McMenemy – Associate Director of HR (AMcM) Jenny Gardiner – Board Secretary (JG) Mark Easter – Director of Pharmacy (ME) Mike Weinbren – Director of Infection Control (MW) Yvonne Gatley – Associate Director of Governance (YG) Angela Reeve – Governance PA Co-ordinator (Minutes) (AJR)
Apologies:	Ian Crich – Chief Human Resources Officer (IC) Nick Stokes – Non-Executive Director, Vice Chair (NS) Paul Martin – Director of Governance (PM) Rita Stewart – Trust Lay Representative (RS) Tim Sawdon – Non-Executive Director, Chair (TS)

Item: 1 2013/27	**GENERAL BUSINESS**
Key Discussion Points:	**1.1 Apologies** - Apologies were noted and accepted **1.2 Minutes & Actions** – • May 2013 minutes accepted as a true and accurate record of that meeting. • All actions noted. • **1.3 Matters Arising** • There were no matters arising
Key Action Points:	•

Item: 2 2012/28	**HR, Equality & Diversity – I Crich**
Key Due to Discussion Points:	• Update for this Committee to be included in the Annual Report next month.
Key Action Points:	•

Item: 3 2012/29	**TRAINING, EDUCATION & RESEARCH – I Crich**
Key Due to Discussion Points:	• This Committee meets bi-monthly, the next report will be due July 2013.
Key Action	•

Points:	

Item: 4 2013/30	**PATIENT EXPERIENCE COMMITTEE, May 2013 - M Radford**
Key Discussion Points:	• MR presented this report and the Committee approved it. There were no further questions.
Key Action Points:	•

Item: 5 2013/31	**PATIENT SAFETY COMMITTEE, May 2013 – M Pandit**
Key Discussion Points:	5.1 MP presented this report and PW asked if there is a trend in serious falls. MP advised that falls are always significant factors in patient safety reports and confirmed there is an action plan in progress. 5.2 PW enquired about the phlebotomy sample rejection and MP advised there had been an issue regarding inappropriate labelling and this is why they were returned. However, sample rejection is now dropping as the situation improves. MP confirmed that whoever draws blood completes the form by hand in accordance with Group & Save requests and Transfusion requests and that there is zero tolerance for any incorrectly completed labels. AP advised there is a robust policy in place to safeguard against problems in this regard. 5.3 HSMR and SHMI report on mortality information was presented by MP. UHCW is comparable with many Trusts. However the best performing Trusts (UCH and Cambridge being good examples) have clearly more favourable figures. It was felt the reasons for this need discussion at Board in order to facilitate UHCW attain equitable levels. 5.3 SUI report was presented by YG. PW asked for clarification regarding Never Events and how this compared to elsewhere. MP advised that at a recent comparison UHCW was in the middle. AP advised that Never Events is a misnomer, but the key point is the reporting process of such incidents to ensure they are reported and investigated without delay and remedial action can be taken swiftly.
Key Action Points:	•

Item: 6 2013/32	**INFORMATION & IT COMMITTEE – D Eltringham**
Key Discussion Points:	6.1 This Committee meets bi-monthly, the next report will be due July 2013.
Key Action Points:	•

Item: 7 2013/33	**RISK COMMITTEE, May 2013 – M Pandit**
Key Discussion Points:	7.1 MP presented this report. PW asked about mandatory training for the use of the defibrillator and felt the Board should discuss the current situation regarding mandatory training. IC to be asked to prepare a report on this for the next Trust Board Meeting. PW expressed **serious concern** about the persistently low proportions of staff who have completed mandatory training and asked that this matter be discussed at Board, led by the Directors of HR and of Medicine. 7.2 Risk Register was presented by MP and the Committee discussed the various items.
Key Action Points:	• IC to be asked to prepare a report for the next Trust Board outlining mandatory training current situation - JG

Item: 8 2013/34	Ad Hoc Reports
	8.1 HR Strategy & Workforce report was presented by A McMenemy. PW asked about the mandatory training figures and which area constituted the worst offender. AMcM confirmed this information could be included in the report to Board. Discussion followed regarding the use of consultants' appraisals and it was agreed this could have an impact on individual revalidation. PW felt it could be useful to have comparators and AMcM said he would prepare the information for Board. Further discussion followed regarding the practicality of ESR (Electronic Staff Reporting) and how it is used. It was also agreed that on any future agenda Patient Safety should be first and Mandatory Training should be second. 8.2 Make Every Contact Count report was presented by AP. Discussion took place regarding the benefits served by this and the best method of organisation. PW wondered whether staff time could be better used and asked for Board discussion. 8.3 The Quality Account was presented by MP and it was confirmed that a draft report had been sent to Trust Board. 8.4 Complaints Annual report was presented by MP and it was confirmed that a report will still be required for the July meeting regarding the Complaints process. 8.5 Medicines Report was presented by M Easter and the Committee were advised that the implementation of walkarounds has been very helpful and informative regarding medicine management. Also highlighted was the introduction of electronically secured medicine cabinets which nurses open by way of thumbprint and swipe card. These were recognised as being a very positive innovation. 8.6 QRP (Quality Risk Profile) presented by MP on behalf of PM. PW asked for a definition of what was meant by the terms 'real' and 'current'. YG explained that sometimes the information provided by CQC is old rather than up to date and corporate leads need to be able to confirm whether this is, in fact, a true risk to the Organisation. AH advised that the report is the meticulously surveyed by the Chief Officers' Group. 8.7 Mental Health Visit Report was presented by MP and the Committee were advised that this was a very positive visit. There were 10 actions identified and these have all be allocated for attention. 8.8 Clinical Negligence report was presented by AH. The Committee were advised that there are currently 378 negligence claims against the Trust with an increase of 65 in the past 3 months. Whilst this represents a relatively sharp rise in claims, the UHCW figure is still low against comparators. MP suggested we may need to look at trends in obstetrics, ED misdiagnosis and orthopaedics. 8.9 Infection Prevention and Control – this report was presented by M Weinbren, who advised the Committee there had been an influenza outbreak on Renal Unit and thus needed to improve the uptake of vaccine amongst staff. It was also found that offering vaccine to patients at haemodialysis sessions resulted in a 100% uptake, and it was therefore considered that this practice could be an effective use of future funding. C Diff did not meet the targets this year, the main culprit being cleaning and the dangers of cross infection. However, the 4 hour wait target also needs to be met, and it is therefore difficult to achieve both requirements given the respective time scales. Environmental contamination is key to this problem and investigations are being carried out into other cleaning methods which do not take so long to complete. Mandatory training to be considered for the infection control and venous access

	teams relating to cannula insertion and care in order to improve prevention of MSSA bacteraemia, which is seen to be the main source of infection. MR to summarise for the next Board meeting. 8.10 Patient Safety Thermometer Report was presented by KB who reported that pressure ulcers are seen as the key risk at the present time. PW asked why this method of monitoring adds to Patient Safety. KB advised that it is a local improvement tool which facilitates the measuring and monitoring of harm free care and which supports many other practices. MR felt it is a very useful tool which helps with comparative data.
Key Action Points:	• MR to summarise Infection Control report for the next Board meeting - MR

Item: 9 2013/35 AOB	• There was no AOB

Date of Next Meeting:	Monday 8 July 2013, 10.00am, CSB

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST

REPORT TO THE TRUST BOARD: PUBLIC

31 July 2013

Subject:	Major Trauma Network Peer Review
Report By:	Dr M Wyse, Trust Trauma Lead
Author:	Dr M Wyse, Trust Trauma Lead
Accountable Executive Director:	Mrs M Pandit, Chief Medical Officer

GLOSSARY

Abbreviation	In Full
BCH	Birmingham Children's Hospital
IEP	Image Exchange Portal
IR	Interventional Radiology
KGH	Kettering General Hospital
MTC	Major Trauma Centre
NGH	Northampton General Hospital
TARN	Trauma Audit Research Network
T&O	Trauma and Orthopaedics
TU	Trauma Unit
UHCW	University Hospitals Coventry and Warwickshire NHS Trust

WRITTEN REPORT (provided in addition to cover sheet)? ☒ **Yes** ☐ **No**

POWERPOINT PRESENTATION? ☐ **Yes** ☒ **No**
NB Presentations need to be submitted for inclusion in Board papers

Title	
Approx. Length	

PURPOSE OF THE REPORT / PRESENTATION:

To appraise the Trust Board of the content of the Peer Review Report.

SUMMARY OF KEY ISSUES:

- No critical issues
- Interventional radiology remains a weakness until IR strategy fully implemented
- Education

SUMMARY OF KEY RISKS:

Failure to act on recommendations contained in the report leading ot loss of Major Trauma Centre status.

RECOMMENDATION / DECISION REQUIRED:

The Trust Board are asked to note the report and the recommendations within.

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST

REPORT TO THE TRUST BOARD: PUBLIC

31 July 2013

IMPLICATIONS:

Financial:	
HR / Equality & Diversity:	
Governance:	
Legal:	

REVIEW:

Trust Standing Committee	**Date**	**Trust Standing Committee**	**Date**
Quality Governance Committee		Remuneration Committee	
Finance and Performance Committee		Executive Meeting	3 July 2013
Audit Committee			

DATA QUALITY:

Data/information Source:	
Data Quality Controls:	
Data Limitations:	

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST

REPORT TO THE TRUST BOARD: PUBLIC

31 July 2013

MAJOR TRAUMA CENTRE NETWORK PEER REVIEW

COMMENTS FROM REVIEWING TEAM

- Executive commitment: strong evidence provided by Executive Officers who attended the presentation. Trust Board signed off the business plan for the Trauma Network and provided full support for continuing status as a Major Trauma Centre.

- Pragmatic view from the Trust that becoming an MTC was a decision that UHCW made some years ago, as an important step to maintaining the relevant specialties on site.

EVIDENCE AROUND STRENGTHS OF THE NETWORK

- Good evidence provided that UHCW has been functioning as an MTC for some years (opened in 2006) with all specialties on site, including plastics (not burns). Since going live as a Network, there has been good evidence of strong links with the Local Emergency Hospitals and improving links with the two Trauma Units, one of which (KGH) has been validated as a TU at a recent visit.

- Network went live on 3 December 2012.

- The Network takes patients from South Leicestershire, as well as its local catchment area. It is part of the West Midlands Trauma System (3 adult MTCs and BCH, a paediatric MTC).

- The documentation provided gave strong evidence of a functioning system of governance with good links between the MTC and the TUs. Very strong links with BCH.

- Evidence provided of good engagement with Air Ambulance Services.

- Evidence provided of regular governance meetings (2 monthly).

- TARN data compliance is very poor at KGH, but better at NGH. Significant room for improvement at both Trusts.

- Research: Matt Costa – Research Lead. UHCW extremely active in trauma research.

- Additional T&O appointments planned.

- TU – development of an educational programme is being finalised.

AREAS FOR FURTHER WORK/RECOMMENDATIONS

- Improved data entry for TARN, especially for KGH.

- Resolve IPE issues; the system works well for KGH but there are still issues at NG>

- Flows of patients from Leicestershire; little further information available here.

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST

REPORT TO THE TRUST BOARD: PUBLIC

31 July 2013

Subject:	Finance and Performance Meeting Report – 28 May 2013
Report By:	Ms S Tubb, Non-Executive Director
Author:	Mrs G Nolan, Chief Finance Officer
Accountable Executive Director:	Mrs G Nolan, Chief Finance Officer

GLOSSARY

Abbreviation	In Full

WRITTEN REPORT (provided in addition to cover sheet)? ☐ **Yes** ☒ **No**

POWERPOINT PRESENTATION? ☐ **Yes** ☒ **No**
NB Presentations need to be submitted for inclusion in Board papers

Title	
Approx. Length	

PURPOSE OF THE REPORT / PRESENTATION:

To advise the Board of the Finance and Performance Committee meeting agenda for 28 May 2013 and of any key decisions/outcomes made by the Finance and Performance Committee.

SUMMARY OF KEY ISSUES:

DEVELOPMENT REPORTS – DEVELOPING UHCW's STRATEGY
A strategy development event had taken place and following on from those discussions, Mr S Parker and Mr C Book attended the meeting and presented a distillation of the ideas outlined by those present at the event and their perspective on how the Trust's strategy could be further detailed and developed. The Committee received the summary and noted that a further strategy day has been organised when all clinical groups will present their outline three year strategy.

DEVELOPMENT REPORTS – PROCUREMENT STRATEGY
Mrs Nolan presented the Procurement Strategy as a framework for the next five years, which focussed on the strategic enhancements to the Trust's procurement efforts to ensure maximum efficiency. The Committee agreed to recommend the approval of the Procurement Strategy by the Trust Board.

DEVELOPMENT REPORTS – SERVICE TRANSFORMATION
An update on the transformation work being undertaken was presented by Professor M Radford. The Committee noted the report and agreed that Professor Radford will provide a further paper on progress at the next meeting.

PERFORMANCE REPORTS – PERFORMANCE FRAMEWORK UPDATE
The Committee received a report which outlined the new Performance Management Framework against which Groups will be monitored by the Performance and Programme Management Committee. The Framework has been agreed by the Chief Officers Group and that the Scorecards have been published and circulated to the Groups. The Committee noted the contents of the report and supported the Performance Management Framework.

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST

REPORT TO THE TRUST BOARD: PUBLIC

31 July 2013

PERFORMANCE REPORTS - INTEGRATED PERFORMANCE REPORT The Integrated Performance Report was presented to the Committee with key issues being highlighted. It was noted that there continues to be substantial external pressures on the Emergency Department which need to be escalated, as well as the internal flow within the Trust which was experiencing problems. Specific reports on progress and plans for improvement to the mandatory training and appraisal rates will be submitted for discussion to the June meeting. The Committee confirmed their understanding of the contents of the report and noted the associated actions.
PERFORMANCE REPORTS – BUSINESS CASE EVALUATION – MAJOR TRAUMA CENTRE An evaluation of the business case in support of the major trauma centre was carried out, together with a financial analysis. The Committee were informed that a Peer Review Team had visited the Trust which resulted in positive feedback. The Committee agreed that this had been an important exercise and that the format of this initial business case evaluation was helpful. It was agreed that the next evaluation will be of the investments made in maternity services and will be presented to the Committee in September. The Committee noted the contents of the report.
PERFORMANCE REPORTS – TRANSFORMATION PROGRAMME: DELIVERY REPORT The purpose of the report is to update the Committee on current progress with the efficiency agenda for 2013/14. The Committee acknowledged that the format of the report was clear and concise. The Committee noted the update and agreed to receive a further update at the next meeting.
FINANCE REPORTS – INTEGRATED FINANCE REPORT An update on the financial position of the Trust for Month 1 of the 2013/14 financial year was presented and attention was drawn to salient points within the report. It was noted that there had been much progress in the contracting process and the agreements made with the Clinical Commissioning Groups which give a clearer understanding of the income position of the Trust. The Committee confirmed their understanding of the financial position for Month 1 of the 2013/14 financial year.
FINANCE REPORTS – ANNUAL ACCOUNTS ANALYTICAL REVIEW A paper was presented which provided an analysis and explanation of the movements between the 2011/12 and 2012/13 outturn financial positions along with the 2013/14 planned position. A short analysis of key performance indicators was also included within the report. It was felt that the analysis shows the need to strengthen understanding of the links between activity, income, expenditure and operational performance. The development of the Integrated Performance Report is a helpful start on this work The Committee noted the contents of the report.
FINANCE REPORTS – FINANCE RISK REGISTER The Risk Register which forms part of the Trust's Corporate Risk Register was presented. The Register was scrutinised in some detail and it was agreed that the Register should reflect both Finance and Performance Risks. The Committee noted the contents of the report.

SUMMARY OF KEY RISKS:

No key risks were identified**.**

RECOMMENDATION / DECISION REQUIRED:

The Board is asked to review and note the minutes of the Finance and Performance Committee meeting held on 28 May 2013.

IMPLICATIONS:

Financial:	
HR / Equality & Diversity:	
Governance:	
Legal:	

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST

REPORT TO THE TRUST BOARD: PUBLIC

31 July 2013

REVIEW:

Trust Standing Committee	Date	Trust Standing Committee	Date
Quality Governance Committee		Remuneration Committee	
Finance and Performance Committee		Executive Meeting	
Audit Committee			

DATA QUALITY:

Data/information Source:	
Data Quality Controls:	
Data Limitations:	

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST

REPORT TO THE TRUST BOARD: PUBLIC

31 July 2013

Subject:	**Foundation Trust Application Update**
Report By:	**Andrew Hardy Chief Executive Officer**
Author:	**Christine Emerton Foundation Trust Programme Director**
Accountable Executive Director:	**Andrew Hardy Chief Executive Officer**

GLOSSARY

Abbreviation	In Full
BAF	Board Assurance Framework
BGAF	Board Governance Assurance Framework
FT SC	Foundation Trust Steering Committee
HDD	Historic Due Diligence
IBP	Integrated Business plan
LTFM	Long Term Financial Model
NTDA	NHS Trust Development Authority
NED	Non-Executive Director
PWC	Price Waterhouse Cooper
SHA	Strategic Health Authority
QGAF	Quality Governance Assessment Framework
PPMO	Performance and Programme Management

WRITTEN REPORT (provided in addition to cover sheet)? ☒ **Yes** ☐ **No**

POWERPOINT PRESENTATION? ☐ **Yes** ☒ **No**

NB Presentations need to be submitted for inclusion in Board papers

Title	
Approx. Length	

PURPOSE OF THE REPORT / PRESENTATION:

To provide an update on the progress and timeline for the Foundation Trust status application and report on decisions made by the FT Steering Committee.

SUMMARY OF KEY ISSUES:

The FT Steering Committee and the Project Team met on 8th July 2013 to review the Master Action Plan and progress against the NTDA FT timeline. A summary of the actions completed since the last report to the Board is included in the attached Exception Report.

SUMMARY OF KEY RISKS:

UHCW NHS Trust is working towards an FT timeline for submitting an application to the Secretary of State in June 2015. The current risks impacting upon achievement of foundation trust status are:

- The maintaining national patient waiting times targets for 18 weeks and A&E.
- The action needed to achieve the financial requirements set out by Monitor.

RECOMMENDATION / DECISION REQUIRED:

The Trust Board are asked to **RECEIVE** and **ACCEPT** this report.

IMPLICATIONS:

Financial:	Financial performance this year. Importance of achievement of CIPs, work to increase predicted surplus and achieve financial assumptions for down-side scenarios.
HR / Equality & Diversity:	Recruitment and maintenance of a representative and diverse membership.
Governance:	Date for achieving Foundation Trust status.
Legal:	Legal constitution and completion of necessary assessment phases.

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST

REPORT TO THE TRUST BOARD: PUBLIC

31 July 2013

REVIEW:

Trust Standing Committee	Date	Trust Standing Committee	Date
Quality Governance Committee		Remuneration Committee	
Finance and Performance Committee		Executive Meeting	
Audit Committee			

DATA QUALITY:

Data/information Source:	
Data Quality Controls:	FT Steering Committee review 8th July 2013
Data Limitations:	

FOUNDATION TRUST PROJECT TEAM EXCEPTION REPORT

17th July for July Trust Board

Actions since last month:

Decisions made by the FT Steering Committee 8th July 2013

1. Integrated Business Plan

Section 7 covering Risk was reviewed by the FT SC and comments made on the contents. Significant work has been completed on this section to address the recommendations and feedback provided by the former Strategic Health Authority. The section now provides a clear and comprehensive description of the trust's risk management process, the Board Assurance Framework, high level risks, mitigations and impact of those risk on the organisation. In August Section 6 Finance will be reviewed by the FT SC and the content updated by the planning team, in preparation for review by the trust Board in September.

2. Monitor Consultations on draft guidance on Choice, Competition, Mergers and Acquisitions 26th June 2013.

In April 2013 Monitor issued new guidance for consultation on Choice, Competition, Mergers and Acquisitions. The consultation documents were circulated to FT SC for comment in May and a formal response was made on 26th June 2013. A copy of the response submitted is attached at Appendix 1.

3. NTDA Accountability Framework April 2013

In April 2013 the NTDA published a revised Accountability Framework, which included a new template for setting out the key milestones for achieving sustainability. Work has been undertaken by the FT Programme Manager and the NTDA Relationship Manager over the past month to align the FT timeline submitted in January, with this revised framework. The key milestone plan was completed and submitted to the NTDA on 20th June following review and agreement by the Chief Officers Group and the FT SC. A copy of the new template setting out the key milestones is attached for information at Appendix 2.

4. Other activities

Membership – FT membership stands at Public 8.953 and Staff 8,514 at the end of June 2013. The trusts original plan was to have 10,000 public members by September 2013. Achievement of this target is being reviewed by the Communications Team who will take over responsibility for FT membership management from August 2013.

Activities for coming month:

- **Planning and IBP –** Incorporate the outputs of the divisional planning seminar held on 17th July and review the IBP with the Director of Strategy once in post, by the end of August 2013.
- **Finance/LTFM –** Finalise the next iteration of the LTFM to include Q1 financial position and undertake a detailed review of the BGAF self assessment finance module.
- **Membership –** Pilot SMS messaging via NHS Mail to "gone away" addresses following recent data cleansing.

Risks:

- FT R 31 Current rate of FT authorisations low
- FT R 12 Financial compliance and failure to demonstrate stable financial footing for FT authorisation
- FT R 11 National targets and deterioration in A&E performance and 18 weeks referral to treatment.
- FT R 47 Quality Governance Framework assessment score of 3.5 well above Monitor QGF threshold.

Mitigations:
• Revised timeline submitted to the NTDA.
• The achievement of national performance targets for patient treatment continues to be a high priority for the trust. Initiatives implemented have succeeded in achievement of week on week performance of 95% for A&E 4 hour wait.
• A detailed review of the Quality Governance Framework has been completed with external support to identify areas of weakness and actions required. A detailed action plan is now being developed by the Governance Team following the Board review in June 2013. • PPMO process established to monitor delivery of CIP.

APPENDIX 2

Key milestones to achieve Sustainability – UHCW (without merger or acquisition) 20th June 2013

Date	Milestone	Status
Stage 1		
Mar 2012	SHA interviews with the board, SHA initial meeting with the commissioners	Completed
Mar 2012	BGAF self assessment completed	Completed
Aug 2012	Financial position review meeting to agree review process with UHCW CFO	Completed
Aug 2012	Board Seminar CIPs and financial plan	Completed
Nov 2012	First draft IBP/LTFM submitted	Completed
Nov 2012	TDA initial Board observation and feedback	Completed
Nov 2012	Evidence for HDD1 submitted to auditors	Completed
Dec 2012	TDA to establish clear baseline for Trust	Completed
Jan 2013	Set of milestones submitted to TDA	Completed
Stage 2		
Jan-Sep 2013	Implement improvements to financial controls and reporting, quality, risk and governance reporting and arrangements as per HDD1 recommendations	On going
Jan 2013	Implement measure to improve ED performance	On going
Feb/Mar 2013	Embed PMO CIP improvements across services with clinical leads	Completed
Feb 2013	Grant Thornton HDD1 report received by Board	Completed
Apr 2013	Second external QGF assessment completed and report received (PWC) by Board	Completed
Apr – Jun 2013	Complete more detailed market assessment	Completed
May 2013	Underpinning strategies; Estates, IT, Membership, Independent third party reports; BGAF, QGF HDD1	Completed
May 2013	1st QGAF self assessment report to Board/Seminar	Completed
June 2013	Action plan developed and lead officers identified	Completed
June 2013	Begin process to appoint to Chair and NED vacancies	In process
July 2013	LTFM reviewed by Board	
June 2013	Organisational Development Improvement Plan launched	In process
Aug/Sep 2013	Appoint to Chair and NED vacancies	In process
Aug 2013	Director of Strategy commences in post	In process
Sep 2013	Develop plans for improved efficiency/length of stay and bed occupancy	In process
Sep 2013	Board review of full IBP	On target
Sep 2013	Board review of progress and evidence of integrated care delivery service transformation	On target
Dec 2013	Two quarters sustainable ED performance achieved	On target
Dec 2013	2nd BGAF external validation/share report with TDA	
Dec 2013	University of Warwickshire's outputs for health economy wide 20 year model to inform baseline plan for next 5-10 years	On target
Jan-Mar 2014	BGAF action plan to be completed	On target
Jan 2014	QGAF must be completed by March 2014	On target
Jan 2014	Development of Public Consultation documents and support strategy	On target
Jan 2014	**TDA MD and ND will conduct a Clinical Quality Review**	**On target**
Jan 2014	Submit Public Consultation documents to Trust Board	
Jan 2014	Board Seminar on Care Quality/Quality Governance	
Feb 2014	**TDA to observe Board and Trust Board sub-committees – Finance and Quality Committee's**	
Feb 2014	IBP to Trust Board prior to submitting to TDA	
Feb 2014	Initial Board interviews	

Mar 2014	QGAF to be completed	
Mar 2014	Submit Public Consultation documents to TDA	
Mar 2014	CQC opinion received	
Mar 2014	Achieve Monitor FRR2	
Mar 2014	**Formal submission of FT application documents to TDA and preparation to inform TF readiness review meeting (includes TDA peer review)**	
Mar 2014	**Following readiness review the Trust will develop further iterations of key documents**	
End Mar 2014	Implement productivity improvements in length of stay and bed occupancy. Reduce occupancy .	
Apr 2014	Public Consultation commences	
Jun 2014	End Public Consultation	
July 2014	Outcome of Public Consultation to Board	
Aug 2014	**Delivery of FT action plans by the Trust with updates to the TDA**	
Sep 2014	**TDA readiness review meeting will be held with the Trust Board after the introductory meeting with Chair and CEO, Medical and Nursing Directors and FT Director**	
Nov 2014	**TDA agree to HDD2 commencing**	
Stage 3		
Jan 2015	**TDA Clinical Quality Review (2nd)**	
Mar 2015	Board Seminar on financial plans, risk assumptions, downsides, BGAF update and HDD2 update	
Mar 2015	Achieve Monitor FRR3	
Mar 2015	Board Seminar on final HDD2 and BGAF findings/action plan, Monitor financial assumptions (if new ones available) Mock B2B preparation	
Mar-Apr 2015	**TDA Interview with HDD2 lead reviewer, BGAF reviewer and QGF reviewer**	
Mar 2015	Board seminar on BGAF development modules, HDD 2 update and review of self certifications	
End Mar 2015	Achieve further improvements in productivity in occupancy and length of stay achieving occupancy rates	
Apr 2015	Final IBP/LTFM to Board (inc. work to model new Monitor financial assumptions)	
Apr 2015	Meet with TDA to lock down IBP and LTFM	
Apr 2015	Locked down IBP/LTFM to Board for information	
Apr 2015	**Trusts make final submissions of key products to inform TDA sign-off of FT application one month before final board to board meeting**	
Apr 2015	**TDA to review final assurance documents**	
Late Apr 2015	Financial Position Review meeting	
May 2015	**Interview with Commissioners (TDA)**	
Early May 2015	Board seminar on Governance rationale, members and governors and B2B preparation	
May 2015	TDA interviews with Commissioners	
May 2015	**Internal TDA Peer Review**	
June 2015	Board seminar on Quality Assurance visit preparation, Board to Board preparation on debrief (depending on timing)	
Early June 2015	**Board to Board meeting between TDA and NHS Trust**	
June 2015	**TDA Exec Team**	
End June 2015	**TDA Board**	

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST

REPORT TO THE TRUST BOARD: PUBLIC

31 JULY 2013

Subject:	West Midlands (South) Health Innovation and Education Cluster Report
Report By:	Meghana Pandit, Chief Medical Officer
Author:	Moosa Patel, Interim Director of Corporate Affairs
Accountable Executive Director:	Meghana Pandit, Chief Medical Officer

GLOSSARY

Abbreviation	In Full
WM(S) HIEC	West Midlands (South) Health Innovation & Education Cluster
AHSN	Academic Health Science Networks

WRITTEN REPORT (provided in addition to cover sheet)? ☐ **Yes** ☐ No

POWERPOINT PRESENTATION? ☐ Yes ☐ **No**
NB Presentations need to be submitted for inclusion in Board papers

Title	NA
Approx. Length	NA

PURPOSE OF THE REPORT / PRESENTATION:

The West Midlands (South) Health Innovation & Education Cluster (WM(S) HIEC) was established in 2010 with a budget of £1.9 million and a partnership comprising twelve NHS, third sector, university and private sector organisations, including UHCW. UHCW also hosted the staff employed within the WM(S) HIEC since its inception in 2010. The University of Warwick managed the budget for the WM(S) HIEC, on behalf of the organisations that comprised the WM(S) HIEC.

Professor Neil Johnson, Pro Dean Education at the Warwick Medical School, the University of Warwick chaired the WM(S) HIEC.

In April 2013 HIECs throughout the country have been replaced by a network of Academic Health Science Networks (AHSNs). The new West Midlands AHSN operates over the whole of the West Midlands region.

Of the two members of staff employed by the WM(S) HIEC, one member of staff secured a new role and the other was made redundant, with the costs being picked up through the WM(S) HIEC budget.

Attached to this Board paper, by way of background, is a short executive summary which highlights the work of the WM(S) HIEC.

The Board is asked to note the changes to the WM(S) HIEC and to also receive assurance that there are no ongoing financial, employment or residual liabilities for UHCW Trust as a result of its historic hosting of the WM(S) HIEC.

SUMMARY OF KEY ISSUES:

These changes and the due diligence exercise that underpinned the transfer process of staff and other assets and liabilities from the WM(S) HIEC to the West Midlands AHSN confirms that no financial, employment or residual liabilities remain upon UHCW NHS Trust from its historic hosting of the WM(S) HIEC.

A contingency fund of £108k has been held by The University of Warwick to cover potential redundancy liabilities for HIEC employed staff. This was reduced to potential liabilities of £80k when the HIEC Manager secured a new post in January 2013, leaving a residual balance of £28k from the original approved budget. The University of Warwick is currently holding a balance of c£351k HIEC funding. In January 2013 the HIEC Board approved the extension of the WM(S) HIEC Partnership Agreement to 30 September 2013 to provide the governance framework for this funding to be held at University of Warwick on their behalf, pending all final payments.

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST

REPORT TO THE TRUST BOARD: PUBLIC

31 JULY 2013

SUMMARY OF KEY RISKS:

None identified.

RECOMMENDATION / DECISION REQUIRED:

The Board is asked to **NOTE** the changes to the WM(S) HIEC and to also **RECEIVE ASSURANCE** that there is no ongoing financial, employment or residual liabilities for UHCW Trust as a result of its historic hosting of the WM(S) HIEC.

IMPLICATIONS:

Financial:	None identified
HR / Equality & Diversity:	None identified
Governance:	None identified
Legal:	None identified

REVIEW:

Trust Standing Committee	**Date**	**Trust Standing Committee**	**Date**
Quality Governance Committee	NA	Remuneration Committee	NA
Finance and Performance Committee	NA	Executive Meeting	NA
Audit Committee	NA		

DATA QUALITY:

Data/information Source:	None identified
Data Quality Controls:	None identified
Data Limitations:	None identified

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST

REPORT TO THE TRUST BOARD: PUBLIC

31 JULY 2013

West Midlands (South) Health Innovation and Education Cluster

Executive Summary

1. Origins and objectives

1.1 The West Midlands (South) Health Innovation & Education Cluster (WM(S) HIEC) was established in 2010 with a budget of £1.9 million and a partnership comprising twelve NHS, third sector, university and private sector organisations:

NHS Partners:
Birmingham and Solihull Mental Health NHS Foundation Trust
Coventry and Warwickshire Partnership NHS Trust
George Eliot Hospital NHS Trust
NHS Coventry
NHS Warwickshire
South Warwickshire NHS Foundation Trust
University Hospitals Coventry and Warwickshire NHS Trust

University Partners:
Coventry University
University of Warwick

Private Sector Partners:
GE Healthcare
Novo Nordisk LTD

Charitable Partner:
Myton Hospices

1.2 Its purpose was to provide high quality care and services by getting the benefits of research and innovation as quickly as possible to patients, and by strengthening the co-ordination of education and training.

1.3 Since 2010 WM(S) HIEC has funded 16 innovation projects covering a wide range of conditions from diabetes, dementia, cardiac care, COPD (chronic, obstructive, pulmonary disease), and stroke, to sexual and mental health. The projects were selected by the WM(S) HIEC Board as local priority areas and all were due to complete by spring 2013.

1.4 Projects have developed new clinical pathways, improved patient self management, trained healthcare staff, improved access to specialist facilities, and developed innovations to help improve awareness, change attitudes and lifestyle behaviours, and improve public health.

1.5 The projects were a mix of innovations developed in the West Midlands (South) area and those developed elsewhere but trialled and evaluated locally using WM(S) HIEC funding. Operationally WM(S) HIEC took an approach to innovation broadly similar to that which later emerged in *Innovation Health and Wealth* (DH, December 2011). This approach was intentionally more evolutionary rather than revolutionary.

2. WM(S) HIEC projects

2.1 The WM(S) HIEC projects were wide ranging, both in terms of conditions targeted and in what they were setting out to achieve. In some cases, such as the sexual health and dementia projects, they aimed to strengthen knowledge and change behaviours surrounding a particular condition. In others such as Ambulatory Care, Neonates and Youthspace the aim was to strengthen the professional healthcare response. Some projects developed their own e-based apps and solutions, others took solutions developed elsewhere and adapted and trialled them in the West Midlands (South) area.

2.2 Project leads have been very positive about WM(S) HIEC and the way it has worked with them over the past two years. Most praised the light touch but 'hands on' approach of WM(S) HIEC staff. The focus on cross sector projects, the emphasis on partnership working and the support that WM(S) HIEC was in most cases able to give to make new working relationships work smoothly, were key to its success.

2.3 Having the 'badge' of the WM(S) HIEC gave projects the credibility and profile to enable clinicians and other partners to justify involvement to their own organisations. For some, working with WM(S) HIEC was also a developmental experience, introducing them to new skills, partners and ways of working.

2.4 A key aim was to facilitate cross sector working and it was a cornerstone of WM(S) HIEC's approach that it would only fund collaborative projects. Whilst sometimes adding to the complexity of a project, this encouraged partners to work together and some project leads felt it gave them access to partners they would not otherwise have been able to reach, particularly in a clinical setting.

2.5 WM(S) HIEC correctly recognised that innovation requires an acceptance of risk, that some projects will not work out as hoped and that some may fail. Accordingly, the projects supported by WM(S) HIEC were by no means all 'safe bets'.

2.6 However, it is also important to recognise that many of the projects are only just beginning to realise their true potential. Some projects, such as Ambulatory Care, Neonates, Psychological Therapies and Heart Failure, Improving Mental Health Liaison Service (RAID), and Youthspace, are ongoing and project leads were able to demonstrate that their influence is continuing to spread. Because many of the projects are web-based, the tools available on their websites continue to be used and, as time goes on, further links to established sites such as NHS Local are being established. Other projects only ever intended to establish proof of concept. This they have done and there is now the potential for their work to be taken up and spread further.

3. Overcoming barriers

3.1 WM(S) HIEC added value to its core funding role because of its emphasis on partnership working, its positive relationships with projects and its flexible approach to funding.

3.2 WM(S) HIEC was seen to operate across an area with a 'natural geography' and a good balance of urban and rural, affluent and socially deprived areas, and with a spread of healthcare providers.

3.3 The lean operation of WM(S) HIEC was seen as strength. The organisation ran with a staff group of two – a Director and Manager. However, this group, with the active support of the Board, was an effective team. It was small enough to get to know the projects, keep up to date with their progress and to help sort out any difficulties.

4. Legacy and learning

4.1 WM(S) HIEC has built a strong network of local partner organisations and funded projects focused around a number of long standing local health priorities. It has successfully bridged organisational boundaries. Its projects have demonstrated improvements in clinical experience, self management of long term conditions, changes in attitude and behaviour amongst patients, carers and clinical staff and in public health. A number of the projects focused on the development and spread of e-health technologies.

4.2 WM(S) HIEC brought £1.9 million into the local health economy. Whilst small in relation to the total local healthcare budget, this £1.9 million was flexible money, able to be deployed as its Board directed. This funding, together with the WM(S) HIEC cohesive and well managed Board and team, has enabled it to pursue its task with considerable energy and enthusiasm.

4.3 There is some evidence that the organisation was unable to maintain its early strategic focus on the local healthcare economy as a whole, largely because of changes to NHS structures and funding, particularly during the time at which the WM(S) HIEC was becoming established.

4.4 The WM(S) HIEC Board has benefited from the involvement of its range of partners.

5. The future

5.1 Going forward, the West Midlands Academic Health Science Networks (AHSNs) will need to find ways to generate innovation in the areas most needed by the NHS and to develop projects that will be genuinely cost saving in the longer run.

5.2 WM(S) HIEC leaves a legacy of genuinely collaborative working, with perhaps a greater mutual respect between academic, clinical and private sector innovators. It has produced solid achievements through its 16 projects aimed at tackling longstanding local healthcare priorities. It leaves a legacy of successful projects, some with a secure and growing future, some that will need further support to scale their innovations, some that have proved what they set out to demonstrate and will add to the sum of knowledge about ‘what works’ and why in the NHS.

5.3 Perhaps more importantly, WM(S) HIEC leaves a network of academic and clinical specialists who have begun to appreciate the benefits of working together and the ways in which knowledge, skills and contacts can be brought together to develop innovation further in the NHS.

5.4 A full copy of the report “Spreading Innovation in the Local Healthcare Economy: Evaluation of the Impact of the West Midlands (South) Health Innovation & Education Cluster” (April 2013) is available upon request from the Interim Director of Corporate Affairs

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST

REPORT TO THE TRUST BOARD: PUBLIC

31ST JULY 2013

Subject:	Review of Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation
Report By:	Mrs G Nolan, Chief Finance Officer
Author:	Mr A Jones, Associate Director of Finance – Corporate Services
Accountable Executive Director:	Mrs G Nolan, Chief Finance Officer

GLOSSARY

Abbreviation	In Full
SOs	Standing Orders
SFIs	Standing Financial Instructions
SoRD	Scheme of Reservation and Delegation
SHA	Strategic Health Authority
PCT	Primary Care Trust
NTDA	NHS Trust Development Authority
CCG	Clinical Commissioning Group
NCB	NHS Commissioning Board

WRITTEN REPORT (provided in addition to cover sheet)? ☒ **Yes** ☐ **No**

POWERPOINT PRESENTATION? ☐ **Yes** ☒ **No**
NB Presentations need to be submitted for inclusion in Board papers

Title	
Approx. Length	

PURPOSE OF THE REPORT / PRESENTATION:

To seek approval from the Trust Board for revisions to Standing Orders (SOs), Standing Financial Instructions (SFIs) and the Scheme of Reservation and Delegation (SoRD).

SUMMARY OF KEY ISSUES:

Changes are required to SOs, SFIs and the SoRD for the following reasons:

1. Changes in the names of job titles and the creation of new posts;
2. Delegation of responsibility to other officers (not specified in the SoRD) and/or deputies;
3. Variation of delegated limits in the SoRD; and
4. References to new or defunct posts, committees, bodies or organisations.

The proposed changes (with one exception noted below) were reviewed by the Audit Committee at its meeting on 8th July 2013. The Audit Committee supported the proposed changes and recommended that they should be submitted to the Trust Board for formal approval.

The proposed change not incorporated in the report to the Audit Committee relates to the changes imposed by the NHS Trust Development Authority (in its recent "Capital Regime and Investment Business Case Approvals Guidance") in connection with delegated capital limits over which the Trust has no direct control (detailed in section 3 of the report).

SUMMARY OF KEY RISKS:

None identified.

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST

REPORT TO THE TRUST BOARD: PUBLIC

31ST JULY 2013

RECOMMENDATION / DECISION REQUIRED:

The Trust Board is asked to formally approve the proposed changes to Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation (as recommended by the Audit Committee).

IMPLICATIONS:

Financial:	None identified
HR / Equality & Diversity:	None identified
Governance:	It is important to review the Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation on a regular basis and amend them appropriately as a result of the review. SOs/SFIs/SoRD provides a comprehensive regulatory framework for the business conduct of the Trust. They protect the Trust's interests and provide guidance (and protection) to staff when conducting business on behalf of the Trust.
Legal:	None identified

REVIEW:

Trust Standing Committee	**Date**	**Trust Standing Committee**	**Date**
Quality Governance Committee		Remuneration Committee	
Finance and Performance Committee		Executive Meeting	
Audit Committee	8-Jul-13		

DATA QUALITY:

Data/information Source:	
Data Quality Controls:	
Data Limitations:	

University Hospitals Coventry and Warwickshire NHS Trust

Review of Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation

Report to Trust Board 31st July 2013

1. Introduction

It is good practice to review the Trust's Standing Orders (SOs), Standing Financial Instructions (SFIs) and the Scheme of Reservation and Delegation (SoRD) at least annually. This review has given rise to a number of proposed amendments which are set out in this report, along with a rationale for the change.

The Trust's Audit Committee has reviewed the proposed changes (with one exception noted below) and recommended that they should be submitted to the Trust Board for formal approval.

The proposed change not incorporated in the report to the Audit Committee relates to the changes imposed by the NHS Trust Development Authority (in its recent "Capital Regime and Investment Business Case Approvals Guidance") in connection with delegated capital limits over which the Trust has no direct control (detailed in section 3 below).

2. Rationale for Changes

The changes proposed for SOs, SFIs and the SoRD are related to the following four key issues:

1. Changes in the names of job titles and the creation of new posts;
2. Delegation of responsibility to other officers (not specified in the SoRD) and/or deputies;
3. Variation of delegated limits in the SoRD; and
4. References to new or defunct posts, committees, bodies or organisations.

Changes to Job Titles/New Posts

In common with most other organisations, changes to structures, post titles and the creation of new posts (or even the removal of posts) could mean that the SoRD can quickly become out of date. Whilst in the past, the Trust has operated within the "spirit" of the SoRD and applied authorisation levels to officers based upon "best fit", this issue has been exacerbated by the change (in May 2012) to a more restricted SoRD which specifically allocates authorisation levels to specified officers.

In order to rectify this and to formalise the authorities provided under the SoRD, it is proposed to incorporate a general provision in the SoRD to allow interpretation by the Chief Executive Officer, Chief Finance Officer, Deputy Chief Finance Officer or Associate Director of Finance to apply authorisation limits to officers not specifically identified in the SoRD.

Delegation of Responsibility

In some instances it is not practical for all functions to be undertaken personally by the officers authorised in the SoRD – examples of such circumstances include:

- Transactions which have to be approved outside normal working hours and are undertaken by officers acting on behalf of or deputising for the authorised officer;
- Urgent transactions which need to be approved in the absence of authorised officers; or
- Transactions which are so voluminous that it is impractical for the authorised officer to personally authorise them.

Whilst current operational practices include delegation of responsibility which are deemed to be within the "spirit" of the SoRD, they are not specifically covered by the authorities set out in that document.

Therefore, in order to accommodate the appropriate delegation of responsibility, is proposed to include a general provision in the SoRD to allow authorised officers to delegate responsibility (but not accountability) to authorise transactions on their behalf subject to such delegated authority being formally recorded and approved by the Chief Executive Officer, Chief Finance Officer, Deputy Chief Finance Officer or Associate Director of Finance. Such delegation of responsibility will only be permissible where appropriate controls and assurances are in place to ensure that the authorised officer effectively maintains accountability.

Variation of Authorised Limits

From time to time additional restrictions on levels of delegated authority are imposed by the Chief Executive Officer and the Chief Officers' Group, but the status of such restrictions is not formally acknowledged in the SoRD.

It is proposed therefore, to include a general provision in the SoRD to allow the Chief Executive Officer and the Chief Finance Officer to approve temporary restrictions to authorised limits and that they shall have effect as if they were incorporated in the SoRD.

References to New or Defunct Posts, Committees, Bodies and Organisations

References in SOs, SFIs and the SoRD to the following need to be amended, removed or added as appropriate:

- Defunct Organisations:
    - Strategic Health Authorities (SHAs); and
    - Primary Care Trusts (PCTs).
- Removed Posts:
    - Chief Nurse and Operating Officer (CNOO); and
    - Chief Marketing Officer.
- New Post:
    - Deputy Chief Finance Officer.

Section 3 of this report identifies the specific changes requested in relation these issues.

3. Changes to SOs; SFIs; and SoRD

The following changes to SOs, SFIs and the SoRD are proposed:

Existing Reference for Deletion or Amendment	Revised or New Reference	Section of SOs, SFIs or the SoRD to be Changed
Strategic Health Authority (SHA)	NHS Trust Development Authority (NTDA)	4.2 (i) Joint Committees Reference to the SHA 5.1.2 (ii) & (iv) Delegation of functions to Committees, Officers or other bodies Reference to the SHA should be amended to the NTDA SoRD – Derived from Accountable Officer Memorandum Reference to the SHA in reporting issues of probity/irregularity should be replaced with the NTDA. Reference to the Chief Executive Officer reporting issues of concern to the SHA relating to the Trust Board over-riding his/her advice should be replaced with the NTDA. SoRD – Schedule of Financial Limits Reference to the SHA in respect of

Existing Reference for Deletion or Amendment	Revised or New Reference	Section of SOs, SFIs or the SoRD to be Changed
		delegated capital limits should be replaced by the NTDA. 23.3.1 Financial Framework Reference to the SHA should be replaced by the NTDA
Primary Care Trust (PCT)	Clinical Commissioning Group (CCG) and/or NHS Commissioning Board (NCB)	5.1.2 (ii) (iii) & (iv) Delegation of functions to Committees, Officers or other bodies Reference to PCTs should be amended to CCGs and the NCB 18.1.1 Service Level Agreements Reference to PCTs should be amended to CCGs 19 Commissioning Reference to the model SFIs for PCTs should be amended to CCGs and the NCB
Chief Nurse and Operating Officer (CNOO)	Chief Nursing Officer (CNO) and/or Chief Operating Officer (COO)	2.1 (3) Composition of the Trust Board Replace reference to CNOO with two posts: CNO and COO 26.1.3 Condemnations - value above which disposal is to be by an authorised officer and register entries made Replace references to CNOO in the SoRD and SFIs to COO (in respect of condemnations of furniture, fittings and hotel services
Chief Marketing Officer		2.1 (3) Composition of the Trust Board Remove reference to post which no longer exists
	Deputy Chief Finance Officer	SoRD – Schedule of Financial Limits All references to Associate Director of Finance should also include reference to the new post of Deputy Chief Finance Officer who will have the same authorisation limits as the Associate Director of Finance
Limit for the authorisation of business cases: Capital • Trust Board (if Trust in deficit) - £1,000,000 • Trust Board (if Trust in surplus) - £3,000,000 • SHA - £35,000,000	Limit for the authorisation of business cases: Capital • Trust Board (if Trust in deficit) - £500,000* • Trust Board (if Trust in surplus) – lower of £5,000,000 or 3% of turnover* • NTDA - £50,000,000 ** Where the Trust has recorded a deficit in its most recent audited accounts, or has an in-year deficit or forecast deficit in the current year, the NTDA has discretion to apply the lower limit (if the lower limit is applied the NTDA will notify the Trust in writing)*	SoRD – Schedule of Financial Limits Business case delegated limits (amended to reflect the NHS Trust Development Authority Capital Regime and Investment Business Case Approvals Guidance for NHS Trusts)

The following new section is proposed to be added at the end of the SoRD to address the issues of changes in titles, delegation of responsibility and variation of limits (note that point 1 below is already incorporated in the SoRD but will be moved under this revised heading:

Application/Interpretation of the Scheme of Reservation and Delegation

1. The Chief Finance Officer will maintain an Authorised Signatory List specifying individual officer limits – this list shall have effect as if incorporated in this Scheme of Reservation and Delegation.

2. Where the Trust makes changes to job titles, creates new posts; removes posts or changes roles/responsibility of posts, the Chief Executive Officer, Chief Finance Officer, Deputy Chief Finance Officer or Associate Director of Finance will interpret this Scheme of Reservation and Delegation to apply authorisation limits to officers not specifically identified in the Scheme of Reservation and Delegation. Such interpretation will be formally recorded in the Authorised Signatory List (see 1 above).

3. In exceptional circumstances, authorised officers may wish to delegate responsibility (but not accountability) to authorise transactions on their behalf. Such delegated authority must be formally recorded (in a form approved by the Chief Finance Officer) and be approved by the Chief Executive Officer, Chief Finance Officer, Deputy Chief Finance Officer or Associate Director of Finance. Such delegation of responsibility will only be permissible where appropriate controls and assurances are in place to ensure that the authorised officer effectively maintains accountability. Examples of circumstances under which delegation of responsibility may be appropriate include:
    - Transactions which have to be approved outside normal working hours and are undertaken by officers acting on behalf of or deputising for the authorised officer;
    - Urgent transactions which need to be approved in the absence of authorised officers; or
    - Transactions which are so voluminous that it is impractical for the authorised officer to personally authorise them.

4. From time to time additional restrictions on levels of delegated authority may be imposed by the Chief Executive Officer and the Chief Officers' Group. Where such restrictions are imposed, they will be formally approved and communicated by the Chief Executive Officer and the Chief Finance Officer and shall have effect as if incorporated in this Scheme of Delegation.

4. Recommendation

The Trust Board is asked to formally approve the proposed changes to Standing Orders, Standing Financial Instructions and the Scheme of Reservation and Delegation (as recommended by the Audit Committee).