University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD MEETING TO BE HELD AT ON THURSDAY 28 JANUARY 2016 AT 10.00 AM IN ROOM 10009/11, CLINICAL SCIENCES BUILDING, UNIVERSITY HOSPITALS COVENTRY& WARWICKSHIRE, CV2 2DX

PUBLIC BOARD AGENDA

ITEM	TITLE	BOARD ACTION	PAPER	TIME
Standing Items				
1.	**Apologies for Absence** Chairman			
2.	**Declarations of Interest** Chairman	For Assurance	Verbal	
3.	**Minutes of Public Board Meeting held on the 17 December 2015** Chairman	For Approval	Enclosure 1	
4.	**Matters Arising** Chairman	For Assurance	Verbal	
5.	**Trust Board Action Matrix** Chairman	For Approval	Enclosure 2	
Business Items				
6.	**Chairman's Report** Chairman	For Assurance	Enclosure 3	5
7.	**Chief Executive's Report** Chief Executive Officer	For Assurance	Enclosure 4	5
Performance				
8.	**Integrated Quality, Performance and Finance Monthly Report** Chief Workforce & Information Officer	For Assurance	Enclosure 5	15
9.	**Trust Development Agency Oversight Monthly Self-Certification Requirements** Chief Finance & Strategy Officer	For Approval	Enclosure 6	5
Patient Quality and Safety				
10.	**Care Quality Commission Action Plan** Chief Medical & Quality Officer/ Chief Nursing Officer	For Assurance	Enclosure 7	10
11.	**Board Assurance Framework Quarter 3 Report** Chief Medical & Quality Officer	For Approval	Enclosure 8	10
12.	**Corporate Risk Register Quarterly Report** Chief Medical & Quality Officer	For Approval	Enclosure 9	10
13.	**Infection Control Quarterly Report** Chief Nursing Officer	For Assurance	Enclosure 10	10
14.	**Patient Experience Quarterly Report**	For Assurance	Enclosure 11	10

ITEM	TITLE	BOARD ACTION	PAPER	TIME
	Chief Medical & Quality Officer			
15.	**Emergency Care Pathway (Winter Plan update)** Chief Operating Officer	For Assurance	Enclosure 12	10
16.	**NHS Preparedness for a Major Incident** Chief Operating Officer	For Assurance	Enclosure 13	10
17.	**Cancer Services Operational Policy** Chief Operating Officer	For Approval	Enclosure 14	10
Strategy				
	No reports			
Research and Innovation				
	No reports			
Regulatory, Compliance and Corporate Governance				
18.	**Fit and Proper Persons Test Annual Declaration** Chairman	For Assurance	Enclosure 15	10
Feedback from Key Meetings				
19.	**Private Trust Board Meeting Session Report of 17th December 2015** Chairman	For Assurance	Enclosure 16	5
20.	**Quality Governance Committee Meeting Report of 18th January 2016** Chair, Quality Governance Committee	For Assurance	Enclosure 17	5
21.	**Finance and Performance Committee Meeting Monthly Report of 11th January 2016** Chair, Finance & Performance Committee	For Assurance	Enclosure 18	5
22.	**Audit Committee Meeting Report of 14th December 2015** Chair, Audit Committee	For Assurance	Enclosure 19	5
23.	**Any Other Business**			
24.	**Questions from Members of the Public Relating to Agenda Items**			
25.	**Date of Next Meeting:** **The next meeting of the Trust Board will take place on Thursday 25 February 2016 at 10.00 am, University Hospitals Coventry and Warwickshire**			

Resolution of Items to be Heard in Private (Chairman)

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.

MINUTES OF A PUBLIC MEETING OF THE TRUST BOARD OF UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST HELD ON THURSDAY 17 DECEMBER 2015 AT 10.00 AM IN ROOM 10009/11 OF THE CLINICAL SCIENCES BUILDING, UNIVERSITY HOSPITAL, COVENTRY

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HTB 15/955 **PRESENT**

Mrs B Beal, Non-Executive Director (BB)
Mr I Buckley, Vice Chair (IB)
Mr D Eltringham, Chief Operating Officer (DE)
Mr A Hardy, Chief Executive Officer (AH)
Mr E Macalister-Smith, Non-Executive Director (EMS)
Mrs K Martin, Chief Workforce and Information Officer (KM)
Mr A Meehan, **Chairman** (AM)
Mr D Moon, Chief Finance & Strategy Officer (DM)
Professor M Pandit, Chief Medical & Quality Officer/Deputy Chief Executive Officer (MP)
Mr D Poynton, Non-Executive Director (DP)
Professor M Radford, Chief Nursing Officer (MR)
Mrs B Sheils, Non-Executive Director (BS)
Professor P Winstanley, Non-Executive Director (PW)

IN ATTENDANCE

Mrs P Young, Corporate Secretary (PY) – note taker

HTB 15/956 **APOLOGIES FOR ABSENCE**

Mrs R Southall, Director of Corporate Affairs (RS)

HTB 15/957 **DECLARATIONS OF INTEREST**

There were no conflicts of interest declared.

HTB 15/958 **MINUTES OF TRUST BOARD MEETING HELD ON 26 NOVEMBER 2015**

PW observed that the third paragraph on page 10 should read 'PW observed a step change in the last five years in terms of the quality of research and emphasised the University's commitment to partnership working'

PW observed that the first line of paragraph three on page 11 should read 'PW observed that the work of Research, Development and Innovation Team had increased attendance at the Trust's Grand Round'

The minutes were **APPROVED** by the Trust Board as a true and accurate record of the meeting, subject to the above amendments.

HTB 15/959 **MATTERS ARISING**

There were no matters arising that were not on the action matrix or the agenda.

HTB 15/960 **TRUST BOARD ACTION MATRIX**

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HTB/15/916 – It was noted that the Board Assurance Framework (BAF) was reviewed at the Audit Committee on 14th December 2015 and a broader issue in terms of identifying gaps in controls and making the descriptions richer, is being addressed. DE assured that the narrative around the specific risk relating to bed occupancy has been reviewed and amended accordingly and as such this action is now closed.

HTB/15/917 – KM assured that improvements to external communication around performance of the Trust continue as an ongoing programme of work and as such this action is now closed.

MP confirmed that she would address the gaps in controls in relation to the mortality risk outside of the meeting.

EMS reflected on the discussions at Audit Committee and emphasised that gaps in controls must be discernible gaps and not a description of the risk.

The Trust Board **NOTED** the items in progress and **APPROVED** the removal of those actions marked as complete.

HTB 15/961 **CHAIRMAN'S REPORT**

The Chairman presented the report and expressed his delight following a recent visit to Downing Street at a reception hosted by Lord Carter of Coles for the cohort of 32 Trusts that have been closely engaged with him. This was both in recognition of the contribution made in terms of helping the NHS drive productivity and efficiency improvements and to discuss how momentum can be maintained. He gave a brief overview of the discussions held including opportunities for better coding, for taking cost out and for increased productivity. DM advised that a recent visit from Lord Cater to the Trust proved very insightful and a further visit will be taking place in the New Year to agree a savings target. He added that the work arising out of the Lord Carter review will inform a more robust approach to the development of cost improvement programmes in provider organisations going forward. He further added that the review revealed that there is no one single action that will improve productivity but there are benefits to using comparative data to help identify opportunities for improvement and an adjusted treatment index (ATI) metric has been developed for this purpose.

In response to a query from BS in relation to whether any of the cohort of providers will work directly with each other; DM advised that there are some sub-streams of work already in place, including pathology, radiology and procurement. He added that University Hospitals Coventry and Warwickshire NHS Trust (UHCW) were ahead of the curve in terms of procurement. MR added that the nursing sub-group networks, including the Enhanced Observational Care Teams are also working well.

DP praised the work being undertaken by Lord Carter and emphasised that providers should be compelled to see this as a driver to increased productivity and not merely advisory.

In response to a query from the Chairman; DM assured that the Lord Carter review complements the ongoing programme of development the Trust has

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recently embarked upon with the Virginia Mason Institute.

IB observed that there has been much recent debate around reference costs and cautioned that the Trust must not allow this to obstruct the vision for the future and plans to get there; AH concurred with this. DM acknowledged this and added that this does raise the question around service line reporting. The Chairman added that the key will be the reporting template, which each provider will be compelled to adopt and may result in organisations looking at different ways of analysing data in the future.

The Trust Board **RECEIVED ASSURANCE** from the Chairman's report.

HTB 15/962 **CHIEF EXECUTIVE OFFICERS REPORT**

AH observed that he had attended the civic funeral for the Councillor Philip Townshend and former Chairman of UHCW on 9th November 2015.

AH provided an overview of his presentation to the Coventry Health and Wellbeing Board in relation to exploring accountable care organisations for Coventry, which was well received and a workshop has been arranged for 20th January 2016 to further focus on this.

AH appraised the Board of a recent NHS Leaders meeting with Jim Mackey, Chief Executive for NHS Improvement and Simon Stevens, Chief Executive of NHS England on 4th December 2015 focusing on planning for 2016/17 and beyond. The meeting was attended by NHS provider Chief Executives and Clinical Commissioning Accountable Officers, and a clear message of realism and stark realities was delivered. He added that the NHS is now working to two timeframes; 31st March 2015 and the future. Tackling the overspend is critical and organisations have been charged with several "must do's", the first being to address the financial position by 31st March 2015. He emphasised that the NHS cannot afford to breach the forecast deficit of £1.8b, and to do so would significantly impact upon financial allocations, which will be set for the initial three years with indicative allocations for years four and five. The second "must do" relates to constitutional rights that must be delivered; such as referral to treatment time (RTT) incomplete pathways, cancer 62-day targets and mental health, a third "must do" is tackling childhood obesity.

In addition "should do's" for 2016/17 include achieving financial stability, a review of cancer services and a similar report in relation to Mental Health, which will shape mental health services going forward.

AH advised that there was a clear message that Spring presents a window of opportunity for Local Health Economies (LHE) to review what the LHE should look like. This aligns with two significant pieces of work in relation to an accountable care organisation for Coventry as outlined earlier and continuing collaboration of services with George Eliot Hospital (GEH). Plans are underway for the Chief Executive Officers and Chairs of both GEH and UHCW to meet in January to progress discussions further.

DP emphasised that the message from the Department of Health has been very clear that should the NHS be in breach of the £1.8b deficit forecast, this will impact on next year's allocation and it is therefore, vital that this is achieved and

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urged that focus is maintained in order to keep the foot on the accelerator.

EMS concurred with DP and observed that the work around the Lord Carter review is based on the assumption that the Trust achieves a mean position and compelled the board to aspire to be in the top quartile. He added that there is a conversation to be had beyond GEH and that it would be useful to understand what else is happening with other provider organisations within the wider LHE.

Discussion ensued in relation to combined authorities and AH observed that there is a disparity in the provision of mental health within the West Midlands and the ambition is to create a combined authority, in order to address this.

AH proceeded to provide an update of progress in relation to the development programme with the Virginia Mason Institute (VMI); advising that a Guiding Board chaired by AH was held earlier in the week. He added that the programme is moving as fast as the process allows and whilst the pace appears slow, this is deliberate.

As part of the programme, the Trust has identified three value streams, the focus of which is delivery of patient centred care. The first value stream will focus on point of referral to consultant appointment in Ophthalmology, which commenced earlier this month and will be followed by a rapid improvement event. It was noted that MR is Executive Sponsor for this value stream and the key performance metrics identified are quality, service delivery, eliminating waste and staff empowerment. Two further value streams will commence in the Spring of 2016, which will focus on incident reporting and theatres.

AH proceeded to provide an overview of the VMI infrastructure noting that the three Kaizen Promotion Office Specialists (KPO's) have been appointed and will support the Executive Guiding Team through delivery of the five year development programme. He emphasised that whilst the VMI method and approach will take primacy, Chief Officers are cognisant of the need to balance messages to promote the inevitable cultural change which will take time. He added that the Trust is keen for the VMI and Service Improvement Teams to work closely together, in order that they deliver one common message throughout the organisation. VMI, Service Improvement and indeed the work from the Lord Carter review all sit under the banner of the Together Towards World Class (TTWC) agenda with the VMI system providing a series of tools that underpin the delivery of TTWC.

Discussion turned to the mechanisms for weekly reporting and AH advised that weekly report outs will be delivered each Friday at 12.15-12.45pm in the lecture theatre before the Grand Round. Furthermore electronic reporting boards will be located prime of place on the 1st floor corridor opposite Wards 10 and 11 from January 2016.

Interviews are to take place on Monday to appoint a Medical Lead for Transformation and a key component of the VMI work are compacts, which serve to ensure alignment with a shared vision. Amicus originated the idea of compacts and as part of the development programme, the Trust Development Authority negotiated time for UHCW to spend with Amicus. It was noted that four of the five organisations selected to embark on the VMI development programme have accepted this. He observed that each of the five organisations are going at

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different paces and acknowledged the need to learn from each other; which is already happening at KPO level. UHCW is keen to embrace this further and has suggested an event to bring together the Executive Guiding Teams and TDA in the Spring of 2016, which has been accepted and coincides with a visit to the United Kingdom from Gary Kaplan, Chair and Chief Executive Officer of VMI. This is likely to take place in either Coventry or London and is likely to attract ministerial interest.

IB queried how Chief Officers will align existing objectives with the "must do's" delivered at the recent NHS leaders event and stop silo working to ensure that priorities are joined-up. AH acknowledged that it is essential that there is primacy of one system, and the VMI approach presents a unique opportunity to deliver this under the banner of TTWC, but also aimed at achieving delivery of objectives such as RTT. He added that VMI provide a set of tools to achieve increased daily efficiency; complementing the work arising from the Lord Carter review to focus on increased productivity. BS concurred with IB and emphasised the need for one common language and joined-up messaging. AH acknowledged this and assured that Chief Officers have considered this carefully and on reflection, believe that it is essential that the Trust adopts the VMI terminology which, whilst not that broad, is an important part of changing the culture, essential to embedding the programme. Furthermore. the Trust will be closely monitored by the TDA in this regard.

In response to a query from IB regarding the consequences for the Trust should it fail to achieve access targets whilst embarking on the VMI programme; AH advised that as part of the programme the Trust and the TDA will sign-off a compact and included as part of that is behaviours and expectations as a provider and regulator.

EMS reflected upon adoption of the VMI approach and the attention this will attract both internally and from external regulators, and the need to demonstrate fidelity to the system will be a huge organisational development piece of work for the Trust, that will also impact on the way Board and Committees agendas are structured.

The Trust Board **RECEIVED ASSURANCE** from the report.

HTB 15/963 **PERFORMANCE UPDATE**

DE appraised the Board of the current performance position; observing that following a period of sustained achievement of the A&E 4-hour standard the Trust has now moved into more trying times as the winter period draws in, with performance of around 90%, which is an improvement on the same time last year. Attendance has increased and a downturn in discharges related to a combination of internal decision making and medically fit for discharge delayed transfers of care (DTOC), is significantly impacting on patient flow.

In terms of planning for the Christmas period, a national directive to make provision for 20% of free bed stock (240 beds) by 23rd December 2015 is presenting an enormous challenge for the organisation.

A recent visit undertaken as part of the Emergency Care Improvement

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Programme, advised that the Trust should continue to focus on FREED metrics and the frail elderly patient pathway, in order to achieve the standard. DE advised that he will be taking a more front and centre role to empower the internal changes needed to support the pathway.

BB observed the tremendous work undertaken this time last year by the Operations Team in anticipation of the challenges that Christmas and New Year present yet despite this, external influences impacted negatively on patient flow. BB queried whether the TDA were cognisant of this and DE advised that the TDA understand the challenges faced by the Trust but their job is to drive the Trust as hard as possible to deliver; the correct approach is to turn a collective problem into something that is more tangible, with focus being sufficient provision of primary care.

EMS expressed concern that there was a lack of primary care provision between Christmas Eve and the New Year, which will inevitably impact on emergency services within secondary care. AH concurred with this and advised that the Trust has raised concerns with both NHS England and the TDA in relation to the Urgent Care Centre located within Coventry City Centre.

DE reported that revised RTT and Cancer 62-day wait recovery trajectories, which extended to 31st March 2016, were signed-off at the Systems Resilience Group last week. He added that the Trust did seek a recovery trajectory beyond March, which was considered unacceptable by regulators who delivered a clear message that there is no room for failure with the revised trajectory. He cautioned that risk lies within the bed holding requirement and internally, specialty level recovery trajectories have been set which the Executive Team will be monitoring progress against on a monthly basis.

Chief Officers **RECEIVED ASSURANCE** from the verbal update.

HTB 15/964 **TRUST DEVELOPMENT AGENCY OVERSIGHT MONTHLY SELF-CERTIFICATION REQUIRMENTS NOVEMBER 2015**

DM presented the report confirming that all of the board statements on the self-certification requirement had been met.

The Trust Board **NOTED** the November submission against the Board and Licence requirements and **APPROVED** submission to the TDA.

HTB 15/965 **PATIENT STORY (YOU SAID WE DID CAMPAIGN)**

MP presented the bi-annual ‘You Said, We Did’ report ,detailing recent actions the Trust has taken after listening to user feedback.

MP emphasised the significance that the Trust places on turning listening into action, demonstrating commitment to acting on user feedback and changing or enhancing systems,processes or environments that will deliver a better patient experience. This aligns with the Trust’s vision of being a national and international leader in healthcare and delivering a world class patient experience.

MP advised that whilst the current report does not include information around user

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feedback where no action had been taken and the mitigation that supports this, which will be considered in future reports.

The Chairman drew attention to feedback in relation to food menus available to patients and observed that despite the extensive menus and choice, this continues to attract negative feedback and requested that this be looked at in greater detail. MR confirmed that a programme of work was undertaken and implemented in the Spring but agreed to review why this was still not meeting the standard expected. **MR**

The Trust Board:-

NOTED the actions taken by staff as result of listening to user feedback and **REQUESTED** that the bi-annual 'You Said We Did Campaign' updates feature separately to the Patient Story Programme, which are to be presented each month to Trust Board going forward. **MP**

HTB 15/966 **SAFER STAFFING**

MR presented the report to update the Board on the standards relating to Safer Staffing and noted that it had provoked solid debate at Quality Governance Committee earlier in the month.

UHCW has taken a systematic approach to staffing wards and services safely over the past two years following the release of the National Quality Board standards in 2013 and National Institute for Health Care Excellence (NICE) Safe staffing guideline in 2014. A full and comprehensive assessment and gap analysis is conducted within UHCW twice yearly and presented to Trust Board.

The latest communication in October 2015 from Monitor, TDA, NHS England, CQC and NICE recommends that providers take a rounded view of staffing and that they should be able to demonstrate that they are able to ensure safe quality care for patients making the best use of resources available. They advocate that a 1:8 ratio is a guide not a requirement, and should not be unthinkingly adhered to.

Acuity and dependency data has been collected twice yearly by UHCW since 2006. The 'Safer Nursing Care Tool' (SNCT) is used, which was re-launched in 2013. This is an evidenced based tool kit, which was endorsed by NICE in October 2014 and linked to its guidance on safe staffing for nursing in acute hospitals.

This tool enables the measurement of both acuity and dependency, which can be applied to patients whose care can be delivered within a general ward setting. A multiplier for calculating establishments will suggest nursing whole time equivalents (WTE) required to provide a safe and appropriate standard of care for each of the five levels of acuity and dependency identified by the SNCT. Also measured are Nurse Sensitive Indicators (NSIs); these are quality indicators, which can be influenced by nursing establishments and skill-mix.

Applying the multipliers to the data collected, the differential between funded establishments and suggested establishments are calculated and demonstrate the overall pattern of 'over' and 'under' established wards, both as WTE and percentages using the 'SNCT' with the new care definitions and revised

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multipliers. It is accepted that being within 10% of the WTE suggested in the SNCT multiplier is within reasonable limits.

Using this as an indicator and according to the 'SNCT' in terms of WTE, there are three wards suggested to be 'over' established or above the agreed parameters ward 20, 22ECU and Cedar ward. Ward 35 is suggested to be 'under' established or below the agreed parameters. Conversely the position of the wards change when presented as a percentage difference between funded and suggested establishments.

Acuity and dependency analysis has taken place for the second time in the acute assessments units. 'SafeCare' is an acuity and dependency module that works in conjunction with the electronic roster and the roll out of its use commenced in October. This has involved a deep dive and an evaluation of templates used on each ward/department for electronic rosters. Nurses will input a patient census twice daily, which will provide a more accurate picture of exactly what staff and skills mix are on each ward at any given time and how this relates to patient needs.

Acuity and dependency is an important element to take into consideration when analysing safe staffing; however, the amount of time staff spend delivering direct patient care is paramount. 'A Guide to Care Contact Time' was published by NHS England in November 2014 and is a method used to determine the percentage of time nurses spend delivering direct patient care. MR advised that whilst data demonstrates that UHCW would appear better than those of Australia and Sterling (Scotland), there is room for improvement in comparison to Virginia Mason.

MR drew attention to the pie charts on page seven of the report and advised that the time spent administering medication is substantially higher than expected and whilst this demonstrates safe practice, it is not an efficient use of nursing time; work is underway with Pharmacy to understand how this can be improved.

MR advised that better utilisation of e-handover will reduce the burden of time taken for shift handover and will improve efficiency.

MR went on to emphasise that care is not delivered in isolation but as part of a multi-professional team. The current process does not take into account other professions which also provide direct care to patients such as therapists. As a result the care contact team are working in partnership with ICT to build an app, which will create an electronic solution to data collection and reporting, making the process more rigorous and timely. At the same time codes are being revisited with a view to developing a multi-disciplinary approach, which would reflect better the reality of care delivery in wards and departments. It will also provide an opportunity for clinical teams to work together using shared outcomes, to improve and streamline systems and processes to increase care contact time for the benefit of the population served.

In response to a query from DP; MR confirmed that the Trust is in possession of intellectual property rights for the app.

PW observed that the pie charts on page seven of the report did not demonstrate registered nurse activity during ward rounds; MR responded that this was due to the model design and that ward round activity is classified as indirect care. MP

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added that work is underway to streamline consultant on-call to provide a consistent ward round approach, which will further support this nurse activity.

DP conveyed surprise that 20% of registered nurse activity comprises of shift handover and queried whether wards continued the practice of shift overlap. MR acknowledged this and debate ensued in relation to the merits of short nursing shifts that require more frequent handovers versus longer nursing shifts and evidence suggesting that more errors occur between the 10th and 12th hour of along shift.

EMS queried whether the desire to achieve safe staffing presented a financial issue for the Trust and whether this resulted in funded establishments on wards being greater than was necessary. MR acknowledged this and added that the assessment tool translates into a nurse per patient calculation and whilst the tool works in general areas; other areas that require a greater nurse to patient ratio of 1:4, presents an irregularity.

In response to a query from BS; MR confirmed that guidance from NICE in relation to acuity in the Emergency Department is a grey area and trying to get the balance right between policy and evidence continues to be challenging.

The Trust Board **NOTED** the report.

HTB 15/967 **NHS WORKFORCE RACE EQUALITY STANDARDS (WRES) UPDATE AND ACTION PLAN**

KM presented the proposed Action Plan developed to support the WRES reporting template, which was initially presented to the Board in September 2015 showing Trust performance against the key elements at that time. The WRES report of September 2015 identified a number of areas where action was required in order to ensure that the systems in place are sufficiently robust to gather data required for the WRES reporting template. KM acknowledged that the organisation could be better at collecting statistical data and the priority is to undertake deep dives with a view to capturing more robust information.

It was acknowledged that there was a need to address issues around black and minority ethnic (BME) staff satisfaction, possible discrimination and equality of opportunity in regard to career progress or promotion. A small working group has been formed to ensure a joined up approach to developing a plan that was both achievable and provides relevant and appropriate outcomes to meet the needs of BME staff. The actions identified directly relate to the WRES reporting template and support the Trust's TTWC programme and align with the Trusts objectives to be an Employer of Choice and to Deliver Excellent Patient Care and Experience. It was noted that all actions will be delivered within existing budgets with the exception of one. As part of the WRES, Trusts are expected to develop and support BME networks. This will incur some costs in relation to time released for BME employees to attend meetings, events, training etc. and also to support the administration associated with the network.

The Chairman drew attention to WRES indicator 7 and cautioned that ring-fencing places on the TTWC leadership programme should be revisited. AH concurred with this adding that there is an existing robust selection criteria in place.

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Discussion ensued in relation to engaging with staff side to better understand the rationale behind why BME staff do not believe that the Trust provides quality of opportunity in regard to career progression or promotion, notwithstanding the fact that this is unable to be verified statistically due to technical data issues. KM assured that the Trust has engaged with staff side and has recently introduced a Partnership and Engagement Forum, inviting staff side to become more involved in strategic elements.

The Trust Board:-

- **NOTED** the content of the Action Plan and the need for funding for the BME network and;
- **APPROVED** the Action Plan to support the WRES reporting template, subject to review of the action relating to WRES Indicator 7. **KM**

HTB 15/968 **TOGETHER TOWARDS WORLD CLASS**

KM presented the report to inform the Board of progress in relation to the TTWC programme.

A preferred bidder has been selected for a new Trust Intranet. It is anticipated that the new system, a vital tool for communicating and engaging with staff across the Trust, will be in place by summer 2016. Implementation plans are currently underway with the selected bidder.

Ninety-seven Hospital Leaders have now commenced the 'Leading Together' programme. A further cohort has been scheduled to commence in March 2016. An initial evaluation and proposals regarding the on-going roll-out of the programme were received by Chief Officers in early December 2015 and approval has been given for the Leading Together programme to become a mandatory requirement for all individuals in formal leadership roles at UHCW, as part of a structured approach to leadership development. From April 2016, 300 Service and Team Leaders will commence on the programme per year, helping to build leadership capacity and capability at all levels of the Trust. DP requested a breakdown of the ninety-seven hospital leaders. **KM**

In response to a query from BS; AH confirmed that initial evaluation has been received from participants but plans are in place to undertake an external review in conjunction with Warwick Business School to seek assurance that the investment made by the Trust is making a difference. DP requested that the evaluation include what opportunities there are for the participants to enhance their skills in the organisation. KM confirmed that this would be included along with the impact the to the organisation.

EMS drew attention to section 3.5 (values based recruitment) and suggested that training for Non-Executive Directors (NED's) for consultant appointment panels would be welcomed. KM confirmed that plans remain under development for roll-out of all recruitment activity and that training for NEDs could be included within this.

The Trust Board **NOTED** the contents of the report.

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HTB 15/969 **PRIVATE TRUST BOARD MEETING SESSION REPORT: 26 NOVEMBER 2015**

The Chairman presented the report of 26th November 2015. There were no questions raised by other Trust Board members.

The Trust Board **RECEIVED ASSURANCE** from the report.

HTB 15/970 **QUALITY GOVERNANCE COMMITTEE MEETING REPORT:7 DECEMBER 2015**

BB presented the report of 7th December 2015, who chaired the meeting in the absence of EMS. There were no questions raised by other Trust Board members.

The Trust Board **RECEIVED ASSURANCE** from the report.

HTB 15/971 **FINANCE AND PERFORMANCE COMMITTEE REPORT 7 DECEMBER 2015**

IB presented the report and there were no questions raised by other Trust Board members.

The Trust Board **RECEIVED ASSURANCE** from the report.

HTB 15/972 **ANY OTHER BUSINESS**

There was no other business conducted.

HTB 15/973 **QUESTIONS FROM MEMBERS OF THE PUBLIC**

In response to a question from a member of the public in relation to the ongoing RTT issues referred to in the Finance and Performance Chairs report of 7th December 2015 and whether the entire Board were fully aware of the actions being taken to improve RTT performance, DE assured that the RTT recovery plan is discussed in great detail at the Trust Board each month. It is also closely monitored weekly by Chief Officers Group, with performance analysed at Finance and Performance Committee and quality elements scrutinised at the Quality Governance Committee. He added that the recovery plan was developed in conjunction with Group Management Teams; consisting of managers, modern matrons and clinical leaders to help deliver the plan. He acknowledged, however, that it has taken considerably more time, than one would have hoped to develop a credible plan.

In response to a question from a member of the public in relation to limiting acceptance of trauma and orthopaedic referrals to patients that reside within the catchment area; AH confirmed that the Board were fully aware of this. He added that trauma and orthopaedics represents a large clinical area and the referrals in question relate to a small sub-speciality within orthopaedics of which UHCW is one of only five providers. Whilst the Trust is not mandated to offer all services to all patients, the decision to limit referrals was not one which was taken lightly.

In response to a question from a member of the public in relation to patients' rights under choose and book to select an appointment with a consultant of choice and the decision taken not to accept referrals outside of the catchment area after

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28th October 2015; AH confirmed that referrals received prior to the date in question have been honoured.

In response to a question from a member of the public in relation to a specific patient case; AH confirmed that it was currently under investigation and he could not therefore, further comment. The offer extended by the Chairman to the member of the public to meet with MP to raise any queries relating to a specific patient matter was accepted.

In response to a query from a member of the public in relation to whether the Board were aware of the Integrated Quality Performance and Finance Report (IQPFR) for November observing that it was not presented in the Trust Board papers for December; the Chairman confirmed that due to the Christmas period the Trust Board is held two weeks earlier than usual and Board members will have opportunity to agree and sign-off the IQPFR report electronically.

In response to a question from a member of the public in relation to the Trust working with Clinical Commissioning Groups to transfer patients to the private sector due to demand and the criteria for referral; DE confirmed that the waiting list is managed in order of urgent clinical prioritisation and not based on geographical location of the patient. The remaining patients on the waiting list are then managed strictly in chronological order. He added that due to the limited infrastructure available within the private sector, the nature of referrals to the private sector is relatively small.

HTB 15/974 **DATE OF THE NEXT MEETING**

The next Public Trust Board will be held on Thursday 28 January 2016 at 10.00 am at University Hospitals Coventry & Warwickshire.

The minutes are approved

SIGNED	**…….....**
	CHAIRMAN
DATE	**…….....**

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST
ACTION MATRIX PUBLIC TRUST BOARD MEETINGS
28 JANUARY 2016

AGENDA ITEM 5 ENCLOSURE 2

The Trust Board is asked to **NOTE** the progress with regards to the actions below and to **APPROVE** the removal of those that are marked completed.

AGENDA ITEM	ACTION	RESPONSIBLE OFFICER	COMPLETION DATE	UPDATE	REMOVAL
ACTIONS FROM JUNE 2015 MEETING					
HTB/15/843 FREEDOM TO SPEAK UP	The Trust Board requested a progress report in six months detailing statistics and analysis of concerns raised.	RS	Mar 2016	The National Policy has been released and is out for consultation. Trust Policy will need to be revisited when the final version is released and it is suggested that this item be scheduled for March 2016.	No
ACTIONS FROM OCTOBER 2015 MEETING					
HTB 15/922 CARE QUALITY COMMISSION ACTION PLAN	The Trust Board requested a further report in January 2016 to demonstrate compliance against the Trust's Action Plan.	MR/MP	Jan 2016	On Trust Board Agenda for January 2016	Yes
ACTIONS FROM NOVEMBER 2015 MEETING					
HTB 15/936 CHIEF EXECUTIVE OFFICER'S REPORT	The Chairman requested that copies of the VMI book 'transforming health care' should be made available to NED's.	AH	Dec 2015	Copies circulated early January	Yes

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST
ACTION MATRIX PUBLIC TRUST BOARD MEETINGS
28 JANUARY 2016

AGENDA ITEM 5 ENCLOSURE 2

AGENDA ITEM	ACTION	RESPONSIBLE OFFICER	COMPLETION DATE	UPDATE	REMOVAL
HTB 15/937 EMERGENCY CARE PATHWAY (WINTER PLAN UPDATE)	DM observed that the Trust continues to see a high volume of patients attending the Trust; despite a drop in A&E attendance figures as patients are being directed to MDU but this is not reflected in the data presented. The Chairman acknowledged this and suggested that attendances through MDU be demonstrated in activity data going forward.	DE	Dec 2015	A "like for like" report has been included in the weekly run charts relating to ED and published by the PPMO. This data may now be used to inform reporting to Trust Board.	Yes
HTB 15/941 NURSING AND MIDWIFERY REVALIDATION UPDATE	The Trust Board agreed to receive an update on progress in relation to first registrants in July 2016.	MR	July 2016	Not yet due	No
ACTIONS FROM DECEMBER 2015 MEETING					

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST
ACTION MATRIX PUBLIC TRUST BOARD MEETINGS
28 JANUARY 2016

AGENDA ITEM 5 ENCLOSURE 2

AGENDA ITEM	ACTION	RESPONSIBLE OFFICER	COMPLETION DATE	UPDATE	REMOVAL
HTB 15/967 NHS WORKFORCE RACE EQUALITY STANDARDS (WRES) UPDATE AND ACTION PLAN	The Trust Board approved the Action Plan to support the WRES reporting template, subject to review of the action relating to WRES Indicator 7.	KM	Jan 2016	The action has been amended, following discussion with the TTWC leadership stream. In place of "ring-fencing" places on the leadership programme, Chief Officers and Groups will be encouraged to nominate BME staff and equally BME staff will be encouraged to apply. It is proposed that the initial "ring-fenced" places be used so that each cohort has a balance in terms of the diversity that exists within the Trust.	Yes
HTB 15/965 PATIENT STORY (YOU SAID WE DID CAMPAIGN)	The Trust Board requested that the bi-annual 'You Said We Did Campaign' updates feature separately to the patient story reports which are to be presented each month to Trust Board going forward.	MP	Jan 2016	Trust Board Work Programme Updated	Yes

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST
ACTION MATRIX PUBLIC TRUST BOARD MEETINGS
28 JANUARY 2016

AGENDA ITEM 5 ENCLOSURE 2

AGENDA ITEM	ACTION	RESPONSIBLE OFFICER	COMPLETION DATE	UPDATE	REMOVAL
HTB 15/965 PATIENT STORY (YOU SAID WE DID CAMPAIGN)	The Chairman drew attention to feedback in relation to food menus available to patients and observed that despite the extensive menus and choice, this continues to attract negative feedback and requested that this be looked at in greater detail. MR confirmed that a programme of work was undertaken and implemented in the spring and agreed to review why this was not meeting the standard expected.	MR	Jan 2016	The patient food menu feedback is currently being progressed with the Patient Information Group. Patient Information Bedside bundles are in the process of being developed which will include: ➢ Bed Boards - includes nutritional alerts ➢ A Hospital Guide - awaiting sign off by Chief Officers ➢ Hospital "Keeping Nourished & Well Hydrated" Folder – this include menus, both pictorial and word, information about hydration, snacks, healthy food options and nutritional recovery including advice on discharge. Diane Eltringham and Lincoln Dawkin are attending the next Nutritional Steering Group at the end of January to scope how to take this forward.	Yes
HTB 15/968 TOGETHER TOWARDS WORLD CLASS	DP requested a breakdown of the ninety-seven hospital leaders;	KM	Jan 2016	Information emailed to DP 23.12.15	Yes

AGENDA ITEM 6 ENCLOSURE 3

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST

REPORT TO THE TRUST BOARD: PUBLIC

28 January 2016

Subject:	Chairman's Report
Report By:	Andy Meehan, Chairman
Author:	Andy Meehan, Chairman
Accountable Executive Director:	Andy Meehan, Chairman

PURPOSE OF THE REPORT:

To update the Trust Board of the key details of meetings and events attended by the Chairman.

SUMMARY OF KEY ISSUES:

Since the last Board meeting, the major meetings and areas of interest were as follows:

- Interviewed for Coventry Hospital Radio
- Board Seminar
- Healing Arts Committee meeting
- Warwickshire Health and Well-being Board
- AUKUH Chairs meeting

STRATEGIC PRIORITIES THIS PAPER RELATES TO (Please check one):

To Deliver Excellent Patient Care and Experience	☒
To Deliver Value for Money	☒
To be an Employer of Choice	☒
To be a Research Based Healthcare Organisation	☒
To be a Leading Training and Education Centre	☒

RECOMMENDATION / DECISION REQUIRED:

The Trust Board are asked to **RECEIVE ASSURANCE** from the report.

IMPLICATIONS:

Financial:	None Highlighted
HR/Equality & Diversity:	None Highlighted
Governance:	None Highlighted
Legal:	None
NHS Constitution:	None Highlighted
Risk:	None Highlighted

COMMITTEES/MEETINGS WHERE THIS ITEM HAS BEEN CONSIDERED: None –the report is for the Trust Board.

AGENDA ITEM 7 ENCLOSURE 4

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST

REPORT TO THE TRUST BOARD: PUBLIC

28 January 2016

Subject:	Chief Executive Officers Report
Report By:	Andy Hardy, Chief Executive Officer
Author:	Andy Hardy, Chief Executive Officer
Accountable Executive Director:	Andy Hardy, Chief Executive Officer

PURPOSE OF THE REPORT:

To update the Trust Board of the key details of meetings and events attended by the Chief Executive Officer and key policy issues.

SUMMARY OF KEY ISSUES:

Summary of Activity

This month I have been involved in the following:

- Virginia Mason Institute Meetings
- Hosting a visit to the Trust by Amicus Incorporated

Consultant Appointments

The Trust has not made any Consultant appointments since the last Trust Board Meeting (17 December 2015).

Policy Issues and Publications:

The following are key issues and reports that have been published that I would bring to the attention of the Trust Board.

- Delivering the Forward View; NHS shared planning guidance for 2016/17-2020/21 has been published by NHS England, NHS Improvement, the Care Quality Commission, Public Health England, Health Education England and NICE. Further discussion will take place over the coming months but the document can be found on the link below: https://www.gov.uk/guidance/delivering-the-forward-view-nhs-planning-guidance-for-201617-to-202021
- Monitor and TDA have produced a set of rules around the use of agency staff which includes a cap that Trusts are able to pay per hour: https://www.gov.uk/guidance/rules-for-all-agency-staff-working-in-the-nhs
- Monitor has also published research on determining local health and care economies which can be found at:
- https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/489862/Considerations_for_determining_local_health_and_care_economies_selective_branding_.pdf

AGENDA ITEM 7 ENCLOSURE 4

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST

REPORT TO THE TRUST BOARD: PUBLIC

28 January 2016

STRATEGIC PRIORITIES THIS PAPER RELATES TO (Please check one):

To Deliver Excellent Patient Care and Experience	☒
To Deliver Value for Money	☒
To be an Employer of Choice	☒
To be a Research Based Healthcare Organisation	☒
To be a Leading Training and Education Centre	☒

RECOMMENDATION / DECISION REQUIRED:

The Trust Board are asked to **RECEIVE ASSURANCE** from the report.

IMPLICATIONS:

Financial:	None Highlighted
HR/Equality & Diversity:	None Highlighted
Governance:	None Highlighted
Legal:	None
NHS Constitution:	None Highlighted
Risk:	None Highlighted

COMMITTEES/MEETINGS WHERE THIS ITEMS HAS BEEN CONSIDERED: None - report is for the Trust Board

University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD PAPER

Title	**Integrated Quality, Performance & Finance Report – Month 9 – 2015/16**
Author	**Ms. Bernie Allen, Interim Associate Director of Performance and Programme Management**
Responsible Chief Officer	**Mrs. Karen Martin, Chief Workforce and Information Officer**
Date	**28th January 2016**

1. Purpose

To inform the Board of the performance against the key performance indicators for the month of December 2015.

2. Narrative

This is the first formal month of reporting performance against the new Trust Scorecard. This scorecard was introduced to ensure performance monitoring focussed on the key national standards around access and treatment times and the corporate objectives set for 2015/16.

Additional performance information is now available, in the form of a specific scorecard that reports the indicators used by the Trust Development Agency to measure the performance of the Trust.

The most key contents of the report are:

- Areas of underperformance – Headlines. This section allows three KPIs to be reported on. These have been selected on the basis of their profile, acuity and trends of deterioration.
- The flash report section flags those significant matters occurring outside of the 'reported' month.

In this report, 15 KPIs achieved the target; 4 of which are classified as national standards and 11 are corporate objectives.

3. Areas of Risk

As detailed in Areas of underperformance – Headlines.

4. Recommendations

The Board is asked to confirm their understanding of the contents of the December 2015 Integrated Quality, Performance and Finance Report and note the associated actions.

Name and Title of Author: Ms. Bernie Allen, Interim Associate Director of Performance and Programme Management
Date: 28th January 2016

University Hospitals Coventry and Warwickshire NHS Trust

Integrated Quality, Performance and Finance Reporting Framework

Reporting period: Month 9 – December 2015

Contents

University Hospitals Coventry and Warwickshire NHS Trust

Trust Scorecard

Reporting Month December 2015

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

DoT	DQ
Improving	High data quality assurance
No change	Medium data quality assurance
Falling	Low data quality assurance

Trust Board Scorecard							
Measure	Previous Position	Latest Position	DoT	YTD Plan	Annual Target	Annual FOT	Trend
National Standards							
18 Weeks Referral to Treatment Time - Incomplete (1 month in arrears)	87.49%	88.24%	↑	92%	92%	92%	
18 Week Referral to Treatment Time - Admitted (1 month in arrears)	77.01%	76.06%	↓	90%	90%	90%	
18 Week Referral to Treatment Time - Non-admitted (1 month in arrears)	90.13%	88.92%	↓	95%	95%	95%	
Diagnostic Waiters - 6 Weeks and Over	0.07%	0.20%	↓	1%	1%	1%	
Cancer 2 Week Wait GP Referral to OP Appointment (1 month in arrears)	97.17%	98.63%	↑	93%	93%	93%	
Cancer 31 Day Diagnosis to Treatment (1 month in arrears)	100.00%	99.49%	↓	96%	96%	96%	
Cancer 62 Day Urgent Referral to Treatment (1 month in arrears)	85.06%	81.32%	↓	85%	85%	85%	
A&E 4 Hour Wait	89.00%	87.43%	↓	95%	95%	95%	
12 Hour Trolley Waits in A&E	0	0	→	0	0	0	
Corporate Objectives							
Chief Workforce and Information Officer							
Vacancy Rate Compared to Funded Establishment	12.41%	12.84%	↓	10%	10%	10%	
Staff Survey - Recommending as a Place of Treatment	89.43%	89.43%	→	74.52%	74.52%	74.52%	
Staff Survey - Recommending as a Place of Work	80.36%	80.36%	→	57.8%	57.8%	57.8%	
Enrolled on Leading Together Programme	97	97	→	125	125	125	
Succession Plan	Yes	Yes	→	Yes	Yes	Yes	
Chief Operating Officer							
Bed Occupancy Rate - Basket of Wards	92.09%	91.63%	↑	93%	93%	93%	
Number of Medical Outliers - Average per Day	61	77	↓	50	50	50	
Delayed Transfers as a Percentage of Admissions	6.62%	5.43%	↑	3.5%	3.5%	3.5%	
Length of Stay - Average	6.65	7.56	↓	5.96	5.96	5.96	
Emergency Admissions - Local Definition	2900	2868	↑	2729	2729	2729	
Last Minute Non-clinical Cancelled Operations - Elective	0.94%	0.84%	↑	0.8%	0.8%	0.8%	
Chief Medical Officer							
NCE POD Categorised E Deaths - Cumulative (3 months in arrears)	2	2	→	7	15	15	
HSMR - Basket of 56 Diagnosis Groups	118.42	95.18	↑	RR	RR	RR	
SHMI - Quarterly (6 months in arrears)	103.89	103.89	→	RR	RR	RR	
Patients Recruited into NIHR Portfolio - Cumulative (2 months in arrears)	2243	2580	↑	2925	5015	5015	
Peer Reviewed Publications - Calendar Year Cumulative	239	246	↑	172	172	172	
Chief Nursing Officer							
Hand Hygiene – Clinical and Non-clinical	84.49%	85.62%	↑	95%	95%	95%	
Cannula - Full Compliance	92.35%	83.38%	↓	90%	90%	90%	
Central Venous Catheter (CVC) Compliance				90%	90%	90%	
MRSA Decolonisation Score	100.00%	64.29%	↓	95%	95%	95%	
MRSA - Elective Screening	90.68%	89.15%	↓	95%	95%	95%	
MRSA Bacteremia - Trust Acquired - Cumulative	0	0	→	0	0	0	
Clostridium Difficile - Trust Acquired - Cumulative	25	28	↓	30	42	42	
Harm Free Care	94.93%	94.55%	↓	95%	95%	95%	
Chief Finance and Strategy Officer							
Forecast Income & Expenditure Compared to Plan - £'000	-19423	-11423	↑	-11423	-11423	-11423	
Forecast Recurrent and Non Recurrent Efficiency Compared to Plan - £'000	34083	34690	↑	34000	34000	34690	
YTD Income & Expenditure Compared to Plan Trust - £'000	-13031	-14785	↓	-14357	-11423	-11423	

RR = Relative Risk : The target for this indicator uses the relative risk as calculated by Dr Foster. The performance is classed as achieving target if the UHCW value is either below or within the expected range.

Scorecard matrix|

	Behind plan	On plan	Ahead of plan
Improving	18 week RTT Incomplete Delayed transfers as a percentage of admissions Emergency admissions (local definition) Last minute non-clinical cancelled ops (elective) No of pts recruited into NIHR portfolio – cumulative Hand hygiene – clinical and non clinical		Two week cancer wait (GP referral to OP appointment) Bed occupancy rate (basket of wards) HSMR (basked of 56 diagnostic groups) Peer reviewed publications (calendar year cumulative) Forecast I&E compared to plan (£,000) Forecast recurrent and non recurrent efficiency compared to plan
Not Changing	Enrolled on leading together programme	12 hour trolley waits in A&E Succession plan SHMI MRSA bacteraemia (Trust acquired) – cumulative	Staff survey – recommending as a place of treatment Staff survey – recommending as a place of work NCEPOP categorised E Deaths - cumulative
Deteriorating	18 week RTT Admitted 18 week RTT Non-admitted 62 days urgent referral to treatment cancer target A&E 4 hour wait target Vacancy rate compared to funded establishment Number of medical outliers – average per day Length of stay – average Cannula – full compliance MRSA - decolonisation score MRSA - elective screening Harm Free Care YTD income and expenditure compared to plan		Diagnostic waiters, 6 weeks and over 31 day diagnosis to treatment cancer target Clostridium difficile (Trust acquired) – cumulative

Trust Heatmap

University Hospitals Coventry and Warwickshire NHS Trust

HEATMAP													Reporting Period:			December 2015	
Measure	Cardiac & Respiratory	Renal	Emergency	Neuro sciences	Oncology & Haematology	Surgery	Trauma & Orthopaedics	Women & Children	Specialist Medicine and Ophthal.	Anaesthetics	Theatres	Care Elderly Acute Medicine	Imaging	Hospital of St Cross	Clinical Support Services	Pathology	Trust	Trust Target
National Standards																		
18 Weeks Referral to Treatment Time - Incomplete (1 month in arrears)	89.84%	98.51%		93.49%	98.07%	84.32%	82.11%	92.71%	93.14%	94.44%		100.00%					88.24%	92%
18 Week Referral to Treatment Time - Admitted (1 month in arrears)	68.79%	98.53%		85.64%	99.05%	71.53%	66.87%	73.33%	86.62%	70.45%		100.00%					76.06%	90%
18 Week Referral to Treatment Time - Non-admitted (1 month in arrears)	91.89%	95.15%		93.72%	98.41%	84.41%	81.15%	94.12%	91.66%	82.50%		97.96%					88.92%	95%
Diagnostic Waiters - 6 Weeks and Over	1.92%			0.00%		1.26%							0.03%				0.20%	1%
Cancer 2 Week Wait GP Referral to OP Appointment (1 month in	100.00%			100.00%	100.00%	98.87%	100.00%	99.23%	97.08%								98.63%	93%
Cancer 31 Day Diagnosis to Treatment (1 month in arrears)	100.00%			100.00%	100.00%	99.19%		100.00%	100.00%								99.49%	96%
Cancer 62 Day Urgent Referral to Treatment (1 month in arrears)	90.48%			N/A	62.50%	73.33%		88.89%	100.00%								81.32%	85%
Corporate Objectives																		
Vacancy Rate Compared to Funded Establishment	18.37%	17.00%	15.69%	15.24%	14.48%	9.74%	15.50%	8.40%	6.83%	14.24%	15.57%	25.85%	10.70%	14.10%	10.01%	14.45%	12.84%	10%
Staff Survey - Recommending as a Place of Treatment	96.51%	93.88%	94.44%	91.25%	91.23%	88.57%	96.81%	92.01%	89.29%	90.63%	87.04%	86.54%	83.02%	97.44%	86.36%	58.82%	89.43%	74.52%
Staff Survey - Recommending as a Place of Work	87.21%	79.59%	72.22%	89.38%	80.70%	74.29%	91.49%	87.50%	79.76%	81.25%	74.07%	92.31%	58.49%	75.64%	70.78%	35.29%	80.36%	57.8%
Number of Medical Outliers - Average per Day	15	1		10	10	18	10	11	1		1			N/A			77	50
Emergency Admissions - Local Definition	103	1428	390	97	38	459	139	65	47	41		61					2868	2729
Last Minute Non-clinical Cancelled Operations - Elective	1.27%	0.70%		0.91%	0.00%	1.68%	0.36%	1.66%	0.23%	0.00%							0.84%	0.8%
HSMR - Basket of 56 Diagnosis Groups	85.03	66.48		91.29	41.60	102.62	159.86	122.52	102.92			89.56					95.18	100
Patients Recruited into NIHR Portfolio - Cumulative (2 months in arrears)	83	33		1	305	727	329	611	140	23		4		0	0		2580	2925
Peer Reviewed Publications - Calendar Year Cumulative	6	22	0	0	6	63	5	17	8	2	0	0	3	0	18	13	246	172
Hand Hygiene – Clinical and Non-clinical	89.79%	90.05%	93.13%	91.56%	86.08%	92.77%	87.20%	90.31%	92.54%	94.32%	96.22%	98.32%	96.00%	95.92%	93.09%	88.61%	85.62%	95%
Cannula - Full Compliance	66.67%	33.33%	69.23%	88.89%	93.33%	62.50%	92.31%	57.14%	20.00%	100.00%	100.00%	91.67%		100.00%			83.38%	90%
MRSA Decolonisation Score	50.00%	50.00%	N/A	N/A	N/A	100.00%	N/A	0.00%	N/A	100.00%	N/A	100.00%		100.00%			64.29%	95%
MRSA - Elective Screening	77.52%	92.50%	N/A	94.59%	55.00%	95.45%	94.55%	94.07%	N/A	N/A		N/A		94.24%			89.15%	95%
MRSA Bacteremia - Trust Acquired - Cumulative	0	0		0	0	0	0	0	0	0		0		0			0	0
Clostridium Difficile - Trust Acquired - Cumulative	10	3		1	0	5	1	2	0	1		3		2			28	30
Forecast Income & Expenditure Compared to Plan	0.50%	-4.60%	-0.70%	-4.50%	0.80%	-3.60%	2.60%	0.10%	0.00%	-3.30%	-6.90%	4.20%	-1.00%	7.10%	-1.50%	-20.10%		0%
Forecast Recurrent and Non-recurrent Efficiency	99%	81%	100%	100%	107%	99%	109%	100%	100%	83%	60%	106%	105%	165%	90%			100%
Bottom line Budgetary Performance - Actual vs Plan - YTD	1.70%	-4.40%	-0.40%	-4.60%	1.30%	-3.00%	4.00%	1.00%	0.00%	-1.30%	-6.80%	5.60%	-0.90%	8.20%	-1.50%	-221.00%		
Supplementary Objectives																		
Excellence in patient care and experience																		
Cancer 2 Week Wait Breast Symptom (1 month in arrears)						100.00%											100.00%	93%
Cancer 31 Day Subsequent Surgery Standard (1 month in arrears)	N/A			100.00%	N/A	90.91%		100.00%	100.00%								94.74%	94%
Cancer 31 Day Subsequent Drug Standard (1 month in arrears)	100.00%			N/A	100.00%	100.00%		N/A	N/A								100.00%	98%
Cancer 31 Day Subsequent Radiotherapy - Group (1 month in arrears)	100.00%			100.00%	100.00%	92.98%		100.00%	90.00%								94.48%	94%
Cancer 62 Day Screening Standard (1 month in arrears)						100.00%		40.00%									91.89%	90%
Cancer 62 Day Consultant Upgrades (1 month in arrears)	100.00%			100.00%	100.00%	N/A		100.00%	N/A								100.00%	85%
Pressure Ulcers Grade 3 and 4 - Trust Associated (1 month in arrears)	2	0		0	0	0	1	1	0	0		0		0			4	0
Falls per 1000 Occupied Bed Days Resulting in Serious Harm	0.00	0.49	0.00	0.44	0.00	0.00	0.00	0.00	N/A	0.00		0.18		0.00			0.12	0.04
Eligible Patients Having VTE Risk Assessment (1 month in arrears)	96.25%	97.33%	91.46%	97.53%	98.83%	95.03%	95.45%	96.86%	95.78%	97.89%		98.04%					96.28%	95%
Never Events - Cumulative	0.00	0.00	0.00	0.50	0.00	0.00	0.00	0.00	0.00	0.00	0.50	0.00		0.00			1.00	0
Number of Maternal Deaths								0									0	0
Number of Registered Complaints	4	1	3	2	1	2	6	6	3	2	0	3	1		0	0	35	40
Friends & Family Test Inpatient Coverage	26.42%	17.58%	9.97%	36.54%	26.92%	29.93%	50.58%	11.72%	12.67%			17.80%					22.52%	38%
Friends & Family Test Inpatient Recommenders	86.08%	85.71%	81.54%	84.21%	88.10%	90.30%	96.77%	96.55%	84.21%			86.42%					89.65%	95%
Friends & Family Test A&E Coverage			16.17%					1.42%	21.45%								13.73%	20%
Friends & Family Test A&E Recommenders			79.65%						90.48%								83.78%	87%
Maternity FFT No of Touchpoints Achieving a 15% Response Rate								4									4	4
All Cancellations on Day of Surgery	29.59%	8.33%		19.44%		13.90%	7.24%	11.41%	8.21%	11.90%							12.36%	6%
Urgent Operations Cancelled for the Second Time	0	0		0	N/A	0	0	0	0	N/A							0	0
Theatre Efficiency - Main	44.19%	74.93%		46.96%		64.25%	69.48%	63.19%	70.76%		60.98%						60.98%	85%
Theatre Efficiency - Rugby						58.39%	71.44%		87.02%		70.38%						70.38%	85%
Theatre Efficiency - Day Surgery		36.46%				55.71%	72.10%	56.94%	77.46%	50.28%	56.33%						56.33%	70%
Theatre Utilisation - Main	64.65%	92.85%		64.68%		82.81%	80.42%	77.71%	87.80%		77.28%						77.28%	85%
Theatre Utilisation - Rugby						71.46%	78.35%		103.11%		79.19%						79.19%	85%
Theatre Utilisation - Day Surgery		72.92%				68.59%	85.76%	64.23%	85.56%	58.17%	67.91%						67.91%	70%
% of Theatre Lists Started within 15 minutes of Scheduled Start Time	37.50%	16.67%		40.00%		25.89%	57.98%	67.44%	48.28%	31.82%							39.30%	65%
Surgical Safety Checklist - WHO	100.00%	100.00%		100.00%		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%						100.00%	100%
Breaches of the 28 Day Readmission Guarantee	0	0		1	N/A	1	5	0	0	N/A							7	0
RTT 52 Week Waits (1 month in arrears)	0	0		0	N/A	0	0	0	0	N/A		0					0	0
30 Day Emergency Readmissions (1 month in arrears)	8.72%	10.97%		5.19%	2.53%	8.23%	3.93%	9.84%	9.76%	6.25%		10.90%					9.11%	7.89%
Employer of choice																		
Personal Development Review - Non-Medical	80.79%	92.48%	88.11%	87.74%	77.26%	87.32%	89.76%	93.46%	91.06%	83.55%	87.45%	78.36%	89.71%	95.56%	87.72%	84.18%	87.48%	90%
Personal Development Review - Medical	82.35%	96.67%	58.62%	62.50%	70.00%	66.30%	71.43%	84.44%	72.88%	81.82%		77.78%	69.23%			95.24%	74.21%	90%
Mandatory Training Compliance	88.43%	91.24%	89.58%	89.28%	89.56%	88.81%	89.25%	93.37%	94.14%	91.81%	95.61%	93.74%	93.65%	92.47%	93.86%	89.43%	85.95%	95%
Sickness Rate	3.73%	5.70%	6.50%	4.65%	4.20%	3.70%	4.59%	4.34%	4.16%	5.76%	6.57%	4.04%	5.99%	6.81%	6.24%	5.30%	4.86%	4%
Consultant Job Planning	50.00%	100.00%	78.57%	90.48%	48.28%	42.86%	89.66%	100.00%	41.38%	83.08%		100.00%	40.91%			100.00%	70.38%	90%
Staff Turnover Rate	7.96%	6.56%	8.41%	7.18%	9.93%	5.81%	10.74%	8.42%	8.23%	8.14%	6.86%	9.23%	8.50%	8.41%	12.93%	12.11%	9.03%	10%
Staff Survey - Response Rate	17.30%	11.42%	6.29%	63.75%	17.43%	5.72%	38.52%	34.00%	27.10%	12.03%	10.80%	25.74%	17.43%	26.44%	27.90%	3.11%	22.76%	11.77%
Leading training and education centre																		
Job Evaluation Survey Tool Score - JEST (1 month in arrears)	3.7	3.7	N/A	3.4	3.3	3.5	3.7	3.8	3.9	4.0		3.8	3.4			4.2	3.7	3.5
No of Specialties at HEWM Level 3 and 4	0	1	0	0	0	0	0	1	0	0		1	0			0	3	0
Doctor Trainers Provisionally Accredited	100.00%	100.00%	100.00%	90.91%	100.00%	97.14%	100.00%	100.00%	95.00%	100.00%		100.00%	92.31%			100.00%	98.47%	100%

Areas of underperformance | Headlines

University Hospitals Coventry and Warwickshire NHS Trust

Scorecard Summary | **15 KPIs achieved the target**; 4 of which are classified as national standards and 11 are corporate objectives.

	Indicators achieved	Indicators in exception	Indicators in watching status	Total indicators
National Standards	4	5	0	9
Corporate Objectives:				
Chief Workforce and Information Officer	2	3	0	5
Chief Operating Officer	1	4	1	6
Chief Medical Officer	4	1	0	5
Chief Nursing Officer	2	5	0	7
Chief Finance and Strategy Officer	2	1	0	3

The revised scorecard shows that the Trust has continued to meet the Diagnostic Waiting Target and key indicators supporting patients referred to the Trust with potential cancer diagnoses. Further detail is provided on page 7 with regard to performance against RTT targets and the 62 day treatment target for cancer patients. Whilst the Trust did not meet the A&E target in December, Chief Officers have commissioned a root cause analysis of performance between Christmas and the New Year and are awaiting the findings of this review; therefore there is no detailed section on the 4 hour target in this report. There is detailed information on both finance and workforce on pages 9 and 13 respectively.

In light of performance pressures, a series of monthly reviews between the Chief Officers and each of the clinical groups has been introduced for the final quarter of 2015/16. These reviews are focussed on the key areas of the 18 week Referral to Treatment incomplete standard, emergency care, the cancer 62 day referral to treatment standard and the Trust's financial plan. Chief Officers continue to monitor performance against corporate objectives at Quarterly Reviews, which will be held during the first week of February.

Decline in nursing KPIs | Patient Safety Thermometer and associated indicators show a variance in performance.

Measure	Previous Position	Latest Position
Cannula - Full Compliance	92.35%	83.38%
MRSA Decolonisation Score	100.00%	64.29%
Harm Free Care	94.93%	94.55%
Pressure Ulcers 3 and 4 Trust acquired	3	4

Cannula compliance score: Reduced scores noted in 5 clinical areas with non compliance for record keeping identified in 2. No emerging trends from previous months' data in 4/5 areas.

Actions: Individual action plans have been submitted to the Chief Nursing Officer for review. Learning and focus for improvement to be discussed at IPC and Cleaning meeting Monday 25th January.

MRSA Decolonisation: The decolonisation rates are particularly sensitive as they are small numbers of patients. For December the compliance was based on 5/14 positive results of patients in two wards. Two patients had infrequent decolonisation, three were missed.

Actions: Ward based MRSA Quick Action Guide review and compliance check by IPC Nurse, MRSA weekly ward round by IPC nurse, CAE review for all non compliance, targeted staff education.

Patient Safety Thermometer: For 2 months the PST data has been just below 95% (94.93% and 94.55% in Nov/Dec). This is due to an increase in new VTE (although VTE screening rates remain above 96%) and new pressure ulcers in a 2/3 areas.

Actions:

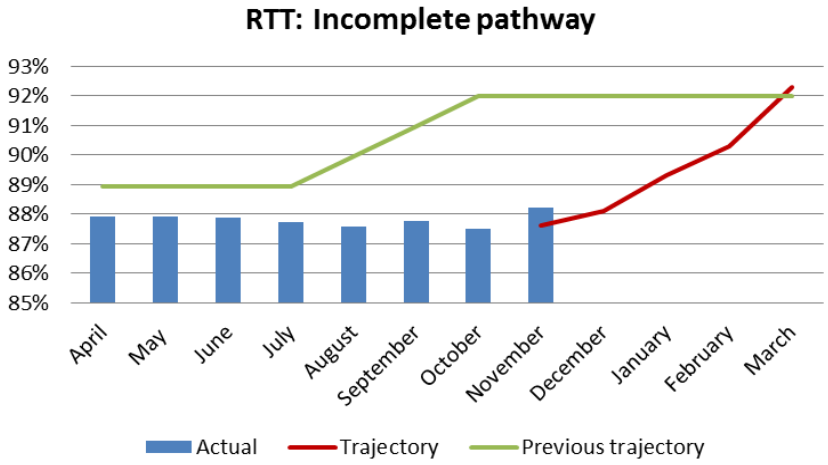
VTE: Clinical review of VTE underway, lessons learnt will be shared.

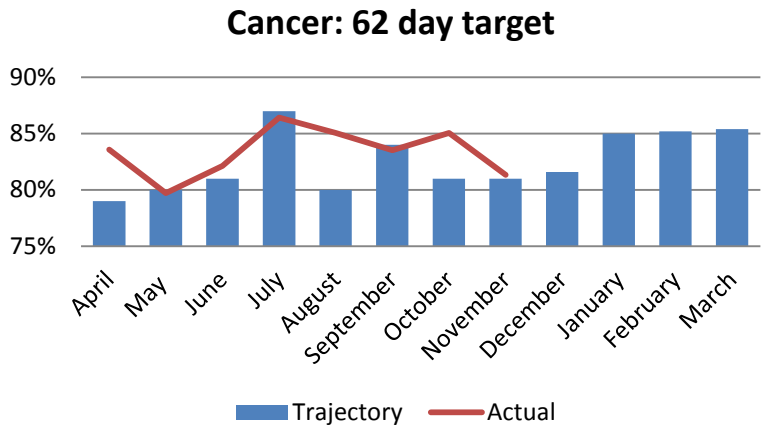
Pressure Ulcers: 2 in specialist units, 2 in general wards. Lack of documented repositioning, inaccurate risk assessment and delay in dynamic mattress order. Individual area actions monitored via performance meetings, and further review to increase available mattresses in admissions units underway.

Areas of underperformance | Headlines

University Hospitals Coventry and Warwickshire NHS Trust

Elective access indicators| **Elective access indicators**| The Trust continues to face challenges in the delivery of its elective access indicators including 18 week RTT and Cancer pathways.





The RTT incomplete trajectory was revised in November with TDA and CCG approval. In month performance shows an improvement against previous months of 88.92 % against the 92% standard.

The size of the challenge to deliver by year end cannot be underestimated. Groups and specialties continue to develop their plans to deliver with additional WLI and focus on the long waiters. Performance and delivery is being monitored through the weekly Access meeting.

Cancer 62 day urgent Referral to Treatment performance continues to show the planned decline at 81.32% against the 85% standard.

Non achievement of the standard is related to the planned treatment of Urology long waiters.
Work continues with referring hospitals to ensure patients are sent to UHCW in a timely manner as 3.5 breaches in month were result of this.

Flash Report | December 2015

Trust calls Black Alert status in early January.

At 4.30pm on Monday 4th January the Trust escalated its command status to 'Black Alert' in response to persistent pressure on the Emergency Department, Critical Care and across the organisation. Over the five days, the hard work and commitment of all the clinical and operational teams delivered a much improved position and as a result the 'Black Alert' was stood down from 4.30pm Friday 8th January.

The **Trust has seen fluctuations in HSMR during July, August and September, with a high relative risk in August 2015.**

Work has taken place to review the recording of all relevant deaths, which has resulted in some coding amendments. It is anticipated that this will positively impact on the reporting for HSMR for August in 3 months' time. The current HSMR position for the twelve month period (Oct-Sept 2015) is a high relative risk. Nationally other trusts have seen degrees of fluctuation in their HSMR performance.

A series of monthly performance reviews between the Chief Officers and each of the clinical groups have been introduced for the final quarter of 2015/16.

The sessions are short, sharp and focussed and have enabled an unprecedented detailed level of discussion with all COs highlighting very specific tasks and objectives to be completed prior to 31st March. This approach to the reviews will continue in February and March.

Key Achievements | December 2015

University Hospitals Coventry and Warwickshire NHS Trust

It has been announced that the largest research centre into the cause of early miscarriage will be in Coventry.

Staff from University Hospital, Coventry and the University of Warwick have been selected to be partners in the miscarriage research centre funded by the leading pregnancy charity, Tommy's. It will be the largest of its kind in Europe and will help patients who have suffered the heartbreak of recurrent miscarriages.

The research centre, which will open in April 2016, will have three sites at University Hospital in Coventry, University of Birmingham and Imperial College, London.

Awards and acknowledgments for research and teaching in Anaesthetics.

Congratulations to Dr Cyprian Mendonca who has been awarded the President's Commendation for his work developing airway protocols and his contributions to the Difficult Airway Society.

This award was granted for his enthusiasm for training and teaching both anaesthetic trainees and medical students. He has shown impeccable long term commitment both towards anaesthetic specialty and training.

Also, Consultant Anaesthetist, Dr Krishna Ramachandran has been successful in the elections to the Council of the Royal College. He is currently one of the College Tutors here and has been lead Tutor across the UK for some time.

Dr Ramachandran has a keen interest in training/education. He has been College Tutor for nearly six years and was elected to the Royal Council of Anaesthetists for a term of six years beginning March 2016.

Finance overview | position summary

University Hospitals Coventry and Warwickshire NHS Trust

Eight finance performance indicators are in reportable escalation this month.

Income remains an area of concern, primarily due to shortfalls in elective delivery. December witnessed an increase in non-elective activity, which is subject to the marginal rate adjustment.

Non Pay is shown in escalation; however, this is primarily driven by timing differences in research and development funding, coupled with high agency fees and RTT pressures.

Debtors over 90 days accounting for more than 5% of total debtors remains in escalation at month 9 albeit the Trust performance in month 9 is 7.93% compared with month 8 at 13.94% after adjusting for impaired debts. A key issue is the proportion of unpaid invoices which are over 90 days old. The Trust is in negotiations to resolve any outstanding queries.

The current financial indicators are still being reviewed by The Trust.

Indicator	Measure	Standard	YTD Plan	YTD Actual	Escalation Status
Monitor COSSR	score	3	1	1	No Escalation Required - on plan
Liquidity Days	days	>-7 days	-22.9	-26.9	No esclation required - within tolerance
Capital Servicing Capacity	score	>1.25	0.7	0.74	Escalation Required - covered through debtors and creditor PMR escalations
EBITDA Margin	%	>=11%	5.2%	4.9%	Escalation Required - below plan
EBITDA Achieved	%	>=85% of plan	100.0%	94.1%	No esclation required - within tolerance
Net Return after Financing	%	>=2%	-5.3%	-5.4%	Escalation Required - below plan
I&E Surplus Margin	%	>=1%	-3.7%	-3.7%	Escalation Required - below plan
Liquidity Ratio*	days	>=15 days	6.8	8.8	No esclation required - within tolerance
Debtors	%	% > 90days		7.9%	Escalation Required - below plan
Creditors	%	% > 90days		15.0%	Escalation Required - below plan
Total Income	% actual v plan	w ithin 0.5% of plan		-1.2%	Escalation Required - below plan
Pay Expenditure	% actual v plan	w ithin 0.5% above plan		0.0%	No Escalation Required - on plan
Non Pay Expenditure**	% actual v plan	w ithin 1.0% above plan		2.0%	Escalation Required - below plan
Non Operating Items	% actual v plan	w ithin 1.0% above plan		-3.3%	No Escalation Required - on plan
CIP	% actual v plan	w ithin 5% below plan		4.5%	No Escalation Required - on plan

Escalation triggered when YTD is red or amber **and** showing a deterioration from plan

* Liquidity ratio - assumes 30 days working capital facility equivalent for Monitor metric

** Non Pay Expenditure excludes Non Operating Items

Finance overview | statement of comprehensive income

University Hospitals Coventry and Warwickshire NHS Trust

The Trust changed its plan by £8.0m from a £19.4m control total deficit to £11.4m deficit in month 9.

The improvement in control total deficit is as a result of the net gain from £8m DoH income from a capital to revenue transfer.

Contract income is forecast at £9.5m adverse to plan driven by under performance against activity targets, risks and penalties.

Group expenditure forecasts include cost pressures of £6.9m, excluding (£4.0m) ET&R timing this is equates to a pressure of £2.9m:

- (£3.3m) premium cover for medical staff vacancies.
- (£1.1m) premium cost of covering ward nursing vacancies
- (£1.1m) RTT and capacity issues
- (£0.8m) for specialing of patients
- (£0.7m) Pathology network
- £0.8m over achievement of CIP
- £1.8m staffing , primarily vacancies
- £1.5m PFI variations and utility costs

The Trust is reporting a year to date deficit of £15.8m in month 9 (£14.8m against break-even duty), which is £0.4m adverse to the planned deficit. This is primarily due to underperformance against activity targets noted above.

Statement of Comprehensive Income	Initial TDA Plan £000	Revised TDA Plan £000	2015/16 Budget £000	2015/16 Forecast Outturn £000	2015/16 Variance £000	Year To Date Budget £000	Year To Date Actual £000	Year To Date Variance £000	Month Budget £000	Month Actual £000	Month Variance £000
Income											
Contract income from activities	479,062	479,062	494,998	485,459	(9,539)	372,127	365,409	(6,718)	41,407	40,545	(862)
Other income from activities	20,317	31,317	17,383	18,303	920	4,466	4,917	451	377	848	471
Other Operating Income	71,528	71,528	73,557	79,657	6,100	55,446	56,647	1,201	6,032	5,803	(229)
Total Income	**570,907**	**581,907**	**585,938**	**583,419**	**(2,519)**	**432,039**	**426,973**	**(5,066)**	**47,816**	**47,196**	**(620)**
Operating Expenses											
Pay	(336,170)	(336,170)	(341,940)	(343,931)	(1,991)	(256,586)	(256,646)	(60)	(28,780)	(28,800)	(20)
Non Pay	(189,035)	(192,035)	(197,531)	(202,432)	(4,901)	(146,425)	(149,346)	(2,921)	(16,189)	(16,522)	(333)
Additional savings required					0			0			0
Reserves	(18,987)	(15,987)	(8,752)	(54)	8,698	(6,675)	57	6,732	(639)	0	639
Total Operating Expenses	**(544,192)**	**(544,192)**	**(548,223)**	**(546,417)**	**1,806**	**(409,686)**	**(405,935)**	**3,751**	**(45,608)**	**(45,322)**	**286**
EBITDA	**26,715**	**37,715**	**37,715**	**37,002**	**(713)**	**22,353**	**21,038**	**(1,315)**	**2,208**	**1,874**	**(334)**
EBITDA Margin %	4.7%	6.5%	6.4%	6.3%		5.2%	4.9%		4.6%	4.0%	
Non Operating Items											
Profit / loss on asset disposals			0	6	6	0	6	6	0	0	0
Depreciation	(21,043)	(21,043)	(21,043)	(20,471)	572	(15,782)	(15,354)	428	(1,754)	(1,325)	429
Interest Receivable	100	100	100	115	15	75	95	20	8	12	4
Interest Charges	(789)	(789)	(789)	(385)	404	(690)	(228)	462	(34)	(24)	10
Financing Costs	(25,303)	(25,303)	(25,303)	(25,303)	0	(18,977)	(18,998)	(21)	(2,109)	(2,142)	(33)
Unwinding Discount	(36)	(36)	(36)	(35)	1	(36)	(35)	1	0	0	0
PDC Dividend	(3,626)	(3,626)	(3,626)	(3,105)	521	(2,720)	(2,366)	354	(302)	51	353
Total Non Operating Items	**(50,697)**	**(50,697)**	**(50,697)**	**(49,178)**	**1,519**	**(38,130)**	**(36,880)**	**1,250**	**(4,191)**	**(3,428)**	**763**
Net Surplus/(Deficit)	**(23,982)**	**(12,982)**	**(12,982)**	**(12,176)**	**806**	**(15,777)**	**(15,842)**	**(65)**	**(1,983)**	**(1,554)**	**429**
Net Surplus Margin %	-4.2%	-2.2%	-2.2%	-2.1%		-3.7%	-3.7%		-4.1%	-3.3%	
Technical adjustments											
Donated/Government grant assets adjustment	(74)	(74)	(74)	(395)	(321)	198	196	(2)	22	22	0
IFRIC 12	1,633	1,633	1,633	1,148	(485)	1,222	861	(361)	135	(228)	(363)
Break-even in-year position	**(22,423)**	**(11,423)**	**(11,423)**	**(11,423)**	**0**	**(14,357)**	**(14,785)**	**(428)**	**(1,826)**	**(1,760)**	**66**

Finance overview | statement of financial position

University Hospitals Coventry and Warwickshire NHS Trust

The statement of financial position shows the assets, liabilities and equity held by the Trust and is used to assess the financial soundness of an entity in terms of liquidity risk, financial risk, credit risk and business risk.

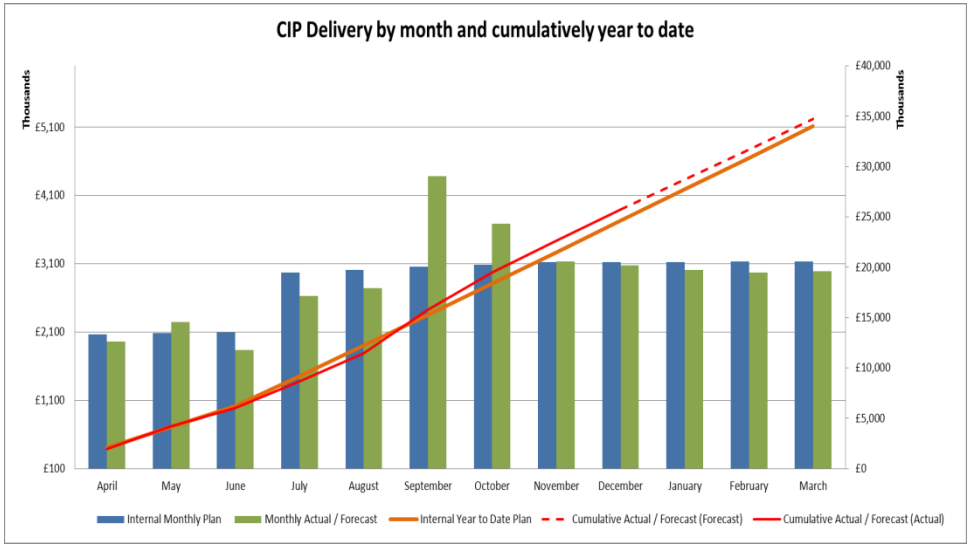
- The TDA requested organisations to assess the scope to reduce capital expenditure in 2015/16 (due to pressures on the capital budget at a national level) and defer the draw down of loans into the following year. Capital Planning Review Group have identified a number of schemes where slippage is likely and expenditure can be deferred to 2016/17.
- An overall reduction of £10.8m on DH Capital loan (Current & Non-Current Liabilities) is due to the capital to revenue budget agreement.
- Public Dividend Capital is £22.9m lower than plan following the confirmation that revenue support would be provided by means of a loan.

Statement of Financial Position	2015/16 Resubmitted Plan £000	2015/16 Forecast Outturn £000	2015/16 Variance £000	Year To Date Plan £000	Year To Date Actual £000	Year To Date Variance £000	Month Planned Change £000	Month Actual Change £000	Month Variance £000
Non-current assets									
Property, plant and equipment	414,511	399,818	(14,693)	386,329	371,879	(14,450)	2,732	836	(1,896)
Intangible assets	3,886	3,886	0	3,886	3,886	0	0	0	0
Investment Property	5,007	5,007	0	5,007	5,007	0	0	0	0
Trade and other receivables	18,245	18,546	301	23,908	28,990	5,082	(1,819)	(1,604)	215
Total non-current assets	**441,649**	**427,257**	**(14,392)**	**419,130**	**409,762**	**(9,368)**	**913**	**(768)**	**(1,681)**
Current assets									
Inventories	11,558	11,558	0	11,558	11,864	306	0	(76)	(76)
Trade and other receivables	27,464	31,128	3,664	23,914	25,235	1,321	(5,186)	(3,847)	1,339
Cash and cash equivalents	2,742	2,742	0	2,825	13,706	10,881	8	(152)	(160)
	41,764	**45,428**	**3,664**	**38,297**	**50,805**	**12,508**	**(5,178)**	**(4,075)**	**1,103**
Non-current assets held for sale	0	0	0	0	0	0	0	0	0
Total current assets	**41,764**	**45,428**	**3,664**	**38,297**	**50,805**	**12,508**	**(5,178)**	**(4,075)**	**1,103**
Total assets	**483,413**	**472,685**	**(10,728)**	**457,427**	**460,567**	**3,140**	**(4,265)**	**(4,843)**	**(578)**
Current liabilities									
Trade and other payables	(50,008)	(52,501)	(2,493)	(54,407)	(74,406)	(19,999)	8,198	3,172	(5,026)
Borrowings	(186)	(186)	0	(1,740)	(1,689)	51	0	0	0
DH Interim Revenue Support loan	0	0	0	0	0	0	0	0	0
DH Capital loan	(3,774)	(2,629)	1,145	(3,774)	(2,390)	1,384	0	0	0
Provisions	(194)	(194)	0	(1,309)	(627)	682	0	86	86
Net current assets/(liabilities)	**(12,398)**	**(10,082)**	**2,316**	**(22,933)**	**(28,307)**	**(5,374)**	**3,020**	**(817)**	**(3,837)**
Total assets less current liabilities	**429,251**	**417,175**	**(12,076)**	**396,197**	**381,455**	**(14,742)**	**3,933**	**(1,585)**	**(5,518)**
Non-current liabilities:									
Trade and other payables									
Borrowings	(268,075)	(265,828)	2,247	(264,828)	(264,596)	232	99	36	(63)
DH Interim Revenue Support loan	0	(13,879)	(13,879)	0	0	0	0	0	0
DH Capital loan	(22,632)	(13,019)	9,613	(19,462)	(11,620)	7,842	(4,613)	0	4,613
Provisions	(2,379)	(2,378)	1	(2,477)	(2,474)	3	0	0	0
Total assets employed	**136,165**	**122,071**	**(14,094)**	**109,430**	**102,765**	**(6,665)**	**(581)**	**(1,549)**	**(968)**
Financed by taxpayers' equity:									
Public dividend capital	83,980	61,080	(22,900)	61,680	55,080	(6,600)	1,400	0	(1,400)
Retained earnings	(8,801)	5	8,806	(3,596)	(3,661)	(65)	(1,981)	(1,549)	432
Revaluation reserve	60,986	60,986	0	51,346	51,346	0	0	0	0
Total Taxpayers' Equity	**136,165**	**122,071**	**(14,094)**	**109,430**	**102,765**	**(6,665)**	**(581)**	**(1,549)**	**(968)**

Efficiency Delivery Report | Key headlines

Reporting Month: December 2015

The Trust is forecasting delivery of £34.7m against £35.7m of potentially identified savings: This gives a potential forecast over-delivery of £700k against the Trust target of £34m for 2015/16.



Headlines

- £0.6m improvement in Month 9 from Month 8 forecast position of £34.7m.
- £25.7m delivered against a cumulative year to date plan of £24.6m.
- Forecast delivery of £34.7m against the Trust target of £34m, giving a forecast over-delivery of £0.7m.
- 10% of the identified savings are classified as opportunities.
- 39% of the identified savings are related to commissioning contract income.
- 37% of the identified savings are non recurrent and will require permanent schemes to replace them.

Risks

- A third of the Trust's identified schemes are non-recurrent with a forecast delivery of £12.8m.
- Any non-recurrent position in 2015/16 will need to be included in the financial planning for 2016/17.
- There is potential for risk associated with the full value of PbR related CIP forecast which forms 40% of the overall CIP programme. The outcome of the income validation exercise in Month 7 suggest a potential risk of £1.7m to forecast delivery of the income schemes. This risk is currently being managed within the overall income position.

Key Actions

- Groups continue to look for recurrent CIP schemes in 2015/16.
- CIP Steering Group to continue scrutiny of Group positions to ensure the position is maintained and minimise the risk of further slippages that could result in under-delivery.

Workforce Information | Headlines

(excluding bank and ad-hoc locums)

University Hospitals Coventry and Warwickshire NHS Trust

Staff in Post | Variation from TDA Plan

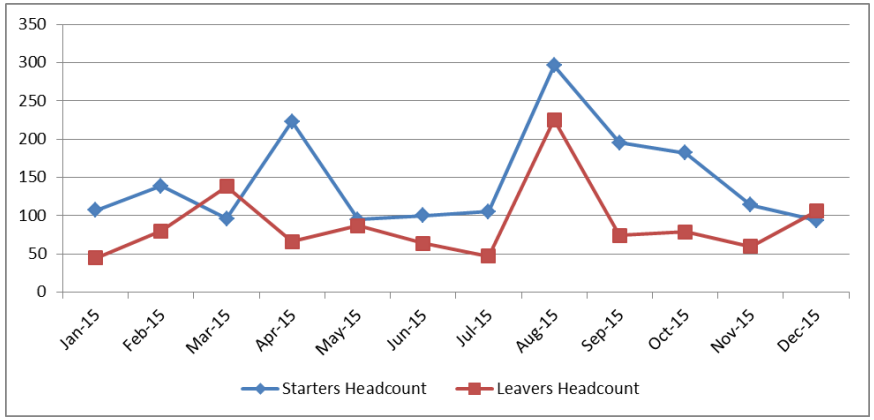
	31st Dec 2015	TDA Plan	Variation from Plan	Last Month's Variation from Plan	ISS
WTE	6613.21	6603.4	-9.83	-46.49	627.3
WTE including ISS	7240.51				
Headcount	8721				814
Headcount including ISS	9535				

Staff in Post | Monthly Variation

Staff Group	Staff In Post WTE 30th Nov 2015	Staff In Post WTE 31st Dec 2015	Variance (WTE)	% Variance
Add Prof Scientific and Technic	239.29	219.81	-19.48	-8.14%
Additional Clinical Services	1447.11	1488.33	41.22	2.85%
Administrative and Clerical	1197.76	1152.83	-44.93	-3.75%
Allied Health Professionals	371.18	365.94	-5.24	-1.41%
Estates and Ancillary	1.00	5	4	400.00%
Healthcare Scientists	324.73	321.78	-2.95	-0.91%
Medical and Dental	916.22	919.83	3.61	0.39%
Nursing and Midwifery Registered	2104.40	2098.49	-5.91	-0.28%
Students	41.20	41.20	0	0.00%
Totals	**6643.89**	**6613.21**	-30.68	-0.46%
ISS	641.5	627.3	-14.2	-1.06%

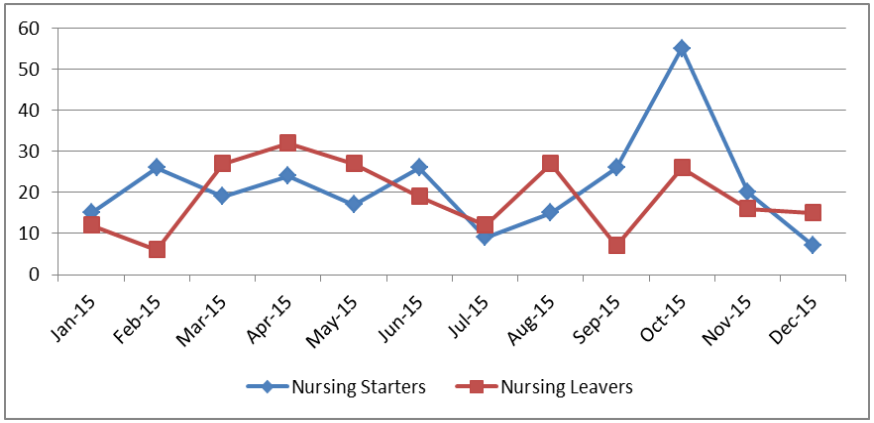
The Trust's staff in post is 9.83 wte ahead of the TDA plan of 6603.4.
The Trust's monthly staff in post has decreased by 30.68 wte.
The reduction in Administrative & Clerical staff is planned as part of cost control measures and the restriction on non essential vacancies.
Estates and Ancillary staff in post numbers have increased due to 2 pathology porters and 2 receipt & distribution porter/storekeepers being previously incorrectly coded as A&C. These staff are directly employed by UHCW and are not RoE staff.

Starters & Leavers | All Staff Groups



Please note that the Trust data includes Junior/Rotational Doctors resulting in spikes of both leavers and starters at the rotation periods, notably April & August.
December leavers are higher than starters for the first time in eight months.

Starters & Leavers | Nursing



December's Nursing Starters are of a lower rate than leavers, this may be a seasonal variation, as the data from 2014 is comparable for this period. It also follows a peak of Newly Qualified Nurses that commenced in September and October.
The recruitment campaigns for nursing staff are in development for 2016.

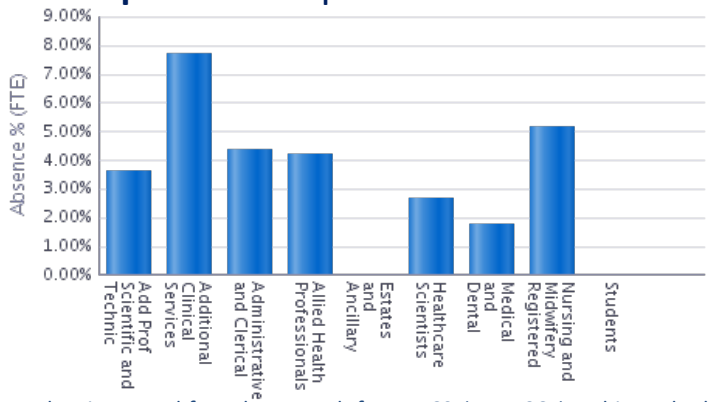
Workforce Information | Headlines

University Hospitals Coventry and Warwickshire NHS Trust

Absence | Specialty Group

Specialty Group	% Abs Rate (WTE)
218 Anaesthetics Specialty Group	5.76%
218 Cardiac & Respiratory	3.73%
218 Care of the Elderly	4.04%
218 Clinical Support Services Specialty Group	6.24%
218 Core Functions	3.26%
218 Delivery Unit	6.04%
218 Emergency Department Specialty Group	6.50%
218 Hospital of St Cross	6.81%
218 Imaging	5.99%
218 Neurosciences Specialty Group	4.65%
218 Oncology and Haematology	4.20%
218 Pathology Network Cov & Warwicks	5.30%
218 Renal Specialty Group	5.70%
218 Specialist Medicine & Ophthalmology	4.16%
218 Surgery Specialty Group	3.70%
218 Theatres Specialty Group	6.57%
218 Trauma & Orthopaedics Specialty Group	4.59%
218 Women & Children Specialty Group	4.34%
Totals	4.86%

Absence | Staff Group

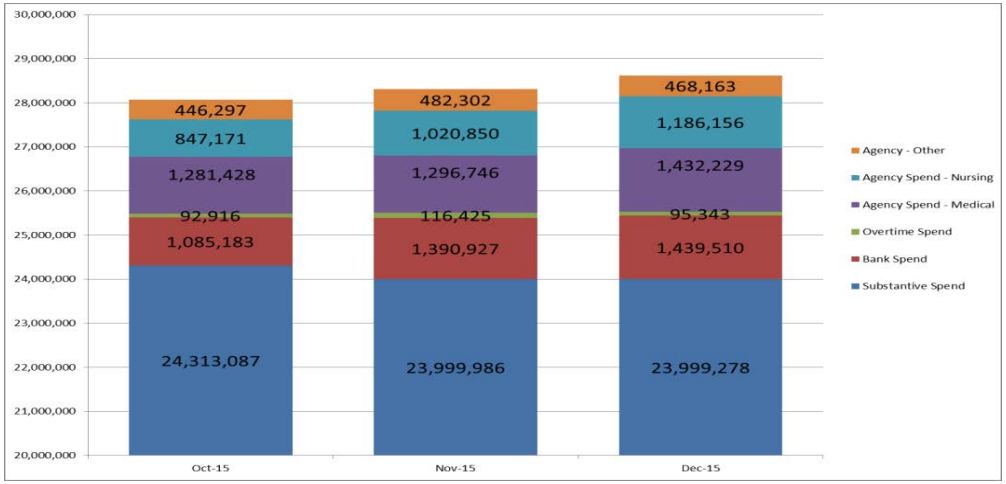


Absence has increased from last month from 4.69% to 4.86% and is at the highest level for 34 months.

Clinical groups have now developed improvement trajectories and action plans to achieve the target of 4% by April 2016, we therefore expect to begin seeing a reduction next month.

In the past month there have been 9 long term sickness cases managed to either return to work or leave the Trust.

Pay Costs | Provided by Finance



Temporary costs equate to 16.15% of the Trusts total pay bill, which is a increase from 15.22% last month. This represents:

- an increase in agency spend of £287k which is 10.78% of the total pay bill. This is an increase of 0.89% from the previous month.
- an increase in bank spend of £49k which is 5.03% of the total pay bill. This is a positive increase of 0.12% from the previous month.
- a decrease in overtime of £21k which is 0.33% of the total pay bill. This is a decrease of 0.08% from the previous month.

The increase in Nurse agency spend primarily relates to an increase of approximately £96k in Cardiac Critical Care and the increase in Medical agency spend relates to Cardiac and Respiratory and outliers over the Christmas period (total £91k) due to increased capacity.

Mandatory Training | Topics

Mandatory training compliance is currently 85.95%.

2 topics are above 95% (Hand Hygiene Non Clinical & Neonatal Life Support Update) with 15 topics between 85% and 95% and 16 topics below 85%.

5 topics with the lowest compliance which are under 75% are Advanced Life Support 43.59%, Advanced Life Support update 55.86%, Immediate Life Support 60.53%, Paediatric Life Support Update 72.03%, Paediatric Basic Life Support 72.45%.

There are sufficient numbers of places available for training, therefore the challenge remains at operational level.

Following a deep dive analysis, an action plan to improve resuscitation competencies is underway, including the following key actions:

(1) Data Validation – A cull on medical locums who have not worked for 6 months or more is underway and will improve reporting and performance from February 2016 onwards. This exercise will be repeated every 6 months.

(2) Hotspot Areas - Clinical Directors will receive a detailed report on resuscitation topics, highlighting non-compliant individuals, this is above and beyond the monthly mandatory training report.

University Hospitals Coventry and Warwickshire NHS Trust

Ward Staffing Levels - Monthly by Trust

Entry Date : December 2015

Staff Type	Target (hours)	Rostered (hours)	Actual (hours)	Percentage	Target (hours)	Rostered (hours)	Actual (hours)	Percentage	Target (hours)	Rostered (hours)	Actual (hours)	Percentage
	Early				Late				Night			
Registered Nurse (RN)	8212	7854	8145	99.2%	8039	7518	7801	97.0%	6328	5815	6315	99.8%
Health Care Support Worker (HCSW)	4261	4218	4181	98.1%	3688	3565	3494	94.7%	2993	2869	2908	97.2%
Specials	2	545	314		2	532	326		2	566	371	
Specialist Trained Neonatal Nurse	276	280	287	104.0%	266	267	268	100.8%	269	267	277	103.0%
Registered Nurse	99	103	108	109.1%	96	98	104	108.3%	69	62	62	89.9%
Nursery Nurse (NN)	61	58	55	90.2%	72	72	72	100.0%	59	74	75	127.1%
Total (non Specials)	12909	12513	12776	99.0%	12161	11520	11739	96.5%	9718	9087	9637	99.2%

Ward Staffing Levels - Monthly Ward Scorecard - Exceptions

Entry Month : December 2015

Staff Type : RN,RM,HCSW

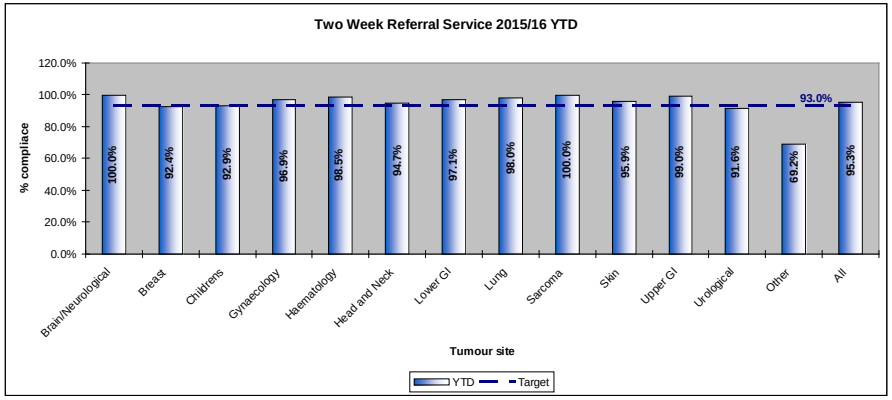
Shift : Early, Late, Night

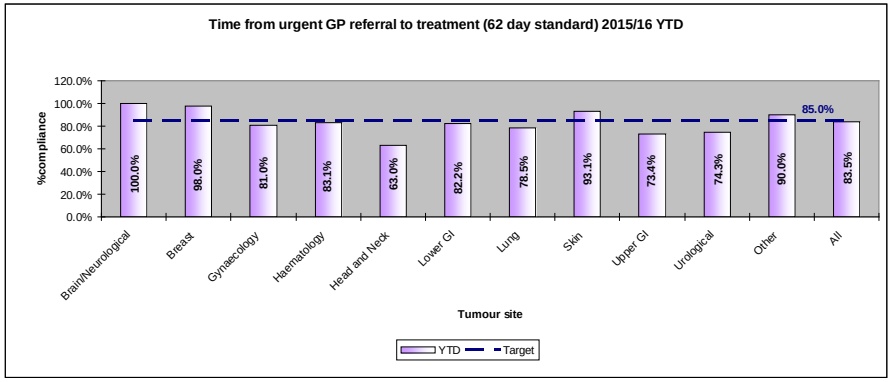
Ward	day RN	day HCSW	Night RN	Night HCSW	
31	99.4%	101.1%	100.8%	105.8%	RN days fill rate continues to improve
34	97.4%	125.8%	98.4%	113.3%	Drop in HCSW fill rate on days
41	97.1%	104.9%	99.4%	148.4%	RN days improved 13%
42	93.9%	130.6%	100.0%	132.3%	RN days improved by 6%
43	81.7%	118.3%	100.0%	101.1%	RN Days fill rate dropped by 18% high level if sickness reported
AMU2	94.1%	73.8%	91.7%	103.4%	Improved RN fill rate on days
Observation Ward	97.8%	87.9%	151.6%	91.9%	Fill rate for HCSW on days much improved by 20%. RN nights - trialling an extra RN to help flow hence 151%

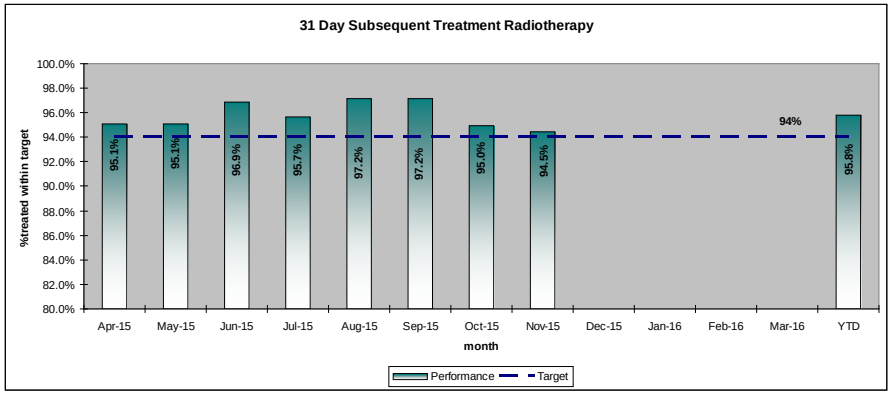
The figures reported above are submitted to the DoH via Unify on a monthly basis to support NHS England Safer Staffing along with the ten expectations from the NQB. These figures show the previous months Trust wide nurse staffing, along with exceptions and actions being taken. Patients are able to view this information on the Trust's Internet Site.

Cancer Information | November 2015

University Hospitals Coventry and Warwickshire NHS Trust







Two week wait standard:

Two Week Wait performance year to date is 95.3% (achieved and improving). The Breast Symptomatic 2ww target is not met, year to date but it is anticipated to be achieved by year end and is 100% for November.

62 day standard:

Gynaecology standard achieved in November and slightly improved YTD position

Haematology - 1.5 breaches in November, out of teams control to affect

Head and Neck – 2 breaches referred > day 62 from tertiary trusts. 1 UHCW pathway delay

LGI – 4 breaches

Lung - standard achieved in November and slightly improved YTD position

UGI – 3 shared breaches, all complex

Urology performance declining due to treatment of backlog of patients

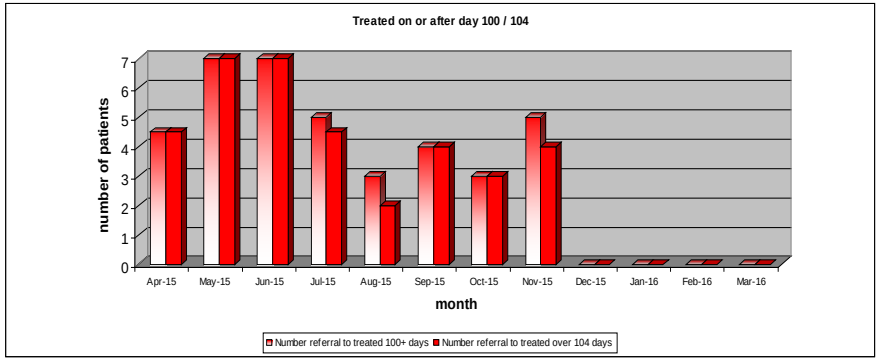
31 day subsequent treatment- Radiotherapy:

Capacity and staffing pressures are putting this target under threat.

100 plus patients:

8 patients treated over 100 days (5.0 has been recorded as 6 were shared in addition to 2 whole UHCW patients).

Year to date 38.5 patients have been treated at >100 days. New NHS guidance 'backstop' measures require the Trust Board to receive details of long waiting patients. This information will be included in the Quarterly Cancer Waiting Times report which is to be included in Trust papers on a quarterly basis.



University Hospitals Coventry and Warwickshire NHS Trust

Additional Scorecards

This appendix contains the following additional scorecards which measure KPIs at Trust level.

Trust Scorecard – (Supplementary)

Reporting Month December 2015

University Hospitals Coventry and Warwickshire NHS Trust

Trust Supplementary Scorecard								
Measure	Previous Position	Latest Position	DoT	YTD Plan	Annual Target	Annual FOT	Executive Lead	Trend
Supplementary Objectives								
Excellence in patient care and experience								
Cancer 2 Week Wait Breast Symptom (1 month in arrears)	98.74%	100.00%	↑	93%	93%	93%	COO	
Cancer 31 Day Subsequent Surgery Standard (1 month in arrears)	96.77%	94.74%	↓	94%	94%	94%	COO	
Cancer 31 Day Subsequent Drug Standard (1 month in arrears)	100.00%	100.00%	→	98%	98%	98%	COO	
Cancer 31 Day Subsequent Radiotherapy Standard (1 month in arrears)	94.97%	94.48%	↓	94%	94%	94%	COO	
Cancer 62 Day Screening Standard (1 month in arrears)	93.33%	91.89%	↓	90%	90%	90%	COO	
Cancer 62 Day Consultant Upgrades (1 month in arrears)	86.11%	100.00%	↑	85%	85%	85%	CMO	
Ambulance Turnaround within 30 minutes	88.17%	87.34%	↓	100%	100%	100%	COO	
Ambulance Turnaround within 60 Minutes	99.73%	99.98%	↑	100%	100%	100%	COO	
Valid NHS Number - Inpatients (2 months in arrears)	99.40%	99.30%	↓	99%	99%	99%	COO	
Valid NHS Number - A&E (2 months in arrears)	97.70%	97.60%	↓	95%	95%	95%	COO	
Pressure Ulcers Grade 3 and 4 - Trust Associated (1 month in arrears)	3	4	↓	0	0	18	CNO	
Falls per 1000 Occupied Bed Days Resulting in Serious Harm	0.09	0.12	↓	0.04	0.04	0.04	CNO	
Eligible Patients Having VTE Risk Assessment (1 month in arrears)	96.10%	96.28%	↑	95%	95%	95%	CNO	
Never Events - Cumulative	1.00	1.00	→	0	0	0	CMO	
Number of Maternal Deaths	0	0	→	0	0	0	CMO	
Number of Registered Complaints	46	35	↑	40	40	40	CMO	
Friends & Family Test Inpatient Coverage	26.94%	22.52%	↓	38%	38%	38%	CMO	
Friends & Family Test Inpatient Recommenders	90.04%	89.65%	↓	95%	95%	95%	CMO	
Friends & Family Test A&E Coverage	13.16%	13.73%	↑	20%	20%	20%	CMO	
Friends & Family Test A&E Recommenders	84.71%	83.78%	↓	87%	87%	87%	CMO	
Maternity FFT No of Touchpoints Achieving a 15% Response Rate	4	4	→	4	4	4	CMO	
All Cancellations on Day of Surgery	9.49%	12.36%	↓	6%	6%	6%	COO	
Urgent Operations Cancelled for the Second Time	0	0	→	0	0	0	COO	
Theatre Efficiency - Main	67.80%	60.98%	↓	85%	85%	85%	COO	
Theatre Efficiency - Rugby	70.16%	70.38%	↑	85%	85%	85%	COO	
Theatre Efficiency - Day Surgery	58.86%	56.33%	↓	70%	70%	70%	COO	
Theatre Utilisation - Main	82.80%	77.28%	↓	85%	85%	85%	COO	
Theatre Utilisation - Rugby	77.76%	79.19%	↑	85%	85%	85%	COO	
Theatre Utilisation - Day Surgery	69.98%	67.91%	↓	70%	70%	70%	COO	
Surgical Safety Checklist - WHO	100.00%	100.00%	→	100%	100%	100%	CMO	
Breaches of the 28 Day Readmission Guarantee	10	7	↑	0	0	69	COO	
RTT 52 Week Waits (1 month in arrears)	0	0	→	0	0	0	COO	
30 Day Emergency Readmissions (1 month in arrears)	8.38%	9.11%	↓	7.89%	7.89%	7.89%	COO	
Medication Errors Causing Serious Harm	0	0	→	0	0	0	CMO	
Reported Harmful Patient Safety Incidents (1 month in arrears)	28.12%	30.99%	↓	26.3%	26.3%	26.3%	CMO	
E-referral Appointment Slot Issues – National data				3%	3%	3%	COO	
Serious Incidents - Number	17	13	↑	7	7	7	CMO	
Serious Incidents - Overdue	1	0	↑	0	0	0	CMO	
CAS Alerts - Overdue	0	1	↓	0	0	0	CMO	
Same Sex Accommodation Breaches	0	0	→	0	0	0	CNO	
C-UTI	99.51%	98.93%	↓	99%	99%	99%	CNO	

Trust Scorecard – (Supplementary)

Reporting Month December 2015

University Hospitals Coventry and Warwickshire NHS Trust

Trust Supplementary Scorecard								
Measure	Previous Position	Latest Position	DoT	YTD Plan	Annual Target	Annual FOT	Executive Lead	Trend
Supplementary Objectives								
Deliver value for money								
Liquidity Days	-26.30	-26.90	↓	-22.9	-15.9	-14.3	CFSO	
Capital Services Capacity	0.70	0.74	↑	0.7	0.7	0.98	CFSO	
Combined Risk Rating	1	1	→	1	1	1	CFSO	
Employer of choice								
Staff Turnover Rate	8.96%	9.03%	↓	10%	10%	10%	CWIO	
Personal Development Review - Non-Medical	85.50%	87.48%	↑	90%	90%	90%	CWIO	
Personal Development Review - Medical	71.24%	74.21%	↑	90%	90%	90%	CWIO	
Mandatory Training Compliance	85.24%	85.95%	↑	95%	95%	95%	CWIO	
Sickness Rate	4.69%	4.86%	↓	4%	4%	4%	CWIO	
Staff Survey - Response Rate	22.76%	22.76%	→	11.77%	11.77%	11.77%	CWIO	
Leading research based health care organisation								
Performance in Initiating Trials - Quarterly	47.22%	37.14%	↓	80%	80%	80%	CMO	
Performance in Delivery of Trials - Quarterly	46.15%	57.89%	↑	80%	80%	80%	CMO	
Portfolio Research Studies Open to Recruitment - Quarterly	153	158	↑	155	155	155	CMO	
Research Critical Findings and Serious Incidents - Quarterly	1	0	↑	0	0	0	CMO	
Submitted Research Grant Applications - Quarterly - Cumulative	56	89	↑	90	120	120	CMO	
Commercial Income Invoiced £000s - Cumulative (1 month in arrears)	607	660	↑	800	1200	1200	CMO	
Leading training and education centre								
Job Evaluation Survey Tool Score - JEST (1 month in arrears)	3.70	3.70	→	3.5	3.5	3.5	CMO	
No of Specialties at HEWM Level 3 and 4	3	3	→	0	0	0	CMO	
Doctor Trainers Provisionally Accredited	98.47%	98.47%	→	100%	100%	100%	CMO	

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

DoT	
↑	Improving
→	No change
↓	Falling

Trust Scorecard – Finance and Performance Committee

Reporting Month December 2015

University Hospitals Coventry and Warwickshire NHS Trust

Finance and Performance Scorecard							
Measure	Previous Position	Latest Position	DoT	YTD Plan	Annual Target	Annual FOT	Trend
National Standards							
18 Weeks Referral to Treatment Time - Incomplete (1 month in arrears)	87.49%	88.24%	↑	92%	92%	92%	
18 Week Referral to Treatment Time - Admitted (1 month in arrears)	77.01%	76.06%	↓	90%	90%	90%	
18 Week Referral to Treatment Time - Non-admitted (1 month in arrears)	90.13%	88.92%	↓	95%	95%	95%	
Diagnostic Waiters - 6 Weeks and Over	0.07%	0.20%	↓	1%	1%	1%	
Cancer 2 Week Wait GP Referral to OP Appointment (1 month in arrears)	97.17%	98.63%	↑	93%	93%	93%	
Cancer 31 Day Diagnosis to Treatment (1 month in arrears)	100.00%	99.49%	↓	96%	96%	96%	
Cancer 62 Day Urgent Referral to Treatment (1 month in arrears)	85.06%	81.32%	↓	85%	85%	85%	
A&E 4 Hour Wait	89.00%	87.43%	↓	95%	95%	95%	
12 Hour Trolley Waits in A&E	0	0	→	0	0	0	
Corporate Objectives							
Chief Operating Officer							
Bed Occupancy Rate - Basket of Wards	92.09%	91.63%	↑	93%	93%	93%	
Number of Medical Outliers - Average per Day	61	77	↓	50	50	50	
Delayed Transfers as a Percentage of Admissions	6.62%	5.43%	↑	3.5%	3.5%	3.5%	
Length of Stay - Average	6.65	7.56	↓	5.96	5.96	5.96	
Emergency Admissions - Local Definition	2900	2868	↑	2729	2729	2729	
Last Minute Non-clinical Cancelled Operations - Elective	0.94%	0.84%	↑	0.8%	0.8%	0.8%	
Chief Finance and Strategy Officer							
Forecast Income & Expenditure Compared to Plan - £'000	-19423	-11423	↑	-11423	-11423	-11423	
Forecast Recurrent and Non Recurrent Efficiency Compared to Plan - £'000	34083	34690	↑	34000	34000	34690	
YTD Income & Expenditure Compared to Plan Trust - £'000	-13031	-14785	↓	-14357	-11423	-11423	

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

DoT	
↑	Improving
→	No change
↓	Falling

Trust Scorecard – Quality and Governance Performance Committee

Reporting Month December 2015

University Hospitals Coventry and Warwickshire NHS Trust

Quality and Governance Scorecard							
Measure	Previous Position	Latest Position	DoT	YTD Plan	Annual Target	Annual FOT	Trend
National Standards							
18 Weeks Referral to Treatment Time - Incomplete (1 month in arrears)	87.49%	88.24%	↑	92%	92%	92%	
18 Week Referral to Treatment Time - Admitted (1 month in arrears)	77.01%	76.06%	↓	90%	90%	90%	
18 Week Referral to Treatment Time - Non-admitted (1 month in arrears)	90.13%	88.92%	↓	95%	95%	95%	
Diagnostic Waiters - 6 Weeks and Over	0.07%	0.20%	↓	1%	1%	1%	
Cancer 2 Week Wait GP Referral to OP Appointment (1 month in arrears)	97.17%	98.63%	↑	93%	93%	93%	
Cancer 31 Day Diagnosis to Treatment (1 month in arrears)	100.00%	99.49%	↓	96%	96%	96%	
Cancer 62 Day Urgent Referral to Treatment (1 month in arrears)	85.06%	81.32%	↓	85%	85%	85%	
A&E 4 Hour Wait	89.00%	87.43%	↓	95%	95%	95%	
12 Hour Trolley Waits in A&E	0	0	→	0	0	0	
Corporate Objectives							
Chief Workforce and Information Officer							
Vacancy Rate Compared to Funded Establishment	12.41%	12.84%	↓	10%	10%	10%	
Staff Survey - Recommending as a Place of Treatment	89.43%	89.43%	→	74.52%	74.52%	74.52%	
Staff Survey - Recommending as a Place of Work	80.36%	80.36%	→	57.8%	57.8%	57.8%	
Enrolled on Leading Together Programme	97	97	→	125	125	125	
Succession Plan	Yes	Yes	→	Yes	Yes	Yes	
Chief Medical Officer							
NCE POD Categorised E Deaths - Cumulative (3 months in arrears)	2	2	→	7	15	15	
HSMR - Basket of 56 Diagnosis Groups	118.42	95.18	↑	RR	RR	RR	
SHMI - Quarterly (6 months in arrears)	103.89	103.89	→	RR	RR	RR	
Patients Recruited into NIHR Portfolio - Cumulative (2 months in arrears)	2243	2580	↑	2925	5015	5015	
Peer Reviewed Publications - Calendar Year Cumulative	239	246	↑	172	172	172	
Chief Nursing Officer							
Hand Hygiene – Clinical and Non-clinical	84.49%	85.62%	↑	95%	95%	95%	
Cannula - Full Compliance	92.35%	83.38%	↓	90%	90%	90%	
Central Venous Catheter (CVC) Compliance				90%	90%	90%	
MRSA Decolonisation Score	100.00%	64.29%	↓	95%	95%	95%	
MRSA - Elective Screening	90.68%	89.15%	↓	95%	95%	95%	
MRSA Bacteremia - Trust Acquired - Cumulative	0	0	→	0	0	0	
Clostridium Difficile - Trust Acquired - Cumulative	25	28	↓	30	42	42	
Harm Free Care	94.93%	94.55%	↓	95%	95%	95%	

RR = Relative Risk : The target for this indicator uses the relative risk as calculated by Dr Foster. The performance is classed as achieving target if the UHCW value is either below or within the expected range.

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

DoT
↑ Improving
→ No change
↓ Falling

Trust TDA Scorecard

Reporting Month December 2015

University Hospitals Coventry and Warwickshire NHS Trust

TDA Scorecard						
Measure	TDA Escalation Previous Position	TDA Escalation Current Position	DoT	Executive Lead	Achievement Trend	Match to TDA
Caring						
Staff FFT Percentage Recommended - Care	Green	Green	→	CWIO		
Inpatient Scores from Friends and Family Test - % Positive	Green	Green	↓	CMO		*
A&E Scores from Friends and Family Test - % Positive	Green	Green	↓	CMO		*
Mixed Sex Accommodation Breaches	Green	Green	→	CNO		*
Effective						
Hospital Standardised Mortality Ratio - DFI	Red	Green	↑	CMO		
Hospital Standardised Mortality Ratio - Weekend	Green	Green	↑	CMO		*
Summary Hospital Mortality Indicator - HSCIC - Date Of Publication	Green	Green	→	CMO		*
Responsive						
Referral to Treatment Incomplete - English Commissioners Only (1 month in arrears)	Red	Red	↑	COO		*
Referral to Treatment Non Admitted - English Commissioners Only (1 month in arrears)	Red	Red	↓	COO		
Referral to Treatment Admitted - English Commissioners Only (1 month in arrears)	Red	Red	↓	COO		*
Referral to Treatment Incomplete 52+ Week Waiters (1 month in arrears)	Green	Green	→	COO		*
Diagnostic Waiting Times	Green	Green	↓	COO		*
A&E All Types Monthly Performance	Red	Red	↓	COO		*
12 Hour Trolley Waits	Green	Green	→	COO		*
Cancer Two Week Wait Standard (1 month in arrears)	Green	Green	↑	COO		*
Cancer Breast Symptom Two Week Wait Standard (1 month in arrears)	Green	Green	↑	COO		*
Cancer 31 Day Standard (1 month in arrears)	Green	Green	↓	COO		*
Cancer 31 Day Subsequent Drug Standard (1 month in arrears)	Green	Green	→	COO		*
Cancer 31 Day Subsequent Radiotherapy Standard (1 month in arrears)	Green	Green	↓	COO		
Cancer 31 Day Subsequent Surgery Standard (1 month in arrears)	Green	Green	↓	COO		*
Cancer 62 Day Standard (1 month in arrears)	Green	Red	↓	COO		
Cancer 62 Day Screening Standard (1 month in arrears)	Green	Green	↓	COO		*
Cancer 104 Day Waits (1 month in arrears)	Red	Red	↓	COO		*
Urgent Ops Cancelled for 2nd time - Number	Green	Green	→	COO		*
Proportion of Patients Not Treated Within 28 Days of Last Minute Cancellation	Red	Red	→	COO		
Delayed Transfers of Care	Red	Red	↑	COO		

Trust TDA Scorecard

Reporting Month December 2015

University Hospitals Coventry and Warwickshire NHS Trust

TDA Scorecard						
Measure	TDA Escalation Previous Position	TDA Escalation Current Position	DoT	Executive Lead	Achievement Trend	Match to TDA
Safe						
Clostridium Difficile - Variance from Plan	Green	Green	→	CNO		*
MRSA Bactaraemias	Green	Green	→	CNO		*
Never Events	Red	Green	↑	CNO		*
Never Events - Incidence Rate	Green	Green	→	CMO		
Serious Incidents Rate	Green	Green	↓	CMO		*
Potential Under Reporting of Patient Safety Incidents	Green	Green	↓	CMO		*
CAS Alerts Outstanding	Green	Red	↓	CMO		
VTE Risk Assessment	Green	Green	↑	CNO		*
Medication Errors Causing Serious Harm	Green	Green	→	CMO		*
Percentage of Harm Free Care	Green	Green	↓	CNO		*
Emergency C-Section Rate	Green	Green	↑	CMO		
Well Led						
Staff Sickness	Green	Green	↓	CWIO		*
Staff Turnover	Green	Green	↓	CWIO		*
A&E FFT Response Rate	Green	Green	↑	CMO		*
Friends & Family Test Inpatient Coverage (Inc. Day Cases)	Green	Green	↓	CMO		*
Staff FFT Percentage Recommended - Work	Green	Green	→	CWIO		
Staff FFT Response Rate	Green	Green	→	CWIO		

* = The data provided in the latest TDA file matches UHCW data.
Note - The data shown above is the latest UHCW data.

University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD PAPER

Title	**Trust Development Authority (TDA) Oversight – Monthly Self Certification Requirements December 2015**
Author	**Lynda Cockrill, Head of Performance & Programme Analytics**
Responsible Chief Officer	**David Moon, Chief Finance & Strategy Officer**
Date	**28th January 2016**

1. Purpose

This paper presents the proposed self-certification against the Board Statements and the Monitor Provider License Compliance statements for the month of December and seeks approval of these prior to submission to the NHS Trust Development Authority (TDA).

2. Background and Links to Previous Papers

It is a requirement of the TDA regulatory regime that a Trust Board approved submission against these statements is made on the last working day of each month. The regime was introduced as a forerunner to NHS Trusts becoming licensed as Foundation Trusts (FT) because Monitor requires that the Board of Directors of each Foundation Trust considers compliance against these on a monthly basis as a core component of the FT governance framework.

In the event that compliance is declared and subsequent events suggests this not to have been the case, Monitor will intervene in the Trust and as such, the TDA mirrored the Monitor arrangements in order that Trusts are accustomed to making declarations and confident in their processes for declaring compliance in readiness for when their FT license is granted.

It is important therefore that Board members are satisfied that the Trust is compliant where compliance is being declared, and members are therefore encouraged to consider each statement and to seek further assurances where this is felt necessary.

3. Narrative

Appendix A details the Trust's assessment against each of the Board Statements. The Trust is able to report compliance against all statements.

Appendix B details the Trust's assessment against the Monitor license conditions and the Trust is declaring full compliance.

4. Areas of Risk

Although compliance against all statements can now be reported, work must continue to maintain the levels of information governance training in order that the Trust remains compliant in forthcoming years against level 2 of the information toolkit and therefore against Board statement 11.

5. Governance

Self-assessment and submission against the Board and License conditions is a regulatory requirement of the TDA.

6. Responsibility

David Moon, Chief Finance & Strategy Officer

7. Recommendations

The Board is invited to **NOTE** the proposed December submission against the Board and License requirements and **APPROVE** submission of the document to the TDA.

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OVERSIGHT: Monthly self-certification requirements - Board Statements	Compliance
CLINICAL QUALITY	
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.	**YES**
2. The Board is satisfied that plans in place are sufficient to ensure on-going compliance with the Care Quality Commission's registration requirements.	**YES**
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.	**YES**
FINANCE	
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.	**YES**
GOVERNANCE	
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.	**YES**
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.	**YES**
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.	**YES**
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.	**YES**
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**).	**YES**
10. The Board is satisfied that plans in place are sufficient to ensure on-going compliance with all existing targets as set out in the NTDA oversight model; and a commitment to comply with all known targets going forward.	**YES**
11. The trust has achieved a minimum of Level 2 performance against the requirements of the Information Governance Toolkit.	**YES**
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.	**YES**
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.	**YES**
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.	**YES**

OVERSIGHT: Monthly self-certification requirements - Compliance Monitor	Page Reference (PDF document) †	Annex Page Number ‡	Compliance
1. Condition G4 – **Fit and proper persons as Governors and Directors (also applicable to those performing equivalent or similar functions).**	**64**	**5**	**YES**
2. Condition G5 – **Having regard to monitor Guidance.**	**66**	**7**	**YES**
3. Condition G7 – **Registration with the Care Quality Commission.**	**68**	**9**	**YES**
4. Condition G8 – **Patient eligibility and selection criteria.**	**69**	**10**	**YES**
5. Condition P1 – **Recording of information.**	**74**	**15**	**YES**
6. Condition P2 – **Provision of information.**	**76**	**17**	**YES**
7. Condition P3 – **Assurance report on submissions to Monitor.**	**77**	**18**	**YES**
8. Condition P4 – **Compliance with the National Tariff.**	**78**	**19**	**YES**
9. Condition P5 – **Constructive engagement concerning local tariff modifications.**	**79**	**20**	**YES**
10. Condition C1 – **The right of patients to make choices.**	**80**	**21**	**YES**
11. Condition C2 – **Competition oversight.**	**81**	**22**	**YES**
12. Condition IC1 – **Provision of integrated care.**	**82**	**23**	**YES**

† https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/285008/ToPublishLicenceDoc14February.pdf

‡ https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/285009/Annex_NHS_provider_licence_conditions_-_20120207.pdf

University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD PAPER

Title	**Care Quality Commission Action Plan – progress update**
Author	**Sue Basham, Associate Director of Quality** **Jenny Gardiner, Director of Quality**
Responsible Chief Officer	**Meghana Pandit, Chief Medical and Quality Officer** **Mark Radford, Chief Nursing Officer**
Date	**28th January 2016**

1. Purpose

This paper presents the Action Plan developed in response to the Trust's Care Quality Commission (CQC) Comprehensive Inspection Report published on 6 August 2015. The Trust Board is asked to note progress to completion of the CQC Action Plan.

2. Background and Links to Previous Papers

The CQC Comprehensive Inspection Report rated the Trust as "Requires Improvement". There were 14 "must do" and compliance actions identified within the report against which the Trust is required to implement a remedial plan of action.

3. Narrative

The Trust's CQC Action Plan is structured around the main themes identified for the Quality Summit held on 4 August 2015, which respond to the "must do" actions and compliance actions from the CQC Report. The report highlighted the following themes which require additional work to improve quality standards in the Trust;

- Medical Equipment and Medical Supplies
- Patient Flow in ED
- Mental Capacity Act
- Medicines Management
- Infection Control
- DNACPR Forms
- Sufficient Suitably Skilled Staff

The CQC identified an additional compliance action regarding Risk Management processes within the Trust. Although this did not appear in the "must do" actions in the CQC report, associated actions have been identified in the action plan.

Additionally not highlighted as a 'must do', a separate set of specific urgent actions have been included in the plan in response to the Inadequate rating for 'Safe' in the Outpatients (Radiology) Service..

The Action Plan was submitted to the CQC by the required deadline of 11 September 2015.

Significant progress has been made by the Trust in completing all actions, however, as at 6 January 2016; there remain 4 out of the original 109 actions outstanding. A summary of the outstanding actions is highlighted below.

Improvement area	Action	Comment
Patient Flow in Emergency Services	Develop a preferred option to increase resuscitation capacity to allow acuity patients to be managed in bays with more space	A preferred option continues to be explored and developed. Timely completion of this action is being hampered by the significant pressures being experienced by Emergency Services where the immediate focus has to be on providing safe and effective care for patients. Service pressures are being driven by an increase in patient requests to be treated at UHCW and very high numbers of delayed discharges due to lack of capacity for care in the community.
Medicines Management	Disseminate remedial medicines management actions resulting from 'Getting the Basics Right Programme' to Ward Managers	The Trust has an internal Assurance Programme called 'Getting The Basics Right'. The medicines management results of the most recent programme are to be discussed with Trust Ward Managers on 18 January 2016, along with required remedial actions, which will complete this action. It should be noted that subsequent audits of medicines management standards have demonstrated continued compliance improvement.
Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR)	Review alignment of Trust DNACPR policy against new national policy (dependent upon national launch by end 2015).	The Trust has a current and robust DNACPR Policy in place. In light of the anticipated publication of an updated national policy in November 2015 it was deemed appropriate to review the Trust's current policy with any new guidance. This action is dependent upon the publication of national policy. Intelligence suggests that the new national guidance will not now be published until February 2016 at the earliest.
Radiology	Review incentives for staff engagement	This action is the last of 18 actions to be completed. Whilst progress has been made against the action plan there is further work to do around cultural development that will be more longstanding in nature.

4. Areas of Risk

There are a number of risks associated with the delivery of the Action Plan. These risks are being mitigated through delivery and completion of the identified actions within the action plan. The risks are:

- Lack of policies to implement change
- Lack of implementation of change
- Lack of performance management
- Poor flow through the Trust
- Inadequate training of staff
- Lack of engagement by staff to address issues

5. Governance

The actions identified within the Action Plan will address areas for improvement in compliance of statutory regulations within the Health and Social Care Act 2008 (amended 2014).

Progress against the Action Plan is monitored by the Chief Inspector of Hospital Programme Board on a fortnightly basis, with oversight by the Quality Governance Committee.

Progress against the delivery of the plan is being monitored by the Trust Development Agency and the CQC.

6. Responsibility

The Action Plan identifies Lead Executive Officers with responsibility for delivery of the actions supported by identified lead officers for the improvement areas.

7. Recommendations

The Board is invited to **NOTE** the Trust's progress against the Action Plan in response to the CQC's Comprehensive Inspection Report.

Name and Title of Author: Sue Basham, Associate Director of Quality
Date**: 28 January 2016**

University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD PAPER

Title	**Board Assurance Framework 2015/16 Quarter 3 Update**
Author	**Rebecca Southall, Director of Corporate Affairs**
Responsible Chief Officer	**Meghana Pandit, Chief Medical and Quality Officer and Deputy CEO**
Date	**28th January 2016**

1. Purpose

To present the Quarter 3 update against the 2015/16 Board Assurance Framework.

2. Background and Links to Previous Papers

The Trust Board approved the Board Assurance Framework (BAF) for 2015/16 at the April meeting. Given that the third quarter of the year has now elapsed, each of the risks has been reviewed by the responsible Chief Officer and the updated position in terms of progress against the actions outlined and the risk score is attached. Also attached at appendix 1 is the risk assessment matrix that forms part of the Trust's Risk Management Strategy and is used for the assessment of all risks.

3. Narrative

The Board is responsible for identifying and monitoring risks to the strategic objectives that it sets. This is achieved through the annual development of a Board Assurance Framework, which is monitored at the Trust Board on a quarterly basis. As part of that monitoring process, board members should consider whether the Board Assurance Framework remains reflective of the current risks to achievement of the annual objectives given the dynamic nature of the healthcare environment.

Quarter 3 Update

Each risk has been reviewed and updated by the Chief Officers and the attached document details:

- The current controls and gaps in controls
- The current assurances and gaps in assurances
- The current score against each of the BAF risks.
- An update against the actions identified as at the end of quarter 3.

It should be noted that good progress continues to be made with the following risks being recommended for a reduction in score as detailed below.

Risk	Proposed Change	Rationale
If the Trust does not reduce vacancy rates, there will be a continuing need for high levels of costly agency staff. This could impact on quality of care to our patients, staff morale and the achievement	Reduction in consequence from (4) to (3)	Reflection of the progress that has been made in relation to recruiting to substantive posts.

of our financial plan.		
The impact of the new Executive team, combined with the Leadership Development Programme is beginning to improve the capability and capacity of our leaders. This momentum needs to continue to optimise our ability to deliver excellent patient care and experience as well as improve performance.	Recommended reduction in likelihood score from (5) to (3)	Positive nature of evaluation of programme, together with the number of leaders that have been through the programme in 2014/15.

No new risks have been recommended for inclusion in the quarter and no risks have been closed.

4. Areas of Risk

If the Trust does not have a robust Board Assurance Framework and system of monitoring in place there is the risk that the strategic objectives will not be achieved, which could have regulatory, reputation and financial implications and could impact on the quality of care that is provided. Monitoring and reporting progress against the mitigation of these risks mitigates against these risks materialising.

5. Governance

The Trust Board will continue to monitor the Board Assurance Framework on a quarterly basis at the board meeting that follows the quarter end.

6. Responsibility

Rebecca Southall, Director of Corporate Affairs
Meghana Pandit, Chief Medical Officer and Deputy CEO

7. Recommendations

The Board is invited to:

1. **NOTE** the updated Board Assurance Framework as at quarter 3,
2. seek further **ASSURANCE** in relation to the management and mitigation of the risks as appropriate
3. **CONSIDER** whether the BAF remains reflective of the current risks to the achievement of the strategic objectives; and to
4. **APPROVE** the reduction in risk scores as identified.

STRATEGIC OBJECTIVE	To deliver excellent patient care and experience To deliver value for money
ANNUAL OBJECTIVE 1	Reduce vacancy rate to below 10%
EXECUTIVE LEAD	Chief Workforce and Information Officer
MANAGEMENT LEAD	Associate Director of Workforce
RESPONSIBLE COMMITTEE	Finance and Performance Committee
RISK	If we do not reduce our vacancy rates, there will be a continuing need for high levels of costly agency staff. This could impact on quality of care to our patients, staff morale and achievement of our financial plan.
NEXT REVIEW DATE	31.03.16

Controls:
Vacancy tracker developed and vacancy information presented monthly to the Corporate Delivery Group which clearly sets out the vacancy position across all staff groups.
Hard to fill posts are identified through the ODP and workforce plan.
All key clinical posts are actioned swiftly and are not subject to current pay controls.
All non-clinical posts are subject to Chief Officer approval.
A range of recruitment activities and initiatives are developed and monitored through the Transforming Workforce Supply Committee.
Managers use appropriate risk assessments in areas with critical vacancies and temporary staffing, including agency, is approved where required for patient safety.

Gaps in controls:
Attraction and Retention Strategy not yet completed.

Assurance:
Vacancy rate reported in the Integrated Quality and Performance Report at Trust Board each month.
Key recruitment metrics included within the Integrated Quality and Performance Report (Trust Board)
Tracked through monthly workforce report and IPR, monthly ODM Meetings and Quarterly Performance Meetings

Gaps in Assurance:
Vacancy rate remains above target at the present time although improvement continues (November 12.41% / August 2015 14.88% / May 2015 16.62%).

Achievement of 10% Trust Wide vacancy rate remains a challenge given the controls and restriction on non-clinical recruitment, therefore the table below depicts the vacancy percentage by separate staff groups. Registered nursing remains the most significant challenge for the Trust along with some difficult to fill medical posts.

taff Group	Funded (WTE)	Staff In Post (WTE)	Funded Vacancies (WTE)	Vacancy Rate %
Add Prof Scientific and Technic	261.62	239.29	22.33	8.54%
Additional Clinical Services	1,562.95	1,447.11	115.84	7.41%
Administrative and Clerical	1,311.91	1,197.76	114.15	8.70%
Allied Health Professionals	402.50	371.18	31.32	7.78%
Estates and Ancillary	3.00	1.00	2.00	66.67%
Healthcare Scientists	368.82	324.73	44.09	11.95%
Medical and Dental	1,044.59	916.22	128.37	12.29%
Nursing and Midwifery Registered	2,588.94	2,104.40	484.54	18.72%
Students	39.65	41.20	-1.55	-3.91%
Grand Total	7583.98	6,642.89	941.09	12.41%

RISK RATING	LIKELIHOOD	CONSEQUENCE	RISK RATING	Progress
Initial Risk Rating	**4 (likely)**	**4 (major)**	**16 (high)**	
Target Risk Rating	**3 (possible)**	**3 (moderate)**	**9 (moderate)**	
Current Risk Rating	**4 (likely)**	**3 (moderate)**	**12 (high)**	

ACTIONS		
Action	**Due Date**	**Progress Update at Quarter 3**
Development of a recruitment Facebook page	Completed	Recruitment Facebook page has been launched which highlights specific recruitment campaigns.
Development of registered nurse recruitment campaigns	On-going	A programme of Specialty group adverts has been developed to support the generic Band 5 nurse campaigns. The latest campaign in November/December for newly qualified nurses resulted in 45 offers of employment. A programme of assessment centres are being scheduled throughout 2016. A business case for overseas nurse recruitment is being considered.
Development of Attraction and Development Strategy	January 2016	Due to best practice examples being sourced, there has been some slippage with this development. The strategy will be published by the end of January 2016
Development of a recruitment microsite	January 2016	The recruitment microsite has now been developed, pending some further refinements to the medical staff and “other clinical” staff web pages. This will be live by mid-January 2016.
Development of a Consultant Recruitment brochure	January 2016	This brochure will be printed and distributed by mid-January 2016.

Recommendation: Due to good progress being made for recruitment in many staff groups, a change to the consequence score of the risk is recommended as at quarter 3. Whilst the national shortage of registered nurses and some difficult to fill medical posts remain, this position has been static for the past 12 months.

ANNUAL OBJECTIVE 2	Achieve above the national average performance for each quarter of the staff Friends and Family Test Survey and National Staff Survey
EXECUTIVE LEAD	Chief Workforce and Information Officer
MANAGEMENT LEAD	Associate Director of Workforce
RESPONSIBLE COMMITTEE	Quality Governance Committee
RISK	If our staff FFT results do not improve this could lead to high levels of staff dis-engagement and ultimately poor patient experience.
NEXT REVIEW DATE	31.3.16

Controls:

Staff FFT undertaken on a quarterly basis, with results cascaded to Group Management Teams and Head of Departments on quarterly basis in order to identify remedial actions to be taken to improve staff engagement.

Information from National Staff Survey, Staff FFT Q1 and information gathered through listening events utilised to determine areas of focus for Together Towards World Class (TTWC) programme projects and areas of focus for 2016/2017.

Programme plans signed off through Together Towards World Class programme board in September 2015 and monitored through bi-monthly board meetings.

National Staff Survey 2015 taken place between September – December 2015, full benchmarking results published week commencing 8th February 2016 although embargoed from public release until 23rd February 2016.

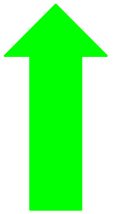
Weekly response rates up-date cascaded using existing communication channels, with targeted cascades to hot spot areas through survey period in order to support higher response rates.

Full Staff Impressions survey scheduled to take place in March 2016 to coincide with TTWC 2nd birthday.

Gaps in controls:

None identified

Assurance: Actions to address issues raised in National Staff Survey 2015 will be presented to the April 2016 Trust Board. Information on staff FFT is provided quarterly and presented to the TTWC Programme Board, Chief Officers and cascaded through Group Management Teams and Heads of Department. Staff FFT is reported to the Trust Board each month via the Integrated Quality & Performance Report
Gaps in Assurance: National staff survey only taken annually and full benchmarking results will not be known until February 2016. Staff FFT quarterly benchmarking is published retrospectively for previous quarter.

	LIKELIHOOD	**CONSEQUENCE**	**RISK RATING**	**Progress**
Initial Risk Rating	**4 (likely)**	**3 (moderate)**	**12 (moderate)**	
Target Risk Rating	**2 (unlikely)**	**2 (minor)**	**4 (low)**	
Current Risk Rating	**3 (possible)**	**3 (moderate)**	**9 (moderate)**	

ACTIONS		
Action	**Due Date**	**Progress Update at Quarter 3**
Impressions survey incorporating staff FFT to be conducted throughout the year	On-going	<u>Staff FFT Results</u>

Category	Q1 2015/2016	Q2 2015/2016	Q3 2015/2016
Recommendation as treatment provider	81%	89%	76%
Recommendation as place to work	65%	80%	68%

		Q1 – Q2 results indicate improvements in results in both numbers of staff recommending Trust as place for their friends and family to be treated and place for their friends and family to work. The Trust is above the national average for both quarters, on both sets of results. Results in Q3 have seen a dip in performance. However it should be noted that these results were gathered through the National Staff Survey which was sent to 850 randomly selected staff. This reduction in recommenders was also seen in Q3 in 2014/2015. Therefore results in Q4 will need to be analysed to ascertain whether this is an on-going deterioration in performance. Despite the reduction in performance from Q2 – Q3 the Trust remains above the average for Acute Trusts also utilising Quality Health as their national staff survey administrator. The average for Acute trusts are 69% recommending as a treatment provider, 7% lower than UHCW's results and 59% recommending as a place to work, 10% lower than UHCW's results. Continued incorporation of SFFT into the IPR is encouraging more local ownership and interventions. <u>National Staff Survey</u> Higher response rate achieved in 2015 (39%) in comparison to 37% in 2014, although remain below average for comparator trusts. Results show improvements against all categories in comparison to 2014 results.

		Furthermore initial comparator benchmarking (against Acute Trust's utilising Quality Health as survey administrator) indicate we are above average in the majority of question categories. Information has been shared with Chief Officers Group and Workforce and Engagement Committee.

Recommendation: All actions are on track and plans are in place.

The risk status remains unchanged in Quarter 3. This conclusion has been reached as despite, reductions in recommenders between Q2 and Q3, initial benchmarking indicates UHCW performance is above average for other Acute Trusts utilising Quality Health as NHS National Staff Survey administrator. Full benchmarking from National Staff Survey will not be published until February 2016 and therefore it would not be appropriate to suggest a reduction in the risk score at this point.

STRATEGIC OBJECTIVE	To deliver excellent patient care and experience To deliver value for money
ANNUAL OBJECTIVE 3	Reduce bed occupancy rates to less than 93%
EXECUTIVE LEAD	Chief Operating Officer
MANAGEMENT LEAD	Director of Operations
RESPONSIBLE COMMITTEE	Finance and Performance Committee
RISK	If we do not reduce our bed occupancy to less than 93% we will fail our performance targets and provide a poorer standard of care to our patients.
NEXT REVIEW DATE	30.03.16
Controls: Delayed Transfer of Care (DTOC) patients identified and formally recorded Health Economy System Resilience Group in existence. Control and Command structure in place to manage operational delivery Action plan in place to manage, monitor and deliver improvements and thereby deliver bed occupancy below 93% FREED metrics in place	
Gaps in controls: Inability to discharge patients that require a package of care/support from partner agencies because processes and capacity do not adequately meet demand. Inability to discharge patients early enough in the day to establish and maintain flow through failure to make timely decisions, prescribe and dispense TTOs consistently. Inability to deliver daily capacity and demand balance seven days per week due to inconsistent application of the FREED safety metrics.	
Assurance: DTOC position reported to the Trust Board each month FREED metrics in place and reports generated Daily performance position report and weekly trend analysis report Monthly report to Finance & Performance Committee and Trust Board	

Delivery of successful Perfect Weeks in July and November 2015.
Gaps in Assurance: Number of patients in DTOC remains statically high. Partial system plan to recover the position in place and monitored at System Resilience Group (SRG)

	LIKELIHOOD	CONSEQUENCE	RISK RATING	Progress
Initial Risk Rating	**4 (likely)**	**5 (catastrophic)**	**20 (high)**	
Target Risk Rating	**2 (unlikely)**	**5 (catastrophic)**	**10 (moderate)**	
Current Risk Rating	**4 (likely)**	**5 (catastrophic)**	**20 (high)**	

ACTIONS		
Action	**Due Date**	**Progress Update at Quarter 3**
Accelerated roll out of pharmacy Computer on Wheels (COW) to aide with TTOs and speed up discharge	Completed	Resourced for the Perfect Week and full deployment plan now in place.
Health economy wide diagnostic exercise	Completed	This work has been commissioned and the diagnostic has a further 6-weeks to run. The completed report has been presented to SRG and future actions will be agreed
3rd Perfect Week exercise planned after success of PW1 and PW2.	February 2016	Planning underway.
Continue to work with partners and regulators to develop system plan to resolve the DTOC issue	On-going	A single tool for assessing the frail elderly has been agreed for use across the Local Health Economy (completed). Plans are in place to develop the Frailty Pathway across the Local Health Economy
Programme of work undertaken across the Health Economy with Emergency Care Improvement Team	Completed	This work has been completed and a plan is in place to ensure that internal delays are minimised by early assessment taking place at the front door and the introduction of a Frailty Team.

Staged internal reconfiguration programme in place GPAU/FEAU	Completed	Medical Decisions Unit was opened on the 1st September 2015.
Programme of work to reduce length of stay	On-going	Changes to the way in which outliers are managed should help to reduce length of stay.

Recommendation: Work continues to reduce bed occupancy on a sustained basis as outlined above and will continue to focus on the adoption of the FREED metrics and joint working across the health economy for the rest of the year. The health and social care system has begun its work with ECIP who visited and undertook an assessment in mid-December. Five key themes emerged:

- The Health Economy has set out its vision at SRG, but this is poorly understood by staff on the ground
- There is variability in the application of FREED in the hospital and it isn't applied outside of the hospital
- Ambulatory Care and Acute Frailty pathways need further development and deployment
- Early functional frailty assessment and access to pathways to avoid admission require further development
- The wider health economy doesn't escalate effectively when the hospital comes under pressure.

Plans are being developed to address these issues. The hospital has deployed a frailty team to the front door and Integrated Discharge Team will start work at the point of admission with effect from 4th January. Further work will be led by the COO who will take the Executive Lead for this issue. Whilst progress is being made, no reduction in the risk score is recommended at this time as DTOC levels remain high.

STRATEGIC OBJECTIVE	To deliver excellent patient care and experience
ANNUAL OBJECTIVE 4 & 5	Reduce the number of avoidable deaths (NCEPOD E) to less than 15 and reduce HSMR to below 100
EXECUTIVE LEAD	Chief Medical Officer
MANAGEMENT LEAD	Director of Quality and Deputy Medical Director
REPONSIBLE COMMITTEE	Quality Governance Committee
RISK	If we do not reduce the number of NCEPOD E deaths and HSMR we will suffer reputational damage
NEXT REVIEW DATE	30.3.16
Controls: Primary and secondary mortality reviews Investigations of high relative risks and CUSUM alerts and associated action plans Actions from NCEPOD E investigations are completed and presented to Patient Safety Committee (PSC). Investigations of top ten HRG / diagnosis groups which represent the highest number of deaths	
Gaps in controls: Identification of timescales for completion of actions in response to the findings of the top ten HRG / Diagnosis group investigations The shortfall in completion of primary mortality reviews and secondary mortality review completion. . Full extent of learning at secondary review not always highlighted and disseminated	
Assurance: Mortality data is monitored on a monthly basis at Mortality Review Committee, with alerts investigated as appropriate. Presentations and learning evidenced at Grand Round, PSC, QGC and Trust Board HSMR and SHMI monitoring on Integrated Quality, Performance and Finance report and group performance scorecards Mortality newsletter TDA recommends other Trusts to adopt our mortality policy Current performance at January 2016 for NCEPOD E deaths is 4	
Gaps in Assurance: Implementation of learning from mortality reviews	

	LIKELIHOOD	CONSEQUENCE	RISK RATING	PROGRESS
Initial Risk Rating	**3 (possible)**	**4 (major)**	**12 (moderate)**	
Target Risk Rating	**2 (unlikely)**	**3 (moderate)**	**6 (low)**	
Current Risk Rating	**3 (possible)**	**4 (major)**	**12 (moderate)**	

ACTIONS		
Action	**Due Date**	**Progress Update at Quarter 3**
Regular Mortality reports to Trust Board, QGC, PSC, Mortality Review Committee	On-going	HSMR and SHMI reported each month to the Trust Board, QGC and PSC
Deep dive into high contributors to HSMR	On-going	Investigations presented to MRC
Grand Round presentations	On-going	Regular grand rounds about themes arising from mortality reviews

Recommendation: Although HSMR for September is within expected limits, as reported in the Scorecard, the 12 month HSMR remains as a high relative risk. The detailed investigation into ten HRGs which are the highest contributor to HSMR is being undertaken. It is not therefore recommended that the likelihood or consequence score be amended at this time.

STRATEGIC OBJECTIVE	To deliver excellent patient care and experience
ANNUAL OBJECTIVE 6	Reduce avoidable infections through improved core infection control practice
EXECUTIVE LEAD	Chief Nursing Officer
MANAGEMENT LEAD	Director of Infection Prevention and Control
RESPONSIBLE COMMITTEE	Quality Governance Committee
RISK	If we do not reduce avoidable infections patients may be harmed, we will not meet our performance targets and our reputation will be damaged.
NEXT REVIEW DATE	30.3.16

Controls:
RCA/PIR process in place to analyse cause and identify necessary actions
Robust root cause analysis process in place to analyse cause and instigate necessary actions.
Key performance metrics and dashboards for groups.
Action plan in place.
Active monitoring at Trust Board of performance against MRSA.C-diff targets, compliance with hand hygiene and elective MRSA screening.

Gaps in controls:
None identified

Assurance:
MRSA & C-diff rates reported to the Trust Board in Integrated Quality and Performance Report each month demonstrate good year to date performance.
Quarterly report to Trust Board on Infection Prevention and Control.
Performance Management Framework in place to support change, monitor variance and rectify exceptions; no MRSA cases reported in 2015/16.
Month on month improvement (Oct-Nov 2015) in Infection Control Nurses Association (ICNA) scores for cleaning

Gaps in Assurance:
The elective screening target is still not being achieved.
Hand hygiene training compliance is still not being achieved.

	LIKELIHOOD	CONSEQUENCE	RISK RATING	Progress
Initial Risk Rating	**4 (likely)**	**4 (major)**	**16 (high)**	
Target Risk Rating	**2 (unlikely)**	**4 (major)**	**8 (moderate)**	
Current Risk Rating	**4 (likely)**	**4 (major)**	**16 (high)**	

Action	**Due Date**	**Progress Update at Quarter 3**
Infection Prevention and Control action plan in place and progress reported to the Trust Board	On-going	Quarterly report on the agenda for the January Trust Board meeting detailing progress against the action plan.
TDA External Review of Infection Prevention and Control Practice	Completed	The review has been completed was presented to the Trust Board during Infection Control reporting.
Action plan in place to bring about improvements to cleaning standards (provided by ISS contractors)	On-going	Continual scrutiny of agreed ISS action plan to ensure sustained improvements has resulted in month on month improvement in ICNA scores.
Enhanced scrutiny and management of hand hygiene training compliance	On-going	Continual and targeted focus at ward level on increasing compliance.
Improvement in elective MRSA screening	Completed On-going	Revised pre-operative pathway completed and place Further work needs to be undertaken in respect of screening for directly admitted patients

Recommendation: Focus has been given to the underpinning assurance processes of good infection control practice (including hand washing, cleaning, antibiotics, lines and education). This is routinely monitored weekly at Group and specific ward areas where concerns exist. Areas of poor compliance are challenged at forums, with clear objective and performance trajectory setting.

Performance to date on MRSA is improving this year, although other infection challenges have emerged such as MSSA in the neonatal unit. C.*difficile* remains close to year to date ceiling with continued work on cleaning and sampling practices in place.

Although good progress is being made, there is still work to be done around compliance in relation to MRSA screening and hand hygiene and for that reason, no reduction in score is recommended at this stage.

STRATEGIC OBJECTIVE	To deliver excellent patient care and experience
ANNUAL OBJECTIVE 7	Improve patient safety thermometer performance to achieve 97% by year end
EXECUTIVE LEAD	Chief Nursing Officer
MANAGEMENT LEAD	Deputy Chief Nursing Officer
RESPONSIBLE COMMITTEE	Quality Governance Committee
RISK	If we do not maintain performance at above 95% patients may be harmed and our reputation will suffer.
NEXT REVIEW DATE	30.3.16
Controls: Data collection around new and old harms in all wards Embedded collection and dissemination systems Displayed on public facing safety boards Routine analysis of harms through Nursing & Midwifery Committee, Patient Safety Committee and Quality Governance Committee. Reporting to Trust Board via the IQPR and scrutiny at Quality Governance Committee. Peer (local and national) benchmark assessment Action plan to improve all harms	
Gaps in controls: None identified	
Assurance: Performance reported in the Integrated Quality and Performance Report Reports to Quality Governance Committee on quarterly basis Significant assurance opinion from internal audit around data quality for VTE assessments	
Gaps in Assurance: Performance is not yet reaching 97% and has deteriorated in quarter 3.	

	LIKELIHOOD	CONSEQUENCE	RISK RATING	Progress
Initial Risk Rating	**3 (possible)**	**3 (moderate)**	**9 (moderate)**	
Target Risk Rating	**3 (possible)**	**1 (negligible)**	**3 (low)**	
Current Risk Rating	**3 (possible)**	**3 (moderate)**	**9 (moderate)**	

ACTIONS		
Action	**Due Date**	**Progress Update at Quarter 3**
Action plan in place to improve performance against all harms – monitored through the Quality Governance Committee	On-going	The action plan has identified a requirement to increase the focus on falls and pressure ulcers. Additional actions have therefore been developed.

Recommendation; the national target (95%) was not achieved in November and December 2015 although the January data demonstrates that the national target is once again being achieved. No reduction in the risk score is recommended at this time however.

STRATEGIC OBJECTIVE	To deliver value for money
ANNUAL OBJECTIVE 8	Deliver the financial plan 2015/16
EXECUTIVE LEAD	Chief Finance and Strategy Officer
MANAGEMENT LEAD	Deputy Chief Finance Officer
RESPONSIBLE COMMITTEE	Finance and Performance Committee
RISK	If we do not deliver our financial plan for 15/16 our services and reputation will be impacted.
NEXT REVIEW DATE	30.3.16
Controls: Operational Delivery Plans in place for Specialty Groups and Corporate Services Financial Recovery Plan in place being monitored by Chief Officers Group Finance Star Chamber Monthly report to the Trust Board as part of Integrated Quality and Performance Report CIP monitoring arrangements in place and embedded	
Gaps in controls:	
Assurance: 2015/16 CIP fully identified Financial Plan 2014/15 is on trajectory. Integrated Quality and Performance report Significant assurance opinion from internal audit around budget setting and CIP Significant assurance opinion around financial systems	
Gaps in Assurance: Continuing impact on income due to inability to carry out elective work because of emergency pressures and flow issues Continuing impact of delayed transfers of care Lack of agreed system-wide plan to resolve flow issues	

	LIKELIHOOD	CONSEQUENCE	RISK RATING	Progress
Initial Risk Rating	**4 (likely)**	**4 (major)**	**16 (high)**	
Target Risk Rating	**4 (likely)**	**2 (minor)**	**8 (moderate)**	
Current Risk Rating	**3 (likely)**	**4 (major)**	**12 (moderate)**	

ACTIONS		
Action	**Due Date**	**Progress Update at Quarter 3**
Financial Recovery Plan	May 2015	Approved at May Trust Board
Plan for closer monitoring/controls around agency spend	May 2015	Directions have been issued to the organisation around agency usage with controls in place
Transfer of additional elective work to Rugby St Cross with additional bed capacity coming on stream	September 2015	Increase in elective work at St Cross. Due to Consultant Orthopaedic vacancies additional beds at St Cross not now due to open in 2015/16.
Staged internal reconfiguration; GPAU/FEAU	October 2015	Medical Decisions Unit (MDU) now in place.

Recommendations: The Trust is on track to deliver the financial plan as at December 2015, delivery is linked to elective activity performance and there has been under-performance against activity targets in electives, day cases and critical care to date; however performance has seen some improvement in October and November which has been underpinned by improved flow in the hospital. Delivery in December remains a concern, CIP is now fully identified. Risk of achievement of the financial plan therefore remains moderate and no change in the risk score is recommended.

STRATEGIC OBJECTIVE	To be a leading training and education centre To be a research based healthcare organisation
ANNUAL OBJECTIVE 9 & 10	Increase the number of papers published by 10% for Medical and Nursing & Midwifery and the number of academics in post
EXECUTIVE LEAD	Chief Medical Officer/Chief Nursing Officer
MANAGEMENT LEAD	Chris Imray and Ceri Jones
RESPONSIBLE COMMITTEE	Quality Governance Committee
RISK	If we do not increase the number of published papers and academics in post then we may not be regarded as a well-established academic centre, leading to recruitment challenges.
NEXT REVIEW DATE	31.03.16
Controls: Routine reminders for staff to submit publications to database On-site statistical support and training available to support data analysis for publications Commitment to recruit additional academics to provide leadership Development of vision and strategy with Warwick University	
Gaps in controls: Metric is reliant on staff self-reporting of publications Current publication database does not allow for coding by staff group Reliance upon reputation and support of local Higher Education Institutions to attract quality academics Publication data is 6-months behind as journals can take time to review/accept articles for publication	
Assurance: Strategy with Warwick University in development led by the Trust Board Number of papers published is reported each month in the Integrated Quality and Performance Report Position reported to the Specialty Groups quarterly Quarterly reports to Quality Governance Committee Bi-monthly reports to the Training, Education and Research Committee	

Gaps in Assurance:
Failure to recruit to academic posts in 2015/16
Service commitments detract from academic time

	LIKELIHOOD	CONSEQUENCE	RISK RATING	Progress
Initial Risk Rating	**3 (possible)**	**3 (moderate)**	**12 (moderate)**	
Target Risk Rating	**3 (possible)**	**2 (minor)**	**6 (low)**	
Current Risk Rating	**3 (possible)**	**3 (moderate)**	**12 (moderate)**	

ACTIONS		
Action	**Due Date**	**Progress Update at Quarter 3**
Amend database to allow prospective coding of staff group	01.06.15	Request for this to take place sent to PPMC for action (09.07.15)
Retrospective coding of publications to date	01.03.16	Database is currently being updated
Activities to highlight need to provide publications to RD&I for database	01.03.16	Commenced; increased level of submissions in first quarter of 21015/16.
Position statement on support and appointment of academic staff	07.01.16	Joint Strategy has been agreed by WMS and presented to the Trust Board. Joint UHCW/University of Warwick took place on January 7th 2016.
Gain commitment from academic partners for joint appointments	01.10.16	Require formal commitment from WMS and other academic partners
Development of joint research strategy with Warwick Medical School	01.06.16	This has been agreed in principle. Details need to be finalised
Recruitment of new research active academics	01.10.16	As above

Recommendation: Whilst much work is underway and results in terms of increased submissions being report are being seen, there is work to be done on the Joint Vision between the Trust and Warwick University later in the year. No change to the consequence or likelihood score is therefore recommended as yet.

STRATEGIC OBJECTIVE	To be a research based healthcare organisation
ANNUAL OBJECTIVE 11	Recruit 5000 patients to portfolio studies
EXECUTIVE LEAD	Chief Medical Officer
MANAGEMENT LEAD	Ceri Jones, Head of Research, Development and Innovation
RESPONSIBLE COMMITTEE	Quality Governance Committee
RISK	If we fail to recruit more than 5000 patients to portfolio studies then we will be regarded as not being research active. This may have an impact on clinical outcomes and our ability to recruit and retain researchers and innovators
NEXT REVIEW DATE	30.3.16
Controls: Board oversight through the monthly Integrated Quality and Performance Reports Detailed feasibility process Research nurse training and competency package Chief Investigators course for research leaders	
Gaps in controls: Metric reliant upon availability of research trials and staff/service commitments	
Assurance: Number of patients taking part in research is reported within the Integrated Quality & Performance Report Position reported to the Specialty Groups each quarter Quarterly reports to the Quality Governance Committee Bi-monthly reports to the Training, Education and Research Committee Data on set-up and delivery submitted to the National Institute of Health Research quarterly (NIHR generate a comparative report) Funding for 2015/16 has been agreed with the Research Network	
Gaps in Assurance: National data and local data can conflict as national data can be 1-2 months behind our actual position	

	LIKELIHOOD	CONSEQUENCE	RISK RATING	Progress
Initial Risk Rating	**3 (Possible)**	**3 (moderate)**	**9 (moderate)**	
Target Risk Rating	**3 (possible)**	**2 (minor)**	**6 (low)**	
Current Risk Rating	**3 (possible)**	**3 (moderate)**	**9 (moderate)**	

ACTIONS		
Action	**Due Date**	**Progress Update at Quarter 3**
Research funding to be agreed by Research Network	31.03.15	Funding agreed by the network on 3rd July 2015
Develop own research nursing capabilities with only ad hoc support from the research network	31.03.16	In progress; TUPE documents submitted to HR/JNCC for first wave transition.
Develop commercial research strategy and delivery plan	01.03.16	To be developed
Develop formal incentivisation scheme for staff	31.12.15	Association of UK University Hospitals (AUKUH) proposal around programmed activities presented to COG Advisory Group. -Agreed
Implement formal incentivisation scheme for staff	01.05.16	In discussion.

Recommendation: Good progress has been made but as the numbers recruited are cumulative and there is further work to do with regard to the Commercial Research Strategy and Incentivisation Scheme, no reduction in the likelihood or consequence score is recommended at the present time.

STRATEGIC OBJECTIVE	To deliver excellent patient care and experience To deliver value for money To be a leading training and education centre
ANNUAL OBJECTIVE 12	Improve management capacity of top 100 leaders
EXECUTIVE LEAD	Chief Workforce and Information Officer
MANAGEMENT LEAD	Associate Director of Workforce
RESPONSIBLE COMMITTEE	TTWC Programme Board
RISK	The impact of the new Executive team, combined with the Leadership Development Programme is beginning to improve the capability and capacity of our leaders. This momentum needs to continue to optimise our ability to deliver excellent patient care and experience as well as improve performance.
NEXT REVIEW DATE	31.3.16
Controls: Bespoke '*Leading Together*' programme in place. Hospital Leaders booked onto '*Leading Together*' programme taking place between April 2015 and March 2016 Existing additional learning and development opportunities are available and individual needs can be identified via the PDR process Leadership Development Group in place as part of TTWC *World Class Leadership* work-stream Regular review of management structures to ensure optimal outcomes Re-alignment of Chief Officer portfolios will support strategic oversight	
Gaps in controls:	
Assurance: On-going evaluation of Leading Together programme undertaken to assess impact on leadership capacity and organisational performance presented to Chief Officers Group and overseen through Together Towards World Class programme board. Long-term evaluation of programme to be undertaken with Warwick Business School	

Development of capability and capacity amongst out leadership will provide opportunity for Chief Officers to operate and focus on strategic aims.
Gaps in Assurance: Full impact of the Leading Together programme will not be felt during 2015 on a Trust wide basis as the 125 leaders are divided into 6 cohorts that are spread across the year and into 2016.

	LIKELIHOOD	CONSEQUENCE	RISK RATING	Progress
Initial Risk Rating	**5 (almost certain)**	**3 (moderate)**	**15 (high)**	
Target Risk Rating	**3 (possible)**	**3 (moderate)**	**9 (moderate)**	
Current Risk Rating	**3 (likely)**	**3 (moderate)**	**12 (moderate)**	

ACTIONS		
Action	**Due Date**	**Progress Update at Quarter 3**
Evaluation of *Leading Together* to be completed and reviewed by the Leadership Development Group	November 2015	Evaluation of Leading Together programme undertaken and presented to Chief Officers Group in December 2015. On-going evaluation and review of programme to be undertaken in partnership with Warwick Business School, commencing in late 2016. Agreement through Chief Officers Group in December 2015 to continue roll-out of Leading Together programme for Service and Team Leaders Long-term, independent evaluation commissioned from Warwick Business School and scheduled to be undertaken in 2016/ 2017.
Identify funding for 'Leading Together' beyond 2015/16	December 2015	Agreement for continuation of programme, resulting in programme becoming mandatory requirement for all those in formalised leadership positions within the Trust. Roll-out to remaining 1200

		leaders at Service or Team Leader level will commence in April 2016, with 12 cohorts (totalling 300 leaders) commencing programme during 2016/2017. Allocations of places and scheduling currently underway, alongside development plan for programme facilitators to ensure continued internal sustainability of programme.

Recommendation: 97 Hospital Leaders have now commenced the programme, with a further sixth cohort (25 places) to commence in March 2016. Initial evaluation is positive, and plans for continued leadership development have been determined for 2016/2017. Further independent, long-term evaluation will be required in order to determine impact on overall leadership capacity and resultant impact on organisational performance, however based on current evaluation, it is suggested that the likelihood score be reduced this quarter.

STRATEGIC OBJECTIVE	To deliver excellent patient care and experience To be a leading training and education centre
ANNUAL OBJECTIVE N/A	This risk does not link directly to the annual objectives because it is a risk that has been identified in year and with the agreement of the Trust Board has been added to the BAF owing to its potential impact on the strategic objectives of the organisation.
EXECUTIVE LEAD	Chief Operating Officer
MANAGEMENT LEAD	Director of Estates and Facilities
RESPONSIBLE COMMITTEE	Trust Board
RISK	Whilst the risk of fire breaking out has not increased, if we do not put into place sufficient, additional measures to mitigate against the shortfalls in the identified fire-stopping issues, there is the potential for increased risk of serious injury to patients, staff and visitors in the event this does occur. There are also consequent risks to the Trust's business (finance and performance), in that in the event of major fire damage to the UH site, the Trust will not be able to deliver the full range of services to the population; this in turn gives rise to risks to the wider health and safety of the population
NEXT REVIEW DATE	31.3.16
Controls: Full range of measures implemented that are supported by the Fire Authority, aimed at preventing fire and at dealing with fire, should one break out. Amendment to the Trust's Fire Strategy to reflect the revised arrangements in place (approved by the Trust Board). On-going risk assessment and dialogue with the Fire Authority. Rectification plan and programme agreed with PFI partner.	
Gaps in controls: The previous agreement that was in place with the Fire Authority around an additional response in the event of the fire alarm being activated has been lifted; this is however likely to be due to the fact that the Fire Authority has engaged with the Trust around the mitigation that it has put into place and feel that the additional response is no longer necessary.	

Assurance:
Written confirmation from the Fire Authority that the additional measures that the Trust has put into place are sufficiently robust. Full programme of remediation works in place and work has commenced; the Trust's Fire expert will be involved throughout the work and in the compliance sign off process.

Gaps in Assurance:
Whilst the Trust has put into place robust mitigation to prevent and deal with fire, the effectiveness of these cannot be fully tested unless a fire breaks out. Whilst this is not in any way desirable, there cannot be full assurance unless these are tested or until the works are completed.

	LIKELIHOOD	**CONSEQUENCE**	**RISK RATING**	**Progress**
Initial Risk Rating	**3 (possible)**	**5 (catastrophic)**	**15 (high)**	
Target Risk Rating	**3 (unlikely)**	**4 (major)**	**12 (moderate)**	
Current Risk Rating	**3 (possible)**	**5 (catastrophic)**	**15 (high)**	

ACTIONS		
Action	**Due Date**	**Progress Update at Quarter 3**
Continue to seek rectification plan and ensure that this meets the requirements of the Trust.	31st October 2015	Completed – received on 6th January 2016
Continually assess the risks arising out of fire and make adjustments as necessary.	On-going	There is a process of on-going risk assessment and the Trust's Fire Expert will be involved in the remediation programme.

Recommendation; although the Remediation Programme and Plan are now in place and work has commenced, the programme is a comprehensive one that will be delivered over a period of time. Once complete the risk will be eradicated and whilst the risk will increase over time as more and more work is completed, no reduction in score is recommended at present as the works are in their very earliest stages.

National Patient Safety Agency

Model matrix

For the full *Risk matrix for risk managers*, go to www.npsa.nhs.uk

Table 1 Consequence scores

Choose the most appropriate domain for the identified risk from the left hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

	Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Table 2 Likelihood score (L)

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur,possibly frequently

Note: the above table can be tailored to meet the needs of the individual organisation.

Some organisations may want to use probability for scoring likelihood, especially for specific areas of risk which are time limited. For a detailed discussion about frequency and probability see the guidance notes.

Table 3 Risk scoring = consequence x likelihood (C x L)

	Likelihood				
Likelihood score	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Note: the above table can to be adapted to meet the needs of the individual trust.

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Extreme risk

Instructions for use

1 Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk.

2 Use table 1 (page 13) to determine the consequence score(s) (C) for the potential adverse outcome(s) relevant to the risk being evaluated.

3 Use table 2 (above) to determine the likelihood score(s) (L) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, assign a probability to the adverse outcome occurring within a given time frame, such as the lifetime of a project or a patient care episode. If it is not possible to determine a numerical probability then use the probability descriptions to determine the most appropriate score.

4 Calculate the risk score the risk multiplying the consequence by the likelihood: C (consequence) x L (likelihood) = R (risk score)

5 Identify the level at which the risk will be managed in the organisation, assign priorities for remedial action, and determine whether risks are to be accepted on the basis of the colour bandings and risk ratings, and the organisation's risk management system. Include the risk in the organisation risk register at the appropriate level.

University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD PAPER

Title	**Corporate Risk Register Quarterly Report**
Author	**Yvonne Gatley, Associate Director of Quality**
Responsible Chief Officer	**Meghana Pandit, Chief Medical & Quality Officer**
Date	**28th January 2016**

1. Purpose

To inform the Board of the Trust's highest rated risks which are currently logged on the Corporate Risk Register. All risks are rated according to the Trust risk scoring matrix:

CONSEQUENCES	LIKELIHOOD				
	Rare (1)	Unlikely (2)	Possible (3)	Likely (4)	Almost certain (5)
Negligible (1)	1	2	3	4	5
Minor (2)	2	4	6	8	10
Moderate (3)	3	6	9	12	15
Major (4)	4	8	12	16	20
Catastrophic (5)	5	10	15	20	25

The risk register is a "live" document held on the central risk management software system, Datix. Risk owners and handlers are required to ensure that they review their risks and update the register. Inevitably, some risks will not have been updated on the system prior to the risk register report being extracted for review.

2. Background and Links to Previous Papers

This quarterly report is included as part of the Board reporting framework.

Previous reports have been made to the Quality Governance Committee each month as part of the quality reporting schedule and the Risk Committee receives a more detailed corporate risk register report on a monthly basis.

The risks are also reviewed by the corporate committee with responsibility for each of the risk subtypes (Patient Safety, Finance, Human Resources, ICT, Health & Safety, Information Governance, Operations & Strategic risks).

3. Narrative

There are 17 "high" corporate risks on the risk register (risk rating 15-20).

The highest rated corporate risk currently (risk score = 25) is:

- Financial recovery plan

There are 8 risks rated at 20:

- Referral To Treatment (RTT) Performance (Admitted pathways)
- Achieving 3.5% DTOC national target
- Cancer (62 day standard)
- DNACPR forms not accompanying patients as they leave the organisation
- Hepatopancreatobiliray (HPB) – Compliance with IOG Guidelines
- Delay in setting up Acute Frailty Unit
- Trustwide Clinical Staffing Vacancies
- MRSA Bacteraemia

There are 4 high risks rated at 16:

- Proton Support – replacement system required
- Shortfalls found in structural fire compartments at University Hospital
- Income from Activities 2015/16
- Agency Staffing Expenditure 2015/16

The other high risks are rated at 12.

The main “categories” (cross-cutting themes) of risk on the corporate risk register are:

- Reputational
- Compliance
- Achievement of targets

4. Areas of Risk

The main areas of concern for the Trust are:

1. **Financial position** - the Trust recorded a deficit in 2014/15.
   The plan for 2015/16 is for a £19.4m deficit, this assumes all activity is delivered in line with ODP agreements and all CIP is achieved (£34m).

   What we are doing:

   - Financial recovery plan drafted.
   - Budgetary control processes.
   - Monthly operational delivery meetings.
   - Quarterly performance review meetings.
   - Finance Star Chamber.

2. **Patient Flow -** incorporating delayed transfers of care (DTOC), the number of outlier patients and the impact on the referral to treatment target (RTT).

   What we are doing:

- Remodelling the service provision to focus resource at the front door and inreach to reduce Length of Stay.

- Introducing the new DTOC guidance locally

Admitted pathways:

- Revised trajectory agreed and signed off by CCG and SRG.

- Revised action plans and performance management tools.

- Weekly performance tracker designed and implemented. (iv) Surgical control room set up.

- Additional theatre lists identified.

- Additional resources allocated to validation.

- Additional consultants in plastic surgery; Urology; General Surgery; T&O.

3. **Staffing Levels -** there had been increased usage of bank and agency staff across the Trust as a result of vacancies and short/dwindling numbers of staff in the market in some specialties/areas.

   What we are doing:

   - Daily staffing review and management by Matrons.

   - Change to working practice, flexibility of working hours, use of bank and agency staff.

   - Daily escalation process in place and report to CNO

   - Targeted plans and actions for areas with particular pressures e.g. renal haemodialysis, gerontology, neurosciences

   - Creating some short term (6 months) Band 3 posts in areas of highest risk- e.g. neurosciences and gerontology

   - Consideration of recruiting mental health nurses for key specialties.

   - Medical posts that are difficult to recruit to - these posts are temporarily being covered by locum doctors.

   - New national guidance on agency caps came into force end November 2015, implications for UHCW being worked through.

   - Recruitment monitored by COG, on monthly IPR and monthly workforce report to F&P Committee.

5. Governance

The Trust Board is responsible for the management of risk; the Corporate Risk Register will be reported to the Trust Board on a quarterly basis as a key component of the risk and control framework.

6. Responsibility

Meghana Pandit, Chief Medical Officer & Deputy CEO as the Chief Officer responsible for Risk Management.
Jenny Gardiner – Director of Quality
Yvonne Gatley – Associate Director of Quality (Safety and Risk)

7. Recommendations

The Board is invited to **NOTE** the quarter 3 Risk Register Report

Name and Title of Author: Yvonne Gatley – Associate Director of Quality (Safety and Risk).

Date: 11th January 2016

Open Corporate "High" Risks at 11.01.16

CORPORATE HIGH RISKS (Total = 17)

ID	Date Identified	Title	Risk Subtype	Description	Principal objectives	Risk level (initial)	Executive Lead	Risk Owner	Handler	Current controls	Gaps in controls	Risk level (current)	Rating (current)	Next review date	Assurance	Gaps in assurance	Risk level (Target)
2395	26-Jun-2015	Financial Recovery Plan	Financial	Failure to develop and deliver a financial recovery plan which meets the statutory breakeven requirements	To deliver Value for Money	HIGH	David Moon	Ms Susan Rollason	Mr Alan Jones	Financial recovery plan drafted. Budgetary control processes. Monthly operational delivery meetings. Quarterly performance review meetings. Finance Star Chamber.	None identified.	HIGH	25	31-Jan-2016	Monthly reports to the Trust Board and Finance and Performance Committee.	Plan not approved by the TDA	LOW
1984	1-Apr-2015	RTT Performance (Admitted pathways)	Operational	The Trust is failing the RTT standard for Incomplete, admitted and non-admitted pathways. This will lead to patients waiting a long time for their treatment; a standard within the NHS constitution will not be met; and a corporate target will not be achieved.	Delivering safe, high quality & evidenced patient care	HIGH	David Eltringham	Mr Mark Kemp	Mr Mark Kemp	(i) A joint Trust/CCG action plan has been drafted. This includes actions for the Trust and the CCG in terms of the wider health economy. (ii) A CCG/Trust RTT delivery group has been established with chief officer membership. This will include representation from NHS England and the TDA. (iii) The RTT trajectory will be validated by IMAS (Intensive Support and Management). (iv) Internal validation of waiting lists is a continuous process. The Trust's waiting list has been validated and signed off by NHS England. (v) Additional information reporting for operational managers has been put in place.(iv) Weekly performance reports are made to COG. (v) Weekly meetings are held with the groups to performance manage local action plans and performance improvement against the standard. (vi) Group action plans revised and presented to COO - 16th September 2015Update: 07/12/2015 (i) revised trajectory agreed and signed off by CCG and SRG. (ii) Revised action plans and performance management tools. (iii) Weekly performance tracker designed and implemented. (iv) Surgical control room set up. (v) Additional theatre lists identified. (vi) Additional resources allocated to validation. (vii) Additional consultants in plastic surgery; Urology; General Surgery; T&O.	No identified gaps in controls	HIGH	20	29-Feb-2016	The RTT trajectory will be validated by IMAS (Intensive Support and Management). The Trust's waiting list has been validated and signed off by NHS England. RTT Board with CCG/TDA and UHCW exec membership Signed off by TDA, NHSE & CCG	None identified	MOD

Open Corporate "High" Risks at 11.01.16

ID	Date Identified	Title	Risk Subtype	Description	Principal objectives	Risk level (initial)	Executive Lead	Risk Owner	Handler	Current controls	Gaps in controls	Risk level (current)	Rating (current)	Next review date	Assurance	Gaps in assurance	Risk level (Target)
2130	15-Jul-2014	Cardiology Day Unit utilised as an overflow ward	Safety - Clinical	If the Cardiology Day Unit is used for General Medical overflow patients then we will be unable to transfer acute coronary syndrome patients from other hospitals or admit our own elective patients. This will result in delayed treatment and increased risk of mortality/morbidity.	Delivering safe, high quality & evidenced patient care	MOD	Meghana Pandit	Dr Peter Glennon	Sr Sarah Abbott	Where possible we try not to cancel patients on the day but this adds substantial pressure to an already stretched team. Reviewed by Chief Medical Officer - risk closed 13.4.15.	None identified	HIGH	20	31-Jan-2016		None identified	LOW
2164	22-Sep-2014	Achieving 3.5% DTOC national target	Strategic	Due to patients' discharges delayed in hospital, reduced patient flow & extended LOS, there is a direct impact upon the performance of the Trust against national targets and also a risk of patients acquiring infections.	Improving business and service framework	HIGH	David Eltringham	Mr Mark Easter	Ms Kerrie Manning	Remodelling the service provision to focus resource at the front door and inreach to reduce LOS. Introducing the new DTOC guidance locally	Partners not updating the discharge plan for their patients Daily discharges meetings not effective use of time reduced to twice weekly with agreement of partner engagement to update status with changes IDT high levels of sickness reducing accuracy of data collected as staff covering additional wards	HIGH	20	3-Mar-2016	Weekly progress chase meeting with partner organisations to agree the DOH guidance Daily discharge meetings with partners, jointly agreed DTOC figure distributed daily Reduced to twice weekly Jun 2015 Working with CCG and partners to review the DTOC process and apply an adapted Worcester model to DTOC from the end Sept 2015 Sept 2015-Senior meeting weekly for 4 weeks to challenge the DTOC position, work jointly with partners to unblock areas of concern and challenge current pathways and processes to improve flow.	The impact of applying the new model is unknown currently	MOD

Source: DATIX Risk Management System

Open Corporate "High" Risks at 11.01.16

ID	Date Identified	Title	Risk Subtype	Description	Principal objectives	Risk level (initial)	Executive Lead	Risk Owner	Handler	Current controls	Gaps in controls	Risk level (current)	Rating (current)	Next review date	Assurance	Gaps in assurance	Risk level (Target)
2185	1-Apr-2015	Cancer (62 day standard)	Safety - Clinical	Risk that the Trust is failing the overall 62 day standard. There are a number of high volume specialties including urology, Lung, head & neck cancer and gynaecology where there is a risk of failing the standard. There are potential delays in radiology due to capacity. The Trust continues to experience late referrals from other Trusts.	Delivering safe, high quality & evidenced patient careTo deliver excellent Patient Care and Experience	HIGH	David Eltringham	Mr David Eltringham	Mr Mark Kemp	Current controls reviewed on 20th September 2015: (i) All cancer pathways discussed at weekly access meeting. Actions agreed and minuted. (ii) Specific meetings with Pathology, Radiology, Urology, Gynaecology and head & neck cancer. Actions agreed and minuted. (iii) External review of performance management and information reporting. (iv) Silver command review of the following days theatre lists to identify and prioritise patients on a cancer pathways. (v) Internal audit of information and performance management systems and processes undertaken which has suggested recommendations for changes in practice (vi) Cancer performance included in weekly COG report (also circulated to RTT Board, TDA and CCG). Cancer now a regular item on the RTT Board which reports into the SRG. (vii) Enhanced training of Group staff planned (to be undertaken by cancer departmental staff). (viii) Urology, head and neck cancer and gynaecology are a particular risk. Closer monitoring of demand and capacity. Lists of patients identified to ensure 100% compliance with breach dates. Additional capacity agreed in Urology. Additional Consultants agreed in Urology plus additional theatre capacity. Weekend working agreed for gynaecology. Recruitment of vacant gynaecology consultant posts to be expedited. (ix) On line Demand and capacity tool in use to manage TWW capacity. (x) Trust submission to the NHSE/TDA assurance process with revised performance trajectory and Trust action plan. (xi) Action plan reviewed at Cancer Board. (xii) Separate Urology action plan reviewed weekly at Urology cancer team meeting. Update 08/12/2015: (i) Revised Cancer trajectory signed off by the CCG and SRG. (ii) Revised plan for prostatectomy including potentially transferring of activity to alternative providers. (iii) Additional consultants across four tumour sites plus histo-pathology recruited.	None identified	HIGH	20	29-Feb-2016	External review of performance management and information reportingInternal audit of information and performance management systems and processes undertakenAction plan and trajectory reviewed by NHSE / TDA as part of region wide assuranceCancer action plan & trajectory signed off at COGAction plan goes to RTT Board, TDA & NHSE	None identified	LOW

Open Corporate "High" Risks at 11.01.16

ID	Date Identified	Title	Risk Subtype	Description	Principal objectives	Risk level (initial)	Executive Lead	Risk Owner	Handler	Current controls	Gaps in controls	Risk level (current)	Rating (current)	Next review date	Assurance	Gaps in assurance	Risk level (Target)
2195	20-Nov-2014	HPB-compliance with IOG guidelines	Strategic	If we do not serve a population of 2 million people we are not able to continue to provide the service according to the recent peer review.	Delivering safe, high quality & evidenced patient care	HIGH	David Moon	Mrs Danielle Taylor	Mrs Danielle Taylor	There will be some joint working on this with UHB.UHCW was requested by Specialised Commissioning to submit a joint service plan for an amalgamation of UHB and UHCW HPB services into one functional centre operating across 2 sites by 30th July 2015. To date, the 2 organisations are yet to meet to discuss the way forward as UHBFT colleagues have challenged the prime contracting model put forward by commissioners within their 15-16 contract – this has now been removed from the contract and a date is being set between UHCW and UHBFT to discuss the implications of this. UHCW NHS Trust remains committed to this joint venture and the establishment of an IOG compliant model of care.	None identified	HIGH	20	31-Mar-2016	To be discussed	UHCW & UHB yet to meet	LOW
2285	6-Feb-2015	Delay in setting up Acute Frailty Unit	Operational	Due changes in planning and alteration to the footprint to Acute Medicine there is a delay in setting up the Acute Frailty Unit.	Building positive reputation and identity Delivering safe, high quality & evidenced patient care Improving business and service framework To deliver excellent Patient Care and Experience	HIGH	David Eltringham	Dr Nick Balcombe	Sr Lorraine Owen	Meetings continue with the Community Team - looking at implementation in due course. Process being reviewed regarding GIM Rota - awaiting solution	Main issue is whether it is possible to implement plan due to knock-on risks for GIM rota. 12/5/15 update - AFU project Group will report to EPIB as a stand alone group - no longer with Acute medicine. 12/5/15 update: The Acute Frailty Unit will now be on Ward 21m as originally planned. AFU project Group will report to EPIB on project progress Business case to be completed and submitted to the planning unit.	HIGH	20	26-Feb-2016	Business Case submitted on 10/6/15 Report to EPIB on project progress Business case to be submitted	No Gaps reported	VLOW

Open Corporate "High" Risks at 11.01.16

ID	Date Identified	Title	Risk Subtype	Description	Principal objectives	Risk level (initial)	Executive Lead	Risk Owner	Handler	Current controls	Gaps in controls	Risk level (current)	Rating (current)	Next review date	Assurance	Gaps in assurance	Risk level (Target)
1114	1-Apr-2014	Proton support - Replacement System Required	Safety - Clinical	Concern that Proton may fail because of a lack of technical support and resource resulting in the loss or unavailability of patient data which would affect patient care.As this is the mechanism by which we are paid there may be financial implications if the system were to fail.	Delivering safe, high quality & evidenced patient careTo deliver Value for Money	HIGH	Meghana Pandit	Dr S Fletcher	Lisa Harrigan	Data manager in post with some knowledge of Proton processes. The renal systems are going to be part of the new iPM system which is a few years off installation. A temporarily solution is being looked into.04.07.14 Tender awarded to CCL.01.08.14 Awaiting confirmation from the Trust re finance03.10.14 Still awaiting confirmation re capital.06.03.15 An all-encompassing system is being assessed by the Trust. Dan Ford in discussions and remains Proton expert - some updates may be possible.18.06.15 IT project group starting today re new system.	Only one individual in ICT provides support.The system is very old and out of date.There is currently no support from Proton if the system were to crash.An upgrade may not be desirable.Identified in Trust capital programme but only level 2 (which may not be funded) and for 2013 - 14.Temporary solution being identified	HIGH	16	30-Jan-2016	Discussed at QIPS 16.03.12To be included on the draft capital programme albeit level 2.	None identified	LOW
1858	1-Apr-2014	Capacity, statutory and reputational impact of cold/hot water pipe failure (Harm to people and loss of infrastructure)	Operational	1. There is a concern that the Girpi water system at UHCW may release water (hot /cold) in an uncontrolled manner.2. This will cause potential harm and damage to people and infrastructure3. Resulting in a, Loss of Services, b, Harm to patients, contractors, and others. In addition a catastrophic failure may result in statutory breaches.	Delivering safe, high quality & evidenced patient care	MOD	David Eltringham	Mr Lincoln Dawkin	Mrs Julie Rice	18/08/15 - Further survey work is currently being undertaken to provide further pipework samples for testing. Upon completion a scope of work will be agreed. Remedial work has commenced in CSSD and the process is managed via a separate working group that meet up on a 2 week basis to manage.	Rev 2 Girpi Risk Assessment_20141104 .docx provides details of Gaps in Controls.	HIGH	16	31-Mar-2016	Clear Maintenance procedures in place and agreed with Project Co and PartnersProtocol / procedure to be developed and adhered to when carrying out any work under licence or permit system. (Trust and Project Co)	Rev 2 Girpi Risk Assessment_20141104.docx this details the gaps in assurance The risk exercise was discussed at Risk Committee and recommendation made that the risk should be escalated to BAF	LOW

Source: DATIX Risk Management System

Open Corporate “High” Risks at 11.01.16

ID	Date Identified	Title	Risk Subtype	Description	Principal objectives	Risk level (initial)	Executive Lead	Risk Owner	Handler	Current controls	Gaps in controls	Risk level (current)	Rating (current)	Next review date	Assurance	Gaps in assurance	Risk level (Target)
2067	24-Apr-2014	Patient Flow (ED 4hr wait)	Operational	The risk is that that we do not have the right capacity to meet demand which prevents the attainment of the Constitutional 4 Hour Standard for A&E.	Delivering safe, high quality & evidenced patient careImproving business and service frameworkTo deliver Value for MoneyTo deliver excellent Patient Care and Experience	MOD	David Eltringham	Mr Alan Cranfield	Dr Dan Strong	1 - Use of predictive capacity and demand models to identify shortfalls in capacity. 2 - Introduction of MAU, incorporating short stay beds, AEC and GPAU. 3. - The development, with partners, of a frailty service to reduce length of stay and admission avoid. 4. - The creation of ringfenced surgical capacity to protect a volume of elective activity. 5. - The introduction of a Trigger system within ED to provide early alerts to enhance breach avoidance 6. - The uplift of 3 middle grade doctors to allow capacity to meet demand.	Clinical engagement and resources Lack of 7 day working Development of staff	HIGH	16	31-Mar-2016	Hourly monitoringProcess & o/c indicators MortalityKPIs - FREED metrics	Complex patient pathways with large numbers of patients affected. Capacity is reliant upon external partnerships, and community pathways being updatedlimited capacity forces short term plans to deal with constraints	MOD
2178	1-Jul-2014	DNACPR forms not accompanying patients as they leave the organisation	Safety - Clinical	1 - The risk is that a patient will be resuscitated on arrival to the organisation when a previous DNACPR order has been made and not rescinded. The family / patient will be aware of this. 2- Potential litigation and or complaints.	Delivering safe, high quality & evidenced patient careTo deliver excellent Patient Care and Experience	HIGH	Meghana Pandit	Dr David Parr	Dr Robert Simpson	06/11/15 - work progressing well with "tab". Flow matrix constructed - programming likely to commence imminently. Revisited DNACPR issues at grand round presentation in October. 27/11/2015 - DNACPR tab at programming stage. Unlikely to be operation before end of 2015 as requires piloting first. Numbers of non-compliant forms returned have reduced but not sufficient to downgrade risk at present	None identified	HIGH	16	20-Jan-2016	Monitored via incident reporting	None identified	MOD

Open Corporate "High" Risks at 11.01.16

ID	Date Identified	Title	Risk Subtype	Description	Principal objectives	Risk level (initial)	Executive Lead	Risk Owner	Handler	Current controls	Gaps in controls	Risk level (current)	Rating (current)	Next review date	Assurance	Gaps in assurance	Risk level (Target)
2291	23-Feb-2015	MRSA Bacteraemia	Safety - Clinical	Concern that until the Trust identifies the underlying cause(s) of the recent MRSA bacteraemia cases, then patients are potentially at risk and there is also potential reputational risk to the organisation.	Delivering safe, high quality & evidenced patient care	HIGH	Mark Radford	Dr Jennifer Child	Sr Katherine Prevc	Standard Precautions are in place.Infection Prevention & Control Policies are available and in place.External review undertaken by TDA - no issues identified. Expert review undertaken by Microbiologist & Consultant Nurse. Environmental sampling - SPAR typing is different for each case. Proactive screening of patients in Gastro - on admission and discharge completed. Awareness campaign - Feb, March & May 2015, focus on screening & de-colonisation. Introduction of WHO 5 Moments Hand hygiene measurement tool from June 2015 Weekly MRSA ward round	Inconsistent adherence to MRSA care bundle across the TrustIP&C Team reviewing Trust processes to identify possible sources	HIGH	16	29-Jan-2016	1:1 meetings between CNO and WM to review ward metrics including MRSA screening compliance No post 48 hour MRSA bacteraemia to end September 2015 Updated MRSA policy approved at IPCC in September 2015 External review (TDA and IPC Experts) - no specific issues identified Thematic analysis completed in-house"SPAR" typing different for each case. Genomic level - no link between cases. Admission and discharge screening of high risk wards shows nil MRSA acquisition rate e.g. patients not becoming colonised with MRSA during in-patient stay New ward level IPC scorecard (key IPC metrics) introduced from July 2015. Review at Quarterly Performance meetings. Weekly MRSA (individual patients screen positive) ward round to check compliance with MRSA Quick Action Guides BSI action plan implementation monitored at Trust Board	Emergency screening compliance below (national) target 98% - guidance being updated to focus on Admission Units screening. Focus on areas where high proportion of patients is assessed prior to ward transfer.	LOW

Source: DATIX Risk Management System

Open Corporate "High" Risks at 11.01.16

ID	Date Identified	Title	Risk Subtype	Description	Principal objectives	Risk level (initial)	Executive Lead	Risk Owner	Handler	Current controls	Gaps in controls	Risk level (current)	Rating (current)	Next review date	Assurance	Gaps in assurance	Risk level (Target)
2359	22-May-2015	Shortfalls found in structural fire compartments at University Hospital	Safety - Non Clinical	Without adequate fire stopping in fire compartments walls there would be a likelihood that a fire would spread from one compartment to another. It is a statutory legal requirement that all fire compartment walls and floors are maintained to a suitable and sufficient fire standard.	Delivering safe, high quality & evidenced patient care	HIGH	David Eltringham	Mr Lincoln Dawkin	Mrs Julie Rice	10/11/15 - Discussions continue between fire engineers employed by both Project Co and the Trust on the best way forward to rectify the shortfalls found in the fire compartment walls at the University Hospital. Numerous measures have been implemented to minimise this risk until all work has been completed and discussions are on-going between the Trust and Coventry and Rugby Hospital Company (the PFI Provider) to ensure rectification works are completed as soon as possible. A revised fire strategy has been implemented during this period. Table-top exercise for the hospital Fire Response Team and the first on-call managers were held on the 2nd and 3rd September. These were followed by a live evacuation simulation which was held on 13th October 2015.	None Identified	HIGH	16	31-Jan-2016	Report has been taken to COG for update on processes in place	None Identified	LOW
2391	26-Jun-2015	Income from Activities 2015/16	Financial	Failure to secure planned levels of income from activities in 2015/16	To deliver Value for Money	HIGH	David Moon	Mr David Moon	Mr Alan Jones	Key contracts agreed (by specialty and POD) for 2015/16. Budgetary control processes. Monthly operational delivery meetings. Quarterly performance review meetings.	None identified	HIGH	16	31-Jan-2016	Key contracts agreed (by specialty and POD) for 2015/16. Monthly reports to the Trust Board and Finance and Performance Committee.	Current forecast shows a gap which still needs to be addressed	LOW

Source: DATIX Risk Management System

Open Corporate "High" Risks at 11.01.16

ID	Date Identified	Title	Risk Subtype	Description	Principal objectives	Risk level (initial)	Executive Lead	Risk Owner	Handler	Current controls	Gaps in controls	Risk level (current)	Rating (current)	Next review date	Assurance	Gaps in assurance	Risk level (Target)
2392	26-Jun-2015	Agency Staffing Expenditure 2015/16	Financial	Failure to control and reduce agency staffing expenditure	To deliver Value for Money	HIGH	David Moon	Mr David Moon	Mr Alan Jones	Budgetary control processes. Financial Recovery Plan (proposal to introduce strengthened agency staffing controls). Monthly operational delivery meetings. Quarterly performance review meetings. New controls over the use of agency staff implemented in July 2015 Additional TDA controls introduced in November 2015	New controls over the use of agency staff to be implemented in July 2015	HIGH	16	31-Jan-2016	Monthly reports to the Trust Board and Finance and Performance Committee.	Continuing high levels of agency spending and use of non-framework agencies Full compliance with revised Trust and TDA controls not assured	LOW
67	1-Apr-2014	Medicines Management - Drug Security	Safety - Clinical	Reviewed yearly and updated following Patient Safety Committee Review. 1 Facilities: Drug Security is compromised due to insufficient resources (poor storage facilities) within Trust to action best practice for the safe storage of medication. The Trust has experienced breaches in drug security as a result of lack of secure facilities. 2 Practice: Drug security compromised due to practice where doors to clinical rooms, drug trolleys and drug cupboards are left unlocked.	Delivering safe, high quality & evidenced patient care	MOD	David Eltringham	Mr Mark Easter	Mr Mark Easter	1 Facilities:15th January 2015 - PSC reviewed risk following presentation of November 2014 Trustwide medicines security audit. Agreed risk rating remains red (High Risk). Options appraisal conducted re. Facilities how to make facilities fit for purpose, preferred option Trustwide robotics. Director of Pharmacy to develop business case. 2 Practice - Monthly Medicines Management Training Workshops to be continued throughout 2015/16 and CD training added to nurse preceptorship programme. Medicines Management training programme added to induction via market place.	None identified	HIGH	15	29-Jan-2016	Monitored at Patient Safety Committee	None identified	LOW

Open Corporate "High" Risks at 11.01.16

ID	Date Identified	Title	Risk Subtype	Description	Principal objectives	Risk level (initial)	Executive Lead	Risk Owner	Handler	Current controls	Gaps in controls	Risk level (current)	Rating (current)	Next review date	Assurance	Gaps in assurance	Risk level (Target)
2279	4-Mar-2015	Trustwide Clinical Staffing Vacancies	Human Resources	As at 30th November 2014, the average nursing vacancy position across the Trust stood at 13% (range 1.22% - 25%) for Registered Nurse/ Midwife and Health Care Support Workers, a total of circa 400 posts. Identified impact (risk on quality and safety KPI's- pressure ulcers (slight sustained increase at grade 2 & 3 since July 2014), poorer scores on EOC benchmarks from previous year across all benchmarks (findings reported Jan 2015).High agency usage in most wards. Some impact on mandatory training compliance.Impact of additional open beds (short term over winter in renal, cardiology, day surgery) requiring additional staffing.	Delivering safe, high quality & evidenced patient careTo be an Employer of choiceTo deliver excellent Patient Care and Experience	HIGH	Mark Radford	Linda Abolins	Linda Abolins	Daily staffing review and management by Matron. Change to working practice, flexibility of working hours, use of bank and agency staff. Daily escalation process in place and report to CNORecruitment Lead Nurse in post since 1st December 2014 with a specific focus on registered and non-registered nurse recruitment/ retention. HR review and streamline of recruitment process. Targeted plans and actions for areas with particular pressures e.g. renal haemodialysis, gerontology, neurosciences Creating some short term (6 months) Band 3 posts in areas of highest risk- e.g. neurosciences and gerontology Consideration of recruiting mental health nurses for key specialties.There are a number of difficult medical posts that the Trust is actively trying to recruit to. These posts are temporarily being covered by locum doctors. April 2015 UHCW active participation to recruitment fayres in Ireland. Process in place to monitor use of agency staff, with non-framework RN requests, and HCSW framework requests requiring Chief Officer sign off. TDA target of no more than 12% of total nursing budget to be spent on agency staff, with a reduction over next 3 years year on year. New national guidance on agency caps came into force end November 2015, currently implications for UHCW being worked through. Recruitment monitored by COG, on monthly IPR and monthly workforce report to F&P Committee.	Timescale from advert to staff on site has improved but ongoing work to streamline this and reduce further to no longer than 3 monthsAgreement to employ greater number of newly qualified staff (work to look at support required for this) as experienced B5 staff not available to match current vacancy levels.	HIGH	15	29-Jan-2016	New Enhanced Care Team to commence in October 2015Monitored at COG, F&P Committee and quarterly Performance Reviews Bi annual review of risk assessment at Nursing and Midwifery Committee Nursing metrics reviewed monthly Twice yearly Safer Staffing report to Trust Board Deep dive review (of quality metrics) on those wards with 1:12 staffing at night received at QGC in June 2015. HCSW recruitment excellent and vacancy numbers reduced to below 30 across Trust	Vacancy rate remains at 13% at May 2015 despite active recruitment activities	MOD

PUBLIC TRUST BOARD PAPER

Title	**Infection Prevention & Control Quarter 3 Report**
Author	**Kate Prevc Modern Matron Infection Prevention and Control**
Responsible Chief Officer	**Professor Mark Radford, Chief Nursing Officer and Director of Infection Prevention and Control**
Date	**28th January 2016**

1. Purpose

To appraise the Trust Board of the infection prevention and control position for quarter 3 against national and locally set targets and to ensure that the Trust Board has sight of any challenges and successes in the infection control agenda.

2. Background and Links to Previous Papers

The Trust Board receives a quarterly report in relation to the Infection Prevention & Control agenda given that delivering high quality care is a key objective of the Trust and is a risk identified on the Board Assurance Framework.

3. Narrative

The nationally set targets for MRSA (0) and Clostridium difficile (42) were known to be challenging at the start of the year. UHCW is currently two cases of Clostridium difficile below trajectory, which is weighted towards the winter months which is historically when most cases occur).

Whilst one case of MRSA bacteraemia has been identified during the year, a multi-agency review concluded that this was not attributable to UHCW but should be sent for third party review. This is currently being evaluated by the TDA and is subject to appeal by NHS England. It has not been reported in the balanced scorecard at this stage as it would not be appropriate to do so given that it has not formally been attributed to UHCW.

There has been an increase in MSSA bacteraemia within the neonatal unit as previously reported to the Trust Board and an Incident Group is managing the increase; we have not had a positive bacteremia since 19th August 2015 and none of the outbreak strain since July 2015.

A national alert around Mycobacterium Chimera and Cardiothoracic theatres did identify potential cases associated with the Trust but this was historical; internal testing has however been carried out decontamination processes have been altered in line with the new requirements**.** These were in fact put into place by the cardiothoracic team before the DH request. Work to decontaminate this equipment continues and we are working with the National Leads.

4. Areas of Risk

The Trust is close to the trajectory and year to date ceiling for Clostridium difficile, although comparative performance is good. Whilst performance against the MRSA target

has also been good, there are risks to the year-end position arising out of the uncertainty around whether the MRSA bacteraemia will be attributed to the Trust.

5. Governance

Infection Prevention and Control risks and issues are monitored through the Infection Prevention and Control Committee (IPCC) and provide assurance to the Trust Board via regular reports to Quality Governance Committee and Trust Board.

6. Responsibility

Mark Radford, Chief Nursing Officer and Director of Infection Prevention & Control

7. Recommendations

The Trust Board is asked to **NOTE** the report and to **RAISE** any questions or concerns.

Name and Title of Author: Kate Prevc Modern Matron Infection Prevention and Control
Date: 19th January 2016

INFECTION PREVENTION & CONTROL
Quarter 3 Report
October – December 2015.

1. Introduction

This report seeks to provide the Trust Board with an update on both our mandatory reporting requirements and key infection prevention issues in Q3.

2. Mandatory reporting

The final numbers for the four infections subject to the national mandatory reporting scheme are shown in Table 1. Comparison of our performance with other large teaching Trusts is shown at appendix 1.

Table 1 April – December 2015.

MRSA, MSSA & *E. coli* bacteraemias, *C difficile* infection			
Period	**Apportioned figures**	**National Ceiling**	**Rate per 100,000**
April 15 – December 15			**Bed days**
MRSA bacteraemia	**1***	**0**	**0.36**
C. difficile	**28**	**42**	**10.05**
MSSA bacteraemia	**14**	**Not applicable**	**5.03**
***E. coli* Bacteraemia**	**219**	**Not applicable**	**-**

3. Staphylococcus aureus bacteraemias

3.1 MRSA

*So far this year, we have had one MRSA bacteraemia apportioned to the Trust, although we are currently appealing against this decision. The CCG agree that it should be apportioned to a "third party". At this point last year we had declared 5 cases of MRSA Bacteraemia. Education to staff on MRSA prevention and management using the " Mr Grey has MRSA" campaign has continued during quarter 3.

Figure 1

Trust-apportioned MRSA bacteraemias, 2006/2007 Q 1 to 2015/16 Q 3

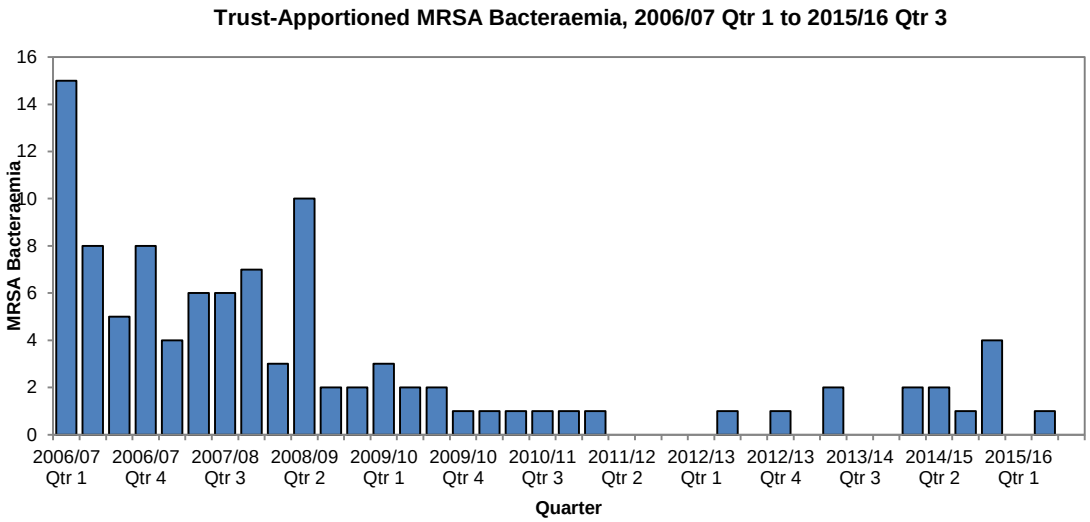
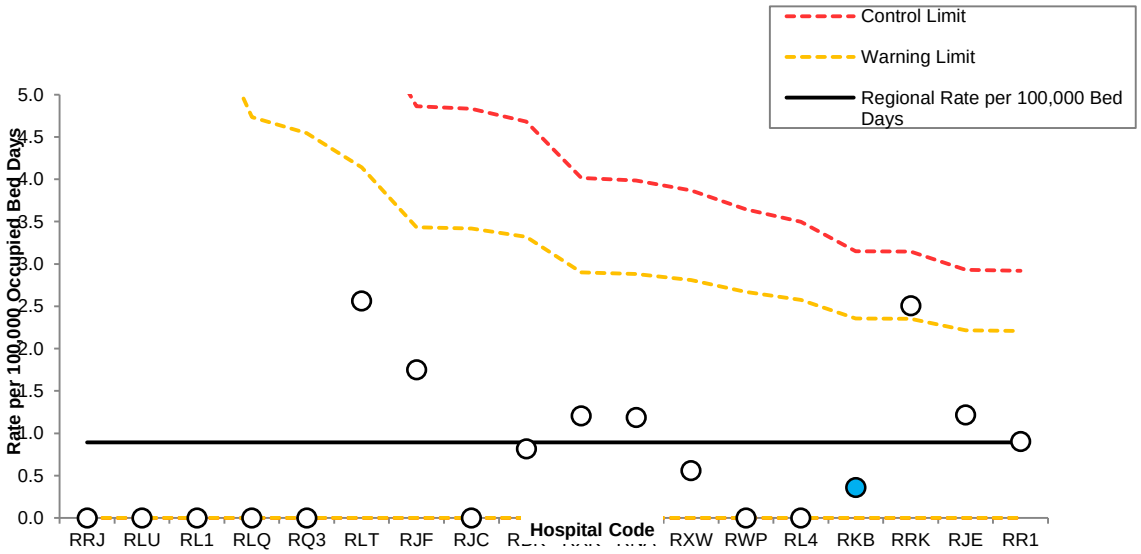


Figure 2 shows the PIR assigned MRSA BSI rates per 100,000 bed days, 2015/16 YTD, in comparison with other Trusts in the West Midlands. This shows that UHCW (blue circle) performs well against other Trusts in the West Midlands.

Figure 2



For full key see appendix 2.

3.2 MSSA

The number of Trust apportioned MSSA bacteraemia, is 14 to date, (Figure 3). At this point last year we had reported 11 cases. We identified an issue in the Neonatal unit, where five cases were reported between June and August. The previous year there were no cases in the neonatal unit. An outbreak management team was formed and Neonates have really interrogated their practices and developed an action plan. They have had no further cases since August 2015 within the unit. The neonatal action plan is included as an appendix to this report. The outbreak was declared over in December as there had

been no further cases of bacteraemia since August and no cases of the outbreak strain for 122 days on 15th September. We continue to carry out active surveillance this is monitored by a watchful waiting group which meets bi weekly.

At the request of UHCW, the TDA undertook a peer review in September to ensure that the outbreak was being managed appropriately and to provide any further advice. UHCW received the TDA report in October. The report identified areas of best practice which included; management of the outbreak, patient flow, team approach including executive engagement. They also acknowledged that staff were clear about their roles and responsibilities and "it was evident that the IPC team were engaged on the unit". A small number of recommendations were made which are included in the action plan (attached).

3.3 Clostridium difficile

The Trust reported 28 hospital acquired cases to the end of December, this was our lowest ever number at this period. This places the Trust at 2 cases below trajectory. This time last year we had reported 30 cases. The annual trajectory limit is challenging but we continue to work to reduce the numbers further. We have refined our RCA process to improve our understanding of causative factors. Our paperwork has been amended to record a discussion around "lapses of care" discussion between CCG, TDA and the Trust. Figure 3 below shows the number of trust-apportioned Clostridium difficile infection (CDI).

Figure 3 compares UHCW performance with other West Midlands Trusts.

Figure 3
Post 72 hr *Clostridium difficile* episodes, 2007/08 Qtr 1 to 2015/16 Qtr 3

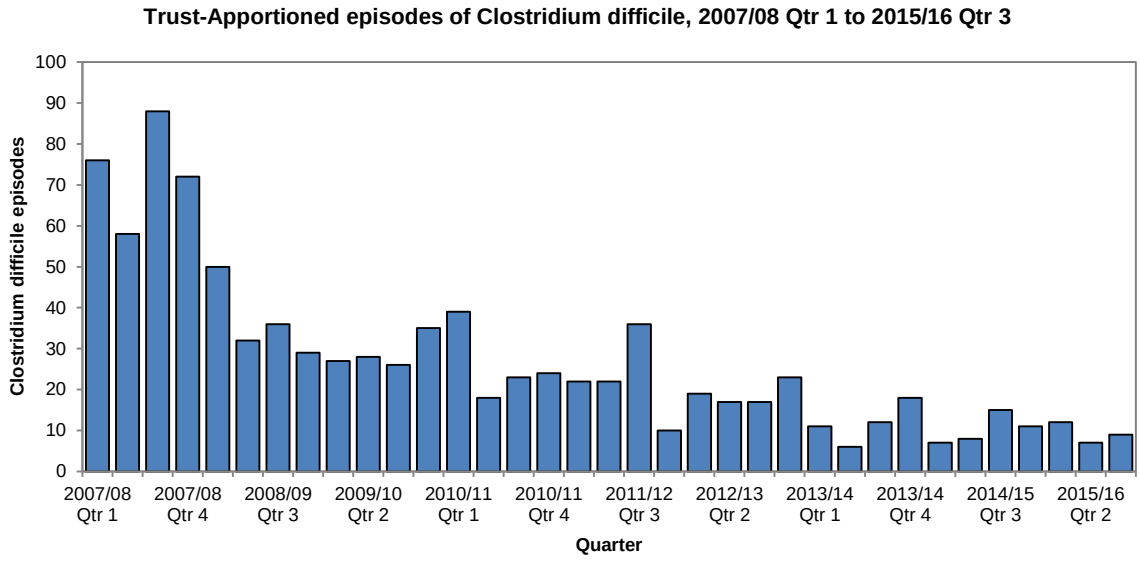
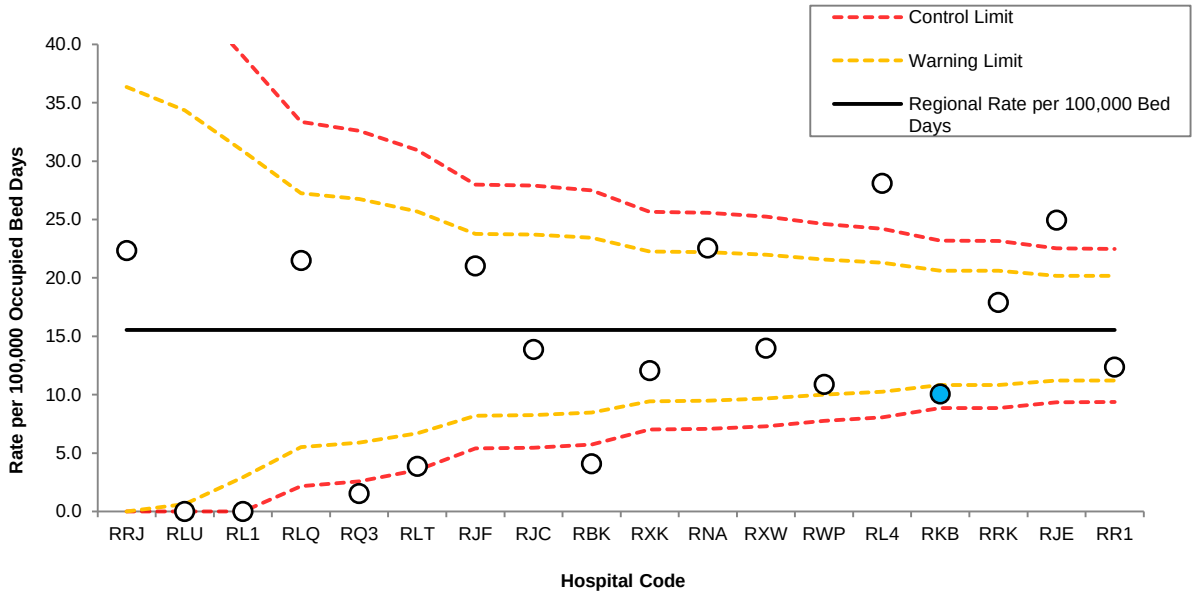


Figure 4

CDI rates 100,000 bed days, 2015/16 YTD, in comparison with other Trusts in the West Midlands

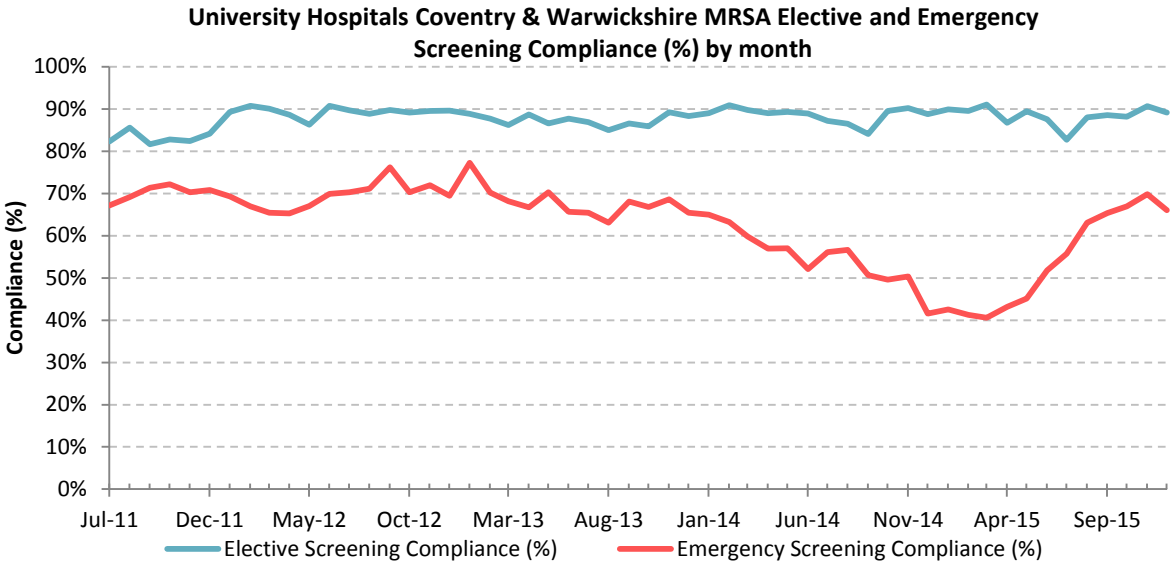


RKB- UHCW. For full key, see Appendix 2

4. MRSA screening compliance

The following chart shows compliance with MRSA screening of both emergency and elective cases up to December-15.

Figure 5



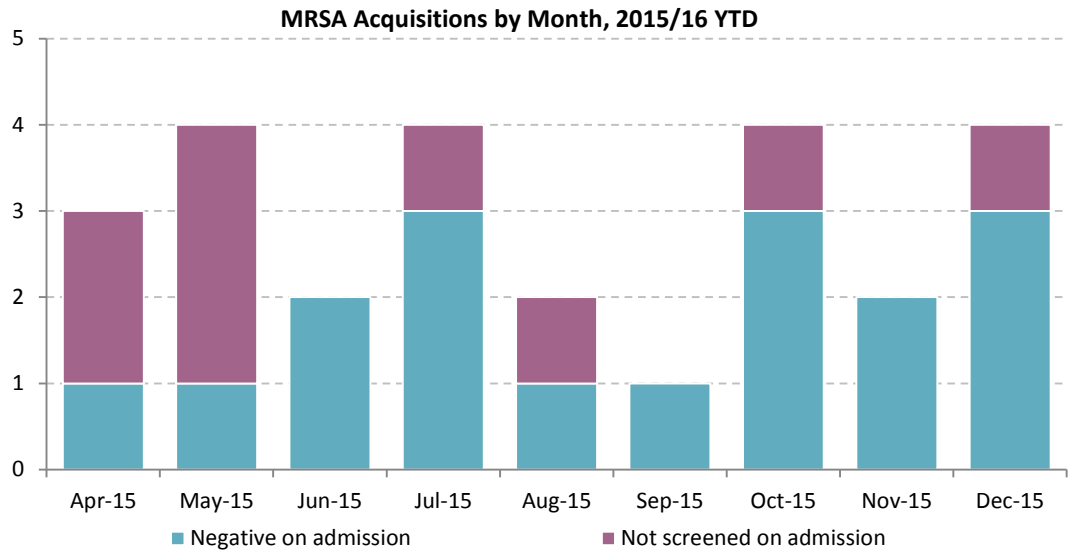
Focused work by the IPC team at ward level, looking out what factors hinder compliance, and how to address the issues has been initiated to improve compliance, most notably in the emergency pathway.

A pathway has been agreed with Preoperative assessment and this has resulted in the department consistantley reporting 98-100% compliance. We still have work to do with direct admissions to departments and some of this is around the issues with waiting list management.

5. MRSA New Acquisitions

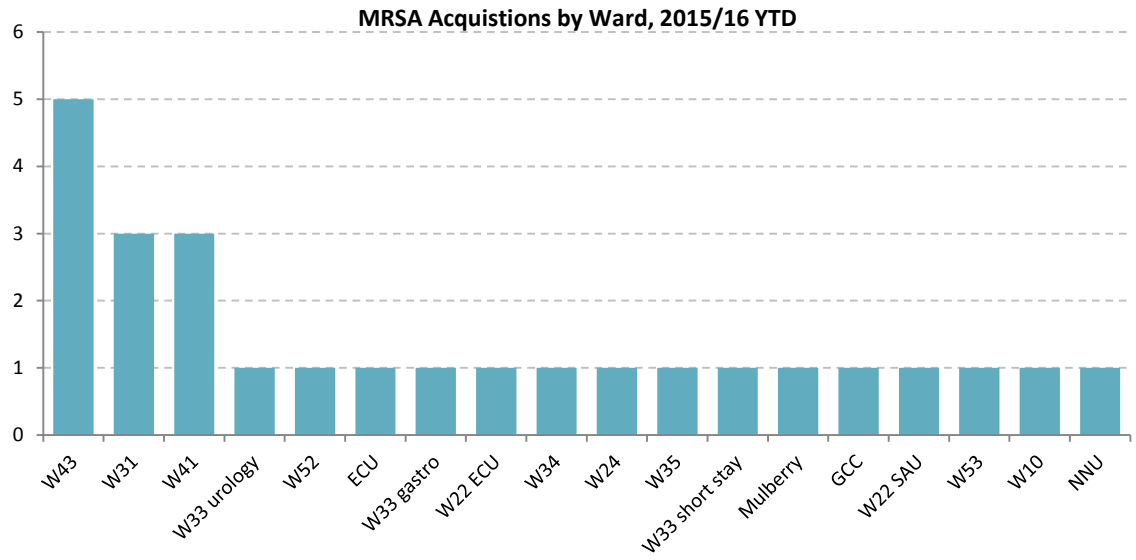
The number of patients who actually acquire MRSA colonisation during their admission at UHCW is a good indication of how well infection prevention and control is managed. These are all new positive MRSA specimens taken 3 or more days after admission that are not from previously known patients. It is important to note the numbers of cases are very small, our worst performing months show 4 cases of acquisition, per month across the Trust in approximately 1100 admissions. This is a rate of 0.36. National rates indicate 0.5 % - 2.1% according to the NOW national prevalence study (DH 2013). The IPC team have introduced a number of measures to tackle MRSA including a nurse led ward round and targeted education.

Figure 6



A breakdown by ward is shown in Figure 7

Figure 7



6. Influenza

Seasonal influenza rates remain lower than seen last year and this is in line with the national picture. We are seeing an increase in acuity of other respiratory viruses within the hospital environment but we are not seeing the slightly increased rates of hospital transmission that other hospitals are reporting. A joint education campaign, which started in September with a combined grand round presentation by Virology, Occupational Health and IPC Team have continued to raise awareness of isolation and appropriate screening for respiratory viruses.

7. TB incidents

A joint meeting with CCG and the TB regional team have progressed to develop an algorithm for the management of TB. This is out for review and will be presented to the IPCC in March. The development of a whole health economy pathway is a welcome development in our management of patients and any potential contacts of TB.

8*. M chimera* infection, cardiothoracic surgery

We continue to monitor the ongoing issues with the Heater cooler units that are suspected of transmitting M> Chimera to patients having Cardiac valve surgery. This is an international issue and we are following the guidance produced by the National task and finish group. We do however continue to isolate M. Chimera from our units water units. We are seeking guidance from Porton Down as to our next steps.

9. Cleaning

The Trust continues to work with Project Co and ISS to address the issues around cleaning. The last three months have seen a month on month improvement with ICNA scores.

Table 2

Average ICNA Score	78.6%	81.2%	83.0%	80.3%
Month	October	November	December	Q3 average.

The Infection Control Nurses Association (ICNA) scores are plotted against the ISS auditing scores (Maximiser). The Maximiser is the contractual measure and the ICNA is for IPC assurance. We use the two methods together to plot trends of improvement or decline. Table 3 shows the two scores for the last four quarters. A regular update of both ICNA and maximiser score is presented at both the Trust Cleaning Group and monitored by the Infection Prevention Committee.

Table 3

	Q4 2014/15	Q1 2015/16	Q2 2015/16	Q3 20151/6	Number
Maximiser	96.7%	96.6%	96.2%	96.0%	396
ICNA	83%	82%	79%	80%	332

10. Infection Control Team News

- The team have been asked to present at a national conference in London. Dr Carolyn Dawson is presenting on the five moments “Urrgh” factor research project. Kate Prevc and Fiona Wells on C diff management and motivating staff.
- The team were invited to run a researchers workshop at Birmingham University for the PhD group including the Post graduate certificate Infection Control leads. This was extremely well received.
- The twitter account of UHCW_inf_con has over 2500 followers, this makes the team a high profile infection control team nationally and we are regularly invited to lead on twitter chats around nursing and Infection Control issues.
- Joan Goodbody was successful in her secondment to Radiology and Outpatient as Modern Matron.

11. Conclusion.

UHCW continues to perform well nationally against other large teaching hospitals. We continue to work to further improve our performance and focus on infection, prevention and control.

Appendix 1

Teaching Hospital Comparison - April to December 2015

Code	Name	Occupied Bed Days for Period	Trust apportioned Rate			Ranked by Occupied Bed Days		
			MRSA	MSSA	CDI	MRSA Rank	MSSA Rank	CDI Rank
RQM	Chelsea & Westminster Hospital	197,570	0.0	2.0	3.0	3.5	1	1
RM3	Salford Royal	169,041	0.0	5.3	7.7	3.5	4	2
RWE	University Hospitals of Leicester	370,802	0.0	5.4	10.8	3.5	5	6
RKB	University Hospitals Coventry & Warwickshire	270,932	0.4	5.2	10.3	9	3	4
RM1	Norfolk & Norwich University Hospitals	259,023	0.0	3.5	16.6	3.5	2	14
RHM	Southampton University Hospitals	280,835	0.4	6.4	10.7	8	9	5
RTH	Oxford University Hospitals	322,043	0.6	5.9	14.9	14	7	10
RGT	Cambridge University Hospitals	233,783	0.0	7.3	18.8	3.5	11	18
RHQ	Sheffield Teaching Hospitals	369,932	0.0	12.7	14.3	3.5	22	9
RXH	Brighton & Sussex University Hospitals	213,134	0.5	7.0	17.8	11	10	15
RJ1	Guy's & St. Thomas	245,578	0.4	9.0	15.9	10	15	12
RQ6	Royal Liverpool & Broadgreen University Hospitals	194,583	0.5	10.3	11.8	12	18	7
RWA	Hull & East Yorkshire Hospitals	259,349	0.8	10.0	13.9	15	17	8
RJZ	King's College Hospital	337,249	0.3	8.3	19.9	7	13	20
RJ7	St. George's Healthcare	244,134	1.2	10.6	9.4	19	19	3
RBL	Wirral University Teaching Hospital	173,991	0.6	5.7	20.7	13	6	23
RXN	Lancashire Teaching Hospitals	215,262	0.9	8.8	20.9	16	14	24
RAL	Royal Free Hampstead	236,467	1.3	5.9	22.4	20	8	26
RRK	University Hospital Birmingham	279,499	2.5	10.0	17.9	27	16	16
RM2	University Hospital of South Manchester	183,344	1.6	13.6	15.8	24	24	11
RA7	University Hospitals Bristol	188,823	2.1	12.2	15.9	25	21	13
RYJ	Imperial College Healthcare	258,712	2.3	7.3	22.0	26	12	25
RW3	Central Manchester University Hospitals	294,453	1.4	15.3	18.3	21	26	17
RR8	Leeds Teaching Hospitals	421,061	1.2	11.6	25.9	18	20	27
RRV	University College London Hospitals	185,386	1.1	12.9	38.8	17	23	28
RTD	The Newcastle upon Tyne Hospitals	350,673	1.4	16.8	20.5	22	27	22
RAE	Bradford Teaching Hospitals	126,156	4.0	14.3	19.0	28	25	19
RX1	Nottingham University Hospitals	372,401	1.6	21.2	20.4	23	28	21

Taken from National MESS database

Director of Infection Prevention and Control,
University Hospitals of Coventry and Warwickshire

Appendix 2- key to regional hospital codes, West Midlands (Figures 2, 4, & 6)

Key

Hospital	Hospital Code
Birmingham Children's Hospital NHS Foundation Trust	RQ3
Birmingham Women's NHS Foundation Trust	RLU
Burton Hospitals NHS Trust	RJF
George Eliot Hospital NHS Trust	RLT
Heart of England NHS Foundation Trust	RR1
Hereford Hospitals NHS Trust	RLQ
Robert Jones & Agnes Hunt Orthopaedic & District NHS Trust	RL1
Royal Wolverhampton Hospitals NHS Trust	RL4
Sandwell & West Birmingham Hospitals NHS Trust	RXK
Shrewsbury & Telford Hospitals NHS Trust	RXW
South Warwickshire General Hospitals NHS Trust	RJC
The Dudley Group of Hospitals NHS Foundation Trust	RNA
The Royal Orthopaedic Hospital NHS Foundation Trust	RRJ
University Hospital Birmingham NHS Foundation Trust	RRK
University Hospital Of North Staffordshire NHS Trust	RJE
University Hospitals Coventry & Warwickshire NHS Trust	RKB
Walsall Healthcare NHS Trust	RBK
Worcestershire Acute Hospitals NHS Trust	RWP

Neonatal MSSA Action Plan - A[illegible] 4th January 2016

University Hospitals Coventry and Warwickshire NHS Trust

Objective		Exec Lead	Delivery Lead	Identified actions	By When	Status	Marker(s) of Evidence
Screening	**Babies**	Mark Radford / Linda Abolins	Kate Blake	a) Screening to commence 27th August 2015.	27/08/2015	Complete	Weekly list from Microbiology
				b) Screening to be carried out weekly and on admission for all babies on NNU and TC.	31/08/2015	Complete	Weekly list from Microbiology
				c) Babies with a positive result to be risk assessed on an individual basis and commenced on decolonisation where appropriate.	04/12/2015	Complete	Weekly list from microbiology and patient healthcare notes as appropriate.
			Kate Prevc/Merja Thomas	d) Weekly reports for positive and negative MSSA screening results to be circulated.	04/09/2015	Complete	Weekly list from Microbiology
			Jenny Child	e) All screens to be sent to Public Health England for Spa typing.	31/08/2015	Complete	Any swabs that are positive for MSSA and Gentamicin Resistant or any other swabs as deemed appropriate are sent for SPA typing..
	Staff		Eileen Williams	f) Screening to commence 7th September 2015.	07/09/2015	Complete	Evidence in Occupational Health Department.
				g) Training to be provided on new swabs for Occupational Health.	04/09/2015	Complete	Training completed.
	Information		Jenny Child	h) Leaflet for staff on decolonisation treatment etc.	07/09/2015	Complete	Copy of information sheet sent to all staff.
			Kate Blake	i) To discuss potential information required for parents.	07/09/2015	Complete	All parents provided with information leaflet and spoken to by consultant or matron on an individual basis.
Reporting		Mark Radford / Linda Abolins	Allison Bradley	a) Report as a Serious Incident via Clinical Governance. Complete DATIX form.	01/09/2015	Complete	Datix submitted - WEB70756.
Communication		Mark Radford / Linda Abolins	Jenny Child	a) Press Statement to be prepared.	28/08/2015	Complete	Email saved on J Drive NNU incident folder
Risk Assessment		Mark Radford / Linda Abolins	Kate Blake	a) Risk assessment to be completed for the continuation of admissions into the unit.	11/09/2015	Complete	Risk Assessment completed and currently on Departmental risk register
Environment	**Environmental Screening**	Mark Radford / Linda Abolins	Jenny Child	a) Enviromental Swabbing	01/10/2015	Complete	Microbiology and Infection Control Deopartments have results of swabbing.
			Merja Thomas	b) Weekly ICNA audits to be performed on NNU and TC.	27/10/2015	Complete	ICNA audits for NNU and TC - consistently between 92-98%
	Environmental Audits/Equipment/ Decontamination	Mark Radford / Linda Abolins	Louisa Eadon	a) Ensure all baby clothes is laundered at 60 degrees	14/10/2015	Complete	All healthcare support workers and nursery Nurses reminded at Unit Meetings. Laminated signs above the washing machine reminding all users of the correct temperature.
		Mark Radford / Linda Abolins	Rose Blake	a) Develop a SOP for equipment cleaning in the decontamination room	15/10/2015	Complete	Sign placed in decontamination room.
		Mark Radford / Linda Abolins	Rose Blake	a) Develop a schedule for equipment cleaning responsibilities	15/10/2015	Complete	List of equipment and cleaning responsibilities emailed to all staff and list included in Co-ordinators folder. List emailed to ISS supervisor.
		Mark Radford / Linda Abolins	Rose Blake	a) All paper rolls to be placed in dispensers within rooms	15/10/2015	Ongoing/ordered	Difficulties sourcing dispensers has delayed this action. However, dispensers on order from TORK for delivery by the end of January 2016.
		Mark Radford / Linda Abolins	Collette Fox	a) All parent areas to have hand hygiene posters	15/10/2015	Complete	Posters reminding parents to wash hands in place

		Mark Radford / Linda Abolins	ISS	All areas to consider colour coded gloves for cleaning.	15/10/2015	On-going	Colour coded gloves to be introduced in line with the National cleaning standards. Not in place- awaiting feedback from ISS
		Mark Radford / Linda Abolins	Rose Blake	All sharps trays will be cleaned and disinfected following use	25/12/2015	Complete	Small trays have been condemmed and Trust sharps trolleys have red and yellow cloths for cleaning.
		Mark Radford / Linda Abolins	Rose Blake	All blue bowls are to be dried and stored pyramid fashion	15/10/2015	Complete	Sign reminding staff placed in decontamination room. Spot checks undertaken.
		Mark Radford / Linda Abolins	Storage	Idenify furter storage in order for all areas to have access for cleaning.	15/10/2015	Complete	No additional areas have been identified. Stock lists are to be reviewed twice anually to ensure minimal stock levels are ordered.
Hand Hygiene		Mark Radford / Linda Abolins	Merja Thomas	a) Weekly WHO 5 Moments hand hygiene audits to be performed on NNU and TC.	04/09/2015	Complete	Weekley 5 moments audit in place.
		Mark Radford / Linda Abolins	Rose Blake	a) Departmental Change Makers to be trained in hand hygiene and 5 moments	30/10/2015	Complete	Complete.
		Mark Radford / Linda Abolins	Rose Blake	All non registered nursing staff/clerical and and ISS staff to be included in hand hygiene audits.	30/12/2015	Complete	Audit of non-nursing staff completed.
		Mark Radford / Linda Abolins	Rose Blake	All Nursing and medical staff to be taught hand hygiene	30/10/2015	Complete	Hand hygiene % currently at 98%
Visitors		Mark Radford / Linda Abolins	Kate Blake	a) Reinforce with visitors to wait downstairs and not on TC.	04/09/2015	Completed	Sign placed on nursery door and all staff are aware.
		Mark Radford / Linda Abolins	Louisa Eadon/Sue Aucutt	a) All parents to be reminded on admission of the importance of hand hygiene within the unit.	16/10/2015	Completed	All staff have been reminded and has been added to the Big 2 for January 2016. A hand hygiene sign has been added to the cot card to indicate when the parents have been taught how to wash their hands using the Ayliffe Technique.
IPC Forum		Mark Radford / Linda Abolins	Kate Blake	a) Neonatal infection control improvement group (NICI) to be set up	01/09/2015	Complete	Last meeting 09 12 15 - minutes in progress
		Linda Abolins/Mark Radford		MSSA Incident meetings	28/08/2015	Complete	Minutes of meetings and action plan updated bi-monthly.
Medicines	**Single use vials**	Linda Abolins/Mark Radford	Louisa Eadon/Sue Aucutt	a) Multi-accessing use of anti-biotic vials to cease	15/10/2015	Complete	Observation
Staff Induction	**All new staff are aware of the hand hygiene and infection control standards at induction.**	Linda Abolins/Mark Radford	Yvonne Huskins	Include a session on Hand hygiene and Infection Control practices in local induction.	25/12/2015	Completed	Agenda item on local induction. Evidenced by Agenda item.

University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD PAPER

Title	**Patient Experience Quarterly Report**
Author	**Sonia Lloyd, Interim Associate Director of Quality** **Jenny Gardiner, Director of Quality**
Responsible Chief Officer	**Meghana Pandit, Chief Medical and Quality Officer**
Date	**28th January 2016**

1. Purpose

This quarterly experience report brings together information on Patient Involvement, Friends and Family Test, external feedback websites, complaints, PALS, compliments and health information.

2. Background and Links to Previous Papers

The paper aims to present patient experience information in an easy to read format suitable for public consumption and is provided to the Trust Board on a quarterly basis.

3. Narrative

In keeping with the Trust's vision of becoming a national and international leader in healthcare and its values, this report aims to bring together the work of the Patient Experience Team and highlight areas of good practice and improvement areas. The report covers: Patient Involvement, Complaints, PALS, Compliments and Health Information.

The complaint response rate for the 25 working day standard indicator has remained relatively stable throughout October and November; we are awaiting confirmation of the position for December.

Four new Parliamentary Health Service Ombudsman (PHSO) requests were received during the quarter.

4. Areas of Risk

There is no CQUIN for the Friends and Family test for 2015/16. However, the Trust continues to track its performance and respond to national developments such as the easy read FFT question.

5. Governance

NHS Constitution

Principle 4 – The NHS aspires to put patients at the heart of everything it does NHS services must reflect and should be coordinated around and tailored to, the needs and preferences of patients, their families and their carers.

Principle 7 - The NHS is accountable to the public, communities and patients that it serves.

6. Responsibility

Meghana Pandit, Chief Medical and Quality Officer

7. Recommendations

The Board is invited to **NOTE** the Patient Experience Quarterly Report and to **RAISE** any questions or concerns.

Name and Title of Author: Sonia Lloyd, Interim Associate Director of Quality

Date: 15/01/2016

University Hospitals Coventry and Warwickshire NHS Trust

We Care

Patient Experience Report Quarter 3 2015-16

28th January 2016

Contents

Compliments – Examples of Compliments Received via Feedback and Impressions

"The care received was brilliant and I'd like to thank all staff for this." Ophthalmology, Outpatients Department, University Hospital, Feedback Inbox

"Received excellent treatment can't speak highly enough of doctors, physios, discharge team, nurses." Mulberry Ward, Hospital of St Cross #105882

The Feedback inbox is used by the Complaint Department and PALS for complainants and service users to communicate with the Trust via email. As well as being used to communicate concerns, it can also be used to communicate compliments and/or praise to individual members of staff or teams.

The Impressions website is used by the Patient Experience Team for service users (patients, family members and visitors) to provide the Trust with their comments about their experience, often via the Friends and Family Test (FFT).

= Impressions = Feedback

"The entire visit for op and after care was extremely excellent, the after care staff and nursing team where very competent and attentive. A very clean hospital and ward was a pleasure to visit." MTEC, University Hospital #117222

"On being first admitted onto the ward can I say the staff were nothing less than efficient, friendly and very informative…I could go on for ever in praise of the staff and I include in this the cleaning staff who takes their duties to the next level resulting in spotless conditions." Ward 11 Cardiology, University Hospital, Feedback Inbox

"Extremely professional staff who are very caring and helpful and need to be commended for the work they do…My thanks go out to all of the staff." Coronary Care Unit, University Hospital #117199

"I was listened to in a very respectful manner and was allowed to participate in my own treatment plan and outcome… exceptional level of care and professionalism." Rugby Urgent Care Centre, Hospital of St Cross, Feedback Inbox

"The hospital is like a small family run business and is very personable. The staff, doctors, nurses are all very professional and could not do enough for patients and all delivered with a smile and compassion. I would not hesitate to have future operations at St Cross." Cedar Unit, Hospital of St Cross #106384

"Good clear approach, lots of staff contact - nursing and medical. Haven't had to come for a few years - forget how good it is despite being a difficult time." Ward 16 Paediatrics, University Hospital #117241

"I was waiting in A & E…for part of the time and I wanted to compliment your staff on the calm, professional and friendly way they dealt with us and with the people there…" A&E, University Hospital, Feedback Inbox

"Staff all very friendly & professional & conscientious. Excellent at explaining procedures." Ward 33 Urology, University Hospital #106381

"…in both departments staff were efficient, professional, kind and very helpful…was especially pleased to be treated in such a way." A&E and Outpatients Department, University Hospital, Feedback Inbox

"Absolutely excellent. First class." Ward 31 Respiratory Medicine, University Hospital #110835

"The service was excellent. The whole team were very professional, welcoming and caring. The consultant was very thorough and caring. Thank you so much to everyone." Eye Casualty, University Hospital #106614

Patient Advice and Liaison Service (PALS) – Overall Performance

PALS are now providing data for each full quarter (commencing in Quarter 1). This enables us to monitor the performance of the service in a similar manner to the performance monitoring of the Complaints service (please note that the collection of data began in mid-May, therefore the figures below represent only half of Quarter 1)

	Q4 (14/15)	Q1 (15/16)	Q2 (15/16)	Q3 (15/16)
Received via telephone	N/A	507	726	**667**
Received via Feedback	N/A	211	407	**378**
Received in person	N/A	131	185	**200**
Received in writing	N/A	7	32	**23**
Total Number of PALS Enquiries Received	N/A	856	1350	**1268**

PALS is often the first point of contact for patients and relatives wishing to raise concerns about their care and with prompt help, these can often be resolved quickly. In Quarter 3, the majority of contacts are by email and telephone. During this Quarter, changes to the service include:

- The appointment of a full time PALS Manager in November 2015
- The service will now be available to staff and service users daily from 8am to 5pm.

Handling PALS enquiries

The work of the PALS can be divided into four distinct areas of activity:

- Face to face meetings are held with patients, relatives or carers who visit the PALS Office
- Ward visits are made at either the request of patients or at the request of ward staff
- Telephone calls are taken and a 24 hour telephone messaging service is also in use
- Enquiries are also received and responded to using the Feedback email account.

Enquiries

Main themes arising from the concerns raised via PALS:

- Appointments – calls relating to delays in receiving appointments and capacity issues in some specialties, errors with appointment times/arrangements, appointments being sent with short notice of clinic date, patients being unable to make contact with departments to arrange appointments or change existing appointment times
- Cancellation of appointments or procedures
- Lack of communication about the changes made to appointment time and dates
- Car parking and attitude of car parking staff.

Although clinical enquiries form a large part of the enquiries received, PALS also handle queries related to community services, visiting hours, bus timetables and other non-clinical queries.

PALS staff also facilitate meetings for service users with medical and nursing staff to discuss concerns. PALS will often support staff through challenging meetings.

Conversion of a PALS enquiry into a complaint

In the case of PALS enquiries which cannot be dealt with at an informal level, the enquirer is given the option of converting their enquiry into a complaint or discontinuing this process. In the case of enquirers who wish to convert their enquiry to a formal complaint, the PALS Officers liaise with the Patient Relations Manager and transfer all relevant information to the latter so that the concerns can be investigated and responded to with a formal response from the Chief Executive Officer.

PALS – Examples of PALS Enquiries Received in Quarter 3

Below you will see a series of examples of PALS enquiries received throughout Quarter 3; they examples below represents the variety of concerns and enquiries that PALS deal with daily, and provide examples of the outcomes achieved by the PALS.

ID	Concern	Outcome
8185	Enquirer contacted PALS to raise concerns about the number of patients/visitors smoking on site despite a site-wide ban on the practice.	Apologised to enquirer and referred to Stop Smoking Manager who attempted to contact the enquirer and left voicemail message to contact them if required.
8184	Enquirer contacted PALS to raise concerns as due to heavy traffic/gridlock in the car park, she was unable to attend her appointment with and now wants an earlier appointment than the one offered.	PALS contacted Estates and Outpatient Specialty and then relayed information back to the enquirer who was happy with the outcome.
8162	Enquirer wanted to raise concerns about his waiting time for an angiogram at UHCW.	PALS contacted the cardiology waiting list co-ordinator – date for procedure provided. PALS called and relayed this information.
8193/ 8194	Enquirer contacted PALS to advise she has been on a waiting list for a while and was concerned she had not heard anything. She wondered if she was still on the list.	PALS checked IPM and advised enquirer was still on the waiting list and at that point had not breached. Advised to contact PALS in January 2016 for further update. Enquirer contacted PALS in January 2016 as suggested was given a date of 31 January at the Hospital of St Cross, Rugby. Enquirer thanked PALS staff for their advice and support during her query.
8195	Enquirer contacted PALS as he is receiving letters in a language other than that which he is fluent in. He is concerned he is missing appointments.	PALS contacted medical secretary and IPM was amended. An MRI appointment was confirmed and copies of appointment letters for 2016 sent via post.
8171	Enquirer wanted to speak to a staff member regarding the Caludon Centre as she stated she was suffering with psychosis.	Advised that the Caludon Centre falls under the CWPT remit and was given contact details for their PALS service.

Complaints – Overall Performance

This table demonstrates the overall performance of the Complaints service's key performance indicators, and compares October, November and December with the previous 9 months.

	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	**Oct 2015**	**Nov 2015**	**Dec 2015**
Total number of formal complaints	29	36	44	59	51	47	58	47	56	**64**	**47**	**34**
% complaints responded to in 25 working days	66%	31%	30%	59%	92%	94%	86%	77%	82%	**78%**	**85%**	**TBC**
Number returned for further local resolution	11	7	15	2	6	6	13	8	10	**10**	**3**	**10**
Number of PHSO requests	0	2	1	2	1	2	1	1	2	**3**	**1**	**0**

Activity

The activity of the Complaint department has increased this year with the average number of complaints received per month (**48**) at its highest level for five years.

While the number of complaints received in October 2015 the highest number (**64**) of complaints received in a month for the previous five years, the number of complaints received in December (**34**) represented a 47% decrease on October's figures.

Further Local Resolution

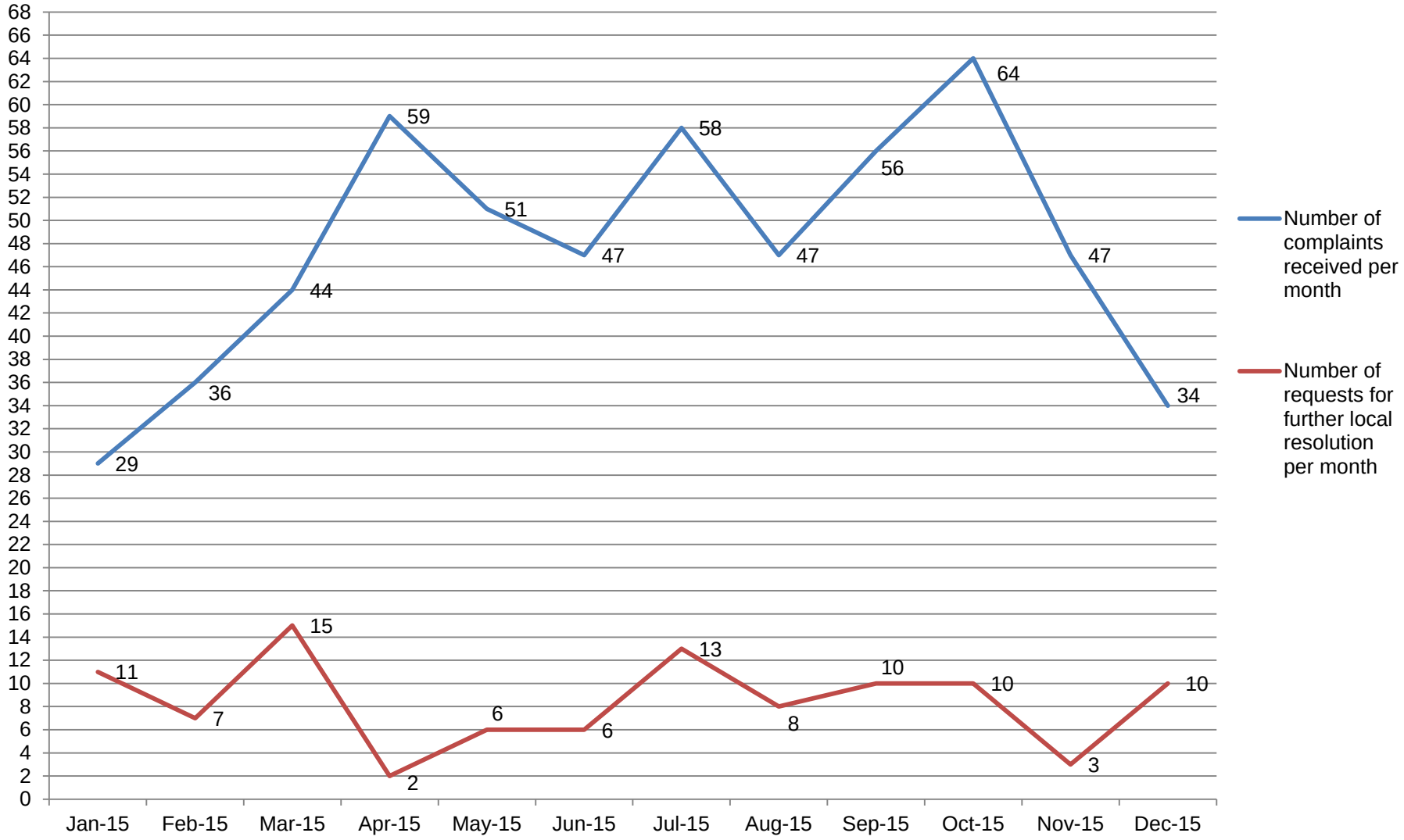
The number of complaints returned for further local resolution during October (**10**) was also higher than the preceding months but there was a decrease in November (**3**).

The Management Plan and Escalation Process

The Complaints service introduced a management plan and escalation process which is used to ensure complaints are responded to within the 25 working day deadline, and that statements from members of staff are received within a timely manner. When staff are unable to return their comments by Day 10, they are reminded that their statement is overdue and provided with a further 5 working days to respond by. If the deadline at Day 15 is also breached by staff, the issue is escalated to the Director of Quality and Chief Medical Officer; members of staff who breach the Day 15 deadline are informed of this escalation. The escalation process has been extremely effective and has contributed greatly to the significant increase in the number of complaints responded to within the 25 working day standard.

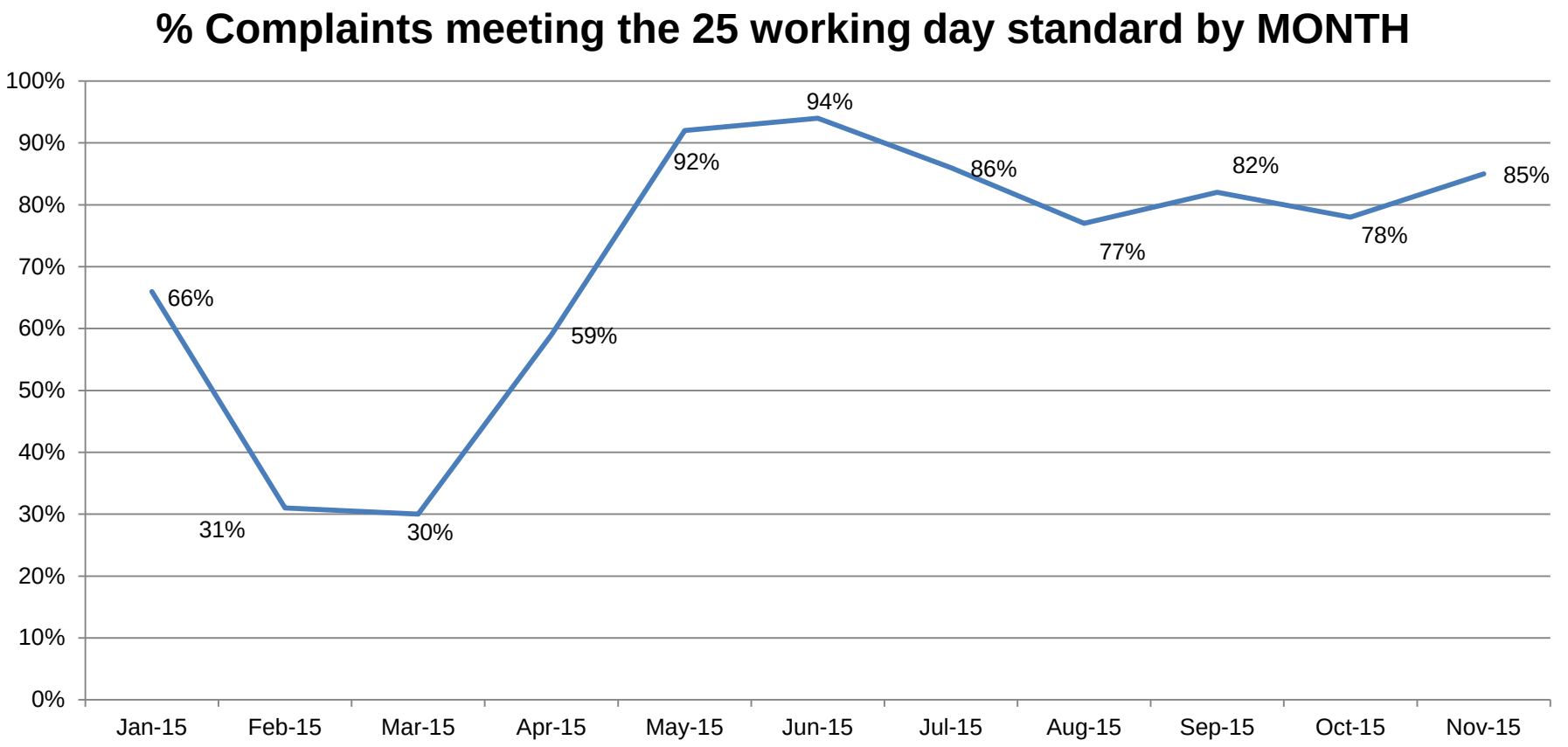
Complaints – Activity in the Complaint Department

This graph demonstrates the trends in the total number of complaints received, in addition to the number of requests for further local resolution per month for the previous eleven months.



Complaints – Performance Against the 25 Working Day Response Standard

This graph demonstrates in more detail the performance of the Complaints service against the 25 working day response standard for the previous eleven months.



Performance

Following a sharp increase in the percentage of complaints responded to within 25 working days during April – June 2015, the figure has remained relatively stable throughout the previous six months. The figure for each individual month does vary depending on the number of complaints received, and other factors such as the time taken to gather statements from staff and to gain sign off of the response letter from the Specialty Group Managers. The implementation of the Management Plan in April 2015 was largely responsible for the overall increase in the achievement of the 25 working day standard.

Complaints – Most Common Subjects for Complaints

The information obtained from the KO41(a) data collection monitors written Hospital & Community Health Services complaints (by service area, profession and type) received by the NHS each year.

Displayed below are the top five subjects of complaints received by the Trust for October, November and December. For each subject, there are a number of 'sub-subjects' to measure which issues occur most frequently.

Dignity scored highly for all five of the top subjects for complaints received during October, November and December; this was also a predominant trend during the previous three months (Jul-Sep). **Attitude** is also a prevalent issue, featuring in 4 out of 5 sub-subjects. **Staffing levels** also feature as a common theme of complaints received by the Trust, and are prevalent in 3 out of 5 sub-subjects.

Complaints – Top 5 Subjects (K041a)	TOTAL
All aspects of clinical treatment	**74**
Communication/information to patients (written and oral)	**26**
Appointments, delay/ cancellation (outpatients)	**12**
Attitude of staff	**9**
Appointments, delay, cancellations (inpatients)	**8**

The most common subjects for complaints about **All aspects of clinical treatment:**
- TTOs and Medication (= 20)
- **Staffing levels (= 15)**
- Re-admission (= 15**)**
- **Dignity (= 14)**
- **Attitude (= 10)**

The most common subjects for complaints about **Communication/information to patients (written and oral)**:
- **Dignity (= 10)**
- Diagnosis (= 10)
- **Attitude (= 6)**

The most common subjects for complaints about **Appointments, delay/cancellation (outpatients)**
- **Attitude (= 5)**
- **Dignity (= 3)**
- **Staffing levels (= 2)**
- Waiting times in ED/OPD (= 2)

The most common subject for complaints about **Attitude of staff**:
- **Staffing levels (= 5)**
- **Dignity (= 3)**
- Diagnosis (= 1)

The most common subject for complaints about **Appointments, delays, cancellations (inpatients):**
- Re-admission (= 3)
- Discharge planning (= 2)
- **Attitude (= 2)**
- **Dignity (= 1)**

Complaints – Parliamentary Health Service Ombudsman (PHSO)

The number of complaints referred to the Parliamentary and Health Services Ombudsman (PHSO) received in October, November and December is consistent with the number of requests for the previous three months. The Complaint Department advises complainants who are dissatisfied with their initial response, or with further local resolution, to seek the opinion of the PHSO, especially in cases where it is felt that staff are unable to offer more explanation in response to grievances, or if it is felt by the complainant that a meeting with staff would not be beneficial.

The complaints requesting further investigation by the PHSO arise from a variety of the specialties and often take longer to investigate than the standard 25 working days. The Complaint Department provides the PHSO with the complaint file once requested; after the complaint has been investigated, the PHSO provide the Trust with a series of reports, recommendations and a verdict on their findings (upheld, partially upheld or not upheld).

This table shows the number of request for investigation by the PHSO received by the Complaint Department from October – December 2015.

Case	Primary Issue(s)	Primary Specialty	Date received from PHSO	Comments
HS-218513	Communication, staff attitude	Neurosurgery	09/10/2015	Not upheld (draft report)
HS-226033/0048	Delay in hip replacement surgery	Orthopaedics	21/10/2015	Under investigation by the PHSO
HS-237766/0037	Poor medical care	Cardiology	26/10/2015	Under investigation by the PHSO
HS-228594/0034	Clinical judgement query	Endocrinology	27/11/2015	Under investigation by the PHSO

This table shows the number of requests for investigation by the PHSO which have been closed between October – December 2015.

Case	Primary Issue(s)	Primary Specialty	Date closed with PHSO	Outcome
HS-216560/0026	All aspects of clinical treatment	Acute Medicine	08/10/2015	Partially upheld
HS-205094	All aspects of clinical treatment	Gerontology	09/10/2015	Partially upheld
HS-207710/0032	Communication	Dermatology	14/12/2015	Partially upheld

Complaints – Learning from Complaints

Below you will see an example of a complaint received in December 2015; the information below explains in more detail how the Trust responds to and clarifies concerns in responses to complainants.

COMPLAINT ID: 8108 (GRADE RED)

The complainant raised a number of specific concerns in relation to her late husband's death following attendance in the Emergency Department (ED) with angina. The concerns were as follows: the appropriate treatment plan was not followed during ED admission; the patient was inappropriately discharged from ED and referred to the Rapid Access Chest Pain clinic; the referral failed to arrive and the patient's GP was required to intervene. The patient passed away a week after attending the Rapid Access Chest Pain clinic. His wife believes that the opportunity to treat her husband successfully was missed and that his death could have been avoided.

In order to respond to the complaint, the Complaints Officer sought the opinion of a Consultant Cardiologist. The Trust was able to confirm that during the patient's attendance at ED, he was treated appropriately; repeat ECGs were performed which showed no change, and the patient had a normal troponin test result in accordance with the time which had elapsed since the last episode of pain. The Consultant Cardiologist also confirmed that a repeat ECG was requested, however due to the negative test results, and no further experience of pain in the 12 hours prior, additional ECGs were not required. The Consultant Cardiologist reassured the complainant that the care and treatment her husband received in ED was appropriate and confirmed that he was discharged from ED on this occasion with advice to return if he had any further concerns.

The Trust also acknowledged that an administrative error had occurred, resulting in the delayed referral to the Rapid Access Chest Pain clinic. The Consultant Cardiologist confirmed that the clinician's decision to investigate was based on the patient's previous medical history of cardiac problems. The clinician felt that the pain was atypical and this was supported by an ECG. The clinician arranged a myocardial perfusion scan (MPI), and also treated the patient with aspirin, statin and a beta-blocker. The Consultant Cardiologist added that further anti-anginal medication could have been given, but would not have affected the patient's prognosis, only his symptoms. The Consultant Cardiologist also explained to the complainant the decisions driving the specific tests which were performed. The Trust reassured the patient's wife that the opportunity to treat her husband was not missed, neither would it have altered the outcome.

Complaints – Examples of the Complaints Received

The table below shows examples of complaints received by the Complaint Department October, November and December 2015; it displays the Datix ID number and grading (pre-investigation) of the complaint, the main issues and concerns raised by the complainant, and the actions taken as a result of the complaint.

ID and Grade (pre-investigation)	Main Issues of Complaint	Outcome and Actions Taken
7992 (BLUE)	Family attended the Walk In Centre with granddaughter and were advised to bring the child to Accident and Emergency (ED) due to concerns over her breathing. The child was discharged from ED with a suspected viral infection; no x-ray was performed. The family were advised to return the following day if still concerned and on attendance the following day, an x-ray found that the child's heart was enlarged and she was suffering from heart failure.	The Chief Executive Officer wrote to the family and agreed that although the diagnosis was not definitive at the time of the first attendance in ED, they were some symptoms present which could have prompted further investigation. Assurances were offered to the family that the delay in diagnosing the heart failure would not have caused any long term effects or harm to the patient.
7998 (AMBER)	Following a procedure at the Hospital of St Cross, the patient was transferred to UHCW due to complications. Following her discharge from UHCW, the patient required a two-week follow-up in Outpatients; after no communication from the hospital the patient contacted UHCW to arrange the follow-up appointment. It was also discovered that a physiotherapy referral was not arranged, resulting in further delays to treatment. In addition to this, a pressure ulcer on the patients toe was also discovered in fracture clinic when she attended for dressing changes. Further to an endoscopy performed during her admission at UHCW, the patient was also informed that cancerous cells had been identified on her thyroid gland. The patient highlighted several concerns in relation to a lack of coordination regarding her care and stressed that she hopes further administrative delays will be avoided now that she is undergoing treatment for cancer.	The patient was provided with a detailed response, contributed to by all specialties involved in her care. It was confirmed that the patient's status as a medical outlier following her transfer from the Hospital of St Cross caused her to be discharged by the medical team, not the orthopaedic team, whose care the patient was originally under for surgery to her foot. There was some confusion as to which team should have arranged the follow-up appointment in Outpatients; apologies were offered for the distress this caused, especially due to the pressure ulcer which developed due to a delay in the plaster being changed. The Ward Manager also offered her apologies and confirmed that the issues will be raised at a ward meeting for awareness of the risks involved with medical outliers. Although it would be normal practise for the therapy referral to be made following the Outpatients appointment, the Therapy team have apologised for not anticipating the referral; this has also been discussed at a team meeting for learning purposes. Staff were able to confirm for the patient that her care pathway for thyroid surgery was being coordinated correctly and this surgery went ahead as planned.

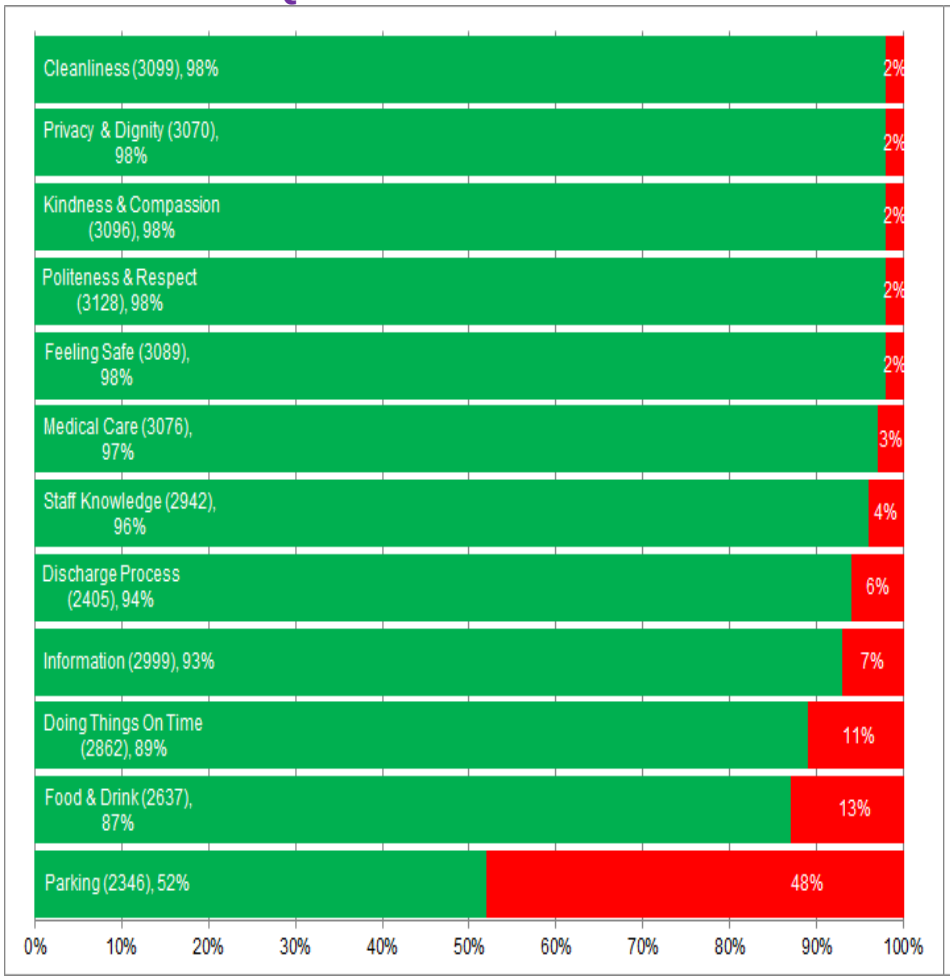
Complaints – Examples of the Complaints Received

ID and Grade (pre-investigation)	Main Issues of Complaint	Outcome and Actions Taken
8024 (BLUE)	The complainant explained that during her admission, she experienced poor/rude attitude from a nurse. During her admission, the patient also required a cannula to be fitted by the nurse. The site of the cannula became infected, resulting in the patient being readmitted for further treatment and another procedure. The patient now has a scar on her wrist.	Following her second discharge, the patient had a dressing applied for review in 3-5 days by her GP Practice Nurse; she was also invited to attend the Trauma clinic for further review by a Consultant. In addition to this, apologies were also made for the nurse's attitude and behaviour; the Ward Manager identified the nurse and shared the complaint with her.
8101 (AMBER)	A baby was transferred to the Special Care Baby Unit following birth and the parents were not invited to accompany their child. Subsequent communication between hospital staff and the parents was very poor, in addition to the lack of consent prior to interventions such as IV antibiotics, a chest x-ray and blood tests. Following this, the family also received a poorly-worded letter from the hospital informing them that their child had contracted MRSA. The letter explained that the child's GP would be informed of the MRSA result but as of the time this complaint was received, the GP had received no notification of the MRSA result. The family did contact PALS following these issues but did not received a return phone call.	Staff explained the reasons for the child's transfer to the Special Care Baby Unit shortly after his birth and elaborated on the reasons for performing blood tests, a chest x-ray and for commencing IV antibiotics. The PALS apologised to the family for their lack of communication following initial contact and explained that the incident has been shared with the wider team to aid with learning and training; PALS also informed the family that a new member of staff had also been recruited to aid with the high concentration of activity. The Infection Control team apologised for the standard of the letter received by the family and explained that on this occasion, it had bypassed the quality-assurance process before being sent. The Infection Control team informed the family that the incident has been noted and offered the family the option to review changes to the letter and offer observations prior to any further circulation.

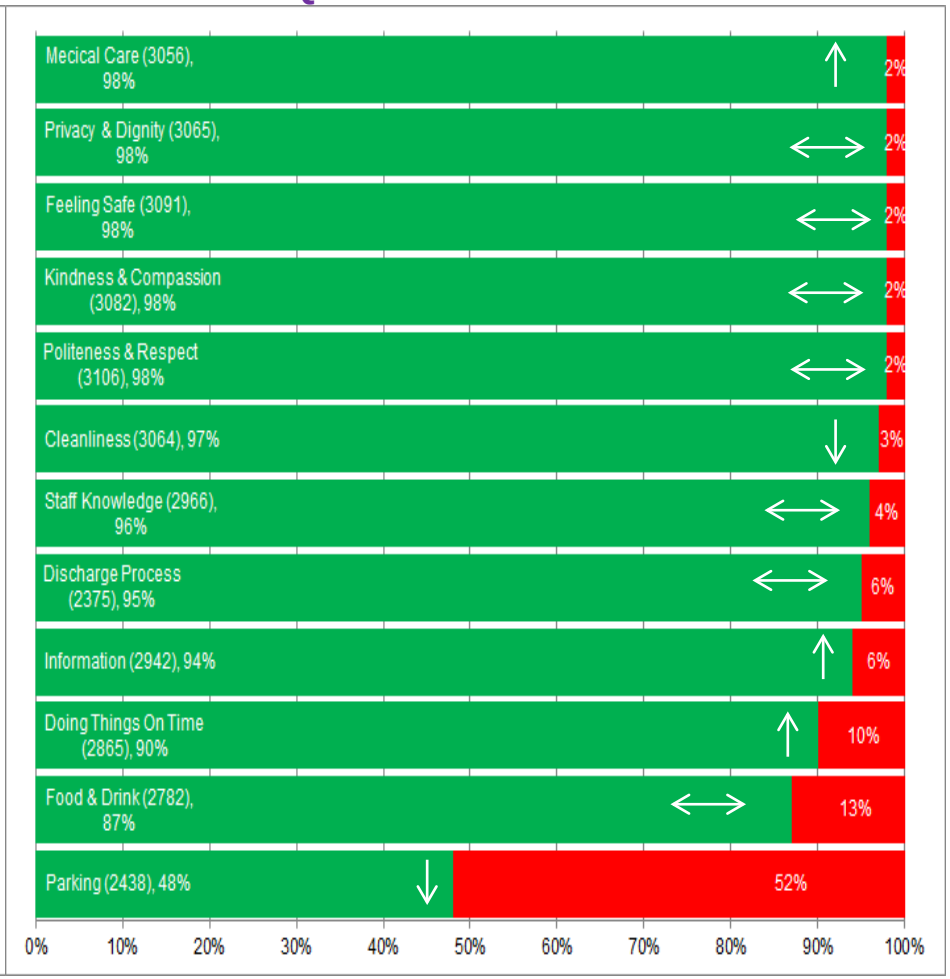
Patient & Public Involvement – Impressions Quarter 3

Impressions is the Trust's bespoke patient survey system which allows feedback from not only patients but relatives, carers and visitors too. The graphs below show feedback from all respondents when asked what service(s) influenced their experience at the Trust and whether the service was, in their experience, mainly good or mainly bad. The green bar shows the percentage (as well as the number in brackets) of respondents who said they had a mainly good impression and the red bar the percentage (as well as the number in brackets) of respondents who said they had a mainly bad impression of the service noted. The graphs below show [any] movement between this year's and last year's Quarter 3. The Top 3 and Bottom 3 Influential Factors are shared at ward level on the Looking After You Nursing Boards. The Trust wide influential factors are detailed on the monthly FFT internal report.

Quarter 3 2014/2015



Quarter 3 2015/2016



Note:

- **Due to rounding up of percentages, some categories show the same [percentage]. However, they are listed in the correct order taking account of this rounding up process. Please see overleaf for an analysis of the data contained in these graphs. The arrows indicate movement in results between the quarters. However, due to respondent number differences any comparison is not necessarily comparable.**

Patient & Public Involvement – Impressions Graphs Explained Quarter 3

COMPARISON BETWEEN Q3 2014/15 & Q2 2015/16

Medical Care has reached the top of this year's Quarter 3 with regard to influencing respondents' experience in a mainly good way, which is an improvement from the previous year's Quarter 3 where it was 6th. Feeling Safe has also improved. However, it is disappointing to note that the three areas affording the least levels of satisfaction in last year's Q3 are still the same in this year's Q3: parking, food and drink and doing things on time.

TOP 3 SERVICE AREAS Q3 2015/2016

Medical Care
98% of (3056) respondents felt that the medical care they received was good.

Privacy & Dignity
98% of (3065) respondents found that staff treated them with privacy and dignity.

Feeling Safe
98% of (3091) respondents felt safe in our care.

BOTTOM 3 SERVICE AREAS Q3 2015/2016 & ACTIONS BEING TAKEN

Parking *(52% of 2438 respondents felt they had a mainly bad experience)*
Parking, congestion and high charges continue to be area with which our patients and visitors have the least satisfaction.
Actions being taken: A programme of on site developments has begun which will see the provision of approximately 200 more spaces being made available for patients and the public. New signs have been put up around the car parks which show whether there are spaces available. There have also been reconfigurations of the roundabouts on site, as well as the off site developments, which should ease congestion in and out of the site.

Food and Drink *(13% of 3211 respondents felt they had a mainly bad experience)*
Main issues raised on this topic include lack of choice and the general standard of the food being served.
Actions being taken: There is a Patient Satisfaction Food & Drink Group, Chaired by Director of Estates, which now meets regularly and oversees all aspects of patient satisfaction (with food and drink).

Doing Things On Time *(10% of 2865 patients felt they had a mainly bad experience)*
Actions being taken: Prolonged discharge times are the subject of several improvement projects currently ongoing at the Trust e.g. projects are looking at both complex and simple discharge, internal standards and work is also ongoing through the Strategic Resilience Group to address the issue 'health economy' wide. Discharge processes have also been addressed through the 'Perfect Week'. The waiting times in the Emergency Department are also a key issue for patients. Reception staff are informed of the situation within the Emergency Department by the nursing team and update the electronic display located within the waiting room accordingly.

Patient & Public Involvement – FFT Quarter 3

The Friends and Family Test (FFT) is a national initiative overseen by NHS England. It is an initial single question, which asks patients whether they would recommend the NHS service they have received to family and friends if they need similar care or treatment, plus a supplementary question asking why the patient has responded how they have. The FFT question is incorporated into Impressions. The results are presented as a percentage of recommenders and non recommenders. The below tables show UHCW's figures for the month and also our internal targets. Specific wards with low recommender % are invited to the Patient Experience and Engagement Committee to discuss information and agree any actions. We do not report on the response rate for some maternity services, as indicated by N/A in the table.

	October Recommender %	November Recommender %	December Recommender %	Internal Target Recommender %
Inpatients	92%	90%	90%	95%
A&E	86%	85%	84%	87%
Antenatal (after 36 weeks) Experience	99%	96%	98%	97%
Birth/Labour Experience	100%	100%	99%	98%
Postnatal (hospital) Experience	95%	95%	97%	93%
Postnatal (community) Experience	99%	98%	100%	97%

	October Response Rate %	November Response Rate %	December Response Rate %	Internal Target Response Rate %
Inpatients	25%	27%	23%	38%
A&E	14%	13%	14%	20%
Antenatal (after 36 weeks) Experience	N/A	N/A	N/A	N/A
Birth/Labour Experience	18%	20%		21%
Postnatal (hospital) Experience	N/A	N/A	N/A	N/A
Postnatal (community) Experience	N/A	N/A	N/A	N/A

Met or exceeded the internal target

1% - 5% below the internal target

6% or more below the internal target

Patient & Public Involvement – National Patient Survey Programme

The National Patient Survey Programme has been running since 2002 and is a mandatory programme which all Trusts have to take part in. The Trust commissions Quality Health Ltd to carry out the surveys on its behalf. The Patient Experience Team oversee the following surveys on behalf of the Trust:

- Inpatients (run annually)
- Out-patients (run every 2/3 years)
- A&E (run every 2/3 years)
- Maternity Services (run every 2/3 years)
- Paediatrics (run every 2/3 years)

Quality Health Ltd provides the Trust with its results for each survey via 3 separate reports:

- Top line results (containing raw figures for the current and previous year's survey) as well as top line recommendations to improve results;
- Management report (containing full statistical analysis including trends and comprehensive recommendations to improve results);
- Comments report (containing all the verbatim comments given by respondents).

The CQC provides the Trust with a benchmark report which compares how the Trust has fared nationally when compared with other Trust's.

Current status of surveys undertaken as part of the National Patient Survey Programme and overseen by the patient Experience Team:

Survey Type	Year	Status
Inpatient	2015/2016	Fieldwork for the 2015 National Inpatient survey closed on Friday 8th January 2016. The overall mean response rate at this stage in the process, for the Trusts that we are surveying is 47%, which is static since the last update. The response rate for UHCW NHS Trust is 44% as of Monday, 4th January. Please note that this response rate is intended to be indicative and following final checks and validation of the data prior to submission, this can fluctuate upwards or downwards. The Trust will receive a Survey Results Manual shortly after final data is submitted to the Co-ordination Centre; it will then receive a Management Report a month after this.
Paediatrics	2014/2015	Management report, produced by Quality Health Ltd, containing all results, received in July 2015. Action plan drawn up by the Specialty and being taken forward.
Maternity	2014/2015	Top line report and top line recommendations, produced by Quality Health Ltd, received in September 2015. Full Management Report expected in October 2015.
Inpatient	2015/2016	Field work currently being carried out by Quality Health Ltd on patients who were inpatients during July 2015.

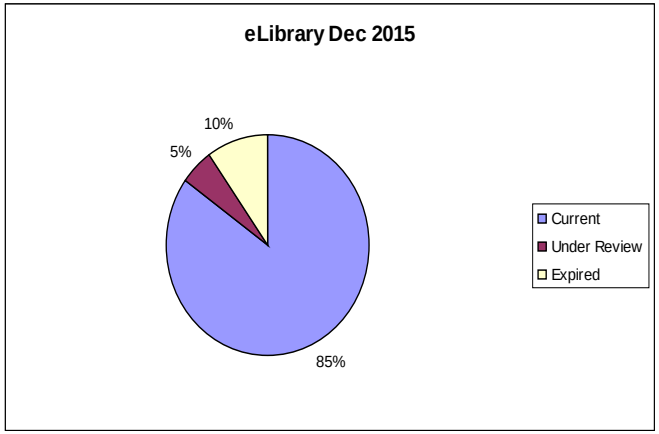
Health Information Centre - eLibrary Activity

The patient information directory of eLibrary has nearly 2000 items of patient information written and provided by speciality staff, and with internet short cuts to relevant national resources. It is a vital resource available to all staff to ensure that patients receive current, approved information in a timely manner.

This quarter the team has worked closely with the departments to update and improve their range of patient information on eLibrary.

The table below highlights how many new leaflets have been produced in the last quarter and how many current leaflets have been updated.

	2014 New	2014 Updates	2014 Total	2015 New	2015 Updates	2015 Total
October	13	61	74	12	103	115
November	3	90	93	5	94	99
December	3	126	129	15	109	124
Total	**19**	**227**	**296**	**32**	**306**	**338**



The Health Information Team endeavour to maintain the status of a high percentage of patient information leaflets as 'current'. Currently 85% of patient information on eLibrary is up-to-date for this quarter and the team are working with specialities to improve this position to meet the internal target of 90%.

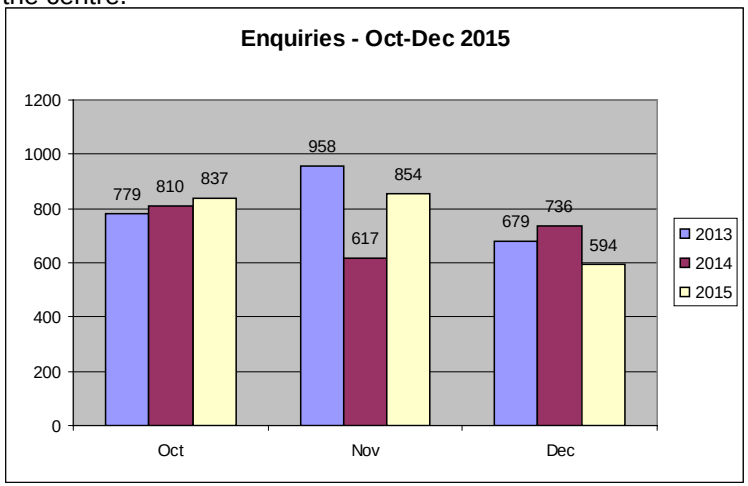
The total number of patient information leaflets on eLibrary at the end of this quarter is 1997 compared to the same period last year when there were 1834 (163 more patient information leaflets available than this time last year).

10% of patient information leaflets on eLibrary have expired. The Health Information Team will contact the authors of these documents to ensure that these are updated and appropriate information is provided to patients, visitors and carers.

Health Information Centre- Enquiries & Referrals

Enquiries

The information on this slide outlines how many face-to-face contacts the Health Information Team have had in this quarter in the centre.



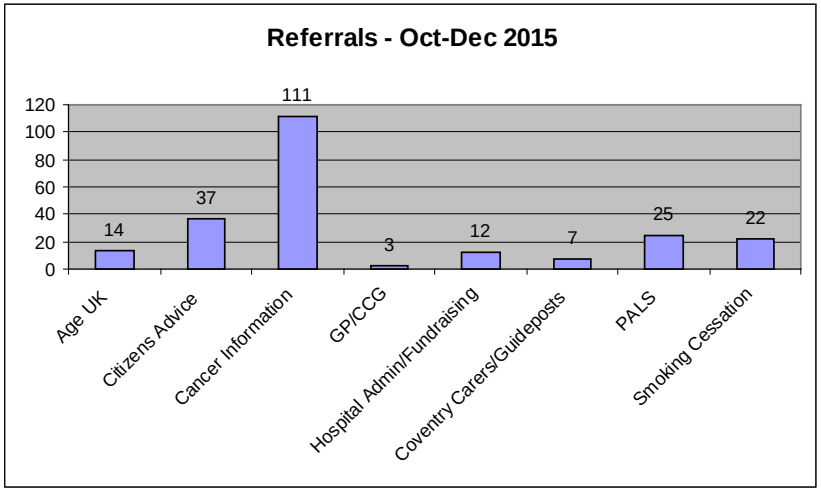
There were over 17 information stands and displays held during this period, including: Alcohol, British Legion, Eye Health, Blood Transfusion, Pressure Ulcers, Roy Castle Support Group, Stop Smoking, Return to Nursing, Occupation Therapy Diabetes and Pancreatic Cancer.

The top ten health enquiries the Health Information Team received this quarter were about Arthritis, Cancer, Dementia, Diabetes, Epilepsy Ophthalmology, Digestive Disorders, Heart, Mental Health, Orthopaedic. There was a decline in enquiries due to the decrease of footfall in the hospital over the Christmas period. There are also times when a member of staff is dealing with one person, if it is a long enquiry, other visitors to the Health Information Centre leave before they can be dealt with.

Referrals

The Health Information Team also refer enquiries to other services (internal and/or external to the Trust). With referrals, most of the time the team answer the enquiry as far as they can but also refer on to enable the enquirer to receive the best outcome, so statistically it is both an enquiry and a referral recorded.

The table below shows referrals to other teams and agencies. The top three services the team referred people to this quarter were for Cancer Information, Citizens Advice Bureau and PALS.



The high numbers of referrals in regards to cancer information may be due to the Health Information Team supporting the Macmillan Information service (temporarily situated in the Health Information Centre) when the member of staff who runs the service was on long term sickness.

TTWC Patient Experience Work Stream Update

The team appreciates it is important to be creative and innovative but we understand work needs to be done when it comes to getting the basics right with the Patient Experience Directorate, because if we are to achieve world class our foundations need to be strong and in order. Last year the Patient Experience TTWC Work Stream didn't include objectives around Complaints and PALS which are important components of the Patient Experience Directorate so we plan to incorporate plans for these services into TTWC work streams this year. We also learnt last year the need for enhanced learning from the data received by the Patient Experience Team, Complaints and PALS. Actions are now being put in place where this will happen as a matter of course.

2015/ 2016 Patient Experience Work Streams update:

Work Stream 1: Provision of Health Information Prescription & Service Expansion to HIC & PALS

The Health Information Team have met with the Macmillan Patient Information Officer to discuss the successful cancer information prescription service. The Health Information Team will take guidance and replicate this service with a chosen specialty by March 2016. In regards to service expansion the newly appointed PALS Manager and Patient Relations Manager commenced their new roles by January 2016. Discussions have been held with the Patient Experience Manager in regards in moving this pilot forward. Principles of the pilot have been agreed and discussed with Human Resources. Consultation will take place with both teams (HIC and PALS) to decide how the extended coverage of both services can work in reality.

Work Stream 2: Triangulation of Patient Experience Data & Action Planning

The redesign of the format for the various reports is complete and the Patient Experience Team are working with the Nursing Team to ensure ward profile reports are relevant and ultimately a useful tool for wards to learn from.

Work Stream 3: Provision of Patient Experience Resource Hub &Training

Intranet:

The Patient Experience Team have attended an Intranet suppliers afternoon and are a member of the Intranet working group led by the Communications Department. Patient Experience content has been developed for the resource hub in anticipation of the new intranet site and current intranet content reviewed and awaiting refresh.

Training:

- A Patient Experience Week is being held 25.2.16 – 2.3.16. Consideration is being given to a roving board informing staff of various elements of patient experience hub and toolkit.
- Following on from last year's well received Delivering Service Excellence Workshops (facilitated by TMI, a company leading in the field of improving customer experience) a series of 3, 1 hour long workshops have been organised to take place during Patient Experience Week.
- The Patient Experience Team and Nursing Team have formed a working group to ensure that any training course is relevant and engaging for nursing and clinical staff. This group's first meeting will be informed by a baseline assessment of existing courses aimed at improving patient experience already being run at the Trust. This will enable a gap analysis to determine content for additional training.

University Hospitals Coventry and Warwickshire NHS Trust

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PUBLIC TRUST BOARD PAPER

Title	**Emergency Care Pathway (Winter Plan Update)**
Authors	**Emma Livesley, Director of Operations** **Alan Cranfield, Deputy Chief Operating Officer – Medicine** **Mark Kemp, Deputy Chief Operating Officer - Surgery**
Responsible Chief Officer	**David Eltringham, Chief Operating Officer**
Date	**28 January 2016**

The National Waiting Time Standard for A&E is set by the Department of Health and features in the Trust Development Authority and NHS England Accountability Framework. It measures the percentage of A&E attendances where the patient spends four hours or less in A&E from arrival to transfer, admission or discharge for which the target is 95%.

1. Purpose

The purpose of this paper is to provide an overview of the Trust's Emergency Pathway and its performance against the 95% Emergency Department (ED) standard. The paper will outline those activities being pursued to both improve and sustain our position going forward.

The Trust's Emergency Pathway and its Performance Against the 95% ED Standard.

1.1 Background

- The Trust last met the 95% Constitutional 4 hour standard over the period July to September 2015. Table 1 below reflects the position for the years 2014/15 and the year to-date.
- The full year performance for 2014/15 was 90.37% and the year to-date position for 2015/16 is 90.45%.
- The Trust is highly unlikely to meet the 95% standard for the full year (2015/2016) given its under-performance in the early part of it. However, improving the current level of performance is paramount going forward to achieve the standard.

Table 1

2014/15	%
April 2014	95.6
May 2014	94.2
June 2014	93
July 2014	92.9
August 2014	93.1
September 2014	91.5
October 2014	91.5
November 2014	90.5
December 2014	87
January 2015	84.1
February 2015	85.6
March 2015	84.2
2015/16	**%**
April 2015	81.8
May 2015	85.5
June 2015	88.2
July 2015	98.2
August 2015	97.7
September 2015	95.4
October 2015	93.4
November 2015	89.0
December 2015	87.4

1.2 What does the data tell us?

Table 2 below provides a direct comparison of the same periods for the past 24 months (by year). A further and more complete suite of data is provided at Appendix 1.

Table 2

Measure	Jan/14 - Dec/14	Jan/15 - Dec/15	Total Variance	%	Weekly Variance
A&E Attendances	184102	181652	-2450	-1.33%	-47
A&E Attendances >=65 yrs	38546	36629	-1917	-4.97%	-37
Type 1 A&E Attendances	138127	134820	-3307	-2.39%	-63
Admissions from A&E	48384	43577	-4807	-9.94%	-92
All Emergency Admissions	53862	49468	-4394	-8.16%	-84
Ambulance Conveyances	50340	48013	-2327	-4.62%	-45
Discharges	64552	65501	949	1.47%	18
Aggregate DTOC (1 mth in arrears)	5.3%	6.5%	1.3%	NA	NA
Avg Medical Outliers	130.2	106.2	-24.0	-18.45%	NA
Emergency LoS (Days)	5.7	5.6	-0.1	-1.71%	NA
Bed Occupancy	95.9%	92.6%	-3.4%	-3.36%	NA

- The data shows a slight decrease in activity relating to A&E attendances (1.33%), however ambulance conveyances have decreased by 4.62%.
- The number of patients attending who are >65 years of age has overall reduced by 5%, despite a slight rise of around 200 over the last month (December).
- Positively, the number of patients admitted from A&E has reduced by 9.9%, the majority of which are attributable to the introduction of new pathways into Acute Medicine through the establishment of a Medical Decisions Unit (MDU),

incorporating a GP Assessment Unit (GPAU) and Ambulatory Emergency Care (AEC).

- The result of these changes has been an impressive overall reduction of 8.2% (4394 patients) in non-elective admissions overall.
- The discharge profile shows periods of improved performance however these are not sustained and often fall away at critical points in the year.
- Delayed Transfers of Care have increased on average to 6.5%. This is 3% over the existing national target and 4% over the revised 2.5%, which equates to 28 inpatient beds.
- Although the overall average for outliers across the 12 months has reduced by 18.5%, as our performance has deteriorated the numbers have begun to rise and presently fluctuates between 80-100.
- Our average Length of Stay (LOS) profile for emergency admissions has decreased slightly from 5.7 days to 5.6.

UHCW takes its performance very seriously and recognises its deficiencies. To improve performance it is continuing to press with some previously agreed actions as well as implementing some new ones and these are reflected in Table 3.

Table 3

A & E Recovery	• Increase by 3 the middle grade doctor staffing • Pursue the development of an ANP service • Improve the 'Triggers' mechanism to show when there is a conflict between capacity and demand • Implement a Frailty MDT at the front door. This will enable all frailty patients to be properly assessed for admission or return to the community with their needs addressed and a comprehensive plan written with points of action.
Discharge Focus	The Trust will refocus its discharge activity to: • Have 30% of discharges completed by Midday. • Improve its weekend discharges so that they reflect 70% of those achieved on a week day • Reduce and maintain those patients with a LoS >14 Days to 300 or less. • Along with partners reduce the number of DTOC to 3.5% in line with national requirements by 31st March
Getting Emergency Care Right (GECR)	The Trust will continue to retain its central pillar of GECR which will focus staff on internal ownership of the Emergency Care Pathway through the agreed 25 safety standards, and a set of principles to apply to each patient

	(FREED metrics[1]).
Emergency Care Improvement Programme (ECIP)	In line with the recommendations of ECIP and with Partners, UHCW will: • Create a vision for emergency and urgent care across the health and social care system • Review the opportunities to systematically embed the FREED patient flow bundle. • Reduce front door admissions through an improved Ambulatory Care provision and Acute Frailty process. • Development of a single early functional assessment in ED. • Review current operational processes in the management of escalations.
Perfect Week	The Emergency Care Improvement Support Team (ECIST) recommends that when Trusts experience a period of underperformance that they 'reset the system' by undertaking a Perfect Week where the absolute focus is centred only on timely and appropriate patient care and discharge. Following our Perfect Week in July we recovered our performance and sustained it for 3 consecutive months before it once again dipped. Our second Perfect Week was held in November and although this did provide some benefit it did not see us recover our performance. We plan to hold a third event in February.
System Transformation	As a whole system we believe that to achieve the strategic aims to improve patient care, the following 4 outcomes are necessary: • No-one comes to hospital who can be managed elsewhere • No-one is admitted to hospital without an acute hospital need • No-one waits more than 24 hours to leave hospital once they are medically fit for discharge • Reduce the number of people requiring long term care To meet these strategic aims the following 3 objectives are to have priority: • Establishment of a Trusted Frailty

[1] FREED = **F**acilitate effective discharge; **R**ight person, right place; **E**arly specialist input; **E**liminate unnecessary diagnostics; and, **D**aily senior Review

	Assessment Process • Creation of an Integrated Based Community Therapeutic Pull Mode • Establishment of step up community response and crisis reduction capacity

Progress and successes since the last report are as follows:

- The establishment of a GP presence in ED as a 7 day service (8am – 8pm) has been positive with around 30 patients per weekday and 50 per weekend day being seen.
- The further development within Acute Medicine of Medical Decisions Unit (MDU) has streamlined the pathway for medical patients presenting as emergencies and they now see 50 patients per day on average with 58% of those patients being discharged home (29 patients). Previously this would have been quite a lot less.

1.3 Actions to maintain performance against the 4 hour standard

Our over-arching strategy required to continue to manage this situation remains three fold:

- Improve and maintain a reduction in emergency admissions.
- Improve flow within the capacity available to the hospital.
- Increase discharges – simple and complex.

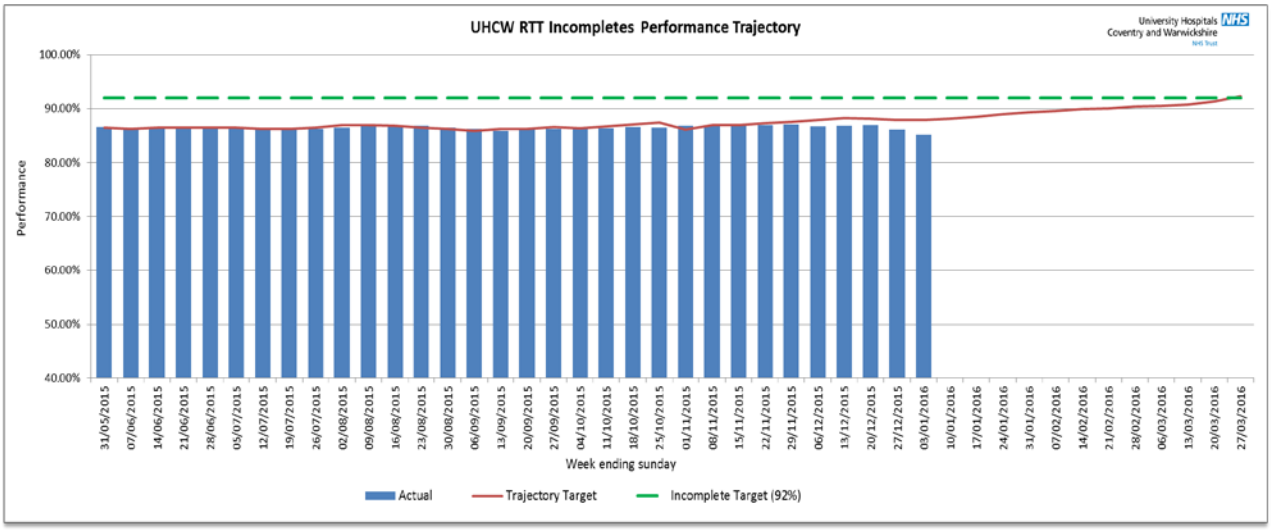
1.4 Impact on other Standards

The result of our underperformance against the 95% A&E standard continues to impact other areas and in particular:

- Admitted Referral to Treatment Time (RTT) performance.
- 62 Day Cancer Indicators

The RTT incomplete performance position is presently 86.29% against the 92% standard. The Trust has taken a direct approach to deal with this backlog and has put in place additional resource to move towards a zero tolerance of ‘Closed Operating Lists’ and ensure that all theatre time is maximised to its fullest extent. A recovery plan for each Specialty has been implemented with a total recovery of the RTT position to the 92% standard by the end of March 2016. The trajectory for this is in Table 4.

Table 4



The Trust's cancer position is summarized at Table 5 below and the Recovery Trajectory is at Table 6. However, to address the issues around cancer we are taking the following steps:

- Additional capacity is being set up in specialities where the Two Week Wait (TWW) standard is not being met, including breast and dermatology.
- An additional locum Breast Surgeon is being recruited on a short term basis until existing vacancies are filled
- A urology cancer action plan is being implemented, which includes additional theatre capacity and two additional consultants.
- Consultant Histopathologists vacancies have been recruited supporting the delivery of the cancer standards.

Table 5

Standard:	**Qtr1**	**Qtr2**	**Nov-15**	**YTD**	**DoH Tolerance**
TWW suspected cancer	94.5%	94.4%	98.6%	95.3%	**93%**
TWW breast symptomatic	93.6%	82.8%	100%	90.8%	**93%**
31 day - 1st treatment	98.9%	99.2%	99.5%	99.2%	**96 %**
31 day - subsequent treatment -surgery	96.2%	97.8%	94.7%	96.7%	**94%**
31 day - subsequent treatment -chemo	100%	100%	100%	100%	**98%**
31 day - subsequent treatment - radio	95.7%	96.6%	94.5%	95.8%	**94%**
31 day - subsequent treatment - other	100%	100%	-	100%	No tolerance set
31 day - rare cancers	100%	100%	100%	100%	No tolerance set
62 day - 1st treatment	82.1%	85.2%	81.3%	83.5%	**85%**
62 day - national screening programme	91.5%	93.8%	91.9%	92.7%	**90%**
62 day - consultant upgrade	96.1%	90.6%	100%	92.5%	CCG tolerance = 85%
62 day - treated on or after day 100+	18.5	12	5	38.5	CCG Tolerance = 0
62 day - treated on or after day 105+	18.5	10.5	4	36	TDA tolerance = 0

Table 6

1.5 Winter Resilience Funding

Historically, Trusts have created 'winter plans' against a known increase in activity over the winter period, although this level of activity is now a year round phenomenon. The Trust has invested significantly in its GECR programme to counter the effects of increased demand and this includes:

- Increased staffing across the ED with specific emphasis on known times of peak activity.
- Improved nursing presence within the major assessment areas to cope with the increased demand.
- The provision of additional nursing support to the base wards areas.
- To accommodate the additional workload it necessary to bolster the clinical support areas such as Imaging, Therapy and REACT.
- The use of Medihome as a 'virtual ward' to allow patients to go home and continue their treatment whilst remaining under the care of the hospital consultant has provided an increase in capacity to the hospital of 30 beds.

The Trust has now moved away from the MediHome service to one provided by the Trust. As a result of the service transfer capacity was lost. UHCW commences this service in October and recruitment has constrained the ability to deliver a full level of service to date. Work continues to build this service as a priority and the cost of meeting the UHCW@Home service will be provided through winter resilience funding at a cost of £1.3M. The flexibility of how we shape the service in the future is significantly greater and more attractive to the Trust and must be realised going forward.

1.6 Risks

The risks to the Trust associated with not achieving the 4 hour A&E standard are:

1. Clinical risk to patients – Patients waiting for extended periods of time may have a poor care experience. This risk is mitigated by constant review of the pathway and the surveillance of patients waiting in the Emergency Department. Clinical resource is key and we are reviewing our footprint.

2. Reputation – Regulators, staff, patients and communities may form a poor view of the service offered by UHCW. This risk is mitigated by constant efforts to manage

pressure, rapid response to specific feedback/complaints, communication strategies which keep all stakeholders informed of waiting times, actions to address issues, and through regular briefings to all groups.

3. Performance – Poor performance is currently being reported against the RTT Standards and Cancer Standards in part as a result of our previous poor A&E performance, which has a deleterious effect for patient access; this represents an active risk. This paper has set out actions to mitigate the performance against these and result in improvements.

Summary

The Trust's ED Performance is presently below the 95% standard having achieved it in the three months from June to September 2015. The challenge going forward is to regain that position. Failure to do so could have implications on other constitutional standards including: Referral to Treatment Time; 62 Day Cancer Indicators; and, cancelled operations.

There are risks that accompany such a position and these surround the potential for clinical risk to patients, reputation and performance going forward.

In recognizing that this is a system responsibility, strategically, the Chief Executives of the partner organizations have committed to set out a compelling vision of the health economy which establishes a direction of travel for the next three years and is likely to include some radical suggestions for the future of the health economy. This will include a Programme Board operating on behalf of the SRG, from which, work streams will be established. These work streams will concentrate on establishing four key themes:

1. No-one comes to hospital who can be managed elsewhere.

2. No-one is admitted to hospital without an acute hospital need.

3. No-one waits more than 24 hours to leave hospital once they are medically fit for discharge.

4. Reduce the number of people requiring long term care

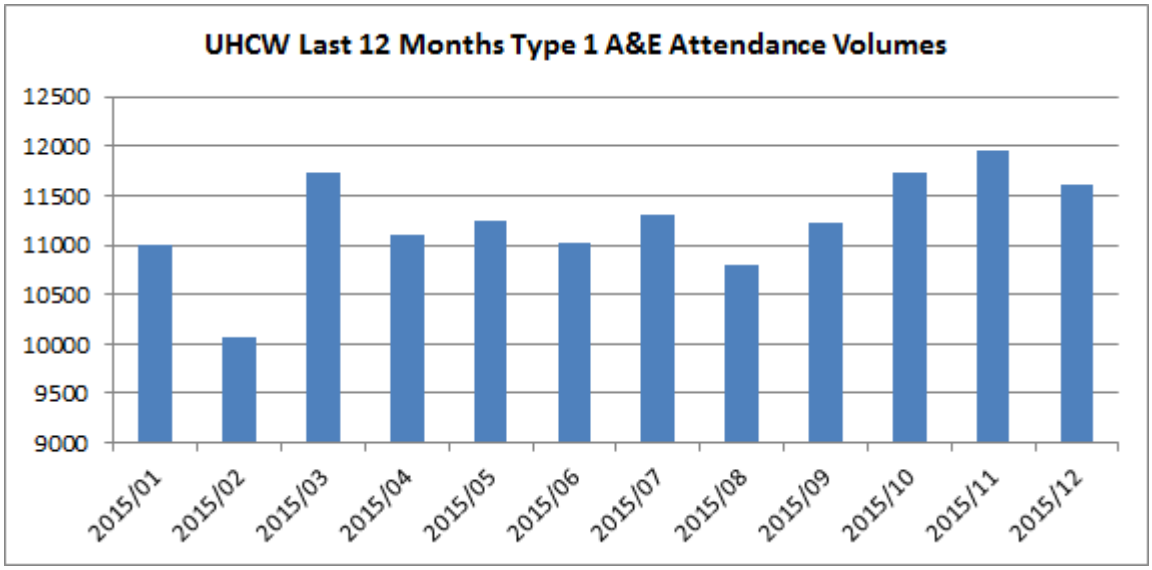
The Trust Board is invited to:

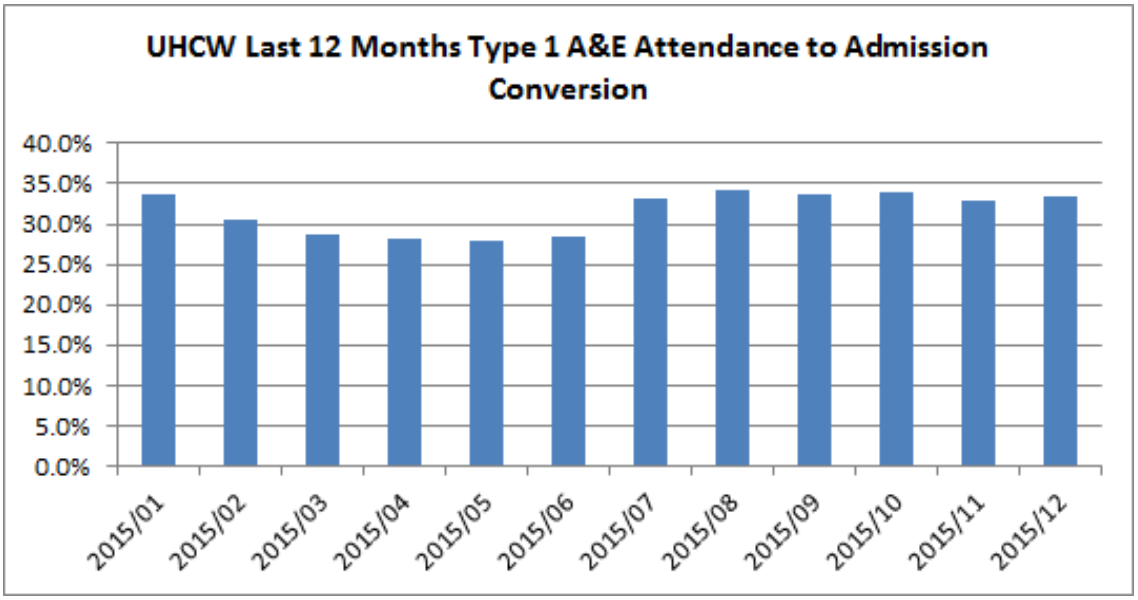
1. **Note** the contents of this report and the Trust's efforts to improve its performance.

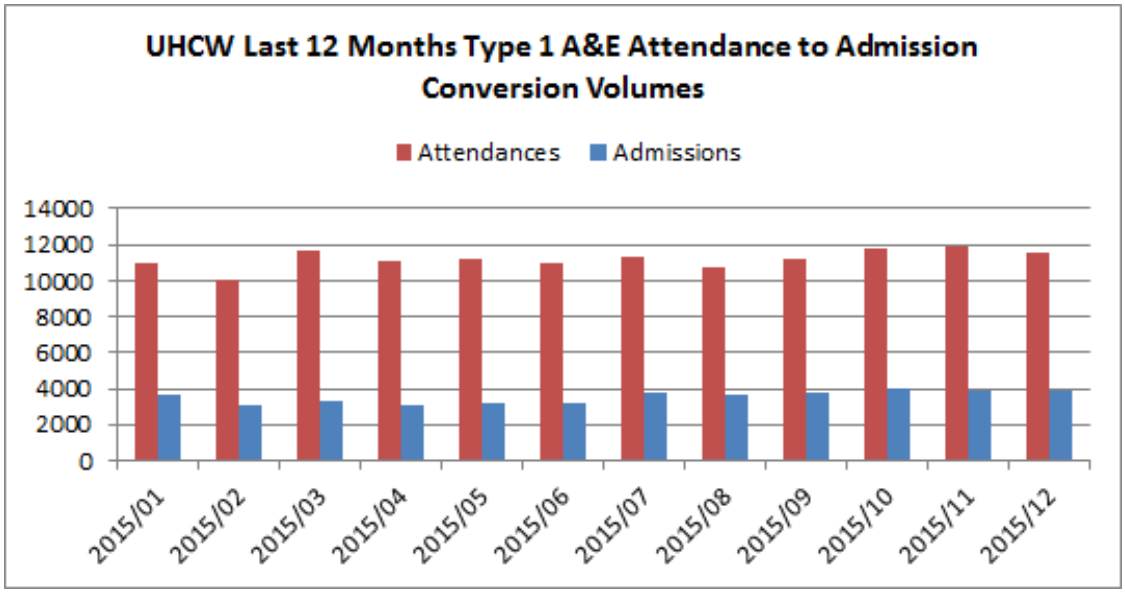
2. **Note** and **support** the significant transformational engagement within the local healthcare community.

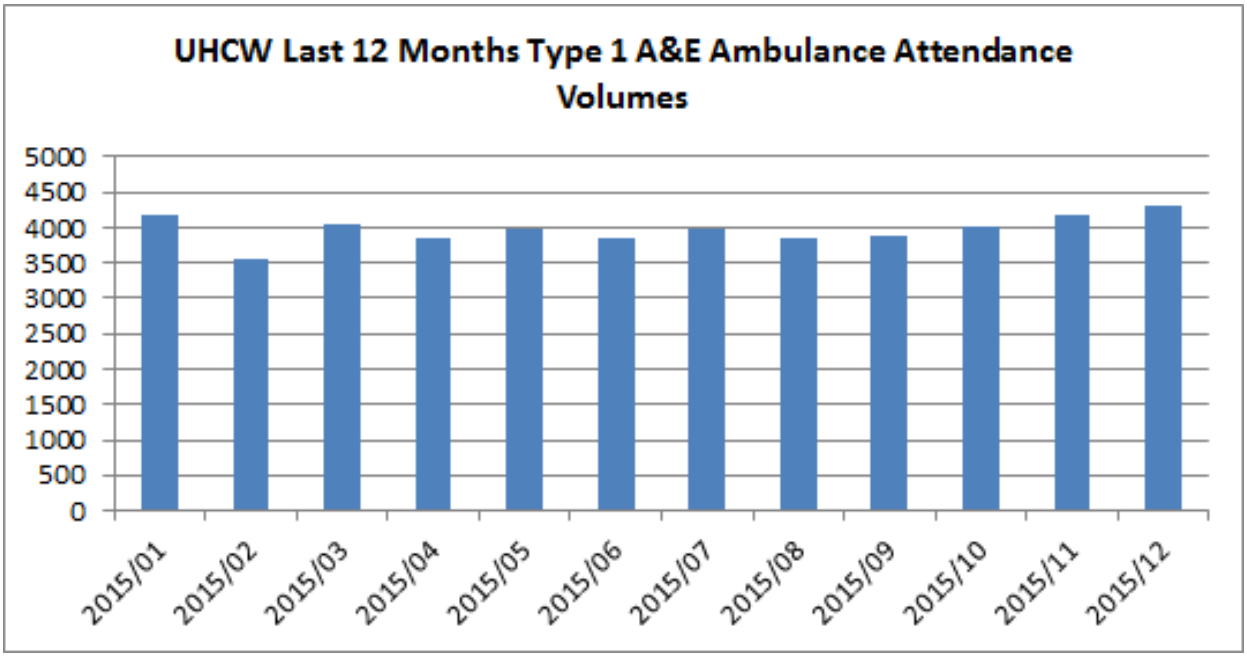
3. **Consider** the frequency of this report given that ED performance is reported in the Trust Scorecard and the data that is required for future reports.

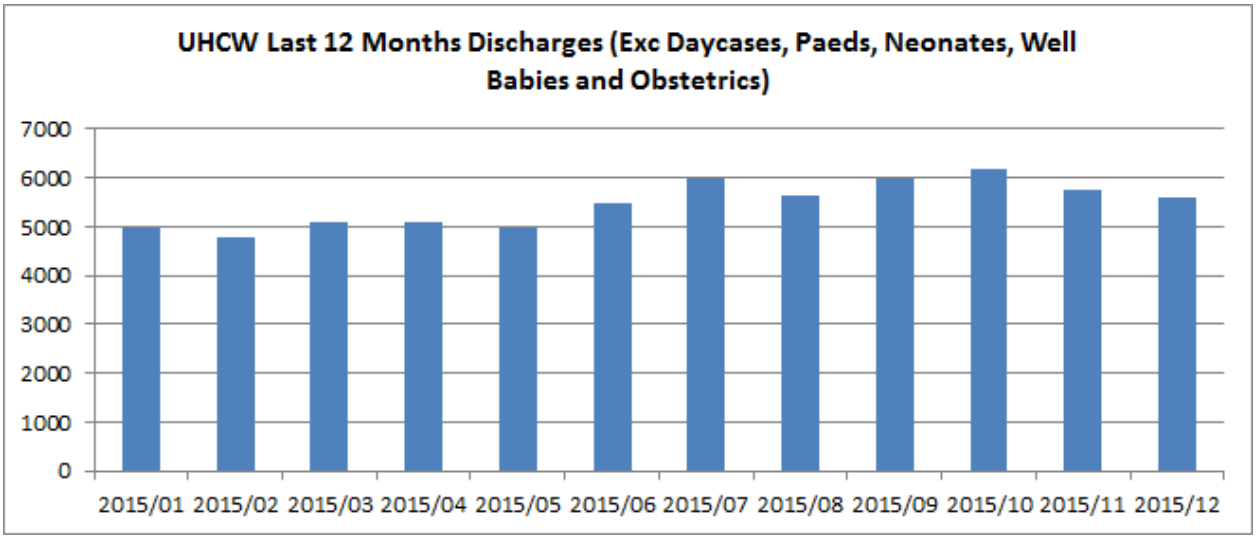
Appendix 1

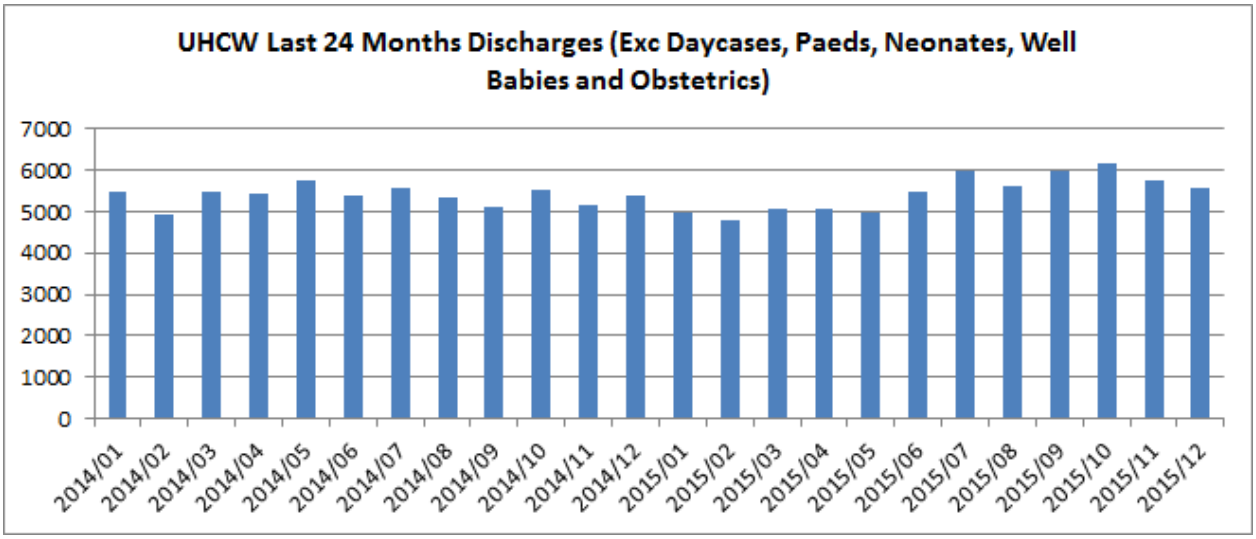

UHCW Last 12 Months Type 1 A&E Attendance Volumes
12500
12000
11500
11000
10500
10000
9500
9000
2015/01
2015/02
2015/03
2015/04
2015/05
2015/06
2015/07
2015/08
2015/09
2015/10
2015/11
2015/12


UHCW Last 12 Months Type 1 A&E Attendance to Admission Conversion
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
2015/01
2015/02
2015/03
2015/04
2015/05
2015/06
2015/07
2015/08
2015/09
2015/10
2015/11
2015/12


UHCW Last 12 Months Type 1 A&E Attendance to Admission Conversion Volumes
Attendances
Admissions
14000
12000
10000
8000
6000
4000
2000
0
2015/01
2015/02
2015/03
2015/04
2015/05
2015/06
2015/07
2015/08
2015/09
2015/10
2015/11
2015/12


UHCW Last 12 Months Type 1 A&E Ambulance Attendance Volumes
5000
4500
4000
3500
3000
2500
2000
1500
1000
500
0
2015/01
2015/02
2015/03
2015/04
2015/05
2015/06
2015/07
2015/08
2015/09
2015/10
2015/11
2015/12


UHCW Last 12 Months Discharges (Exc Daycases, Paeds, Neonates, Well Babies and Obstetrics)
7000
6000
5000
4000
3000
2000
1000
0
2015/01 2015/02 2015/03 2015/04 2015/05 2015/06 2015/07 2015/08 2015/09 2015/10 2015/11 2015/12


UHCW Last 24 Months Discharges (Exc Daycases, Paeds, Neonates, Well Babies and Obstetrics)
7000
6000
5000
4000
3000
2000
1000
0
2014/01
2014/02
2014/03
2014/04
2014/05
2014/06
2014/07
2014/08
2014/09
2014/10
2014/11
2014/12
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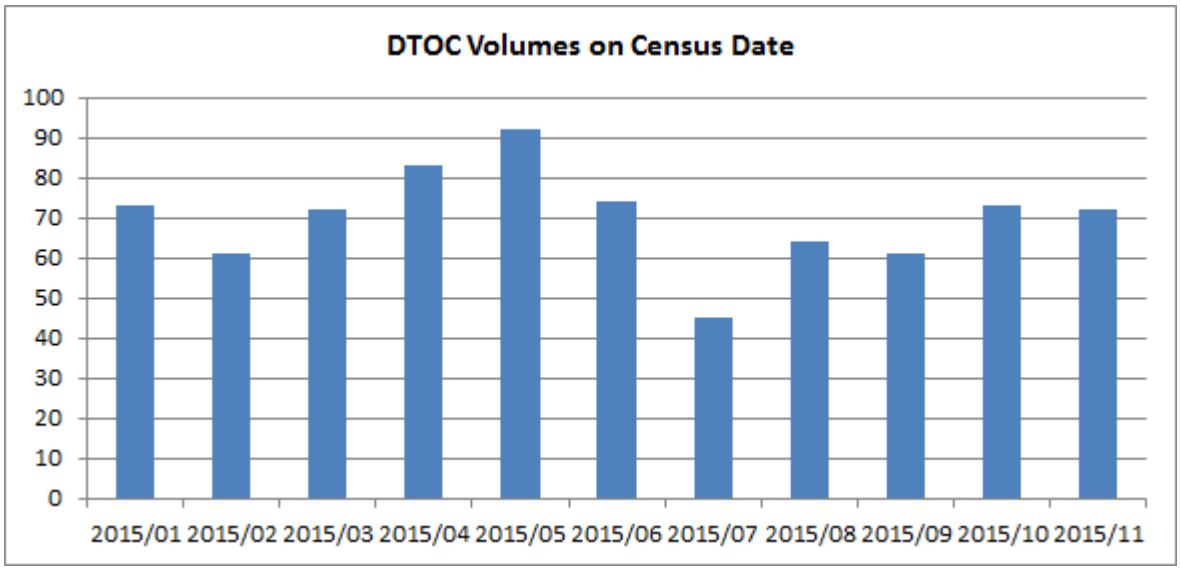
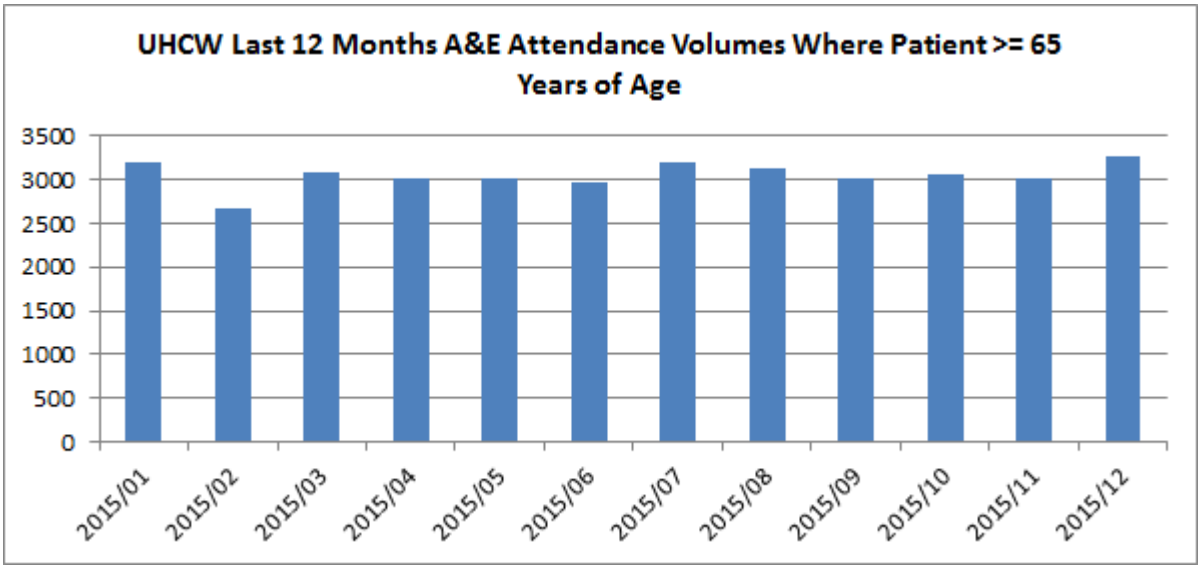
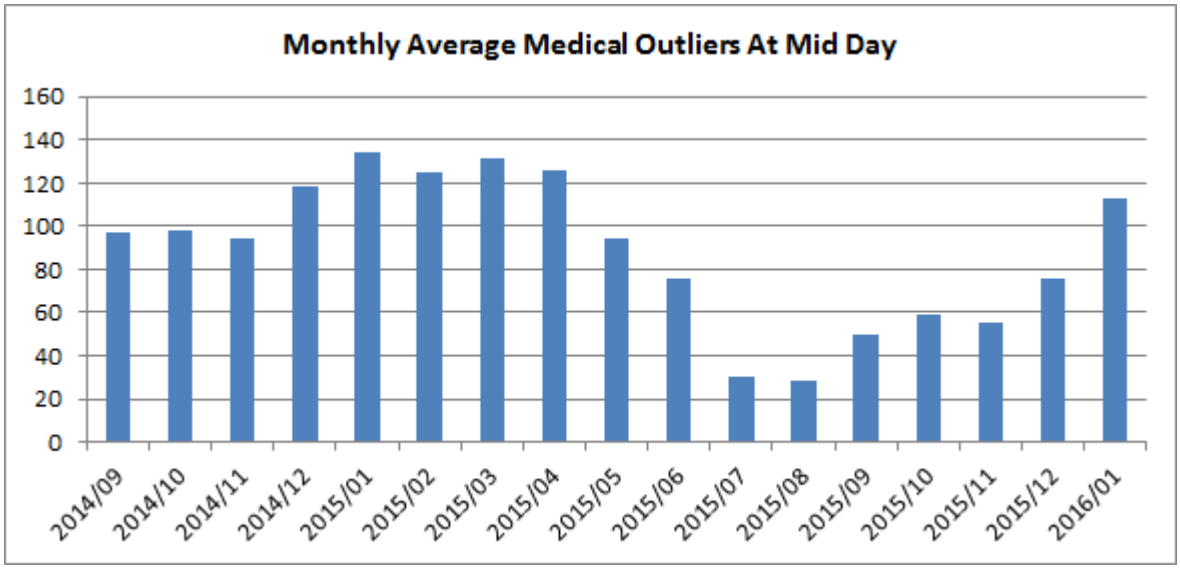
2015/10
2015/11
2015/12


DTOC Volumes on Census Date
100
90
80
70
60
50
40
30
20
10
0
2015/01 2015/02 2015/03 2015/04 2015/05 2015/06 2015/07 2015/08 2015/09 2015/10 2015/11


UHCW Last 12 Months A&E Attendance Volumes Where Patient >= 65 Years of Age
3500
3000
2500
2000
1500
1000
500
0
2015/01
2015/02
2015/03
2015/04
2015/05
2015/06
2015/07
2015/08
2015/09
2015/10
2015/11
2015/12


Monthly Average Medical Outliers At Mid Day
160
140
120
100
80
60
40
20
0
2014/09
2014/10
2014/11
2014/12
2015/01
2015/02
2015/03
2015/04
2015/05
2015/06
2015/07
2015/08
2015/09
2015/10
2015/11
2015/12
2016/01

University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD PAPER

Title	**NHS Preparedness for a Major Incident**
Author	**John Dodds, Emergency Planning Manager**
Responsible Chief Officer	**David Eltringham, Chief Operating Officer**
Date	**28 January 2016**

1. Purpose

Following on from the tragic events in Paris in November 2015, a Gateway Publication (ref 04494) **NHS Preparedness for a Major Incident** was circulated on 9th December 2015, requesting assurance on several areas:

- Staff Cascade systems
- Site access
- Critical Care Capacity
- Access to Specialist Advice

2. Background and Links to Previous Papers

On Friday 13 November, 2015 a series of co-ordinated Marauding Terrorist Firearms Attacks (MTFA) took place in Paris, resulting in 3 explosions and 4 shooting sites, including an enclosed theatre area. The attacks caused a mass casualty incident, as defined by the NHS England EPRR Framework, 2015; with a large number of both high velocity ballistic and blast injuries:

- 129 dead on scene
- 2 Dead on Arrival (DOA)
- 2 deaths in hospital
- 76 Priority 1 (P1) casualties (P1 casualties require immediate lifesaving treatment)
- 226 patients requiring non immediate surgery (302 patients in total)

As a result, NHS England has requested assurance that all NHS Trusts have the ability to respond appropriately to any threat, and particularly in relation to areas outlined above.

The NHS England Framework referred to above requires that all Trusts undertake an EPRR assurance process, and this has been completed by UHCW in line with Gateway publication reference 03470, 20 May 2015. NHS England Regional teams are currently undertaking the process with NHS England Central teams.

A paper was submitted to COG on 15 December 2015 for consideration at the meeting on 6 January 2016, and was received for assurance.

3. Narrative

Gateway 04494 requires assurance as follows:

3.1 *"You have reviewed and tested your cascade systems to ensure that they can activate support from all staff groups, including doctors in training posts, in a timely manner including in the event of a loss the primary communications system".*

The Trust has an automated primary cascade system, known as Rapid Reach, which alerts the primary tranche of senior staff. Individual departments, including ED, Anaesthetics, Surgical specialities, Theatres; and both General Critical Care (GCC) and Cardiothoracic Critical Care (CTCC) have cascade mechanisms for contacting doctors in training, nursing and AHP personnel, and ensure that a mix of staff can be contacted immediately, whilst recognising that others may be required for business continuity 24 – 48 hours later.

Rapid Reach is reviewed monthly, and has been activated within the last 2 months. Individual departmental cascades are used on a frequent basis, as they are utilised for advertising internal bank shifts, and the SMS message can be tailor-made for the scenario, and can be accessed and activated 24 / 7.

Rapid Reach can be activated either electronically, or by phone to an external provider. The system has inbuilt resilience by providing both UK based contact numbers, and overseas numbers.

In the event of a Rapid Reach failure, switchboard provide a daily on call sheet, listing contact details of all on call staff for the day, and this is emailed to the Emergency Planning Manager on a daily basis.

3.2 *"You have arrangements in place to ensure that staff can still gain access to sites in circumstances where there may be disruption to the transport infrastructure, including public transport where appropriate, in an emergency".*

The Trust is not easily served by the rail network, and minimal staff attend work utilising this method. The University Hospital site is a major bus hub, served by multiple bus operators, and failure of one service is usually covered by another provider, albeit at less regular frequencies. Out of hours, there is ample car parking space on site, and at surrounding venues which are a short walk away from the site.

The Trust is close to the Managed Motorway Network, and should we require staff to attend work whilst the network is affected, alternative routes can be advised to staff to avoid congestion. Alternatively, staff can be advised to meet at a specific RVP points as guided by Police or Local Authority colleagues, and be transported in en masse.

Should the transport infrastructure be affected by severe weather, access to an accredited 4 x 4 service via the local LRF can be activated by the Emergency Planning on call.

3.3 *"Plans are in place to significantly increase critical care capacity and capability over a protracted period of time in response to an incident, including where patients may need to be supported for a period of time prior to transfer for definitive care".*

In the short term, General Critical Care (GTT) and CTCC can flex in to unfunded space, and would be able to manage this internally for the first 12 – 18 hours, and potentially ventilate patients within a theatre environment in the short term. In line with the current Pandemic Flu plans, both GCC and CTCC can increase capacity and sustain that over a period of time, but this would potentially be subject to implementing a buddying system.

3.4 *"You have given due consideration as to how the trust can gain specialist advice in relation to the management of a significant number of patients with traumatic blast and ballistic injuries".*

The Trust has several members of staff within the surgical and anaesthetics teams who are Regular and Reservist members of the military, and have significant exposure to these types of injuries on operational tours.

If more formal advice is required, the Royal Centre for Defence Medicine (RCDM) at UHB is linked into the regional trauma network, and can provide specialist clinical pathways advice.

In addition, the Trust has 24/7 access to the West Midlands Ambulance Service (WMAS) National Interagency Liaison Officers (NILO), who are specialists ballistics and CBRN advisers, and can be activated via the WMAS control.

The Trust can request invocation of the national Military Aid to Civil Authority (MACA) arrangements, via the NHS England Area team, which can provide military specialist advice (either remotely, via tele conferencing or in person) for Anaesthetics, Emergency Medicine, General Surgery, Plastics, Radiology and Trauma and Orthopaedics.

4. Areas of Risk

Cabinet Office Briefing Room (COBRA) met on the morning of 14 November 2015, and have decided to keep the UK Threat Level as:

SEVERE – This means that an attack is highly likely and is the second highest threat level; this has been the case since August 2014.

The threat level is constantly reviewed at a national level, and is only raised to CRITICAL if the security services have intelligence that an attack is imminent. To put this is context, the last time the threat level was raised to CRITICAL in the UK was in June 2007, following the attempted Tiger Tiger bombing, and the Glasgow Airport Attack.

Current threat level can be accessed at:

https://www.mi5.gov.uk/home/about-us/what-we-do/the-threats/terrorism/threat-levels.html

The Threat level can change at any time.

Any national change in threat Level will be communicated via Media statements and changes to the above website. Any local actions arising from that will be notified via NHS England Area Team on call, directly to the on call team - that may be the on call manager or EP on call.

Police and Security presence is being increased at high profile sporting and public events across the UK, and general enhanced security in public areas across all Police services, but NO events are currently being cancelled for security reasons.

What does this mean for the Trust:

- There is no change in the likelihood of an incident occurring than existed in November prior to the Paris attacks
- Staff should carry on working normally and be undertaking normal vigilance, reporting anything suspicious as they would normally do
- Ensure all staff wear ID cards
- Challenge people they do not recognise in non-public areas
- Report any suspicious activity to their managers

Our Local Resilience Forum partners and NHS England, will receive notification via National and Regional cascades, and will forward anything to ourselves if required.

5. Governance

The NHS England Framework referred to above requires that all Trusts undertake an EPRR assurance process, and this has was completed in line with Gateway publication reference 03470, 20 May 2015. NHS England Regional teams are currently undertaking the process with NHS England Central teams.

6. Responsibility

Author: John Dodds, Emergency Planning Manager

Responsible Chief Officer: David Eltringham, Chief Operating Officer

7. Recommendations

The Board is invited to **NOTE** the above assurances about the resilience of the Trust.

Name and Title of Author: John Dodds, Emergency Planning Manager
Date**:** 12th January 2016

Publications Gateway Reference No.04494

Dame Barbara Hakin
National Director: Commissioning Operations
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To:
NHS Trust Chief Executives
NHS Trust Medical Directors
Accountable Emergency Officers

9 December 2015

Dear Colleague

RE: NHS preparedness for a major incident

In light of the recent tragic events in Paris, NHS England together with the Department of Health and other national agencies are reviewing and learning from the incidents that occurred and will ensure that this is then reflected fully in our established Emergency Preparedness Resilience and Response procedures. We have already undertaken significant work on the clinical implications and expect to communicate with you on this shortly. In the meantime, I am writing to request your support in continuing to ensure that the NHS remains in a position to respond appropriately to any threat.

It is important to be clear that the threat level remains unchanged since 29 August 2014. The threat assessment to the UK from international terrorism in the UK remains SEVERE. SEVERE means an attack is highly likely.

We appreciate that you will currently be in the process of undertaking the annual EPRR assurance process, in line with the recently refreshed NHS England Assurance Framework, available at: https://www.england.nhs.uk/ourwork/eprr/gf/. In addition, it will be important that all trusts review the following immediately and that you are able to provide assurance that:

- You have reviewed and tested your cascade systems to ensure that they can activate support from all staff groups, including doctors in training posts, in a timely manner including in the event of a loss the primary communications system;

- You have arrangements in place to ensure that staff can still gain access to sites in circumstances where there may be disruption to the transport infrastructure, including public transport where appropriate, in an emergency;

- Plans are in place to significantly increase critical care capacity and capability over a protracted period of time in response to an incident, including where patients may need to be supported for a period of time prior to transfer for definitive care; and

- You have given due consideration as to how the trust can gain specialist advice in relation to the management of a significant number of patients with traumatic blast and ballistic injuries.

Ambulance trusts should also assure themselves that they:

- Ensure that the Marauding Terrorism and Firearms, Hazardous Area Response Team, Chemical, Biological, Radiological and Nuclear capacity and capability is declared live in Proclus and updated a minimum of every 12 hours.

Please could you ensure that your responses to the above form part of a statement of readiness at a public board meeting in the very near future as part of the normal assurance process.

Both my team and I appreciate your continuing support in ensuring that the NHS is in a position to respond to a range of threats and hazards at any time.

Yours faithfully

Dame Barbara Hakin
National Director: Commissioning Operations

Cc.
Prof. Sir Bruce Keogh – National Medical Director – NHS England
Prof. Keith Willett – NHS England – Director for Acute Care
Dr Bob Winter – NHS England – National Clinical Director EPRR
Richard Barker – NHS England - North
Paul Watson – NHS England – Midlands & East
Anne Rainsberry – NHS England – London
Andrew Ridley– NHS England – South
Hugo Mascie-Taylor - Monitor
Helen Buckingham – Monitor
Dr K McLean – NHS Trust Development Authority
Peter Blythin – NHS Trust Development Authority
National on Call Duty Officers NHS England
NHS England Heads of EPRR
NHS England Medical Directors

University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD PAPER

Title	**Cancer Services Operational Policy**
Author	**Danielle Taylor, Deputy Associate Director of Cancer Services**
Responsible Chief Officer	**David Eltringham, Chief Operating Officer**
Date	**28 January 2016**

1. Purpose

To present the Cancer Services Operational Policy to the Trust Board for approval in order to comply with the NHS Trust Development Authority's Sustaining Cancer Improvement: 8 High Impact Actions

2. Background and Links to Previous Papers

On 14th July 2015 all acute providers received a tripartite letter (Gateway 03614 - attached) requesting a self certification against the eight high impact changes to improve cancer delivery. High impact change 3 requires there to be a cancer operational policy in place that is approved by the Trust Board.

The UHCW Cancer Board approved the Operational Policy at the November 25th meeting and the Policy is presented to the Trust Board for approval.

3. Narrative

The Trust Development Authority requires every Trust to have a cancer operational policy in place, which specifically includes:

- The approach to auditing data quality and accuracy (pages 31-36 of the operational policy)

- The approach to ensure that Multi-Disciplinary Team Co-coordinators are effectively supported and have sufficient dedicated capacity to fulfill the function effectively (page 10 of the operational policy)

The operational policy ensures that all healthcare professionals, who care for patients with suspected or diagnosed cancer at the Trust, understand their responsibilities and duties in achieving national Cancer Waiting Times Standards.

4. Areas of Risk

There are no risks associated with the approval of the Policy; the risk arises out of failing to have a Trust Board approved Policy in place given that this is a requirement. The Policy also mitigates against the risk that staff are not clear about their responsibilities around the treatment of patients with cancer and the associated national standards.

5. Governance

Trust Board approval of the Cancer Services Operational Policy is required in order to comply with the NHS Trust Development Authority's Sustaining Cancer Improvement: 8 High Impact Actions.

6. Responsibility

The Trust Board's named Executive Director responsible for delivering the national cancer waiting times standards is the Chief Operating Officer Mr. David Eltringham. Facilitation of effective, timed pathways is the responsibility of the Core Cancer Team and delivery against the pathways is the responsibilities of relevant Clinical Directors and Group Managers

7. Recommendations

The Board is invited to **APPROVE** the Cancer Services Operational Policy

Name and Title of Author: Danielle Taylor, Deputy Associate Director Cancer
Date**:** 31.12.2015

CANCER WAITING TIMES OPERATIONAL POLICY

eLibrary ID Reference No: *This id will be applied to all new Trust-wide CBRs and will be retained throughout its life span.*	
Newly developed Trust-wide CBRs will be allocated an eLibrary reference number following CBRC approval. Reviewed Trust-wide CBRs must retain the original eLibrary reference number.	
Version: *(must be a rounded number, i.e. 6.0, 7.0 etc.)*	4.0
Date Approved by Trust Board: *(if applicable)*	
Date Approved by Corporate Business Records Committee (CBRC): *(to be applied by CBR Officer following CBRC approval)*	
Review Date: *(a 3 year review date will be applied unless stated otherwise)*	
Title of Author:	Danielle Taylor Deputy Associate Director Cancer
Title of Clinical Director: *(if applicable)*	Dr Clive Irwin Associate Medical Director Cancer
Title of Chief Officer:	David Eltringham Chief Operating Officer
Target Audience:	All UHCW staff involved in the management of patients within the suspected cancer / confirmed cancer pathways
If printed, copied or otherwise transferred from eLibrary, Trust-wide Corporate Business Records will be considered 'uncontrolled copies'. Staff must always consult the most up to date PDF version which is registered on eLibrary. As a controlled Trust-wide CBR, this record should not be saved onto local or network drives but should always be accessed from eLibrary.	

Summary of Trust-wide CBR: *(Brief summary of the Trust-wide Corporate Business Record)*	This policy confirms the processes at UHCW to support the successful delivery of National Cancer Waiting Times Standards predicated on a balanced position between demand and capacity for cancer services.
Purpose of Trust-wide CBR: *(Purpose of the Corporate Business Record)*	The purpose of this document is to ensure that all healthcare professionals, who care for patients with suspected or diagnosed cancer, understand their responsibilities and duties in achieving national Cancer Waiting Times Standards.
Trust-wide CBR to be read in conjunction with: *(List overarching/underpinning strategies, policies and procedures)*	Improving Outcomes: A Strategy for Cancer 4th Annual Report, NHS England (December 2014) Progress I improving cancer services and outcomes in England, National Audit Office (Jan 2015) Achieving World Class Cancer Outcomes A Strategy for Cancer 2015-2020: Report of the Independent Cancer Taskforce (2015) Waiting Times for Suspected and Diagnosed Cancer Patients 2014-15 Annual Report, NHS England (May 2015) Managing long waiting cancer patients – policy on "backstop" measures, NHS England Gateway reference: 04237 (November 2015)
Relevance: *(State one of the following: Governance, Human Resource, Finance, Clinical, ICT, Health & Safety, Operational)*	Governance
Superseded Trust-wide CBRs (if applicable): *(Should this CBR completely override a previously approved Trust-wide CBR, please refer to eLibrary and state full title and eLibrary reference number and the CBR will be removed from eLibrary)*	
Author's Name, Title and email address: *(must not be the same as reviewer)*	Danielle Taylor, Deputy Associate Director, Cancer Services Danielle.taylor2@uhcw.nhs.uk
Reviewer's Name, Title & email address: *(must not be the same as author)*	Helen West, Deputy Associate Director, Cancer Services Helen.west@uhcw.nhs.uk
Group Manager's Name, Title & email address:	N/A

(if appropriate)	
Title of Group/Department/Specialty:	Corporate / Cancer Services

Version	Consultation Committees/Meetings/Forums etc *List **all** Trust Committees/Forums/Bodies/Groups where this version of the CBR has been consulted on during the development/review stages.*	Date
V1	Chief Operating Officer - Executive Lead for Cancer, Deputy Chief Operating Officer – Elective Care, Associate Medical Director Cancer Lead Cancer Nurse	September 2015
V2	Cancer Board	October 2015
V3	Addition of NHS England backstop policy for management of long waiters	November 2015
V4	Confirmation of Strategic Cancer Lead	November 2015

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1.0 SCOPE

1.1 This policy applies to:

- all UHCW staff involved in the management of patients within the suspected cancer / cancer pathways

- patients cared for under Cancer Waiting Times. Within the NHS in England this is defined as activity with ICD codes C00-C97 (excluding basal cell carcinoma) or D05 (breast carcinoma in situ). This **includes** patients:

    - being treated within a clinical trial;
    - whose cancer care is undertaken by a private provider on behalf of the NHS;
    - diagnosed with a second new cancer;
    - without microscopic verification of the tumour (i.e. histology or cytology) if the patient has been told they have cancer and/or have received treatment for cancer;
    - with any skin squamous cell carcinoma (SCC) i.e. the standards are applicable to each SCC an individual skin cancer patient has.

The 31 day standard applies to NHS patients with a newly diagnosed cancer or recurrence of a previously diagnosed cancer, regardless of the route of referral (including patients who may be diagnosed during routine investigation for another condition e.g. an incidental finding).

The 62 day standard applies to NHS patients referred through a two week referral route by the GP or GDP with suspected cancer, patients who are referred to a specialist because of breast symptoms where cancer is suspected, cancer is suspected from any national cancer screening programme, or the patient is upgraded by a consultant because cancer is suspected.

Patients **excluded** from the cancer waiting times standard - any patient:

- With a non-invasive cancer i.e. carcinoma in situ (with the exception of breast)
- Basal cell carcinoma
- Who dies before treatment can begin
- Receiving diagnostic and treatment privately unless the patient chooses to be seen privately but is then referred for treatment under the NHS or the patient is seen under the 2 wk standard chooses to have diagnostic tests privately but returns to the NHS for further treatment.
- Patients who refuse to undergo diagnostic tests are excluded from the 62 day standard, but if they are subsequently diagnosed with cancer they will follow the 31 day treatment standard.
- Patients who decline treatment

2.0 INTRODUCTION

2.1 The purpose of this document is to ensure that all healthcare professionals, who care for patients with suspected or diagnosed cancer, understand their responsibilities and duties in achieving national Cancer Waiting Times Standards.

Waiting times have a very direct link with the quality of service provided; the 62 day standard is one of the most important operational standards in the NHS and has a strong relationship with the determinants of good cancer outcomes and positive patient experience.

UHCW NHS Trust is committed to working collectively to improve, maintain and build upon our cancer performance so that our outcomes compare favourably with our European peers.

This commitment is demonstrated through our:

Vision: To be a national and international leader in healthcare

Mission: Care, Achieve and Innovate

Objectives: To deliver excellent patient care and experience

To deliver value for money

To be an employer of choice

To be a research based healthcare organisation

To be a leading training and education centre

Values: compassion, openness, learn, improve, partnership and pride

There are 11 cancer waiting times standards overall and these are illustrated in the table below along with the national compliance threshold

The Cancer Waiting Times Standards

Standard:	DoH Tolerance
TWW suspected cancer	**93%**
TWW breast symptomatic	**93%**
31 day - 1st treatment	**96 %**
31 day - subsequent treatment -surgery	**94%**
31 day - subsequent treatment -chemo	**98%**
31 day - subsequent treatment - radio	**94%**
31 day - subsequent treatment - other	No tolerance set
31 day - rare cancers	No tolerance set
62 day - 1st treatment*	**85%**
62 day - national screening programme	**90%**
62 day - consultant upgrade	CCG tolerance = 85%

3.0 STATEMENT OF INTENT

3.1 The successful delivery of any maximum waiting time standard is predicated on the following factors:

- patient pathways capable of delivering a short wait, and which clearly describe what should happen, in what order and when;
- a balanced position between demand and capacity;
- a maximum number of patients waiting that is consistent with the level of

demand and key pathway milestones e.g., maximum time from referral for suspected cancer to the first outpatient appointment;

- patients are treated in order by clinical priority; and against the two week wait standard;
- patients are actively managed against the pathway for their condition and the key milestones.

While all of these factors are important, a balanced position between demand and capacity is essential. If demand exceeds capacity then the numbers of patients waiting will grow and waiting times will lengthen and the ability to provide short waits will deteriorate.

4.0 DEFINITIONS

None

5.0 DUTIES / RESPONSIBILITIES

5.1 Responsibilities of the Chief Executive

The overall and final responsibility for this policy in the Trust rests with the Chief Executive.

5.2 Responsibilities of the Executive Leads for Cancer (Operational and Strategic)

A single executive lead for cancer with board level accountability for CWT and cancer delivery is the Chief Operating Officer (COO). The COO is responsible for delivery of the national Cancer Standards and will discharge this responsibility through the Clinical Group structure, the Cancer Management team and the Operations team. The identification of a single executive lead for cancer does not negate the need for CEO personal involvement when necessary.
A single executive lead for cancer strategy is the Chief Finance and Strategy Officer (CFSO).

5.3 Responsibilities of the Chief Officers

The Trust's Chief Officers are responsible for ensuring effective delegation of

responsibilities within their areas of responsibility, and effective support of their managers' decisions and recommendations in terms of the provision of appropriate resources.

5.4 Responsibilities of the Associate Medical Director for Cancer

The Associate Medical Director for Cancer has overall responsibility for ensuring high standards of cancer clinical care across the organisation in a timely manner, leading the development of the cancer strategy with director, managerial and clinical support.

This responsibility includes facilitation of the delivery of CWT performance and has professional management responsibility for the Multi Disciplinary Team (MDT) clinical leads in their roles as such and who are responsible for delivery of CWT within their tumour site.

5.5 Responsibilities of the Director of Operations

The Director of Operations will act with the full authority of the Chief Operating Officer and/or Chief Finance and Strategy Officer (in their absence) with respect to the delivery of the Trust's Cancer Strategy and Cancer Performance:

- Hold Groups, Clinical Teams, and the Cancer Team to account for the delivery of the Trust's Cancer Strategy and Cancer Performance.
- Act on behalf of the Chief Operating Officer and/or Chief Finance and Strategy Officer to ensuring effective delegation of responsibilities and effective support of management decisions and recommendations in terms of the provision of appropriate resources.
- Ensure there is appropriate management information and performance reporting structures in place.
- Report to Chief Officers on the delivery of the Trust's Cancer Strategy and Cancer Performance.
- Line manage the Deputy Associate Director for Cancer

5.6 Responsibilities of the Deputy Chief Operating Officers

The Deputy Chief Operating Officers (DCOO) will hold Group Managers to account for ensuring balanced capacity and demand to facilitate achievement of Cancer Waiting Times standards through the Operational Delivery Planning process and, on

an ad hoc basis, where capacity constraints impact on achievement of the standards. The DCOO will agree and facilitate corrective actions arising from any deviations from standard pathways in order to ensure adequate provision of appropriate resources.

5.7 Responsibilities of the Deputy Associate Director for Cancer

The Deputy Associate Director for Cancer has overall responsibility for facilitation of the delivery of cancer waits. This manager has a corporate responsibility for cancer, including monitoring cancer waiting times data quality and accuracy, maintenance of a valid and cancer specific PTL, implementation of the cancer strategy, and a lead role in coordinating peer review and with the remit of management of the cancer trackers (MDT coordinators) .

The Deputy Associate Director will escalate any deviations from standard pathways in order to agree corrective action and will be responsible for reviewing MDT co-ordinator resource across the Trust's cancer MDTs to ensure adequate provision of appropriate resources.

5.8 Responsibilities of the TWW Booking Office Manager

The TWW Booking Office Manager has overall responsibility for ensuring that TTW appointments are allocated within 14 days from receipt of referral and in line with agreed booking rules within each specialty. They are also responsible for initiating the escalation policy if an appointment cannot be booked within 14 days (Appendix 1 Escalation Matrix).

5.9 Responsibilities of the Trust Lead Cancer Nurse

The Trust Lead Cancer Nurse has co-responsibility for facilitating the delivery of CWT. This role includes development of a cancer nursing strategy, and a lead role in coordinating peer review.

The Lead Cancer Nurse has professional line management responsibility for cancer specialist nurses within the organisation who, in turn, have a role to play in supporting patients through their cancer pathways in a timely manner. The Trust Lead Cancer Nurse has a professional line management link to the Chief Nurse

5.10 Responsibilities of the MDT Lead Clinician

There is a named lead clinician from the MDT assigned for each of the tumour sites (as per peer review requirements). This same person is accountable for CWT delivery (including data quality and completeness), breaches avoidance and learning (with support from the relevant senior specialty manager, e.g. general manager). The MDT Lead Clinician will facilitate the agreement of timed pathways of care to include the point within the 62 day pathway by which key activities such as OP assessment, key diagnostics, inter-provider transfer and TCI dates need to be completed.

5.11 Responsibilities of the MDT Clinical Nurse Specialist

Each cancer specialist nurses within the organisation has a role to play in supporting patients through their cancer pathways in a timely manner, working effectively with their tumour site MDT co-ordinator and the MDT Clinical Lead

5.12 Responsibilities of the MDT Co-ordinator

The MDT co-coordinators have responsibility to ensure that all suspected cancer patients are actively tracked throughout their pathway until either a low suspicion or non diagnosis of cancer is confirmed or until the patient has received first definitive treatment.

The MDT co-coordinators prepare and maintain all related documentation ensuring that MDT outcomes and treatment plans are recorded in the medical notes and that patient and GP letters are dispatched within the time frame stipulated. The Dendrite Web System is the UHCW NHS Trust's Cancer Waiting Times database and provides electronic-MDT management and collation of Cancer Outcomes and Services Dataset material. All clinical information and investigation details are recorded within IPM and oncology-specific information is recorded within Mosaiq.

5.13 Responsibilities of the Dendrite System Manager

The Dendrite System Manager (DSM) provides specialist advice to inform and lead the co-ordination of the evolving Dendrite Web System across all cancer specialties and is responsible for analysis, investigation and resolution of complex IM&T issues to ensure that Dendrite meets the clinical information requirements needs of the individual specialties. The DSM will work closely with the Performance and Programme Management Office (PPMO) and with Information and

Communications Technology Services (ICT) to ensure reporting and system resilience with regard to Cancer Waiting Times information.

5.14 Responsibilities of the Group Managers and Clinical Directors

The Clinical Directors and Group Managers have overall responsibility for implementing and adherence to this policy within their division. This includes:

- Ensuring that effective processes are in place to manage patient care and treatment that meet national, local and NHS Constitution targets and standards for each specialty within the division.

- Managing resources allocated to the division with the aim of achieving access targets. This includes having the staff and other resources available to operate scheduled outpatient clinics, patient treatment and operating theatre sessions and avoid the need to cancel patient treatment.

- Working with other Clinical Directors and Group Managers to provide a joined-up approach to implementing this policy and achieving the cancer access targets, particularly around outpatient and operating theatre capacity and availability of diagnostic services.

- Achieving cancer access targets.

- Ensuring that the duties, responsibilities and processes laid down in this policy are implemented with the group.

- Ensuring all business unit staff that need to operate this policy are aware of this policy and receive training so that they can meet the policy requirements.

- Implementing effective monitoring systems with the Trust , as advised by the Core Cancer Team, to ensure compliance with this policy and avoid breaches of the targets: escalate any actual or potential breaches

to the Chief Operating Officer

- Implementing systems and processes that support data quality and for validating data to ensure that all reports are accurate and produced within agreed timescales

Day to day operational management of this policy will be delegated to Group Managers as set out in the governance arrangements for each Group.

5.15 Responsibilities of the General Medical / Dental Practitioners and other referrers

The trust relies on GP's and other referrers, supported by local commissioners to ensure patients understand their responsibilities and potential pathway steps and timescales when being referred. This will help ensure patients are:

- Referred under appropriate clinical guidelines
- Aware of the speed at which their pathway may be progressed
- In the best possible position to accept timely appointments throughout their treatment

GPs should use their clinical judgement to determine what to tell a patient and when but it is deemed good practice for a GP to ensure that a patient understands that they need to be referred urgently and for what reason where possible and the importance of keeping an appointment once it has been made (as recommended in NICE referral guidelines for suspected cancer).

5.16 Responsibilities of Patients

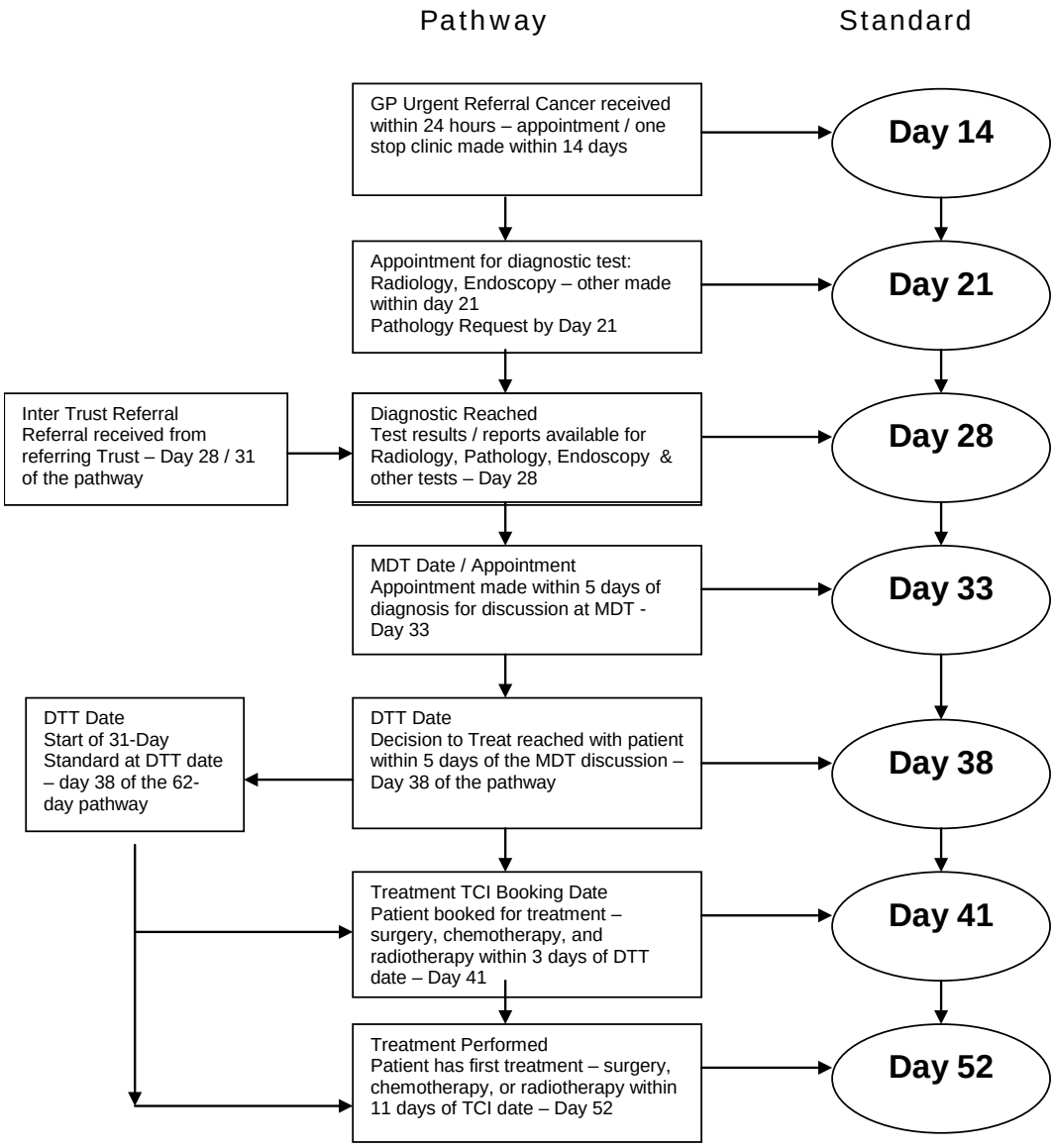
Everyone has a role to play to ensure that the Trust is able to deliver care within the Cancer pathways. Patients also have a role to play as outlined in the NHS Constitution these include:

- Attending their hospital appointment or ensuring that they contact the hospital to cancel it, giving as much notice as possible if they are unable to attend.
- Managing their own health where possible

- Use the part of the service appropriate for their needs
- Be involved in the management of their treatment pathway
- Ensuring that they inform their healthcare provider of any changes in personal circumstances, particularly contact details and registered GP.

6.0 DETAILS OF THE POLICY

6.1 Key dates within the 31/62 day pathway are illustrated below and drive pathway redesign and service improvement



6.1.1 Referral

This policy assumes all GPs/GDPs are informing patients that they are being referred as a 2WW and that as a fast track pathway a patient may be offered a series of appointments at short notice.

All suspected cancer referrals should be referred by the GP/GDP on the relevant body site proforma available on the Web site and submitted via the NHS E-Referral Service.

All patients must be seen within 14 days of receipt of referral to comply with national standards and day 0 is date the referral is received. (The Department of Health operational standard is 95%)

The Booking Centre should confirm the agreed appointment date to the referring GP practice via safe-haven fax or NHS E-Referral Service within 2 working days. If the patient does not have an appointment at day 2 the Booking Centre escalation process will be followed.

6.1.2 Patient Cancellations

Patients may cancel an appointment due to ill health, social or other reasons. A cancellation by the patient, prior to the appointment, regardless of the notice given will not change the need for the patient to be seen within two weeks of referral and patients must be re-appointed within 14 days of the original referral.

Cancer Waiting Times (CWT) A Guide V8 does not allow patients to be referred back to the GP after multiple cancellations unless this has been agreed by the patient. However, it is good practice to let the GP know that a patient has deferred appointments, as they may wish to either contact the patient or possibly downgrade the referral.

In the event of a patient cancelling two or more first appointments within the 2 weeks rule timescale every effort will be made to rebook the appointment as soon as possible and the GP should be notified of the repeated cancellations in case the patient requires additional support. Patients should not be referred back to their GP after multiple (two or more) appointment cancellations unless this has been agreed with the patient – the cancellation of an appointment has shown the patient's

willingness to engage with the Trust.

6.1.3 Patients who do not attend

Patients may DNA (did not attend) an appointment for the same reasons as a cancellation i.e. ill health, social or other reasons. Do not attend means that a patient does not arrive for their appointment and does not cancel the appointment regardless of the notice given.

If a patient does not attend their initial out-patient appointment this allows the clock to be reset from the receipt of the referral to the date upon which the patient rebooks their appointment. This adjustment is relevant to the cancer two week wait and the 62-day standard.

All dates for suspected cancer/cancer patients, whether for outpatients, diagnostic tests, or treatment should be dates that are subject to choice and agreed with the patient. Trust policy is for patients who DNA appointments to be referred back to the GP, except where a clinician decides the patient should be rebooked for clinical reasons. Patients with a suspected cancer who DNA an appointment will be contacted by the outpatient team to ascertain the reason for the DNA and rebooked if appropriate.

If it is the patient's wish not to attend for the agreed care, then a letter will be sent to the GP or referring clinician informing them of the patient's decision. If a cancer patient DNA's 2 consecutive appointments, the patient will be referred back to the GP, unless the consultant feels this is clinically inappropriate.

Prior to the patient being discharged back to the referrer the consultant will be informed. The consultant will write to the GP within 5 working days to inform them of the action so that the patient can be followed up if needed within primary care. Regardless of the reason (cancellation or DNA) if it is not possible to offer an appointment either due to time constraints, e.g. cancelled on day 13 of pathway or no second appointment available to offer within the target time then the TWW Rebook Alert Process must be followed (Appendix 2).

Patients that cancel after day 11 of the pathway should be immediately booked into

the next available appointment to reduce the impact on the 62 day pathway and prevent further pathway delays.

6.1.4 First appointment

The first appointment can be either an outpatient appointment with a consultation or investigation relevant to referral i.e. straight to test.

6.1.5 Emergency admissions/attendances during 2 week rule period

In the event of a patient being seen/admitted as an emergency prior to attending for a two week wait appointment for the same condition as the referral, then they should no longer be recorded against the two week wait standard i.e. the referral will be closed down (however, such a patient could still be upgraded onto the 62 day upgrade pathway if the Consultant suspects cancer is the cause of the admission).

If a patient is being seen / admitted as an emergency for another condition, the 2ww referral still applies.

6.1.6 Downgrading referral priority

A referral can only be downgraded with the consent of the referring GP. Therefore if a Consultant, on reviewing the proforma, considers the referral should be downgraded they should contact the GP for agreement. Once this has been done PAS must be amended by removing the 2ww out patient waiting list with clear comments to explain that the referral has been downgraded. The PAS will be updated with comments. If the priority of the referral changes from TWW to Urgent a new waiting list entry will be opened at the same time that the TWW referral is closed.

6.1.7 Incomplete referral information

If an incomplete referral is received, the Booking Centre should contact the referring GP/GDP immediately to minimize the delay in the pathway. This does not constitute a reason for making a pause to the pathway; patients should not be referred back to their GP to stop a pathway.

In circumstances where the minimal data set is not complete, or the TWW referral

proforma is not used, the Booking Centre will contact the GP to ensure complete information is made available in the correct format. The referral must continue to be processed so that the patient's treatment is not delayed while the missing information is sought from the referring practitioner. The referral will not be paused or referred back to the GP

6.1.8 Two referrals on the same day

If two referrals are received on the same day, both referrals must be seen within 14 days and, if two primary cancers are diagnosed, treatment for both cancers must start within 62 days of receipt of referral if clinically appropriate.

6.1.9 Breast symptomatic referrals

All patients referred with breast symptoms must be seen within 14 days or receipt of referral. This excludes patients referred for breast augmentation, gynaecomastia or family history; these referrals should be booked within normal waiting times standards.

If any doubt over referral patient should be booked within 14 days

Referrals to the breast symptomatic service can be received from a wide range of health care professionals including other clinicians in secondary care. All breast symptomatic referrals must therefore be sent immediately to the Outpatient Booking Centre to ensure the 14 day standard is met.

6.2. Diagnostic & staging pathway

As a result of the first appointment, diagnostic appointments should be directly booked while the patient is in the hospital. No patient should leave the hospital without a date for at least the next step in their pathway. Specialties should create "reserve" lists, or other means of enabling this. Reserved diagnostic slots for staging examinations are available to each specialty as part of this.

All tests should be made for the earliest available appointment and agreed with the patient.

6.2.1 Patient unavailability, DNA or cancellation

The operational standard applied to the 62-day standard takes account of the volume of patients likely to defer appointments or be unfit at stages of their pathway.
Patients cannot be downgraded from the 62 day pathway due to unavailability.
For multiple cancellations, the patient should be contacted by the specialty team rather than just giving multiple re-appointments. Patients may not understand the details of the test being requested, or may be anxious and require reassurance. If the patient does not wish to proceed then they should be referred back to their GP and removed from the 62-day pathway.
If the patient later rejoins the pathway they should then be monitored against the 31-day standard only.

6.2.2 Communication of Diagnosis to the GP or referrer

The GP should be notified of confirmed new diagnosis via the Clinical Results Reporting System or safe-haven fax within 1 working day of the diagnosis being discussed with the patient.

6.2.3 Consultant Upgrades

Hospital specialists have the right to ensure that patients who are not referred urgently as suspected cancer referrals but who have symptoms or signs indicating a high suspicion of cancer is managed on a 62 day pathway.

Any patient that is not already on a 62 day pathway i.e. referred from a GP/GDP as an urgent suspicion of cancer referral or with breast symptoms (i.e. 2ww) and who is not referred through the screening programmes may be upgraded onto a 62 day pathway by the receiving specialty. The 62 day target starts on the date the upgrade decision is made.

The points in the pathway where a referral may be upgraded are:-

- on reading the referral letter;
- □ after seeing the patient for the first time;
- after seeing test results (before or after seeing the patient);
- □after discussing the patient's case at a multidisciplinary team meeting.

Upgrade must occur on/or before the decision to treat date. Patients not upgraded by this point will be measured against the 31 day decision to treat to first definitive treatment. **The upgrade will only be applicable for patients that have a suspicion of a new cancer NOT those who may be suspected of a recurrence.**

6.3 Treatments

6.3.1 First treatment

For newly diagnosed cancers all patients should be treated within 31 days of decision to treat date (DTT) irrespective of the treatment.

First definitive treatment is normally the first intervention which is intended to remove or shrink the tumour. Examples of which are listed below:

Surgery – the following count as definitive treatment

- Excision biopsies if it is complete or if the intention is to remove the tumour
- Palliative surgical interventions e.g. stenting
- Partial excision or de-bulking of a tumour

Non-surgical cancer treatment

- Chemotherapy
- Hormone therapy
- Immunotherapy
- Radiotherapy
- Brachytherapy
- Specialist palliative care
- Active monitoring
- Other palliative treatments e.g. radiofrequency ablation

Other treatments may be considered as first definitive treatment provided the intention is therapeutic or no other active intervention is intended.

Where there is no definitive active oncological treatment almost all patients will be offered a palliative intervention (e.g. stenting) or palliative care, which would be

counted as the first definitive treatment.

6.3.2 Subsequent treatments

This 31 day standard currently only applies to those treatments, either curative or palliative, that aim to remove/shrink or delay the growth/spread of tumour/cancer. All patients will be treated within 31 days of Decision to Treat

6.3.3 Offers of treatment

All offers of treatment should be made within a reasonable timeframe under the guidance of Cancer Waiting Times (CWT) A Guide. For cancer patients under the 31 or 62 day standard 'reasonable' is classed as any offered appointment between the start and end point of 31 or 62 day standards .The adjustment would be the time between the date of the declined appointment (the offered To Come In date) to the point when the patient could make themselves available for an alternative appointment.

6.3.4 Surgery

Includes all outpatient, day case and inpatient surgical treatments where intent is to remove the tumour. Admission date is classed as treatment date even if it is before the surgical procedure date.

If a patient is admitted as an emergency and during the admission undergoes surgery which subsequently diagnoses a cancer, the admission date is classed as the treatment date for the purposes of cancer waiting times.

If on receiving the histology report surgical margins are not clear of cancer as long as the intent was to remove the tumour this will still be classed as a treatment.

If a diagnostic procedure is undertaken but it is subsequently found to have removed the entire tumour then this would be classed as a treatment.

If a wider excision is required following a previous cancer treat but no tumour is found in the histology, this is still classed as a cancer subsequent treat and tracked/reported for cancer waiting times.

If patients are admitted for a procedure which is intended to treat the cancer but on operating the surgeon is unable to proceed due to clinical findings this would be classed as “open and close” surgery and would still class as treatment as the intent was to treat. This does not apply if the patient is reviewed pre-operatively and deemed unfit to proceed; in this situation the 62 day pathway cannot be closed – a revised treatment plan will need to be formulated and agreed with the patient which will generate a revised 31 day target from agreement to treatment.

6.3.5 Specialist palliative care

Patients requiring symptomatic and supportive care provided by the specialist palliative care team could be either a first or subsequent treatment.

Treatment commences when the team assess the patient.

6.3.6 Enabling treatments

Most enabling treatments that are carried out prior to active treatments are not classed as first definitive treatments for example: PEG/RIG tube insertions prior to radiotherapy are not classed as first treatment unless the radiotherapy commences during the same admission as the PEG then the date of admission is the date of first treatment.

However some exceptions do apply:

- Colostomy for bowel obstruction as part of a palliative care package
- Insertion of oesophageal stent
- NSCLC stent
- Ureteric stenting for advanced cervical cancer
- Insertion of pancreatic stent if planned to resolve jaundice before the patient has a resection or starts chemotherapy.

6.3.7 Clinical Trials

If a patient is entered into a clinical trial and may or may not receive a placebo this would still count as first/subsequent treatment and treatment must still be provided within 31/62 days of the pathway

6.3.8 Blood transfusions

If a patient is not planned to have active anti cancer treatment, a blood transfusion would count as first treatment as part of a palliative care treatment package, in all other cases blood transfusion would not count as first treatment.

6.4 Recurrences

A recurrence is classed as subsequent treatment and is defined when a patient has been diagnosed and treated for an original primary and informed that they are free of disease and then cancer returns in the same site.

Clinical input is required to determine if the patient has a recurrence or a second primary in the same site.

Recurrent cases are monitored against the 31 day pathway only irrespective of route of referral. Therefore if a patient on a 62 day pathway is diagnosed with a recurrence then they are removed off the 62 day pathway and will be tracked under the new 31 day target.

6.5 Metastases

Metastases are classed as a subsequent treatment and are defined as a tumour that has spread from another primary site. Data entry/monitoring are reliant on clinical input to determine if the treatment is to the primary or metastatic site. A metastatic treatment is classed as a first treatment only if there is an unknown primary. If the primary is known and treatment is given to the metastatic site first this is still classed as a subsequent treatment and monitored under the 31 day pathway even if this occurs before the treatment to the primary site. If the patient is on a 62 day pathway the clock does not stop with the metastatic treatment, it continues until the primary site is treated.

6.6. Clock stops, pauses and adjustments

6.6.1Clock Stops

The 31- and 62-day pathways end at treatment, or when a patient refuses treatment.

6.6.2 Pauses/ Adjustments are allowed in two places within the pathway only:

1) If a patient DNAs their initial out-patient appointment – this would allow the clock to be re-set from the receipt of the referral to the date upon which the patient rebooks their appointment. This adjustment is relevant to the cancer two week wait and the 62-day standard.

2) If a patient declines an offer of admission for treatment in an in-patient (ordinary admission or day case) setting provided the offer of admission was "reasonable". For cancer patients under the 31 or 62 day standard 'reasonable' is classed as any offered appointment between the start and end point of 31 or 62 day standards. The adjustment would be the time between the date of the declined appointment (the offered To Come In date) to the point when the patient could make themselves available for an alternative appointment.

6.7 Reasonable offers

All patients offered outpatient (both new and follow-up) and diagnostic appointments must be given reasonable notice.

- For a verbal appointment offer, for an initial TWW appointment, reasonable notice has been agreed locally as two appointment dates on different days within 14 days of receipt of the referral.
- For a written appointment offer, reasonable notice has been agreed locally as an appointment date with at least two weeks from when the appointment letter is dated.
- If a patient accepts an offer at shorter notice this also represents a reasonable offer in respect of subsequent cancellations and delays.

6.7.1 Patient thinking time

It is good practice to allow patients a period of thinking time prior to considering treatment; this is one of the reasons why the operational standard is not set at 100%. Pathways need to take account of this and be able to accommodate a reasonable period for the patient to consider options. If a longer period of thinking time is agreed, it may be appropriate for the clinician to agree Active Monitoring as a treatment and therefore a clock stop. For this to be genuine there would need to be

a follow-up appointment agreed. It is not acceptable to use Active Monitoring to avoid breaches where the agreed thinking time is reasonable.

6.7.2 Earliest Clinically Appropriate Date (ECAD)

This applies if there has been a previously agreed and clinically appropriate period of delay before the next treatment can commence. When determining the ECA date, only patient issues should be considered, capacity constraints do not apply.

Some examples of ECAD

- If a patient is booked for a check cystoscopy following a treatment for cancer and during the cystoscopy a recurrence is diagnosed and resected then the ECAD and treatment is the date of the cystoscopy.
- If the patient is diagnosed but then booked for treatment the ECAD is the date of the cystocopy and the treatment must be booked within 31 days.
- Patient with rectal cancer to have radiotherapy then surgery 6 weeks post radiotherapy. ECAD date would be 6 weeks after radiotherapy completed
- Patient with breast cancer to have surgery then radiotherapy. The patient would not be fit for radiotherapy until they can lift arm above their head. Therefore the ECAD date would be set when radiotherapy planning commences.

An ECAD can be reviewed and changed as long as the date has not passed. If an ECAD is set but on patient review on/prior to the ECAD the patient is clinically not able to progress to the next treatment the ECAD can be changed to a later date.

If a patient is to commence radiotherapy and requests to delay their treatment start owing to a holiday, providing the patients Consultant agrees to this request, the ECAD commences when the patient makes themselves available on their return.

If the patient is unwell after the ECAD then the ECAD cannot be reset and a wait time adjustment will not apply.

6.7.3 Active Monitoring

This could relate to either a first or subsequent treatment where the intention is for long term surveillance where the decision had been taken to monitor the progress of the disease. For example, a slow growing tumour where there is not an immediate problem and it is clinically appropriate to step back and monitor the situation until an active intervention is more appropriate.
When Active Monitoring is discussed and agreed with the patient this constitutes treatment and the clock stops.

6.7.4 Inter-provider transfers (IPT)

An Inter-provider Transfer (IPT) occurs when a patient follows a pathway of care that involves a referral between providers

Referrals to UHCW NHS Trust from other providers need to ensure the timely transfer of clinical and administrative information between providers so that:

- Patients receive appropriate assessment, diagnosis and treatment within the specified target times.
- The patient journey is appropriately monitored, with key events communicated between all providers involved in the patient pathway.
- Problems are escalated appropriately and in a timely manner to the relevant staff so that remedial action can be taken.
- Breaches are agreed and appropriately allocated between providers.

IPTs from any initial referral source should be made in accordance with timescales and pathways agreed by site specific advisory groups. Any specialist diagnostics or treatment requiring completion by a particular day should be explicitly described in the pathway documentation.

Discussion at SMDT should not be delayed if the complete Clinical Dataset is unavailable, however any resulting transfer of the patient to the tertiary provider must be accompanied by the complete minimum data set including Cancer Waiting Times information.

Referral for diagnostics should follow the timescales specified by the pathways and be accompanied by the Cancer Waiting Times dataset. It need not be sent with an SMDT referral form unless being referred to the SMDT first.

Referral to UHCW for Oncology opinion and Radiotherapy / Chemotherapy or concurrent Chemo-Radiotherapy must also include completion of an IPT.

In all cases, the referral for treatment should be made before day 38 of the 62 day cancer in order to ensure compliance with the 62 day standard

6.7.5 Minimum data set

An IPT may not be recognised as a referral without receipt of the minimum data set, which consists of two parts:

- **Clinical dataset**, including:

  The Specialist MDT Referral Form

  Imaging and Pathology (with accompanying reports) - supplied by secondary provider and as specified in the SMDT referral form.

- **Cancer Waiting Times Dataset**, transferred via the:

  Inter-Provider Transfer Form – mandatory fields completed as a minimum. This dataset includes the national Cancer Waiting Times dataset plus the inter-provider referral date

6.7.6 Referrals to a Specialist Multi-Disciplinary Team Meeting (SMDT) shall include:

Full Clinical dataset including reports

Cancer Waiting Times dataset

In the case of referrals for diagnostics and treatment, which do not require SMDT discussion, the clinical referral letter should be accompanied by the cancer waiting times dataset only.

6.7.7 Data Protection

Email accounts used for information transfer should only be accessible to relevant and appropriate personnel within each individual provider organisation. The email address must be an NHS.net address (email address with suffix @nhs.net) to allow secure transfer of encrypted information, both for sending and receiving information.

In exceptional cases, for example where electronic transfer is not possible due to technical failure, paper information should be transferred via safe haven fax. Information transferred by post (for example hard copies of faxed paper information) should be clearly marked “Private and Confidential – To be opened by the addressee only”.

6.7.8 Patient Tracking of IPTs

UHCW’s core cancer team has systems in place for the effective tracking and navigation of all cancer patients and will continue to track the patient once the notification of transfer has been sent to us.

UHCW will start to track the patient as soon as the Inter-Provider Transfer form has been received, or the patient is listed for an SMDT meeting, whichever is sooner.

The Lead Cancer Manager/designated person at the referring organisation is responsible for ensuring that the Deputy Associate Director Cancer Services at UHCW is informed of any key events or changes to the target date, for all patients that they are tracking.

The Deputy Associate Director Cancer Services at UHCW is responsible for ensuring that the inter-provider transfer form is updated to reflect treatment planning, key events and changes to target dates. They must ensure that this is electronically transferred to Lead Cancer Managers/designated person at the referring organisation on a weekly basis. This returned form is known as the inter-provider transfer (IPT) weekly report and is reinforced by verbal updates between MDT co-ordinators.

6.7.9 Escalation of inter-provider transfers

Robust lines of communication exist between all people who collect Cancer Waiting Times data at UHCW, and this applies to inter-provider referrals that are a regular part of a patient pathway. Queries and anomalies, in particular relating to potential

breaches, are highlighted and resolved as quickly as possible.

It is the responsibility of the referring organisation to ensure that the Deputy Associate Director Cancer Services at UHCW is notified immediately of any patient referred later than day 38.

The Lead Cancer Manager, at the referring organisation, is responsible for notifying the Executive Lead (or equivalent), within their organisation, if an IPT has not been notified to UHCW by day 38 of the 62 day pathway.

6.8 Inter-Provider Breaches

Discussion between UHCW and other relevant providers is required to reach joint decisions about breach allocation. Any delay to the agreed timed clinical pathway i.e. transfer for diagnostics or treatment would trigger a discussion and breach allocated accordingly.

Should discussion confirm that the full breach was the responsibility of an individual provider, this will not affect Department of Health monitoring which will still apportion the breach equally between the ”first seen provider" and the “treating provider".

When a patient has been referred after day 38 of the 62 day pathway and a breach occurs UHCW will write formally to the referring organisation’s Chief Operating Officer requesting completion of a root cause analysis, harm review and remedial action to prevent recurrence by the referring organisation.

Records of late referrals will be kept and a quarterly report produced setting out the source of late referrals. Recurrent late referrals patterns will be escalated via the referring Trust COO and if necessary the relevant CCG and regulator

The breach reason will be agreed between providers by the 25th working day following the end of each month (prior to final upload).

6.8.1 Referrals to a specialist MDT (SMDT)

Referrals to a SMDT should be made within one working day of the decision to refer

the patient (DTR). This applies to:

- Referrals from an LMDT to a SMDT.
- Referrals to a SMDT or member of an SMDT made outside of an LMDT meeting e.g. consultant to SMDT referrals and radiotherapy referrals.

It is the responsibility of the referring organisation to put in place systems to ensure that all referrals are made within one working day of the decision to refer the patient.

It is the responsibility of UHCW to ensure that there are systems in place to inform the SMDT Coordinator, within one working day of receipt of the referral, so that the patient can be included in the next SMDT meeting. This is achieved by referrals going directly to the site specific MDT co-ordinator and specifying the cancer waiting time's target that applies to the referral, the date the referral was made and the breach reason if applicable.

6.8.2 Radiotherapy/Visiting Consultant referrals (not via SMDT)

It is the responsibility of the referring organisation to ensure that there are systems in place to inform the SMDT Facilitator at UHCW of radiotherapy or visiting consultant inter-provider referrals, within one working day of the referral, so that the patient can be tracked appropriately. This includes completion and sending of the notification of transfer form.

It is the responsibility of UHCW to have systems in place to receive and track the referral and to ensure the notification of treatment planning is updated and returned to the referring organisation on a weekly basis via the IPT weekly report. At UHCW referrals for Radiotherapy are made via an electronic booking form and tracked against the 31 day pathway within the Radiotherapy Department as well as against the 62 day standard by the Cancer Services Team

6.8.3 Screening

Patients seen initially at UHCW's screening centre are then offered the choice of returning to their local provider for ongoing investigations/treatment via a clinical referral form and the daily inter-provider notification of transfer form with all the relevant information for the 62 day pathway. Both referrals must take place within 1

working day of the screening centre tests or after patient choice.

6.8.4 Actions required to deliver performance against the Cancer Waiting Times Standards

Daily actions (MDT facilitators and Pathway Tracker)

- Review and update of Access and Excel TWW tracking sheets; this information is then uploaded onto the Dendrite system (data repository) to enable upload of national reporting requirements
- Any patients falling outside the escalation standards will be made known to the MDT and Deputy Associate Director Cancer Services and followed up for completion

Weekly actions (Deputy Associate Director Cancer)

- Review data completeness and accuracy via the Dendrite system.
- Review the overall PTL and weekly performance data ahead of the weekly corporate PTL meeting.
- Through the corporate PTL meeting and the Productivity & Performance Management Office, identify common issues and concerns, and ensure solutions are enacted for any issues not resolved through initial escalation.
- Review capacity plus any performance issues for the week ahead, escalating any unresolved issues.
- Ensure MDT agendas state breach dates

Weekly actions (Group Managers)

- Review group breaches and escalation issues for the month, ensuring root causes and recurring themes are identified and appropriate countermeasures are enacted.
- Review capacity & demand metrics and ensure the service is able to consistently operate at the pace of demand. Make changes to respond flexibly to demand as required.
- Review predictable changes for the period ahead, such as cancer team annual leave and bank holidays. Ensure appropriate actions in place to support clinical MDTs.

Monthly actions (Deputy Associate Director Cancer)

- Review breaches and escalation issues for the month, ensuring root causes and recurring themes are identified and appropriate countermeasures are enacted.
- Review capacity & demand metrics and ensure the service is able to consistently operate at the pace of demand. Make changes to respond flexibly to demand as required.
- Review predictable changes for the period ahead, such as annual leave and bank holidays. Ensure appropriate actions in place.
- Undertake spot checks of accuracy of the tracking information
- Root Cause Analysis of any 100+ day patients

Weekly actions (Deputy Chief Operating Officer)

- Chair the weekly Access (Cancer) meeting to review performance and agree actions with the Groups for the delivery of cancer access standards.
- Chair weekly meetings, where necessary or appropriate, with clinical teams representing the tumour sites, supported by the Deputy Associate Director Cancer and/or Associate Medical Director of Cancer. These meetings will provide assurance that actions are being completed to deliver capacity and/or service improvements, so that Cancer Access standards are achieved and maintained.
- Receive and sign off weekly cancer performance reports.
- Report the latest cancer performance on a weekly basis to COG.

6.8.5 Breach analysis

A root cause breach analysis is carried out for each pathway not meeting current standards; this includes trend analysis and patients treated within 48 hours of breaching – these are reviewed in weekly PTL meetings.

Key elements of the pathway not meeting the standard will require capacity and demand analysis as well as an assessment of sustainable list size – this in turn will inform an Improvement Plan with a detailed recovery trajectory for the relevant

pathway to achieve the national standard. Improvement plans will be agreed with commissioners and any other providers involved in the pathway.

6.8.6 Managing long waiting cancer patients – policy on "backstop" measures

Generally, any waiting time of over 62 days from urgent referral to treatment is classified as a long wait. For the purposes of this document however, long waiting times means those in excess of 104 days (the backstop measure).

Some patients will have a legitimate long waiting time for cancer diagnosis and treatment, for either choice or medical reasons. The operational standard for delivery of cancer care within 62 days of urgent referral was set at 85%, to take account of these cases.

Patients classified as "long waiters" are expected to form a minority of cases breaching the operational standard.

6.8.7 Identifying long waiters

UHCW maintains a weekly patient tracking list (PTL) and hold weekly targeted PTL meetings, involving the departments/ group managers directly supporting and overseeing the delivery of cancer waiting times.

The PTL meeting should be able to review a patient-specific list of those waiting on a cancer waiting times pathway, against any of the 31 and 62 day standards.

Performance and capacity data for the 14 day wait to first seen standard should also be reviewed (as required).

The patient-specific list should allow decisions to be taken at the meeting which can respond to individual patient delays, as required.

6.8.8 Tracking long waiting time patients

UHCW has electronic records to track patient pathways and to provide evidence of action taken to expedite diagnosis and treatment within agreed timeframes where necessary.

All actions taken to progress patient pathways are noted within these electronic records and reviewed regularly (at least weekly).

Tracking of cancer patients continues after a breach has occurred up to the point at which first definitive treatment occurs whether that is provided by UHCW or another provider.

6.8.9 Reporting of cancer patients with a long waiting time

The UHCW Trust Board receives routine reports on cancer waiting times performance; showing performance against each of the cancer operational standards and the actions being taken to improve and sustain cancer performance.

These reports are presented in a way which allows the Trust Board to see the number and proportion of patients with a long waiting time.

Where required the Trust Board should see outcomes of the root cause analysis (RCA) in relation to the cancer pathway/s concerned, and may request further forms of exception reporting as required by local circumstances.

Clinical Commissioning Groups (CCGs or equivalent) may request further exception reporting and ensure that themes identified within the RCAs are embedded in the Trust's Cancer Improvement Plan.

6.9 Root cause analysis

RCA should always be carried out for each pathway not meeting current standards (i.e. failing the 85% standard), by reviewing the last ten patients breaches and near misses (defined as patients who came within 48 hours of breaching).

Long waiting patients, as defined by this policy, should be the subject of individual RCA. These should be reviewed in the weekly PTL meetings.

In addition, for long wait patients (over 104 days) with a confirmed cancer diagnosis, a clinical harm review should be undertaken.

The RCA should involve a senior oversight by either the Lead Cancer Clinician, or by another consultant within the multi-disciplinary team.

The RCA process must be supported by the departments involved in the pathway (such as radiology and pathology, or the chemotherapy, surgical and radiotherapy service as appropriate).

The Lead Cancer Manager and/or Lead Cancer Nurse would also be expected to be involved with the RCA process.

For long waiting patients the RCA must be completed as soon as possible after the

patient receives their cancer care. In many cases, it will be possible to commence the RCA process sooner, when the delays are initially identified, tracked, and where possible mitigated via the weekly PTL meeting. Where the RCA identifies a delay/s which caused the breach, then the breach should be reported on as “avoidable” and, where a thematic issue, be addressed via an Improvement Plan.

6.9.1 Root cause analysis for shared pathways

All providers involved in the patients care should participate in the RCA. The providers must communicate with each other at an early stage to agree which trust will lead on the RCA. Normally, the treating Trust would lead the RCA, or, if the delay reason is very clear and attributable to the actions/inactions of a provider then they should lead the process. .

Trusts should avoid each commencing a separate RCA process and not identifying the delay reasons for stages of the pathway managed by the other provider/s and vice-versa. They should also consider the possibilities for early escalation to Trust Boards and Commissioning Clinical Leads, should a Serious Incident (SI) likely to have occurred.

Where any provider in shared pathways is concerned that a RCA should have been undertaken or potential harm event investigated in line with this guidance, then the Medical Director or Lead Cancer Clinician should contact their counterpart at the earliest opportunity.

6.9.2 Process for potential clinical harm reviews

Where an individual patient with a confirmed cancer diagnosis has waited over 104 days, there should be a clear, transparent process in place to identify if the extended delay has caused harm to the patient.

Where there was a medical reason for the patient to wait for cancer treatment then there should be clear evidence that the patient pathway has been reviewed at regular intervals.

If either a single delay or a sequence of delays can be shown to have resulted in a serious harm event for the patient concerned, or the available evidence suggests that this may have been the case, then UHCW should follow the policy for investigating and reporting the case as a SI. It would be good practice to undertake SI-type reviews for cases of harm not considered to be ‘serious’ under SI definitions.

A serious communication breakdown or administrative error in a patient pathway may also be considered as a SI. The RCA will shape the terms of reference for the SI investigation process. Where a SI investigation commences the Trust must follow its escalation process through to the senior clinical lead at the relevant CCG (or other process as locally agreed).

6.9.3 Regional review

The CCG Clinical Lead will bring details of such cases for discussion at the next Clinical Quality Reference Group (CQRG) meetings and may refer to either the senior leadership team within a Strategic Clinical Networks (SCNs), or other cancer focussed commissioning or provider collaborations as appropriate, to ensure specific knowledge-share.

CQRG's will work will the Regional teams to ensure that themes are captured and support provided where serious concerns are highlighted in providing timely care to patients.

The Commissioning Clinical Lead would be expected to confirm with the provider the actions taken as a result of the SI, as part of its overall existing process.

7.0 DISSEMINATION AND IMPLEMENTATION

(Outline the details of how the dissemination and implementation of this policy will be actioned and record all underpinning operational policies and procedures (developed or to be developed) to support this.) (Delete upon insertion of text)

7.1 This operational policy will be widely advertised via the Intranet and through the Cancer Board and Clinical Quality Reference Group. All Group Manager, Clinical Directors and Cancer MDT Lead Clinicians will be sign posted to the policy

8.0 TRAINING

8.1 All new UHCW staff involved in the implementation of this policy will undertake initial training as part of their local induction arrangements. This will include:

- training undertaken by ICT trainers on the PAS and Dendrite system which will include specific reference to the requirements relating to Cancer Waiting Times
- familiarity with this policy and, specifically, the process for potential clinical harm reviews
- 8.2 MDT lead clinicians will be advised on the process for potential clinical harm reviews for their tumour site

9.0 MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

Compliance with this policy will be monitored as set out below.

- Weekly validation checks as part of Cancer PTL review
- Monthly validation checks

  All data fields are completed and submitted as required

  Totals are correct – e.g. that the total is a sum of overall treatment functions

  Large changes in volumes compared to previous months will be investigated.
- Quarterly validation checks

9.1 Monitoring Table

Aspect of compliance or effectiveness being monitored	Monitoring method	Individual/ department responsible for the monitoring	Frequency of the monitoring activity	Group / committee which will receive the findings / monitoring report	Group / committee / individual responsible for ensuring that the actions are completed
Staff are aware of the roles and responsibilities associated with this policy	Review understanding through PDR process and attendance at Cancer Board	Director of Operations/ Clinical Directors	Annual	Cancer Board	Cancer Board
Effective communication with internal and external stakeholders	Regular communication regarding CWT performance, breach /RCA analysis to share safety lessons and establish trends	Associate Medical Director Cancer, Deputy Associate Director Cancer	Monthly	Cancer Board Trust Board CQRG	Cancer Board
Follow up of relevant improvement plans	Review of CWT performance against improvement plans	Director of Operations/Deputy Chief Operating Officers/ Clinical Directors	Monthly	Cancer Board Trust Board CQRG	Cancer Board

10.0 STAFF COMPLIANCE STATEMENT

All staff must comply with this Trust-wide Corporate Business Record and failure to do so may be considered a disciplinary matter leading to action being taken under the Trust-s Disciplinary Procedure. Actions which constitute breach of confidence, fraud, misuse of NHS resources or illegal activity will be treated as serious misconduct and may result in dismissal from employment and may in addition lead to other legal action against the individual/s concerned.

A copy of the Trust's Disciplinary Procedure is available from eLibrary.

11.0 EQUALITY & DIVERSITY STATEMENT

Throughout its activities, the Trust will seek to treat all people equally and fairly. This includes those seeking and using the services, employees and potential employees. No-one will receive less favourable treatment on the grounds of sex/gender (including Trans People), disability, marital status, race/colour/ethnicity/nationality, sexual orientation, age, social status, their trade union activities, religion/beliefs or caring responsibilities nor will they be disadvantaged by conditions or requirements which cannot be shown to be justifiable. All staff, whether part time, full-time, temporary, job share or volunteer; service users and partners will be treated fairly and with dignity and respect.

12.0 REFERENCES AND BIBLIOGRAPHY

Achieving World Class Cancer Outcomes A Strategy for Cancer 2015-2020: 2015 Report of the Independent Cancer Taskforce

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The NHS Constitution

http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx

Progress improving cancer services and outcomes in England
https://www.nao.org.uk/.../2015/.../Progress-improving-cancer-services-and-outcomes

Cancer Waiting Times annual report, 2014-15 - NHS England
https://www.england.nhs.uk/.../2015/.../cancer-waiting-times-annual-report-2014-15

Managing long waiting cancer patients – policy on ... - NHS England
https://www.england.nhs.uk/.../managing-long-waiting-cancer-patients.pdf

13.0 UHCW ASSOCIATED RECORDS

13.1 Procedure for Investigation and Root Cause Analysis

13.2 Access Policy

14.0 APPENDICES

None

To: NHS CCG Accountable Officers
Trust and Foundation Trust Chief Executive Officers
System Resilience Group Chairs

CC: NHS England Regional Directors
NHS TDA Director of Delivery & Development
Monitor Regional Directors

14 July 2015

NHS England Publications Gateway Reference: 03614

Dear colleague

Improving and sustaining cancer performance

2014/15 was a challenging year for commissioners and providers. Performance against the cancer standards was generally strong, with certain areas making significant improvements in difficult circumstances. Despite this, performance against the cancer 62 day referral to treatment standard was consistently below the required 85% at national level.

We understand that operational performance standards can be challenging to meet in the context of current pressures. In some cases the pressure to meet them could lead to perverse consequences, and Sir Bruce Keogh's recent review of standards addressed that issue head on – making changes which are specifically designed to support you all in doing what is best for patients.

But when it comes to cancer standards, we know that waiting times have a very direct link with the quality of service we provide. We know that waiting for test results or treatment causes real anxiety for patients and their families. We know that many treatment options will only be effective if we employ them early enough. Ultimately, we know that delays in diagnosis and treatment are part of the reason that cancer outcomes in this country do not always compare well with our European peers.

We have made huge progress in addressing these issues over the past decade. Age-standardised mortality rates have decreased year-on-year and nine out of ten patients now rate their care as excellent or very good. It is critical that we work together to maintain and build upon these improvements.

Monitor, the National Trust Development Authority and NHS England have therefore agreed to lead a national delivery group for improving 62 day performance, which will work closely with the Cancer Waiting Times Taskforce (CWTT) and Intensive Support Team (IST). This reflects a recognition that, as with many areas of operational performance, poor 62 day performance and the required solutions will sit with a combination of commissioners and often multiple providers. This letter sets out the group's key streams of work.

We recognise that some regions have already been taking action to address performance issues and this group is intended to bring together this work under a national programme.

Eight key priorities

The CWTT led by Dr Kathy McLean and Mr Sean Duffy have identified 8 key priorities for local health systems to implement as a matter of urgency – please see Annex A for details.

These priorities offer practical actions to help providers and also support CCGs with effective commissioning of cancer services.

They have been identified to ensure that effective cancer resilience planning is undertaken in the current financial year.

All acute Trusts will be asked to complete a self-assessment of compliance with the 8 key priorities and return a plan to achieve full compliance, (or explanation of planned non-compliance), by the end of August 2015.

We believe the system will benefit if these priorities are supported by a strong assurance process. However, there are no quick fixes and as such we need to be realistic. These priorities should not be assured as a "tick box" exercise, but assurance should be used as a tool to get to a better position where we are able to deliver and sustain excellent care to our patients.

Cancer delivery plan

In addition to the 8 key priorities, a cancer waits action plan has been devised by the National Tripartite in response to the challenges we currently face and has the support of the Secretary of State for Health.

The key now is to ensure the recommendations set down in the plan – as outlined below – are fully embedded.

Improvement Plans

All Trusts will be segmented as poor/high concern/low concern/good based upon current and recent performance data.

All poor or high concern Trusts will be expected to produce an Improvement Plan by the end of August for review and sign off by its Regional Tripartite.

Trusts rated as good are likely to be followed up to discuss which additional operational measures have proved to be beneficial to performance so that this learning can be shared across other local health systems.

We will be significantly increasing the capacity of the Elective IST so they can support the production of these Improvement Plans.

Performance Reporting

To support this, all Trusts and Foundation Trusts will be expected to produce weekly PTLs for the 62 day standard.

Submissions from Foundation Trusts should be made via UNIFY2, so that information can be shared with commissioners. This will be coordinated through CCGs using the already established TDA weekly UNIFY PTL collection for NHS Trusts and which will be shared with FTs for use from week commencing 20 July.

Patients who have breached the 62 day standard will be externally monitored in the same way that 18 week breaches are monitored externally.

We will ask the CWWT to provide us with advice on the appropriate “backstop” measure which will then be operationalised into routine monitoring systems as we move forward.

Regional Tripartites will liaise with commissioners to remind them that the Remedial Action Plan process should be used where Trusts are not delivering the 62 day standard. NHS England will review the relevant sections of the national NHS Contract to ensure that the withholding regime for this standard reflects the importance of reliable delivery.

Capacity Planning

Each local health system will be required to prepare a cancer capacity plan setting out how it will deal with the projected increase in cancer demand. We will write to you again to set the detailed requirements and the required timeline for the production of local system capacity plans. We will also work on developing guidance to support this planning process.

System Resilience Groups

The remit of System Resilience Groups (SRGs) will be explicitly expanded to cover the 62 day cancer standard given the need to drive better and sustained performance.

Confirmation that the remit of SRGs explicitly now includes 62 day standard will be formally communicated in NHS England's SRG Winter assurance letter 2015/16 which is due to go out later in July.

Review breach allocation policy

We appreciate this is a particular issue for some providers, although we should bear in mind that "shared" cases only account for less than a third of breaches. It is also clear that deterioration in performance of shared cases has been exactly the same as non-shared cases. The ALB delivery group will look to commission a review of the current breach allocation policy by the CWTT to report back by end of August 2015.

Focus on endoscopy

Long waits for endoscopy procedures has become an increasing problem. Each system with long waits will be required to clear its backlog as a matter of urgency.

To support this work *InHealth* are mobilising a Programme Management Office to facilitate this process and help providers to clear the endoscopy backlog.

This will be operational from 1 August 2015, and will utilise a range of NHS and Independent Sector providers who are able to offer capacity.

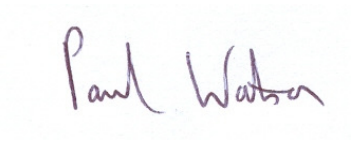
Further work is also being undertaken to look at a number of Trusts to understand local and national challenges and what might be done to help reduce waiting times and improve performance.

Next steps

The 62 day standard is one of the most important operational standards in the NHS. It has a strong relationship with the determinants of good cancer outcomes and positive patient experience. Delivering it is a key priority and we hope that the steps outlined in this letter – particularly the increased support available from the IST, Cancer Waiting Times Taskforce and Endoscopy PMO – will support you in doing what is needed in your own areas.

If you have any queries in the meantime, please do not hesitate to liaise with your relevant local contact.

Yours sincerely,



Paul Watson
NHS England

Lyn Simpson
NHS TDA

Adam Sewell–Jones
Monitor

Annex A

Cancer Waiting Time Standard: Eight Key Priorities

- The Trust Board must have a named Executive Director responsible for delivering the national cancer waiting time standards.

- Boards should receive 62 day cancer wait performance reports for each individual cancer tumour pathway, not an all pathway average.

- Every Trust should have a cancer operational policy in place and approved by the Trust Board. This should include the approach to auditing data quality and accuracy, the Trust approach to ensure MDT coordinators are effectively supported, and have sufficient dedicated capacity to fulfil the function effectively.

- Every Trust must maintain and publish a timed pathway, agreed with the local commissioners and any other Providers involved in the pathway, taking advice from the Clinical Network for the following cancer sites: lung, colorectal, prostate and breast. These should specify the point within the 62 day pathway by which key activities such as OP assessment, key diagnostics, inter-Provider transfer and TCI dates need to be completed. Assurance will be provided by regional tripartite groups.

- Each Trust should maintain a valid cancer specific PTL and carry out a weekly review for all cancer tumour pathways to track patients and review data for accuracy and performance. The Trust to identify individual patient deviation from the published pathway standards and agree corrective action.

- A root cause breach analysis should be carried out for each pathway not meeting current standards, reviewing the last ten patient breaches and near misses (defined as patients who came within 48hours of breaching). These should be reviewed in the weekly PTL meetings.

- Alongside the above, a capacity and demand analysis for key elements of the pathway not meeting the standard (1st OP appointment; treatment by modality) should be carried out. There should also be an assessment of sustainable list size at this point.

- An Improvement Plan should then be prepared for each pathway not meeting the standard, based on breach analysis, and capacity and demand modelling, describing a timetabled recovery trajectory for the relevant pathway to achieve the national standard. This should be agreed by local commissioners and any other providers involved in the pathway, taking advice from the local Cancer Clinical Network. Regional tripartite groups will carry out escalation reviews in the event of non-delivery of an agreed Improvement Plan.

University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD PAPER

Title	**Fit and Proper Persons Test Declaration**
Author	**Rebecca Southall, Director of Corporate Affairs**
Responsible Chief Officer	**Andy Meehan, Chairman**
Date	**28th January 2016**

1. Purpose

This paper seeks to provide assurance that all members of the Trust Board meet the requirements set out in Regulation 5 of the Care Quality Commission fundamental standards, which came into force on 27th November 2014.

2. Background and Links to Previous Papers

Members of the Trust Board last made a public declaration around their compliance with the requirements of the Fit and Proper Persons Test (FPPT) at the January 2015 Trust Board meeting. Whilst members of the Trust Board are clear that the duty to comply is an enduring one, the Trust Board resolved to make a public declaration of compliance on an annual basis for reasons of probity and transparency.

3. Narrative

The Chairman is responsible for ensuring that all members of the Trust Board and those that are regularly in attendance at meetings meet the requirements of the FPPT. The Trust already undertakes a range of pre-employment checks to ensure that all staff have the qualifications and capability to undertake them and that they are generally of sound character.

Although the suite of checks that are already in place as part of the Trust's recruitment processes will continue to be undertaken, all new members of the Board or individuals to whom the regulations apply will be asked to sign the attached declaration on appointment and to commit to informing the Chair of any changes in circumstance that mean that they no longer comply. A register will be held by the Director of Corporate Affairs and Board members will make a signed declaration each year, which will be formally reported to the Trust Board.

Each member of the Board has confirmed their compliance with the regulations on an individual basis and the signed forms will be retained by the Director of Corporate Affairs as evidence of this.

4. Areas of Risk

If the Trust does not comply with the FPPT regulations then the following risks arise:

Regulatory risks; if the Trust does not comply with the requirements of the regulation and evidence this, regulatory action and consequent damage to the Trust's reputation could follow, which could result in public confidence in the organization being

undermined. The measures described above and the written declaration and reporting proposal are aimed at mitigating this risk.

Clinical Risks/Patient Experience risks; the regulations are aimed at ensuring that Boards of Board of providers of NHS are capable of governing the organisation to a high standard and ensuring that decisions that it takes are in the interests of patients and the wider community. If the Trust does not implement these regulations then there is the risk that these objectives may not be met and the best interests of patients will not be served. The process outlined in this paper mitigates against this risk.

5. Governance

The Fit and Proper Persons test is part of the CQC essential standards, which are a core component of the Trust's governance framework. An annual declaration of compliance with FPP will therefore be made at a Public Trust Board meeting.

6. Responsibility

Andy Meehan, Chairman supported by Rebecca Southall, Director of Corporate Affairs

7. Recommendations

The Trust Board is asked to **NOTE** that declarations of compliance with the requirements of the Fit and Proper Persons Test have been received from each member of the Trust Board. Board members are also asked to **COMMIT** to informing the Chair of any change in individual circumstances that might affect compliance on an on-going basis.

University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD PAPER

Title	**Report of December Private Trust Board Meeting**
Author	**Rebecca Southall, Director of Corporate Affairs**
Responsible	**Andy Meehan, Chairman**
Date	**28 January 2015**

1. Purpose

To report in public the substantive business that was transacted in the section of the December Board meeting that members of the public and the press were excluded from pursuant to Section 1(2) of the Public Bodies (Admission to Meetings) Act 1960, and the Public Bodies (Admissions to Meetings) (NHS Trusts) Order 1997.

2. Background and Links to Previous Papers

The Trust Board is at liberty to exclude members of the public and the press from board meetings when the nature of the business that is prejudicial to the public interest due to its confidential nature. In the interests of transparency however, the Chairman provides a report on the substantive items that were discussed to the next public meeting of the Trust Board.

3. Narrative

The following substantive items were discussed and/or approved at the December private session of the Trust Board:

- Plans to develop an Innovation Hub on the University Hospital site.
- An update in relation to rectification works underway on the UH site.

4. Areas of Risk

There no specific areas of risk to highlight arising out of the matters discussed.

5. Governance

A further report will be submitted to the February Trust board detailing the business transacted in the January Trust Board. Reporting in this way ensures that we are fulfilling our obligations around transparency and openness.

6. Responsibility

Andrew Meehan, Chairman
Rebecca Southall, Director of Corporate Affairs

7. Recommendations

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

INTERIM COMMITTEE REPORT TO BOARD
Purpose: This report has two purposes; firstly to **ASSURE** the Board that the committees that it has formally constituted are meeting in accordance with their terms of reference and secondly to **ADVISE** Board Members of the business transacted at the most recent meeting and to **INVITE** questions from non-committee members thereon. The Board is asked to note the business discussed at the meeting and to raise any questions in relation to the same.
Committee Name: Quality Governance Committee
Committee Meeting Date: 18th January 2016
Quoracy: Yes
Apologies: Meghana Pandit & Peter Winstanley
Chair: Ed Macalister-Smith
1. Minutes; the minutes of the December 2015 meeting were approved as an accurate record.
2. Delayed Transfers of Care (DTOC): the Committee received a detailed report setting out the risks associated with the DTOC position and the mitigation that is in place. This included an update on the ECIP work across the Local Health Economy and the actions that are in place as a result to improve pathways across partner organisations.
3. Pressure Ulcers; the Committee noted that a further pressure ulcer had been reported and the Chief Nursing Officer gave assurance that a root cause analysis was underway and that lessons learned would be identified and actions put into place to prevent recurrence.
4. Safeguarding Children & Vulnerable Adults; the Committee received a well written and positive report demonstrating the increasing volume of work that was being undertaken by the team and were pleased to note that additional staff were being recruited to accommodate this. Also noted requirements around PREVENT training and the significant burden this imposed on a very large organisation such as UHCW.
5. Cervical Screening Report; the report was very positive and it was noted that KPIs are being met and that turnaround times for Coventry & Warwickshire were amongst the best in the West Midlands.
6. Maternity Dashboard Annual Report; the number of births at UHCW continues to rise with a number of expectant mothers either booking or self-referring from outside of the immediate catchment area. This was felt to be due at least in part to the reputation of the Lucina Birthing Centre. The number of women with complex needs is rising. UHCW continues to be rated green for caesarean section rates.
7. Risk – Defibrillators; the Committee was advised of an on-going problem with defibrillators and were given assurance that whilst the new models were awaited, together with the associated training, first responder units were in use across the Trust.
8. Getting the Basics Right/CQC; the post-inspection programme continues to run. QGC noted that six of the must-do actions in the CQC Action Plan were reported outstanding, two closed since the report issued.

INTERIM COMMITTEE REPORT TO BOARD
Purpose: This report has two purposes; firstly to **assure** the Board that the committees that it has formally constituted are meeting in accordance with their terms of reference and secondly to **advise** Board Members of the business transacted at the most recent meeting and to **invite** questions from non-committee members thereon.
Committee Name: Finance and Performance Committee
Committee Meeting Date: 11th January 2016
Quoracy: Yes
Apologies: David Eltringham
Chair: Ian Buckley
Report submitted by: Ian Buckley, Non-Executive Director & Vice Chair
1. Minutes The minutes of the December meeting were approved as an accurate record.
2. Integrated Performance Report Achievement of the referral to treatment incomplete pathway, Emergency Department 4-hour wait and 62 day wait for cancer treatment targets continue to present a challenge. As a result, Chief Officers have convened monthly performance review meetings with the senior management of each of the Groups between January and March 2016, to identify improvements and focus attention, in order to achieve all key targets by 31st March. Discussion ensued in relation to theatre productivity and it was agreed that a report demonstrating assurance of the impact of initiatives taken, trajectory for improvement and explanations as to why and where theatre time is lost will be presented to the Committee in June 2016.
3. Integrated Finance Report The Trust amended the internal plan to reflect the £3m 'stretch' target requested by the Trust Development Authority (TDA). The month 8 IFRS forecast position is a deficit of £20.7m,with a post International Financial Reporting Standards (IFRS) adjusted forecast deficit figure of £19.4m, in line with the TDA plan. It was agreed that the financial recovery plan with refreshed planning assumptions would be presented to the Committee in March 2016.
4. Efficiency Delivery Report It was noted that at month eight, £34.1m Cost Improvement Programme (CIP) was forecast to be delivered against £34m plan, giving a potential forecast over-delivery of £0.1m. This was caveated subject to performance in month nine.
5. Workforce Information Report The Committee discussion centred on key concerns regarding long-term sickness and was noted to have been a key area of challenge to the senior management teams at the monthly performance reviews in January. Assurance was provided that the Trust is looking at the management of attendance overall, starting with revision of the current attendance policy alongside additional training for senior managers in order to create the necessary mind shift to improve sickness absence. The Trust is working with staff side throughout the review process who have been invited to contribute to the development of training for staff.
6. Position Statement Report on the Trust's 2014/15 Reference Costs The Trust's reference cost indices (RCI) for 2014/15 is 102; identical to that for 2013/14. The gap between the cost of the Trust's service delivery and the national average cost increased by c£1.2m between 2013/14 to 2014/15. The Trust is considered to be c£11m more expensive that the national average in relation to elective, non-elective, outpatient and A&E

services and mitigations of the RCI values for services within activity types where cost was above the average was provided. It was noted that whilst benchmarking amongst peers was helpful; organisations use varying methodologies to inform their reference cost calculation and this should be considered when reflecting upon the benchmarking data.

It was agreed that a deep dive into how the procurement agenda links with reference costs will be presented to the Committee in March 2016.

The Board is asked to note the business discussed at the meeting and to raise any questions in relation to the same.

INTERIM COMMITTEE REPORT TO BOARD
Purpose: This report has two purposes; firstly to **assure** the Board that the committees that it has formally constituted are meeting in accordance with their terms of reference and secondly to **advise** Board Members of the business transacted at the most recent meeting and to **invite** questions from non-committee members thereon.
Committee Name: Audit Committee
Committee Meeting Date: 14th December 2015
Quoracy: Yes
Apologies: David Poynton, Paula Young
Chair: Ed Macalister-Smith, Non-Executive Director
Report submitted by: David Poynton, Non-Executive Director
1. Consent Audit and further action to be taken An audit around Consent was carried out as part of the Internal Audit 2015/16 internal audit plan and highlighted the findings for (i) surgical procedures within theatres and (ii) radiology. Although the review did not highlight any weaknesses within surgical theatre procedures, it did identify some control weaknesses they may have impacted on the delivery of certain system objectives. It was agreed that the report would be referred to the Quality Governance Committee for further discussion with Duncan Watson invited to attend.
2. Clinical Engagement for Costs Implementation A follow-up review of Reference Costs was presented which had been undertaken to assess the level of progress made against recommendations from the original report. The review also assessed the level of progress made by the Trust against suggested actions contained within the May 2014 external audit report. The Trust will be engaging better with Clinical Directors in relation to understanding the data and the way that it can be utilised to drive performance.
3. Financial system The review provided assurance in relation to financial delivery and demonstrated that the level of control in the system remain unchanged, with an overall opinion of significant assurance being provided. Assurance was provided that actions to bring about improvement were in place with regards to medical and nursing agency staff bookings.

The Board is asked to **NOTE** the business transacted at the meeting and to **RAISE** any questions in relation to the same.