University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD MEETING TO BE HELD ON THURSDAY 30th JUNE 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.	**Confirmation of Quoracy** Chairman	For Assurance	Verbal	
4.	**Minutes of Public Board Meeting held on the 1st June 2016** Chairman	For Approval	Enclosure 1	
5.	**Matters Arising** Chairman	For Assurance	Verbal	
6.	**Trust Board Action Matrix** Chairman	For Approval	Enclosure 2	
Business Items				
7.	**Chairman's Report** Chairman	For Assurance	Enclosure 3	5
8.	**Chief Executive's Report** Chief Executive Officer	For Assurance	Enclosure 4	5
Performance				
9.	**Integrated Quality, Performance and Finance Monthly Report** Chief Workforce & Information Officer	For Assurance	Enclosure 5	10
Patient Quality and Safety				
10.	**Medical Education Report** Chief Medical and Quality Officer	For Assurance	Enclosure 6	10
11.	**Safer Staffing Bi-Annual Report** Chief Nursing Officer	For Assurance	Enclosure 7	10
12.	**You Said, We Did Update Report: November 2015 - March 2016** Chief Medical and Quality Officer	For Assurance	Enclosure 8	10
13.	**Equality and Diversity Annual Update** Chief Workforce & Information Officer	For Assurance	Enclosure 9	10
14.	**Complaints and PALS Annual Report 2015-16** Chief Medical and Quality Officer	For Approval	Enclosure 10	10
15.	**Quarter 4 and 2015-16 Cancer Waiting Times Performance** Chief Operating Officer	For Assurance	Enclosure 11	10

ITEM	TITLE	BOARD ACTION	PAPER	TIME
Strategy				
16.	**Together Towards World Class Programme Update** Chief Workforce & Information Officer	For Assurance	Enclosure 12	10
Research and Innovation				
	No reports			
Regulatory, Compliance and Corporate Governance				
17.	**Auditor Committee and Auditor Panel Terms of Reference** Director of Corporate Affairs	For Approval	Enclosure 13	10
18.	**Matters delegated to Board Committees** Chairman	For Assurance	Verbal	5
Feedback from Key Meetings				
19.	**Quality Governance Committee Monthly Report of 20th June 2016** Chair, Quality Governance Committee	For Assurance	Enclosure 14	5
20.	**Finance and Performance Committee Meeting Monthly Report of 22nd June 2016** Chair, Finance & Performance Committee	For Assurance	Enclosure 15	5
21.	**Any Other Business**			
22.	**Questions from Members of the Public Relating to Agenda Items**			
23.	**Date of Next Meeting:** **The next meeting of the Trust Board will take place on Thursday 28th July 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 WEDNESDAY 1 JUNE 2016 AT 1.15PM IN ROOM 10009/11 OF THE CLINICAL SCIENCES BUILDING, UNIVERSITY HOSPITAL, COVENTRY

AGENDA ITEM	DISCUSSION	ACTION

HTB 16/106 PRESENT

Mrs B Beal, Non-Executive Director (BB)
Mr I Buckley, Vice Chair (IB)
Mr D Eltringham, Chief Operating Officer (DE)
Professor A Hardy, Chief Executive Officer (AH)
Professor C Imray, Director of Research, Development & Innovation (CI) – HTB/16/116
Ms Ceri Jones, Head of Research, Development and Innovation (CJ) – HTB/16/116
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)
Mrs B Sheils, Non-Executive Director (BS)

IN ATTENDANCE

Mrs K Beadling, Head of Communications (KB)
Mrs P Young, Corporate Secretary (PY) – note taker

HTB 16/107 APOLOGIES FOR ABSENCE

Professor M Radford, Chief Nursing Officer (MR)
Mrs R Southall, Director of Corporate Affairs (RS)

HTB 16/108 CONFIRMATION OF QUORACY

Apologies were noted and the Chairman declared the meeting to be quorate.

HTB 16/109 DECLARATIONS OF INTEREST

There were no conflicts of interest declared.

HTB 16/110 MINUTES OF TRUST BOARD MEETING HELD ON 28 APRIL 2016

BS requested that the record show that she was present for the meeting on 28 April 2016.

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

HTB 16/111 MATTERS ARISING

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

HTB 16/112 TRUST BOARD ACTION MATRIX

AGENDA ITEM	DISCUSSION	ACTION

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

HTB 16/113 **CHAIRMAN'S REPORT**

The Chairman presented the report summarising the commitments he had attended since the previous Trust Board meeting.

There were no were no questions raised by other Trust Board members.

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

HTB 16/114 **CHIEF EXECUTIVE OFFICER'S REPORT**

AH presented the report detailing the key meetings and events that he had attended since the previous Trust Board meeting, and was pleased to report that the Sustainability and Transformation Plan for the Coventry and Warwickshire footprint was now moving at a pace with all parties working collaboratively to address common issues. The next steps include submission of the STP by the end of June to NHS England (NHSE) and NHS Improvement (NHSI), following which STP leads will be invited to meet with the Chief Executive Officers of NHSE and NHSI in July to review the submissions. NHSE and NHSI have made clear that at this stage, there is no requirement for organisations to publish the high level plans, which is acknowledged will require further development.

AH reported that a recent visit to the Fourth European Academic Medical Centres Conference in Stockholm proved enlightening and reflected upon discussions around opportunities for joint working in relation to research topics for the future.

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

HTB 16/115 **INTEGRATED QUALITY, PERFORMANCE AND FINANCE REPORT**

KM introduced the report; presented in a revised format in response to feedback from Board members.

DE reflected upon recent performance and acknowledged that performance within the Emergency Department (ED) continues to present a substantial challenge with significant issues at the front-end of the care pathway; regardless of whether there is sufficient capacity, which is disappointing. The Trust has been undertaking an ongoing piece of work with the Emergency Care Improvement Programme (ECIP) and as part of that, analysis of the emergency care pathway is being undertaken in order to identify the source of the problem with a view to addressing this. He assured that Performance Reviews with the Group Management Teams will focus on emergency care pathways and holding leaders to account.

In response to a query from IB regarding skill mix, DE acknowledged that the staffing profile within ED does not fulfil the requirements to meet the demand during peak periods of attendance. However, it is possible to predict peaks and troughs and it is imperative that every opportunity is taken to plan for this. This has; however, been met with some challenge and it is hoped that the work with ECIP will help to reconfigure working patterns to better meet periods of high

AGENDA ITEM	DISCUSSION	ACTION

demand. It was agreed that an emergency care pathway update including outputs of the ongoing work with ECIP will be presented to the Finance and Performance Committee in July. **DE**

In response to a query from DP regarding discharge; DE acknowledged that the level of discharges were not where they needed to be. Whilst attention is focusing on addressing the aforementioned issues within ED, issues with delayed transfers of care (DTOC) continue and remain a significant problem on any given day. He assured that discussions with partners in the Local Health Economy continue, in order to address this system-wide issue.

BB sought further clarity around the consultant resource within ED. DE advised that the establishment is 18.03 whole time equivalent (WTE) but the department is carrying 5 WTE vacancies, which are largely covered by existing staff undertaking additional shifts or medical locums. He assured that Chief Officers were keen to recruit to the posts substantively.

DE explained that the Trust had reported an unprecedented 52 week breach, relating to a patient residing at her Majesty's pleasure and several appointments were changed at the behest of the Prison Service. He assured that the Trust will not receive a financial penalty for the breach but acknowledged that this does present a reputational issue and NHSE are aware of the circumstances around the breach.

DP praised the work of the Workforce Department in reducing the sickness absence rate.

DP drew attention to theatre efficiency on page 10 of the report and expressed concern that despite previous concerns raised at Trust Board, this key performance indicator remains an issue. DE assured that this was scrutinised in detail at the most recent Finance and Performance Committee and further discussion is scheduled for the next meeting on 22nd June 2016. He added that Chief Officers are challenging the Groups to improve the pace of improvement.

DM provided a finance update, advising that underperformance in elective and day case activity presented a challenge in month one. Two-thirds of the issue relate to 79 high value elective cases being cancelled on the day in month. Furthermore, loss of elective activity due to the Junior Doctors Industrial Action resulted in a loss of income of £300k.

DM emphasised that there was an assumption in the Financial Recovery Plan (FRP) to see demonstrable improvement in theatre efficiency and utilisation, and disappointingly this is not yet being realised. The FRP includes a plan for £1.1m surplus based on the assumption of 2.5% CQUIN from all Commissioners made prior to a national dictate from Specialised Commissioning to top slice CQUIN payment by 0.4% for those Trusts not designated as Hep C centres. It has therefore, been agreed by NHSI that the Trust's performance against the control total will be £0.4m less [£0.7m] and the Trust will not be penalised for this. A letter confirming this arrangement is expected from NHSI.

In response to a query from IB in terms of recovering the £300k income lost to Junior Doctors Industrial Action, DM assured that discussions at Performance reviews will focus on challenging the Groups on activity achievements.

AGENDA ITEM	DISCUSSION	ACTION

Discussion ensued around the volume of activity required to achieve the in-year trajectory and meet performance targets. MP emphasised the importance of the Operational Delivery Plans (ODP's) and confirmed that work is underway to align the planning cycle with the job planning cycle through the establishment of a Medical Job Planning Oversight Committee.

BS commended the greater grip on performance as the Trust enters a new financial year and the steps being taken to hold Groups to account. AH acknowledged this and added that investment in the new Boardroom IT provides the opportunity to display activity against plan and comparison to the previous year, thus enabling better examination and scrutiny.

In response to a query from EMS regarding low levels of performance against the cancer 62 day target within Urology, MP advised that the Trust has experienced an unprecedented demand for robotic prostatectomies and has extended the theatre operating time in response to this. However, it is important to strike a balance between timeliness, cost effectiveness and patient outcomes. There has been an exponential rise in demand and it is not possible to meet the capacity required. She assured that the number of robotic cases per theatre list has doubled and in some instances three cases are performed per list. DM added that the Trust has overachieved in terms of performing radical prostatectomies and prior to the implementation of the Da Vinci robot, undertook a sixth of this activity.

In response to a query from EMS regarding the management of complaints; MP assured that this continues to drive forward in the right direction. She was pleased to report that the backlog of outstanding complaints had been eliminated and the Trust proactively responds to complaints, as and when they are submitted. She acknowledged that the Trust is 1% short of the 90% internal standard to turnaround complaints within less than 25 days and provided assurance in relation to the direction of travel to meet this standard.

BB commended KM on the revised report providing a clearer focus on areas of good performance and exceptions; supporting greater debate and scrutiny.

The Trust Board **RECEIVED ASSURANCE** from the Integrated Quality, Performance and Finance Report for April 2016 and **NOTED** the associated actions.

HTB 16/116 **RESEARCH, DEVELOPMENT & INNOVATION ANNUAL REPORT**

The Trust Board welcomed CI and CJ to the meeting to present the annual report.

CI paid gratitude to CJ and the Team for their continued hard work and for keeping research, development and innovation (RDI) at the forefront of the Trust. Furthermore, he demonstrated his appreciation of the Trust Board for key decision making, which has contributed to raising the RDI profile.

CI proceeded to provide an update and assurance on delivery against the four key objectives within the RDI Strategy including; expansion of Arden Tissue Bank; sustained improvement in research set-up and delivery times; significant increase in Research Capability Funding; appointment of six Professors with Coventry University; the award of Tommy's Recurrent Miscarriage Research Centre Status;

AGENDA ITEM	DISCUSSION	ACTION

development and launch of programmes to support researchers of the future; and joint strategy agreed with Warwick University. RDI are also developing relationships with the Universities of Birmingham, Leicester and Oxford.

Challenges included; meeting the patient recruitment target and set-up and delivery targets; slow development of West Midlands Research Network and lack of clarity around funding; fall in commercial income and grant income remaining reliant on a few individuals and operational pressures and capacity within finance teams, hindering the ability to move some work streams forward.

CI advised that whilst the patient recruitment target was not met, performance is in line with peer benchmarking. He countered that improvements in data collection and reporting has ensured that a more realistic recruitment target has been set for 2016/17, based on expected open portfolio studies and studies in the pipeline.

CI explained that the National Institute of Health Research (NIHR) funds patient focused research and is a key research funder for the NHS. For every £1 of NIHR income secured, each Trust receives additional Research Capability Funding (RCF). This funding stream has been prioritised, with the result that RCF has grown from £80k to over £1m in four years. Funding is based on the previous year's performance and the Trust is set to receive £1.14million in 2016/17. The aspiration is to reach £2m.

In 2015, a bespoke training programme, developed with Coventry University, to develop and support the researchers of the future amongst non-medical staff groups was launched. The Interdisciplinary Non-medic Clinical Academic (INCA) programme ranges from monthly informal sessions to a formalised support programme (bronze, silver and gold), whereby staff can be released from their clinical duties to develop their own research. Dedicated non-medic research peer support workshops are now running monthly, with two-weekly writing groups aimed at given non-medics time in a supportive environment to write up research. Seven UHCW NHS Trust staff members embarked on the INCA Silver programme this year, with the Gold programme launching in May 2016. The formal evaluation of the INCA silver programme has concluded and will be reported in 2016/17.

CI emphasised the need to better utilise space, observing that there is limited space in outpatients to review patients and dedicated research areas are nearing capacity. The administration teams are dispersed and unable to provide the 'one stop' experience that the team once built its reputation on.

He concluded that the "Our RDI Summit", which is taking place on 1 July 2016; provides the prospect for staff to understand the opportunities afforded by research and innovation and enable researchers and innovators to showcase their work.

IB praised the report and sought to understand the primary challenge faced by RDI; CI advised that recruitment into key areas remains the biggest source of challenge. He praised the step taken by MP to be the first Chief Medical Officer to include supporting professional activities (SPA's) dedicated to research within consultant job plans, linked to demonstrable outputs. However, he emphasised the need for clinicians to promote this more widely.

AGENDA ITEM	DISCUSSION	ACTION

MP highlighted the requirement to provide the necessary vehicles to enable consultants to deliver research and opening avenues for staff by providing one SPA within the job plan, in furtherance of the Trust's ambition to be a research based healthcare organisation.

BB commended the report and suggested that it would be helpful if future reports included progress and challenges related to nurse research. CI agreed and acknowledged the considerable work undertaken by allied health professionals.

BS applauded the report. The Chairman concurred and queried whether opportunities for staff to undertake research is promoted within recruitment literature. KM reminded the Board of the discussions at the joint Seminar with the University of Warwick in January, whereupon it was agreed that joint recruitment material would be developed, which is currently in traction. Furthermore, details of the Trust's achievements relating to RDI are provided via links to the website within recruitment adverts.

In response to a query from EMS regarding whether the key performance indicators relating to RDI within the Integrated Quality, Finance and Performance Report are the right areas of focus, CJ confirmed that she would feed into the next report to Board to ensure that these responsive.

The Trust Board **NOTED** the work that has been achieved around the research, development and innovation agenda and **AGREED** the future developments as set out in the report.

HTB 16/117 **QUALITY GOVERNANCE COMMITTEE TERMS OF REFERENCE**

MP presented the revised terms of reference for the Quality Governance Committee for approval.

In line with the Trust Board Code of Conduct and Statement of Responsibilities, Trust Board Committees will only carry out board level work, and the review that has been undertaken has focused upon ensuring that this is the case, and upon implementing the recommendations made in the Committee Review undertaken in 2015.

The main changes relate to membership in that only members of the Trust Board are members of the Committee; a number of officers with specific responsibilities are however in attendance to support the discussion and debate. In addition, it is proposed that specific areas are delegated to the Quality Governance Committee (QGC) by the Trust Board, to ensure that there is clarity around reporting lines and authority in terms of approval. The quorum for the Committee equates to the quorum for the Trust Board and as such, approval of the items delegated is appropriate in governance terms. In the interests of transparency, any approvals given by QGC will be reported to the Trust Board in the meeting that follows through the usual Committee Chair's Report.

EMS acknowledged the detailed work undertaken to revise the annual work plan, with the main focus being on eliminating duplication between the work of the Trust Board and the work of the Committee and commended this. EMS also confirmed that the work plan was approved at QGC in May.

AGENDA ITEM	DISCUSSION	ACTION

It was noted that some former QGC items will now report directly to the Trust Board because they relate to annual objectives or key priorities and other items have been delegated to the Committee rather than being received by the full Trust Board. This should result in the Trust Board agenda being driven by the agreed objectives and the risks to achieving these.

EMS confirmed that following debate at QGC and revision of the Integrated Quality, Finance and Performance Report, QGC will continue to receive the report in the new distilled form.

The Trust Board **NOTED** the proposed changes to the terms of reference and the specific areas that have been delegated to the Committee, and **DELEGATED AUTHORITY** to the Committee to oversee those areas and **APPROVED** the terms of reference.

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HTB 16/118 **TRUST SEAL REGISTER 2015/16**

The common seal of the Trust is affixed when a document needs to be executed as a deed as opposed to a simple contract. Affixation is governed by the Trust's Standing Orders, which dictate that a report detailing the usage of the seal shall be periodically submitted to the Trust Board. The report set out the usage of the common seal of the Trust during the year 2015/16.

The Trust Board **NOTED** the usage of the common seal of the Trust 2015/16.

HTB 16/119 **MATTERS DELEGATED TO BOARD COMMITTEES**

It was agreed that an emergency care pathway update including the outputs of the ongoing work with ECIP will be presented to the Finance and Performance Committee in July.

HTB 16/120 **FINANCE AND PERFORMANCE COMMITTEE MEETING MONTHLY REPORT 10 MAY 2016**

The Trust Board members noted the meeting report of 10 May 2016 and there were not questions raised.

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

HTB 16/121 **QUALITY GOVERNANCE COMMITTEE MONTHLY REPORT 16 MAY 2016**

The Trust Board members noted the meeting report of 16 May 2016 and there were not questions raised.

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

HTB 16/122 **ANY OTHER BUSINESS**

There were no other matters raised by Trust Board Members.

HTB **QUESTIONS FROM MEMBERS OF THE PUBLIC**

AGENDA ITEM	DISCUSSION	ACTION
16/123	In response to a question from a member of the public regarding closure of the Paybody Unit and the provision of intermediate care services; AH advised that at the time of decommission, the land which housed Paybody Unit was not considered for the purposes of intermediate care. He added that a significant development now exists adjacent to the land which housed Paybody Unit and is utilised by the Trust.	
HTB 16/124	**DATE OF THE NEXT MEETING** The next Public Trust Board will be held on Thursday 30 June at 10.00am 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
30 JUNE 2016

AGENDA ITEM 6 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	June 2016	Deferred to allow due process/consultation to be followed. Current policy is already closely aligned to the national policy in any event and changes will be minor,	No
ACTIONS FROM NOVEMBER 2015 MEETING					
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 FEBRUARY 2016 MEETING					
HTB/16/048 QUESTIONS FROM MEMBERS OF THE PUBLIC	In response to a question from a member of the public regarding what revenue the Trust receives from treating visiting European Union (EU) nationals and non-EU nationals. DM confirmed that he would be happy to provide this information within his presentation at the AGM in July.	DM	July 2016	Not due until AGM	No

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST
ACTION MATRIX PUBLIC TRUST BOARD MEETINGS
30 JUNE 2016

AGENDA ITEM 6 ENCLOSURE 2

ACTIONS FROM JUNE 2016 MEETING					
HTB 16/115 INTEGRATED QUALITY, PERFORMANCE AND FINANCE REPORT (IQPFR)	It was agreed that an emergency care pathway update including the outputs of the ongoing work with ECIP will be presented to the Finance and Performance Committee in July.	DE	July 2016	F&P Committee meeting administrator emailed 8.6.16 to schedule on agenda for July	Yes

AGENDA ITEM 7 ENCLOSURE 3

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST

REPORT TO THE TRUST BOARD: PUBLIC

30 JUNE 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:

- Board Walk-round in the Arden Cancer Centre
- Board Walk-round in the Children's Emergency Department
- Chairs and Chief Executives Network meeting
- Virginia Mason Institute (VMI) National Sharing and Learning Event
- Chairs dinner with Sir Mike Aaronson (former Chair of Frimley Park Hospitals)

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 8 ENCLOSURE 4

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST

REPORT TO THE TRUST BOARD: PUBLIC

30 June 2016

Subject:	Chief Executive Officer's 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:

- Coventry & Warwickshire Sustainability & Transformation Programme Board
- VMI Transformation Guiding Board Meeting
- Independent Review of Healthwatch Warwick – Stakeholder Workshop
- 2016 NHS Confederation Annual Conference

Consultant Appointments

The Trust has made the following Consultant appointments since the last Trust Board Meeting (3 June 2016):

- Mr. Daniel Westacott – Paediatric Orthopeadic Consultant
- Mr. Antonio Martin-Ucar – Consultant Thoracic Surgeon
- Dr. Penelope Kechagioglou – Consultant Clinical Oncologist

Policy Issues and Publications:

No publications for noting.

AGENDA ITEM 8 ENCLOSURE 4

UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST

REPORT TO THE TRUST BOARD: PUBLIC

30 June 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 2 – 2016/17**
Author	**Miss. Lynda Cockrill, Head of Performance and Programme Analytics**
Responsible Chief Officer	**Mrs. Karen Martin, Chief Workforce and Information Officer**
Date	**30th June 2016**

1. Purpose

To inform the Board of the performance against the key performance indicators for the month of May 2016.

2. Narrative

The attached Integrated Quality, Performance & Finance Report covers the reported performance for the period ending 31st May 2016.

In the Trust Board Scorecard, 22 KPIs achieved the target.

Key indicators in breach are the Trusts performance against:

- the 4 hour A&E target;
- Referral to Treatment incomplete standards (including a breach of the RTT 52 week wait standard)
- 62 day urgent referral to treatment cancer standard.

Key indicators achieving the target include:

- MRSA bacteremia and Clostridium Difficile
- the staff sickness rate

The Trust is reporting a £0.6m forecast control total surplus against a plan of £1.1m in Month 2.

The Trust is forecasting delivery of £19.2m against £19.5m of potentially identified savings. This gives a potential forecast under-delivery of £5.5k against the Trust internal target of £24.6m for 2016/17.

3. Areas of Risk

As detailed in the performance trends pages

4. Recommendations

The Board is asked to confirm their understanding of the contents of the May 2016 Integrated Quality, Performance and Finance Report and note the associated actions.

Name and Title of Author: Miss. Lynda Cockrill, Head of Performance and Programme Analytics

Date: 30th June 2016

University Hospitals Coventry and Warwickshire NHS Trust

Integrated Quality, Performance and Finance Reporting Framework

Reporting period: May 2016

Contents

Executive Summary

University Hospitals Coventry and Warwickshire NHS Trust

22 KPIs achieved the target in May

	Indicators achieved	Indicators in exception	Indicators in watching status	Total indicators
Excellence in Patient care and experience	17	15	4	36
Delivery of value for money	1	4	0	5
Employer of choice	3	2	2	7
Leading research based health care organisation	0	3	0	3
Leading training and education centre	1	1	0	2
All domains	**22**	**25**	**6**	**53**

KPI Hotspot

What's Good?

- MRSA bacteremia – Trust Acquired
- Sickness rate
- Complaints turnaround <= 25 days

What's Not So Good?

- A&E 4 hour wait
- RTT 52 week wait
- Never event

The Trust's overall performance has deteriorated this month. Underperformance continues against targets related to aspects of the emergency pathway (A&E waiting times and delayed transfers of care) and the elective pathway targets including RTT incomplete pathways and last minute non-clinical cancelled operations. There has also been a second breach of the RTT 52 week wait standard this month. The 62 day urgent referral to treatment performance failed to meet the 85% standard this month, with the majority of breaches in the Head and Neck or Urological pathways. Further detail for all cancer standards is described later in this report.

The Trust continues to deliver against the infection control targets (MRSA bacteremia and Clostridium Difficile). The progress against the staff sickness rate KPI has been maintained this month with performance of 3.86% being reported against a target of 4%.

There has been a reported never event in May relating to wrong route administration of medication. This declaration means that the target for the Trust to have zero never events for the year has been breached.

The KPI pertaining to doctors provisionally trained has been removed from the scorecard this month. This is due to a revision to the indicator which will in future reflect the number of doctors that are fully accredited.

The Vacancy rate compared to funded establishment indicator has improved this month, although remains above the target of 10%. This is reflected in the agency costs against total costs which has decreased from 10.05% to 9.19%. There has also been a reduction across the board in all agency usage. Further information on workforce and the delivery of the Value for Money KPIs can be found the Finance and Workforce section of this report.

Trust Scorecard
Reporting Month May 2016

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

DoT
Improving
No change
Falling

University Hospitals Coventry and Warwickshire NHS Trust

Performance Summary

Trust Board Scorecard								
Measure	Previous Position	Latest Position	DoT	YTD Plan	Annual Target	Annual FOT	Executive Lead	Trend
Excellence in patient care and experience								
Patient Outcomes								
Clostridium Difficile - Trust Acquired - Cumulative	2	5	↓	6	42	42	CNO	
MRSA Bacteremia - Trust Acquired - Cumulative	0	0	→	0	0	0	CNO	
Serious Incidents - Number	9	13	↓	15	15	15	CMO	
Never Events - Cumulative	0.0	1.0	↓	0	0	1	CMO	
Same Sex Accommodation Breaches	0	0	→	0	0	0	CNO	
HSMR - Basket of 56 Diagnosis Groups	99.0	93.3	↑	RR	RR	RR	CMO	
Harm Free Care	96.7%	95.8%	↓	95%	95%	95%	CNO	
Patient Experience								
Friends & Family Test Inpatient Recommenders	87.2%	88.9%	↑	95%	95%	95%	CMO	
Friends & Family Test A&E Recommenders	81.5%	80.1%	↓	87%	87%	87%	CMO	
Complaints per 1000 Occupied Bed Days	1.63	1.55	↑	0.99	0.99	0.99	CMO	
Complaints Turnaround <= 25 Days (1 month in arrears)	85%	98%	↑	90%	90%	90%	CMO	
Theatres								
Theatre Lists Started within 15 mins of Start Time	34.6%	37.9%	↑	75%	75%	75%	CMO	
Surgical Safety Checklist - WHO	100.00%	99.97%	↓	100%	100%	100%	CMO	
Emergency Care and Patient Flow								
A&E 4 Hour Wait	80.2%	80.9%	↑	95%	95%	95%	COO	
12 Hour Trolley Waits in A&E	0	0	→	0	0	0	COO	
Ambulance Turnaround within 30 minutes	80.9%	82.5%	↑	100%	100%	100%	COO	
Delayed Transfers as a Percentage of Admissions	5.4%	5.7%	↓	3.5%	3.5%	3.5%	COO	
30 Day Emergency Readmissions (1 month in arrears)	8.1%	8.3%	↓	8.68%	8.68%	8.68%	COO	
Number of Medical Outliers - Average per Day	64	70	↓	50	50	50	COO	
Length of Stay - Average	7.3	7.2	↑	5.96	5.96	5.96	COO	
Bed Occupancy Rate - KH03 (3 months in arrears)	98.3%	98.3%	→	93%	93%	93%	COO	
Elective Care								
Last Minute Non-clinical Cancelled Operations - Elective	1.2%	1.3%	↓	0.8%	0.8%	0.8%	COO	
Breaches of the 28 Day Readmission Guarantee	11	7	↑	0	0	18	COO	
18 Weeks Referral to Treatment Time - Incomplete (1 month in arrears)	89.7%	89.3%	↓	92%	92%	92%	COO	
RTT 52 Week Waits Incomplete (1 month in arrears)	1.0	1.0	→	0	0	0	COO	
Referral to Treatment Incomplete - Backlog Size (1 month in arrears)	2685	2888	↓	2087	2087	2087	COO	
Diagnostic Waiters - 6 Weeks and Over	0.79%	0.47%	↑	1%	1%	1%	COO	

Trust Scorecard
Reporting Month May 2016

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

DoT
Improving
No change
Falling

University Hospitals Coventry and Warwickshire NHS Trust

Performance Summary

Trust Board Scorecard								
Measure	Previous Position	Latest Position	DoT	YTD Plan	Annual Target	Annual FOT	Executive Lead	Trend
Excellence in patient care and experience								
Cancer Standards								
Cancer 2 Week Wait GP Referral to OP Appointment (1 month in arrears)	96.6%	95.1%	↓	93%	93%	93%	COO	
Cancer 2 Week Wait Breast Symptom (1 month in arrears)	100.0%	100.0%	→	93%	93%	93%	COO	
Cancer 31 Day Diagnosis to Treatment (1 month in arrears)	97.6%	99.5%	↑	96%	96%	96%	COO	
Cancer 31 Day Subsequent Surgery Standard (1 month in arrears)	100.0%	96.1%	↓	94%	94%	94%	COO	
Cancer 31 Day Subsequent Drug Standard (1 month in arrears)	100.0%	100.0%	→	98%	98%	98%	COO	
Cancer 31 Day Subsequent Radiotherapy Standard (1 month in arrears)	96.3%	94.5%	↓	94%	94%	94%	COO	
Cancer 62 Day Urgent Referral to Treatment (1 month in arrears)	85.6%	76.6%	↓	85%	85%	85%	COO	
Cancer 62 Day Screening Standard (1 month in arrears)	96.6%	100.0%	↑	90%	90%	90%	COO	
Cancer 104 Day Waits - TDA Measure (1 month in arrears)	10.5	3.5	↑	0	0	0	COO	
Deliver value for money								
Liquidity Days	-21.6	-21.1	↑	-20.8	-24.7	-24.6	CFSO	
Capital Services Capacity	1.4	1.0	↓	1.6	1.6	2	CFSO	
Income & Expenditure Margin	1	1	→	-1.2	1.1	3	CFSO	
Forecast Income & Expenditure Compared to Plan - £'000	668	600	↓	1100	1100	600	CFSO	
CIP Delivery - £'000	1514	2850	↑	3316	24612	19167	CFSO	
Agency expenditure as a % of pay bill	10.1%	9.2%	↑	TBC	TBC	TBC	CWIO	
Employer of choice								
Personal Development Review - Non-Medical	88.40%	87.94%	↓	90%	90%	90%	CWIO	
Personal Development Review - Medical	75.05%	72.71%	↓	90%	90%	90%	CWIO	
Mandatory Training Compliance	88.41%	88.39%	↓	95%	95%	95%	CWIO	
Sickness Rate	3.88%	3.86%	↑	4%	4%	4%	CWIO	
Staff Turnover Rate	9.07%	9.00%	↑	10%	10%	10%	CWIO	
Vacancy Rate Compared to Funded Establishment	15.07%	14.78%	↑	10%	10%	10%	CWIO	
Staff Survey - Recommending as a Place of Work	71.39%	71.39%	→	57.8%	57.8%	57.8%	CWIO	
Leading research based health care organisation								
Patients Recruited into NIHR Portfolio - Cumulative (2 months in arrears)	4089	4372	↑	5015	5015	5015	CMO	
Commercial Income Invoiced £000s - Cumulative (1 month in arrears)	930	69	↓	100	1200	1200	CMO	
Peer Reviewed Publications - Calendar Year Cumulative (3 months in arrears)	0	3	↑	11	197	197	CMO	
Leading training and education centre								
No of Specialties at HEWM Level 3 and 4	2	2	→	0	0	0	CMO	
Job Evaluation Survey Tool Score - JEST (1 month in arrears)	3.7	3.6	↓	3.5	3.5	3.5	CMO	

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.

Performance Trends

University Hospitals Coventry and Warwickshire NHS Trust

Improving

(3 months consecutive improvement)

Measure	Target	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
Sickness Rate	4%	3.97%	4.14%	4.01%	4.27%	4.56%	4.69%	4.86%	4.8%	4.51%	4.25%	3.9%	3.9%
Cancer 2 Week Wait Breast Symptom (1 month in arrears)	93%	94.7%	77.1%	78.4%	93.5%	98.7%	100.0%	96.2%	98.2%	98.7%	100.0%	100.0%	
Breaches of the 28 Day Readmission Guarantee	0	5	10	4	1	5	10	7	8	22	13	11	7

- The progress against the staff sickness rate KPI has been maintained this month
- 172 patients were seen in April who had been referred as Cancer 2 Week Wait Referred patients for Breast Symptoms. All were seen within the 14 day target
- There has been an improving trend in the number of patients whose operation was cancelled, by the hospital, for non-clinical reasons, on the day of or after admission, who were not rescheduled within 28 days. This month T&O and Specialist Medicine and Ophthalmology reported zero patients breaching this target

Deteriorating

(green indicators worsening)

(3 months consecutive deterioration)

Measure	Target	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
Cancer 2 Week Wait GP Referral to OP Appointment (1 month in arrears)	93%	96.6%	93.4%	93.3%	96.5%	97.2%	98.6%	98.2%	96.5%	98.1%	96.6%	95.1%	

- The tumour sites with the highest numbers of breaches were Head and Neck and Urological which are primarily due to a lack of capacity. Additional sessions are being provided to attempt to clear the backlog

Deteriorating

(red indicators worsening)

(3 months consecutive deterioration)

Measure	Target	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
Friends & Family Test A&E Recommenders	87%	83.50%	87.20%	86.40%	84.20%	85.50%	84.70%	83.80%	82.70%	82.60%	83.20%	81.50%	80.10%

- Although the Friends and Family test A&E recommender KPI isn't in exception, the target has not been met since July 2015 and there has been a downward trend for the past three months. The main issues raised through FFT in April for A&E related to communication, discharge processes and parking

Failed Year End Target

Measure	Target	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
Never Events	0	0	0	0	0	0	1	1	2	3	3	0	1

- A never event has been declared in May 2016. This relates to wrong route administration of medication and is being investigated by the Deputy Chief Nursing Officer with an RCA meeting scheduled for 8 June

Trust Heatmap

University Hospitals Coventry and Warwickshire NHS Trust

Performance Summary

Reporting Period:															May 2016	
Measure	Cardiac & Respiratory	Renal	Emergency	Neuro sciences	Oncology & Haematology	Surgery	Trauma & Orthopaedics	Women & Children	Specialist Medicine and Ophthal.	Theatres and Anaesthetics	Care Elderly Acute Medicine	Imaging	Hospital of St Cross	Clinical Support Services	Pathology	Trust	Trust Target
Group Level Indicators																	
Excellence in patient care and experience																	
Clostridium Difficile - Trust Acquired - Cumulative	2	2		0	0	0	0	0	1	0	0		0			5	6
MRSA Bacteremia - Trust Acquired - Cumulative	0	0		0	0	0	0	0	0	0	0		0			0	0
Never Events - Cumulative	0.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0		0.0			1.0	0
HSMR - Basket of 56 Diagnosis Groups	67.8	84.2		86.8	100.0	89.5	140.0	192.7	107.7		68.0					93.3	100
Harm Free Care	96.2%	92.7%	100.0%	98.3%	91.5%	100.0%	96.1%	99.2%	91.2%	88.9%	93.3%		90.4%			95.8%	95%
Friends & Family Test Inpatient Recommenders	94.8%	85.1%	77.9%	84.2%	96.9%	87.4%	94.5%	95.7%	72.7%		85.5%					88.9%	95%
Friends & Family Test A&E Recommenders			75.0%						81.0%							80.1%	87%
Complaints per 1000 Occupied Bed Days	0.55	2.19	10.53	1.18	1.42	1.17	2.38	1.28	4.10	1.12	0.00		0.35			1.55	0.99
Complaints Turnaround <= 25 Days (1 month in arrears)	100%	50%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	98%	90%
Theatre Lists Started within 15 mins of Start Time	70.5%	17.7%		19.6%		34.3%	59.0%	56.1%	4.4%	50.0%						37.9%	75%
Surgical Safety Checklist - WHO	100.00%	100.00%		100.00%		100.00%	100.00%	99.44%	100.00%	100.00%						99.97%	100%
30 Day Emergency Readmissions (1 month in arrears)	6.4%	11.0%		5.6%	2.3%	7.9%	3.6%	9.1%	8.5%	0.0%	10.7%					8.3%	8.68%
Number of Medical Outliers - Average per Day	2	20		N/A	N/A	4	N/A	N/A	13		29		N/A			70	50
Last Minute Non-clinical Cancelled Operations - Elective	0.4%	0.0%		3.8%	0.0%	1.8%	2.6%	1.4%	1.1%	0.0%						1.3%	0.8%
Breaches of the 28 Day Readmission Guarantee	0	N/A		1	N/A	6	0	0	0	N/A						7	0
18 Weeks Referral to Treatment Time - Incomplete (1 month in arrears)	95.8%	97.5%		93.2%	98.1%	85.2%	84.0%	93.0%	91.5%	97.4%	100.0%					89.3%	92%
RTT 52 Week Waits Incomplete (1 month in arrears)	0.0	0.0		0.0	N/A	1.0	0.0	0.0	0.0	N/A	0.0					1.0	0
Referral to Treatment Incomplete - Backlog Size (1 month in arrears)	88	6		157	5	1387	540	157	529	18	0					2888	2087
Diagnostic Waiters - 6 Weeks and Over	3.07%			0.00%		3.44%						0.04%				0.47%	1%
Cancer 2 Week Wait GP Referral to OP Appointment (1 month in	97.9%			100.0%	100.0%	94.3%	100.0%	97.7%	96.5%							95.1%	93%
Cancer 31 Day Diagnosis to Treatment (1 month in arrears)	100.0%			100.0%	100.0%	99.1%		100.0%	100.0%							99.5%	96%
Cancer 31 Day Subsequent Surgery Standard (1 month in arrears)	100.0%			100.0%	N/A	94.1%		100.0%	100.0%							96.1%	94%
Cancer 31 Day Subsequent Drug Standard (1 month in arrears)	100.0%			N/A	100.0%	100.0%		100.0%	N/A							100.0%	98%
Cancer 31 Day Subsequent Radiotherapy - Group (1 month in arrears)	100.00%			100.00%	100.00%	94.29%		90.00%	83.33%							94.48%	94%
Cancer 62 Day Urgent Referral to Treatment (1 month in arrears)	85.0%			N/A	75.0%	71.8%		56.3%	100.0%							76.6%	85%
Cancer 62 Day Screening Standard (1 month in arrears)						100.0%		N/A								100.0%	90%

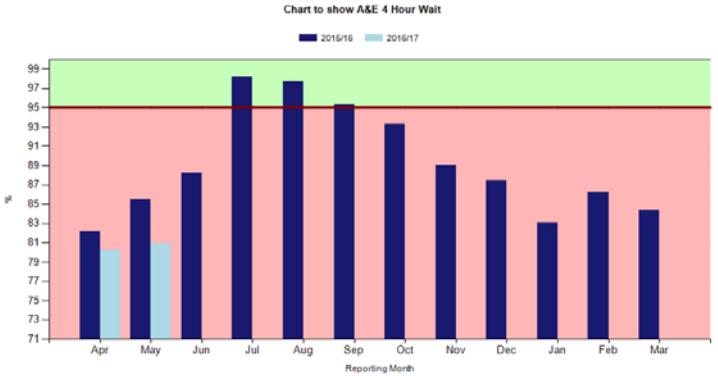
Trust Heatmap

University Hospitals Coventry and Warwickshire NHS Trust

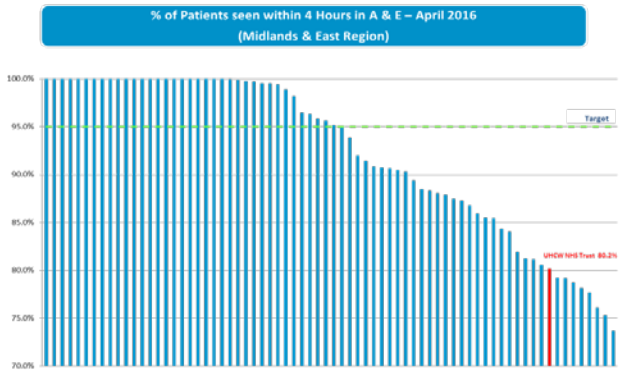
Measure	Cardiac & Respiratory	Renal	Emergency	Neuro sciences	Oncology & Haematology	Surgery	Trauma & Orthopaedics	Women & Children	Specialist Medicine and Ophthal.	Theatres and Anaesthetics	Care Elderly Acute Medicine	Imaging	Hospital of St Cross	Clinical Support Services	Pathology	Trust	Trust Target
												Reporting Period:			May 2016		
Group Level Indicators																	
Deliver value for money																	
Agency expenditure as a % of pay bill	10.5%	25.4%	12.3%	18.2%	6.7%	11.6%	2.9%	1.0%	8.8%	6.9%	25.9%	10.0%	-1.6%	6.0%	11.1%	9.2%	
Employer of choice																	
Personal Development Review - Non-Medical	85.02%	91.55%	89.43%	92.30%	91.55%	93.37%	94.68%	92.52%	75.74%	88.92%	81.71%	85.97%	94.97%	84.17%	83.10%	87.94%	90%
Personal Development Review - Medical	65.79%	85.71%	72.41%	63.89%	80.00%	69.39%	71.43%	80.00%	62.30%	79.75%	64.29%	68.18%			95.45%	72.71%	90%
Mandatory Training Compliance	91.12%	93.47%	88.56%	89.85%	93.43%	91.98%	91.46%	93.63%	90.06%	95.60%	93.82%	94.09%	93.66%	94.42%	86.10%	88.39%	95%
Sickness Rate	2.08%	3.70%	4.51%	2.88%	4.56%	3.49%	2.05%	4.88%	4.47%	4.18%	2.93%	2.46%	2.97%	5.30%	6.12%	3.86%	4%
Staff Turnover Rate	8.21%	5.38%	8.50%	8.42%	7.54%	6.62%	7.05%	9.08%	16.92%	3.20%	6.22%	9.74%	10.00%	12.39%	12.72%	9.00%	10%
Vacancy Rate Compared to Funded Establishment	16.78%	18.70%	18.20%	22.46%	16.87%	14.28%	15.19%	12.73%	12.99%	10.41%	28.91%	11.46%	18.01%	8.38%	16.83%	14.78%	10%
Staff Survey - Recommending as a Place of Work	84.13%	73.91%	74.42%	79.03%	61.97%	76.19%	87.84%	71.58%	80.00%	75.00%	80.00%	50.00%	76.92%	71.32%	46.43%	71.39%	57.8%
Leading research based health care organisation																	
Patients Recruited into NIHR Portfolio - Cumulative (2 months in arrears)	95	73		6	527	1438	508	1043	185	37	4		0	0		4372	5015
Peer Reviewed Publications - Calendar Year Cumulative (3 months in	1	0	0	0	0	0	0	0	0	0	0	1	0	0	0	3	11
Leading training and education centre																	
No of Specialties at HEWM Level 3 and 4	0	1	0	0	0	0	0	0	0	0	1	0			0	2	0
Job Evaluation Survey Tool Score - JEST (1 month in arrears)	3.5	2.9	3.9	3.6	4.1	3.4	3.9	3.8	3.6	3.9	3.3	3.5			4.3	3.6	3.5

Group summary of performance – A&E and associated FREED metrics

University Hospitals Coventry and Warwickshire NHS Trust



The Trust continues to struggle with performance around the 4 Hour A&E Standard and for May posts a below standard performance of 80.91%. Patient attendances at A&E have not been above average and admissions through A&E are slightly below average, however, overall discharge performance was poor.



The Trust takes its performance very seriously and is striving to improve its standing through numerous initiatives internally as well as in conjunction with our community partners. An action plan has been constructed to recover ED performance which includes;

The establishment of an Emergency Care Pathway Recovery Group, which amongst other aspects will look at:

- Improving discharge performance across all areas and by working with partners to reduce DTOC
- Fully establish and evolve the Trust's UH@Home Service
- Further improve the Ambulatory Service to divert patients away from ED and avoid admission
- Better management of patients with a greater than 14 days stay
- With partners, establish a frailty service that seeks to reduce the conveyance of this group to hospital and where they are conveyed, avoid their admission or reduce their length of stay

Patient Flow metrics

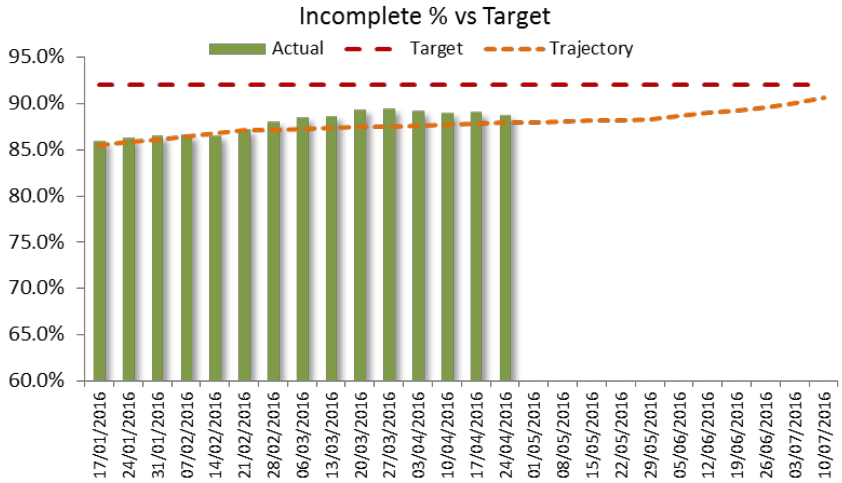
Measure	Target	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
Number of Medical Outliers - Average per Day	50	76	30	29	48	58	54	74	88	69	65	64	70
Diagnostic Waiters - 6 Weeks and Over	1%	0.04%	0.02%	0.11%	0.05%	0.07%	0.07%	0.20%	0.57%	0.57%	0.59%	0.79%	0.47%
Last Minute Non-clinical Cancelled Operations - Elective	0.8%	0.8%	0.9%	0.8%	0.5%	0.9%	0.9%	0.8%	2.0%	1.1%	0.8%	1.2%	1.3%
Length of Stay - Average	6.0	7.5	7.1	6.3	6.5	6.5	6.7	7.6	6.9	7.4	7.1	7.3	7.2

Neurosciences had the highest percentage of cancelled operations (3.8%) in May. These were primarily due to bed availability on the wards. Trauma & Orthopaedics (2.6%), Surgery (1.8%) Women & Children (1.4%) and Specialist Medicine & Ophthalmology (1.1%) were also groups not achieving the 0.80% target.

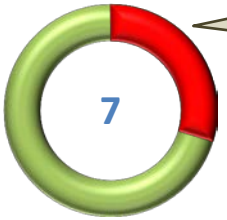
There has been an overall increase in the numbers of patients awaiting diagnostic tests with a month end position of 10,469, the highest ever reported for the Trust.

The Surgery and Theatres groups were able to identify further theatre time to address some of the capacity issues for cystoscopies reported last month, however this test continues to have the highest number of breaches of the 6 weeks and over target.

Group summary of performance – Referral To Treatment

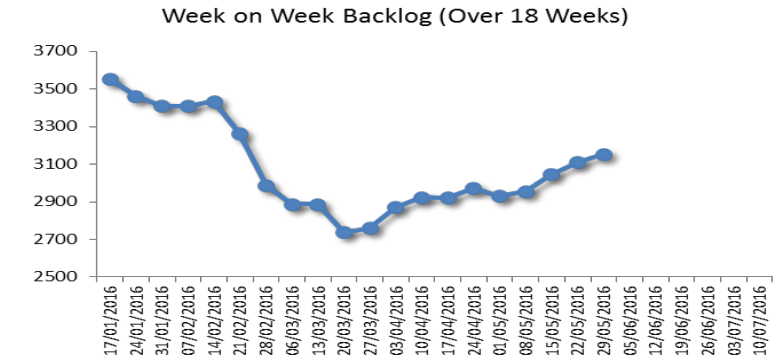


7 out of 10 groups achieved the incomplete target



Underperforming groups
- Trauma & Orthopaedics (84.0%)
- Surgery (85.2%)
- Specialist Medicine and Ophthalmology (91.5%)

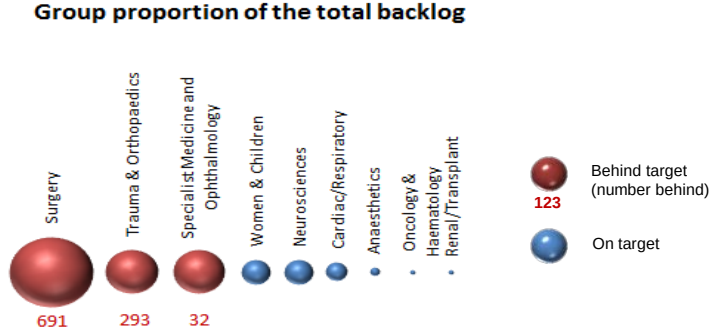
The delivery against the RTT incomplete target has plateaued in April with the Trust reporting 89.3% against the 92% target. The Trust did meet the monthly target of 88.3% against the NHSI improvement trajectory that was submitted earlier in the year. Due to revisions in the reporting rules for RTT, which no longer allows for suspensions, there is a risk that the Trust may not meet the NHSI target next month (May's submitted data).



The backlog has increased this month with the Surgery group having the largest proportion of the Trust's total. Surgery is 691 patients behind its internal target that has been set to reduce the backlog to a sustainable level.

Sustained focus by the clinical groups on increased capacity and comprehensive action plans are in place to support progress against this standard.

Performance and delivery is monitored through the weekly Access meeting with plans and patient level detail discussed each week. In addition, theatres management and other key operational issues are raised weekly to aid resolution in reducing lost theatre capacity and improving key blockages to RTT delivery.



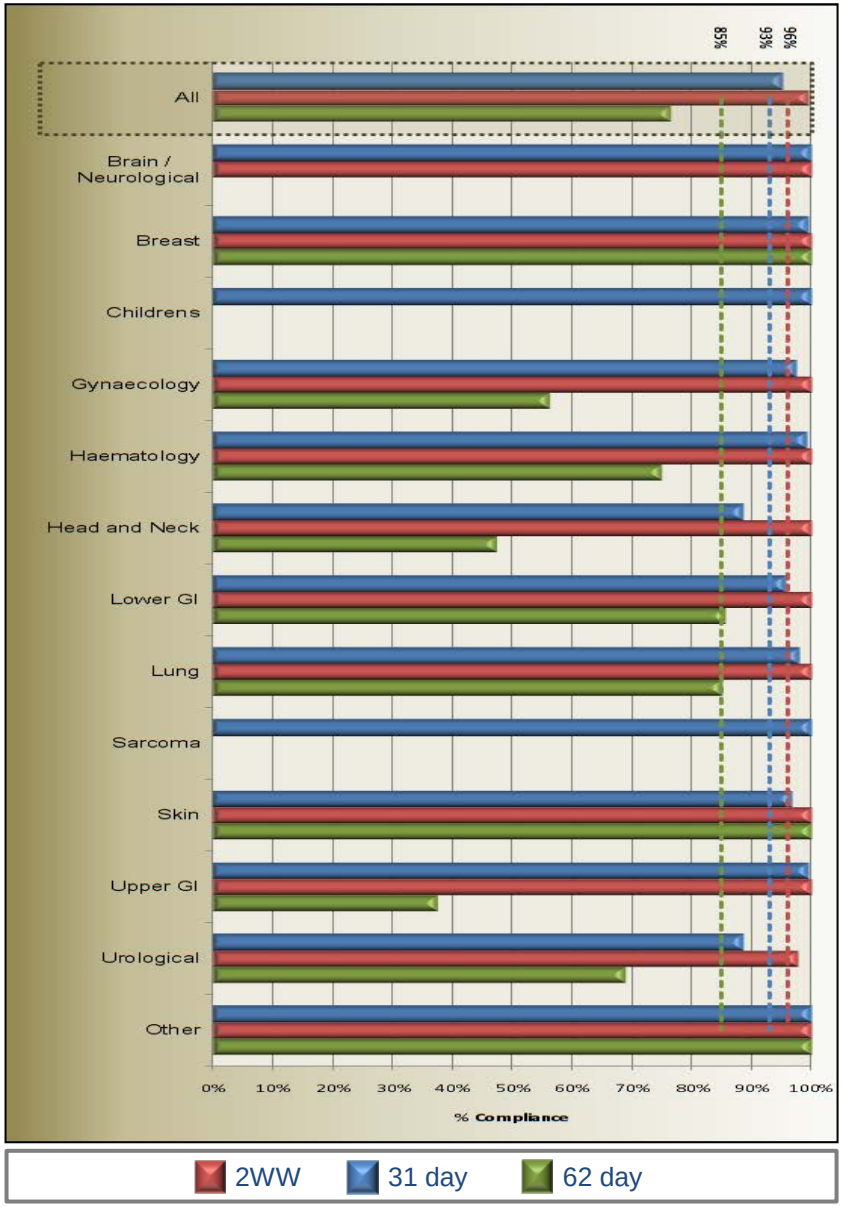
The Trust has reported a 52 week incomplete pathway breach in April which was found during a validation exercise. This breach was discussed with the TDA/NHSI at the time of identification.

The change in reporting rules relating to suspensions is also having an impact on the number of 52 week wait patients the Trust is seeing.

Group summary of performance – cancer standards

University Hospitals Coventry and Warwickshire NHS Trust

Performance against cancer standards by tumour site



In April 2016 the Trust achieved 7 of the 8 national cancer standards.

The 62 Day Cancer Waiting Times Standard was not achieved with 76.6% of patients treated against the 85% standard.

The Trust achieved 100% for Two Week Wait Breast Symptomatic and for the 62 day national screening programme standards.

104+ day target not met

6 breaches (7 patients) of the target:

- 2 Head & Neck
- 0.5 Lower GI
- 1 Lung
- 2.5 Urological

62 day time from urgent GP referral to treatment standard not met for the month of April

There were 21.5 breaches of the 62 day standard during April:

- 3.5 Gynaecology
- 1 Haematology
- 5 Head and Neck
- 1.5 Lower GI
- 1.5 Lung
- 2.5 Upper GI
- 6.5 Urological

April 2016 performance

Standard:	Apr-16	DoH Tolerance
TWW suspected cancer	95.1	93%
TWW breast symptomatic	100	93%
31 day - 1st treatment	99.5	96 %
31 day - subsequent treatment -surgery	96.1	94%
31 day - subsequent treatment -chemo	100	98%
31 day - subsequent treatment - radio	94.5	94%
31 day - subsequent treatment - other	100	No tolerance set
31 day - rare cancers	100	No tolerance set
62 day - 1st treatment	76.6	85%
62 day - national screening programme	100	90%
62 day - consultant upgrade	93.9	CCG tolerance = 85%
62 day - treated on or after day 100+	6	CCG Tolerance = 0
62 day - treated on or after day 105+	3.5	NHSI tolerance = 0

Quality and Safety Summary

University Hospitals Coventry and Warwickshire NHS Trust

This section includes the Quality and Safety scorecard which contains all relevant indicators that are included within the overarching Trust scorecard, together with additional pertinent KPIs that enable headline areas such as harm free care to be explored in more detail e.g. with the underpinning pressure ulcer and falls KPIs. Ward staffing information is also included in this section.

Performance against quality and safety indicators has deteriorated slightly this month although more indicators have moved into watching status this month with fewer in exception.

There has been a reported never event in May relating to wrong route administration of medication. This declaration means that the target for the Trust to have zero never events for the year has been breached.

The Surgical Safety Checklist - WHO indicator has been placed in a watching status this month for the first time in twelve months. This is as a result of the process not being completed for one patient. The cause for this is being reviewed.

There has been a decline in all of the indicators relating to harm free care. Actions to address the reasons behind this are being undertaken by the relevant teams.

20 KPIs achieved the target in May

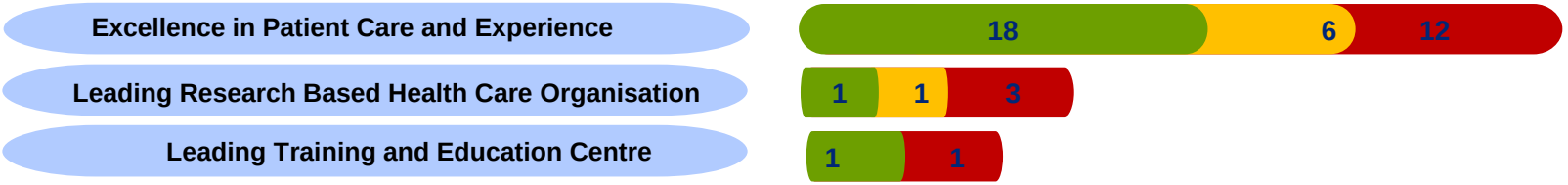
Quality & Safety Scorecard	Indicators achieved	Indicators in exception	Indicators in watching status	Total indicators
Excellence in Patient care and experience	18	12	6	36
Leading research based health care organisation	1	3	1	5
Leading training and education centre	1	1	0	2
All domains	**20**	**16**	**7**	**43**

The Leading Research Based Health Care Organisation KPIs for Trials have been revised according to national changes in definition, which has resulted in an improved position for the Trust.

The two areas that are currently at HEWM level 3 are Acute Medicine and Care of the Elderly. The Deanery are due to visit the Trust in early July.

The KPI pertaining to doctors provisionally trained has been removed from the scorecard this month. This is due to a revision to the indicator which will in future reflect the number of doctors that are fully accredited.

An exercise is being undertaken to review the capture of medical PDRs onto the Electronic Staff Record (ESR) system to ensure alignment with the national NHS Revalidation Management System. This should reflect in an improvement against this indicator in future months.



Trust Scorecard – Quality and Governance Performance Committee

Reporting Month May 2016

University Hospitals Coventry and Warwickshire NHS Trust

Quality and Safety Scorecard								
Measure	Previous Position	Latest Position	DoT	YTD Plan	Annual Target	Annual FOT	Executive Lead	Trend
Excellence in patient care and experience								
Patient Outcomes								
Clostridium Difficile - Trust Acquired - Cumulative	2	5	↓	6	42	42	CNO	
MRSA Bacteremia - Trust Acquired - Cumulative	0	0	→	0	0	0	CNO	
MRSA Decolonisation Score	94.7%	100.0%	↑	95%	95%	95%	CNO	
MRSA - Elective Screening	90.9%	88.7%	↓	95%	95%	95%	CNO	
MRSA - Emergency Screening (MA)	77.9%	83.5%	↑	TBC	TBC	TBC	CNO	
Serious Incidents - Number	9	13	↓	15	15	15	CMO	
Serious Incidents - Overdue	5	13	↓	0	0	0	CMO	
Medication Errors Causing Serious Harm	1	1	→	0	0	0	CMO	
Reported Harmful Patient Safety Incidents (1 month in arrears)	28.2%	25.1%	↑	24.94%	24.94%	24.94%	CMO	
CAS Alerts - Overdue	0	0	→	0	0	0	CMO	
NCE POD Categorised E Deaths - Cumulative (3 months in arrears)	4	4	→	14	15	15	CMO	
Never Events - Cumulative	0.0	1.0	↓	0	0	1	CMO	
Same Sex Accommodation Breaches	0	0	→	0	0	0	CNO	
HSMR - Basket of 56 Diagnosis Groups	99.0	93.3	↑	RR	RR	RR	CMO	
SHMI - Quarterly (6 months in arrears)	106.50	106.50	→	RR	RR	RR	CMO	
Harm Free Care	96.7%	95.8%	↓	95%	95%	95%	CNO	
Pressure Ulcers Grade 3 and 4 - Trust Associated (1 month in arrears)	0	1	↓	0	0	1	CNO	
Falls per 1000 Occupied Bed Days Resulting in Serious Harm	0.1	0.2	↓	0.04	0.04	0.04	CNO	
Eligible Patients Having VTE Risk Assessment (1 month in arrears)	96.2%	95.9%	↓	95%	95%	95%	CNO	
C-UTI	99.9%	99.8%	↓	99%	99%	99%	CNO	
Transfer of Patients at Night (UH to Rugby)	21	31	↓	0	0	0	COO	
Patient Experience								
Friends & Family Test Inpatient Recommenders	87.2%	88.9%	↑	95%	95%	95%	CMO	
Friends & Family Test Inpatient Coverage	25.4%	24.9%	↓	35%	35%	35%	CMO	
Friends & Family Test A&E Recommenders	81.5%	80.1%	↓	87%	87%	87%	CMO	
Friends & Family Test A&E Coverage	13.8%	13.8%	→	20%	20%	20%	CMO	
Maternity FFT No of Touchpoints Achieving a 15% Response Rate	4	4	→	4	4	4	CMO	
Number of Registered Complaints	52	51	↑	33	32	32	CMO	
Complaints per 1000 Occupied Bed Days	1.63	1.55	↑	0.99	0.99	0.99	CMO	
Complaints Turnaround <= 25 Days (1 month in arrears)	85%	98%	↑	90%	90%	90%	CMO	
Theatres								
Surgical Safety Checklist - WHO	100.00%	99.97%	↓	100%	100%	100%	CMO	
National Quality Requirements								
Valid NHS Number - Inpatients (2 months in arrears)	99.4%	99.3%	↓	99%	99%	99%	COO	
Valid NHS Number - A&E (2 months in arrears)	97.7%	97.7%	→	95%	95%	95%	COO	

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

DoT	
↑	Improving
→	No change
↓	Falling

Integrated Quality, Performance and Finance Reporting Framework

Trust Scorecard – Quality and Governance Performance Committee

Reporting Month May 2016

University Hospitals Coventry and Warwickshire NHS Trust

Quality and Safety Scorecard								
Measure	Previous Position	Latest Position	DoT	YTD Plan	Annual Target	Annual FOT	Executive Lead	Trend
Excellence in patient care and experience								
Operational Quality Measures								
12 Hour Trolley Waits in A&E	0	0	→	0	0	0	COO	
Ambulance Turnaround within 30 minutes	80.9%	82.5%	↑	100%	100%	100%	COO	
Ambulance Turnaround within 60 Minutes	99.6%	99.5%	↓	100%	100%	100%	COO	
Urgent Operations Cancelled for the Second Time	0	0	→	0	0	0	COO	
RTT 52 Week Waits Incomplete (1 month in arrears)	1.0	1.0	→	0	0	0	COO	
Leading research based health care organisation								
Patients Recruited into NIHR Portfolio - Cumulative (2 months in arrears)	4089	4372	↑	5015	5015	5015	CMO	
Performance in Initiating Trials - Quarterly	37.5%	54.6%	↑	80%	80%	80%	CMO	
Performance in Delivery of Trials - Quarterly	42.0%	75.0%	↑	80%	80%	80%	CMO	
Research Critical Findings and Serious Incidents - Quarterly	0	0	→	0	0	0	CMO	
Peer Reviewed Publications - Calendar Year Cumulative (3 months in arrears)	0	3	↑	11	197	197	CMO	
Leading training and education centre								
No of Specialties at HEWM Level 3 and 4	2	2	→	0	0	0	CMO	
Job Evaluation Survey Tool Score - JEST (1 month in arrears)	3.7	3.6	↓	3.5	3.5	3.5	CMO	

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.

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

DoT	
↑	Improving
→	No change
↓	Falling

Quality and Safety Summary

Performance Trends

University Hospitals Coventry and Warwickshire NHS Trust

Quality and Safety Summary

Improving

(3 months consecutive improvement)

Measure	Target	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
MRSA Bacteremia - Trust Acquired - Cumulative	0	0	0	0	0	0	0	0	0	0	0	0	0
Same sex accommodation breaches	0	0	0	0	0	0	0	0	0	0	0	0	0
12 Hour Trolley Waits in A&E	0	0	0	0	0	0	0	0	0	0	0	0	0
Urgent Operations Cancelled for a Second Time	0	0	0	0	0	0	0	0	0	0	0	0	0

- This month there are no indicators in the Quality and Safety scorecard that have had a period of improvement for 3 consecutive months. The four indicators highlighted above have notable performance records, achieving their targets for at least the last consecutive twelve months. This should be acknowledged considering the operational pressures the Trust continues to face

Deteriorating

(green indicators worsening)

(3 months consecutive deterioration)

Measure	Target	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
Eligible Patients Having VTE Risk Assessment (1 month in arrears)	95%	96.5%	96.2%	95.4%	95.8%	96.1%	96.3%	96.1%	96.6%	96.5%	96.2%	95.9%	95.9%

- The VTE indicator deteriorated from February to April but has maintained performance in May. It remains within the normal reporting range for this indicator and will be monitored for any further deterioration. Work is being undertaken by the clinical lead to understand the non-compliant patient pathways

Deteriorating

(red indicators worsening)

(3 months consecutive deterioration)

Measure	Target	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
Ambulance Turnaround within 60 minutes	100%	99.60%	99.80%	100.00%	99.90%	99.90%	99.70%	100.00%	99.70%	99.60%	99.80%	99.60%	99.50%
Friends & Family Test A&E Recommenders	87%	83.50%	87.20%	86.40%	84.20%	85.50%	84.70%	83.80%	82.70%	82.60%	83.20%	81.50%	80.10%

- The system has been changed to capture ambulance turnaround times electronically rather than using the manual written process previously used and therefore an improvement should be seen next month as the process becomes embedded. Work has also been undertaken in both the walk-in and ambulance triage areas to improve flow
- Although the Friends and Family test A&E recommender KPI isn't in exception, the target has not been met since July 2015 and there has been a downward trend for the past three months. The majority of issues raised through FFT in April for A&E related to waiting times

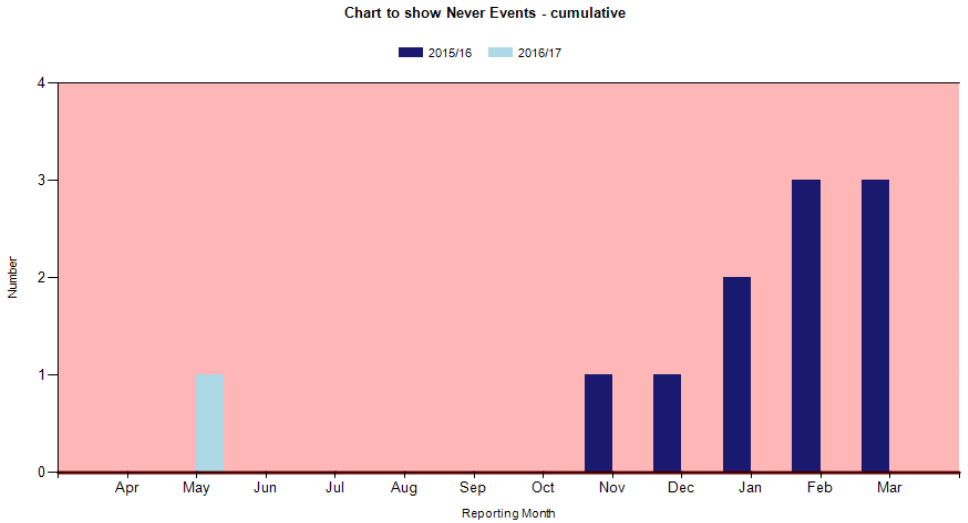
Failed Year End Target

Measure	Target	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
Never Events	0	0	0	0	0	0	1	1	2	3	3	0	1

- A never event has been declared in May 2016. This relates to wrong route administration of medication and is being investigated by the Deputy Chief Nursing Officer with an RCA meeting scheduled for 8 June

Area of underperformance - Never Event

A medication administration never event has been declared in May.



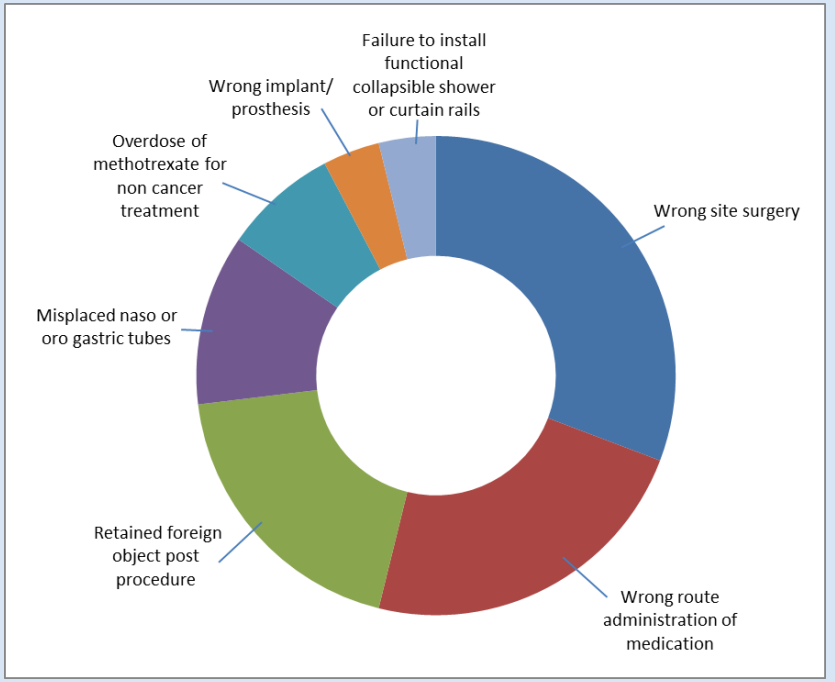
A never event has been declared in May 2016. This relates to wrong route administration of medication involving the accidental administration of 1ml (2mg) of Oramorph solution intravenously instead of a saline flush. The event was noticed and the administration stopped immediately. The patient experienced no harm; they received an explanation and apology from the Trust and was discharged home later that day.

The incident is being investigated by the Deputy Chief Nursing Officer and a root cause analysis investigation meeting is scheduled for 8 June 2016. The investigation report will be reviewed at Significant Incident Group (SIG) in due course. Although we await the outcome of the full RCA, alerts have been sent to all staff and actions taken immediately to change practice. Further actions may be required following the outcomes of the RCA.

This reported event means that the target for the Trust to have zero never events for the year has been breached.

Nationally reported never events by type

The latest figures published by NHS Improvement are for April 2016 and show that the largest proportion of the 26 reported never events across the country are for wrong site surgery (30.8%), closely followed by wrong administration of medication (23.1%) and retained foreign object post procedure (19.2%).



Ward Staffing Levels - Monthly by Trust

Entry Date : May 2016

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)	8248	7942	8230	99.8%	8041	7616	7922	98.5%	6395	5963	6463	101.1%
Health Care Support Worker (HCSW)	4338	4323	4355	100.4%	3679	3670	3684	100.1%	3039	3012	3104	102.1%
Specials	0	321	224		0	321	225		0	322	228	
Specialist Trained Neonatal Nurse	307	296	306	99.7%	296	290	296	100.0%	300	286	301	100.3%
Registered Nurse	82	78	81	98.8%	65	61	64	98.5%	55	53	53	96.4%
Nursery Nurse (NN)	64	59	63	98.4%	75	71	75	100.0%	59	59	59	100.0%
Enhanced Care Team (ECT)	0	87	82		0	79	73		0	93	90	
Total (non Specials)	13039	12785	13117	100.6%	12156	11787	12114	99.7%	9848	9466	10070	102.3%

Ward Staffing Levels - Monthly Ward Scorecard - Exceptions

Entry Month : May 2016

Staff Type : RN,RM,HCSW						
Shift : Early, Late, Night						
Ward	Day RN	Day HCSW	Night RN	Night HCSW	Care Hours Per Patient Day (CHPPD)	
20	97.3%	125.1%	100.8%	133.8%	8.1	Good fill rate despite RN vacancies
21S	97.6%	100.7%	94.7%	100.0%	6.5	Sustained improvement on fill rates
30	99.8%	104.0%	98.9%	124.8%	6.7	Sustained improvement across all domains for fill rates
33 Gastro	101.6%	116.9%	99.0%	129.0%	6.6	Sustained improvement across all domains for fill rates
41	96.4%	88.5%	101.4%	103.4%	6	Sustained improvement with fill rates.
43	86.2%	153.2%	99.0%	151.6%	6.9	Reduced RN fill rates from previous months, high level of RN vacancies.
Total Fill rate	**99.4%**	**107.7%**	**101.7%**	**113.5%**	**8.4**	**Sustained fill rates across days and nights for RN and HCSW**

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.

Finance and Workforce Summary

This section includes the Finance and Performance scorecard which contains all relevant indicators that are encompassed within the overarching Trust scorecard, together with additional pertinent KPIs such as theatre efficiency and utilisation, which underpin the headline indicators. This report highlights areas of compliance and underperformance.

All KPIs reported within the Delivery of Value for Money section are within tolerance of plan. As a result, an escalation report has not been produced for Month 2. Further information has been provided to support areas of significant under-performance i.e. Activity Income and Cost Improvement Plans.

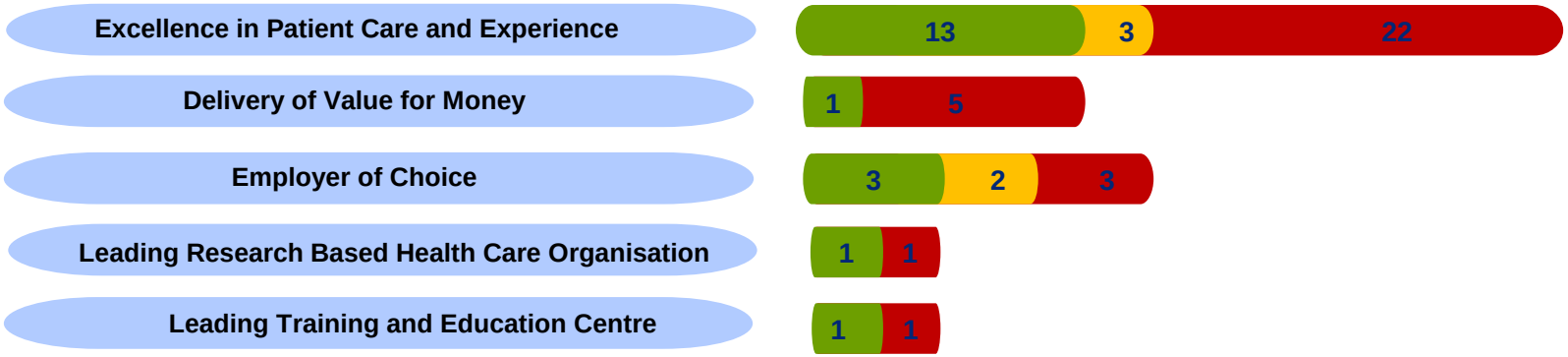
19 KPIs achieved the target in May

	Indicators achieved	Indicators in exception	Indicators in watching status	Total indicators
Excellence in Patient care and experience	13	22	3	38
Delivery of value for money	1	5	0	6
Employer of choice	3	3	2	8
Leading research based health care organisation	1	1	0	2
Leading training and education centre	1	1	0	2
All domains	**19**	**33**	**5**	**56**

The technical issues which prevented the Trust from being able to report the position against agency expenditure as a percentage of the pay bill for April have now been resolved and the figures included with the dashboard.

The progress against the staff sickness rate KPI has been maintained this month with performance of 3.86% being reported against a target of 4%. Mandatory training compliance has stabilised this month and is still falling short of the target. Performance against PDRs remains below target.

Operationally, the A&E 4 hour and RTT standards continue to perform below their respective targets. Due to revisions in the reporting rules for RTT, which no longer allows for suspensions, there is a risk that the Trust may not meet the NHSI target on the improvement trajectory that was submitted earlier in the year. This has also had an impact on the number of 52 week wait patients the Trust is seeing.



Trust Scorecard – Finance and Performance Committee

Reporting Month May 2016

University Hospitals Coventry and Warwickshire NHS Trust

Finance Summary

Finance and Workforce Scorecard								
Measure	Previous Position	Latest Position	DoT	YTD Plan	Annual Target	Annual FOT	Executive Lead	Trend
Excellence in patient care and experience								
Emergency care								
A&E 4 Hour Wait	80.2%	80.9%	↑	95%	95%	95%	COO	
12 Hour Trolley Waits in A&E	0	0	→	0	0	0	COO	
Ambulance Turnaround within 30 minutes	80.9%	82.5%	↑	100%	100%	100%	COO	
Ambulance Turnaround within 60 Minutes	99.6%	99.5%	↓	100%	100%	100%	COO	
Delayed Transfers as a Percentage of Admissions	5.4%	5.7%	↓	3.5%	3.5%	3.5%	COO	
30 Day Emergency Readmissions (1 month in arrears)	8.1%	8.3%	↓	8.68%	8.68%	8.68%	COO	
Number of Medical Outliers - Average per Day	64	70	↓	50	50	50	COO	
Length of Stay - Average	7.3	7.2	↑	5.96	5.96	5.96	COO	
Non emergency care								
Last Minute Non-clinical Cancelled Operations - Elective	1.2%	1.3%	↓	0.8%	0.8%	0.8%	COO	
Breaches of the 28 Day Readmission Guarantee	11	7	↑	0	0	18	COO	
Urgent Operations Cancelled for the Second Time	0	0	→	0	0	0	COO	
18 Weeks Referral to Treatment Time - Incomplete (1 month in arrears)	89.7%	89.3%	↓	92%	92%	92%	COO	
18 Week Referral to Treatment Time - Admitted (1 month in arrears)	72.1%	74.1%	↑	90%	90%	90%	COO	
18 Week Referral to Treatment Time - Non-admitted (1 month in arrears)	88.4%	90.6%	↑	95%	95%	95%	COO	
RTT 52 Week Waits Incomplete (1 month in arrears)	1.0	1.0	→	0	0	0	COO	
Referral to Treatment Incomplete - Backlog Size (1 month in arrears)	2685	2888	↓	2087	2087	2087	COO	
E-referral Appointment Slot Issues – National data (1 month in arrears)	33.8%	31.2%	↑	3%	3%	3%	COO	
Diagnostic Waiters - 6 Weeks and Over	0.79%	0.47%	↑	1%	1%	1%	COO	
Bed Occupancy Rate - KH03 (3 months in arrears)	98.3%	98.3%	→	93%	93%	93%	COO	
Cancer								
Cancer 2 Week Wait GP Referral to OP Appointment (1 month in arrears)	96.6%	95.1%	↓	93%	93%	93%	COO	
Cancer 2 Week Wait Breast Symptom (1 month in arrears)	100.0%	100.0%	→	93%	93%	93%	COO	
Cancer 31 Day Diagnosis to Treatment (1 month in arrears)	97.6%	99.5%	↑	96%	96%	96%	COO	
Cancer 31 Day Subsequent Surgery Standard (1 month in arrears)	100.0%	96.1%	↓	94%	94%	94%	COO	
Cancer 31 Day Subsequent Drug Standard (1 month in arrears)	100.0%	100.0%	→	98%	98%	98%	COO	
Cancer 31 Day Subsequent Radiotherapy Standard (1 month in arrears)	96.3%	94.5%	↓	94%	94%	94%	COO	
Cancer 62 Day Urgent Referral to Treatment (1 month in arrears)	85.6%	76.6%	↓	85%	85%	85%	COO	
Cancer 62 Day Standard plus 31 Day Rare Cancers (1 month in arrears)	85.8%	77.4%	↓	85%	85%	85%	COO	
Cancer 62 Day Screening Standard (1 month in arrears)	96.6%	100.0%	↑	90%	90%	90%	COO	
Cancer 62 Day Consultant Upgrades (1 month in arrears)	91.3%	93.9%	↑	85%	85%	85%	CMO	
Cancer 104 Day Waits - TDA Measure (1 month in arrears)	10.5	3.5	↑	0	0	0	COO	
Theatre Productivity								
Theatre Efficiency - Main	67.4%	68.1%	↑	85%	85%	85%	COO	
Theatre Efficiency - Rugby	70.3%	69.4%	↓	85%	85%	85%	COO	
Theatre Efficiency - Day Surgery	56.0%	58.0%	↑	70%	70%	70%	COO	
Theatre Utilisation - Main	83.7%	84.7%	↑	85%	85%	85%	COO	
Theatre Utilisation - Rugby	77.5%	75.5%	↓	85%	85%	85%	COO	
Theatre Utilisation - Day Surgery	66.0%	70.5%	↑	70%	70%	70%	COO	
Surgical Safety Checklist - WHO	100.00%	99.97%	↓	100%	100%	100%	CMO	
Theatre Lists Started within 15 mins of Start Time	34.6%	37.9%	↑	75%	75%	75%	CMO	

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

DoT	
↑	Improving
→	No change
↓	Falling

Trust Scorecard – Finance and Performance Committee

Reporting Month May 2016

University Hospitals Coventry and Warwickshire NHS Trust

Finance Summary

Finance and Workforce Scorecard								
Measure	Previous Position	Latest Position	DoT	YTD Plan	Annual Target	Annual FOT	Executive Lead	Trend
Deliver value for money								
Liquidity Days	-21.6	-21.1	↑	-20.8	-24.7	-24.6	CFSO	
Capital Services Capacity	1.4	1.0	↓	1.6	1.6	2	CFSO	
Income & Expenditure Margin	1	1	→	-1.2	1.1	3	CFSO	
Forecast Income & Expenditure Compared to Plan - £'000	668	600	↓	1100	1100	600	CFSO	
YTD Income & Expenditure Compared to Plan Trust - £'000	-864	-2377	↓	-435	1100	600	CFSO	
CIP Delivery - £'000	1514	2850	↑	3316	24612	19167	CFSO	
Agency expenditure as a % of pay bill	10.1%	9.2%	↑	TBC	TBC	TBC	CWIO	
Employer of choice								
Personal Development Review - Non-Medical	88.40%	87.94%	↓	90%	90%	90%	CWIO	
Personal Development Review - Medical	75.05%	72.71%	↓	90%	90%	90%	CWIO	
Mandatory Training Compliance	88.41%	88.39%	↓	95%	95%	95%	CWIO	
Sickness Rate	3.88%	3.86%	↑	4%	4%	4%	CWIO	
Staff Turnover Rate	9.07%	9.00%	↑	10%	10%	10%	CWIO	
Vacancy Rate Compared to Funded Establishment	15.07%	14.78%	↑	10%	10%	10%	CWIO	
Staff Survey - Recommending as a Place of Work	71.39%	71.39%	→	57.8%	57.8%	57.8%	CWIO	
Enrolled on Leading Together Programme - All	44	65	↑	75	300	300	CWIO	
Leading research based health care organisation								
Submitted Research Grant Applications - Quarterly - Cumulative	90	129	↑	120	120	120	CMO	
Commercial Income Invoiced £000s - Cumulative (1 month in arrears)	930	69	↓	100	1200	1200	CMO	
Leading training and education centre								
No of Specialties at HEWM Level 3 and 4	2	2	→	0	0	0	CMO	
Job Evaluation Survey Tool Score - JEST (1 month in arrears)	3.7	3.6	↓	3.5	3.5	3.5	CMO	

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

DoT
↑ Improving
→ No change
↓ Falling

SOCI – Finance and Performance Committee

Reporting Month May 2016

University Hospitals Coventry and Warwickshire NHS Trust

Statement of Comprehensive Income	Plan	2016/17 Budget	2016/17 Forecast Outturn	2016/17 Variance	Year To Date Budget	Year To Date Actual	Year To Date Variance	Month Budget	Month Actual	Month Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Income										
Contract income from activities	505,518	507,856	505,672	(2,184)	83,809	82,085	(1,724)	41,758	40,328	(1,430)
Other income from activities	24,427	24,369	24,083	(286)	3,976	3,954	(22)	2,016	1,968	(48)
Other Operating Income	72,969	75,074	73,905	(1,169)	12,747	12,882	135	6,385	6,372	(13)
Total Income	**602,914**	**607,299**	**603,660**	**(3,639)**	**100,532**	**98,921**	**(1,611)**	**50,159**	**48,668**	**(1,491)**
Operating Expenses										
Pay	(353,298)	(355,952)	(365,620)	(9,668)	(60,418)	(59,520)	898	(30,190)	(29,662)	528
Non Pay	(196,284)	(198,144)	(199,533)	(1,389)	(34,266)	(34,201)	65	(17,574)	(17,614)	(40)
CIP gap to target delivery			2,842	2,842			0			0
Additional savings required			8,237	8,237			0			0
Reserves	(5,644)	(6,180)	(3,076)	3,104	1,326	0	(1,326)	873	0	(873)
Total Operating Expenses	**(555,226)**	**(560,276)**	**(557,150)**	**3,126**	**(93,358)**	**(93,721)**	**(363)**	**(46,891)**	**(47,276)**	**(385)**
EBITDA	**47,688**	**47,023**	**46,510**	**(513)**	**7,174**	**5,200**	**(1,974)**	**3,268**	**1,392**	**(1,876)**
EBITDA Margin %	7.9%	7.7%	7.7%		7.1%	5.3%		6.5%	2.9%	
Non Operating Items										
Profit / loss on asset disposals			27	27	0	27	27	0	24	24
Depreciation	(21,621)	(20,894)	(20,894)	0	(3,482)	(3,477)	5	(1,741)	(1,736)	5
Interest Receivable	115	115	115	0	21	17	(4)	10	6	(4)
Interest Charges	(396)	(465)	(465)	0	(71)	(71)	0	(35)	(35)	0
Financing Costs	(22,388)	(22,278)	(22,278)	0	(3,715)	(3,712)	3	(1,888)	(1,885)	3
Unwinding Discount	(35)	(34)	(35)	(1)	(34)	(35)	(1)	(34)	(35)	(1)
PDC Dividend	(2,110)	(2,214)	(2,214)	0	(370)	(370)	0	(185)	(185)	0
Impairments			(10)	(10)		(10)	(10)	0	(10)	(10)
Total Non Operating Items	**(46,435)**	**(45,770)**	**(45,754)**	**16**	**(7,651)**	**(7,631)**	**20**	**(3,873)**	**(3,856)**	**17**
Net Surplus/(Deficit)	**1,253**	**1,253**	**756**	**497**	**(477)**	**(2,431)**	**(1,954)**	**(605)**	**(2,464)**	**(1,859)**
Net Surplus Margin %	0.2%	0.2%	0.1%		-0.5%	-2.5%		-1.2%	-5.1%	
Technical adjustments										
Donated/Government grant assets adjustment	(153)	(153)	(166)	(13)	42	44	2	21	22	1
Impairments			10	10		10	10	0	10	10
Break-even in-year position	**1,100**	**1,100**	**600**	**(500)**	**(435)**	**(2,377)**	**(1,942)**	**(584)**	**(2,432)**	**(1,848)**

The Trust reports a £0.6m forecast control total surplus against a plan of £1.1m in Month 2.

The Trust is forecasting a £0.5m under-performance against its control total. The £0.5m reflects an agreed underperformance with NHSI. This is a change in CQUIN funding agreed through the contracting process after the Trust had submitted its financial plan.

Contract income is forecast at £3.6m adverse to plan driven by under-performance against activity plans, risks and penalties. The decline is due to under-performance on Day-case, Outpatient, and Emergency activities. The Trust is looking at measures to ensure targets are met from month 4 (July 16) onwards.

Operating expenditure is £4.5m favourable to budget. Group expenditure forecasts £9.9m adverse to budget; largely driven by over-spends on Medical costs (£3.4m), and under-delivery against CIP position by £2.8m.

The under-delivery of the CIP target continues to drive the non-pay forecast variance as at Month 2.

The Trust is reporting a year to date deficit of £2.4m against a £0.1m planned control total deficit, which is £1.8m adverse to the planned surplus. This is primarily due to under-performance against activity targets noted above.

SOFP – Finance and Performance Committee

Reporting Month May 2016

University Hospitals Coventry and Warwickshire NHS Trust

Statement of Financial Position	2016/17 Plan	2016/17 Forecast Outturn	2016/17 Variance	Year To Date Plan	Year To Date Actual	Year To Date Variance	Month Planned Change	Month Actual Change	Month Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Non-current assets									
Property, plant and equipment	402,458	390,513	(11,945)	361,152	347,857	(13,295)	(141)	(1,217)	(1,076)
Intangible assets	3,886	5,087	1,201	3,886	5,087	1,201	0	0	0
Investment Property	8,230	8,230	0	8,230	8,230	0	0	0	0
Trade and other receivables	21,991	25,939	3,948	29,110	33,162	4,052	(361)	(383)	(22)
Total non-current assets	**436,565**	**429,769**	**(6,796)**	**402,378**	**394,336**	**(8,042)**	**(502)**	**(1,600)**	**(1,098)**
Current assets									
Inventories	11,558	13,274	1,716	11,558	12,844	1,286	0	(556)	(556)
Trade and other receivables	21,668	29,308	7,640	29,431	41,325	11,894	(7,364)	(2,294)	5,070
Cash and cash equivalents	2,700	2,703	3	2,700	2,850	150	(21)	(7,296)	(7,275)
	35,926	**45,285**	**9,359**	**43,689**	**57,019**	**13,330**	**(7,385)**	**(10,146)**	**(2,761)**
Non-current assets held for sale	0	0	0	0	0	0	0	0	0
Total current assets	**35,926**	**45,285**	**9,359**	**43,689**	**57,019**	**13,330**	**(7,385)**	**(10,146)**	**(2,761)**
Total assets	**472,491**	**475,054**	**2,563**	**446,067**	**451,355**	**5,288**	**(7,887)**	**(11,746)**	**(3,859)**
Current liabilities									
Trade and other payables	(51,991)	(59,347)	(7,356)	(59,983)	(71,465)	(11,482)	6,894	8,904	2,010
Borrowings	(5,876)	(5,860)	16	(1,577)	(1,561)	16	0	0	0
DH Interim Revenue Support loan	0	0	0	0	0	0	0	0	0
DH Capital loan	(4,517)	(4,405)	112	(2,489)	(2,489)	0	0	0	0
Provisions	(194)	(194)	0	(194)	(2,659)	(2,465)	0	0	0
Net current assets/(liabilities)	**(26,652)**	**(24,521)**	**2,131**	**(20,554)**	**(21,155)**	**(601)**	**(491)**	**(1,242)**	**(751)**
Total assets less current liabilities	**409,913**	**405,248**	**(4,665)**	**381,824**	**373,181**	**(8,643)**	**(993)**	**(2,842)**	**(1,849)**
Non-current liabilities:									
Trade and other payables									
Borrowings	(262,380)	(262,400)	(20)	(263,178)	(263,208)	(30)	40	33	(7)
DH Interim Revenue Support loan	(16,643)	(17,563)	(920)	(12,479)	(12,479)	0	0	0	0
DH Capital loan	(26,238)	(25,227)	1,011	(11,314)	(11,314)	0	445	445	0
Provisions	(2,282)	(2,260)	22	(2,476)	(2,454)	22	(98)	(99)	(1)
Total assets employed	**102,370**	**97,798**	**(4,572)**	**92,377**	**83,726**	**(8,651)**	**(606)**	**(2,463)**	**(1,857)**
Financed by taxpayers' equity:									
Public dividend capital	59,330	60,741	1,411	59,330	59,330	0	0	0	0
Retained earnings	(12,209)	(14,840)	(2,631)	(13,939)	(18,945)	(5,006)	(606)	(2,463)	(1,857)
Revaluation reserve	55,249	51,897	(3,352)	46,986	43,341	(3,645)	0	0	0
Total Taxpayers' Equity	**102,370**	**97,798**	**(4,572)**	**92,377**	**83,726**	**(8,651)**	**(606)**	**(2,463)**	**(1,857)**

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.

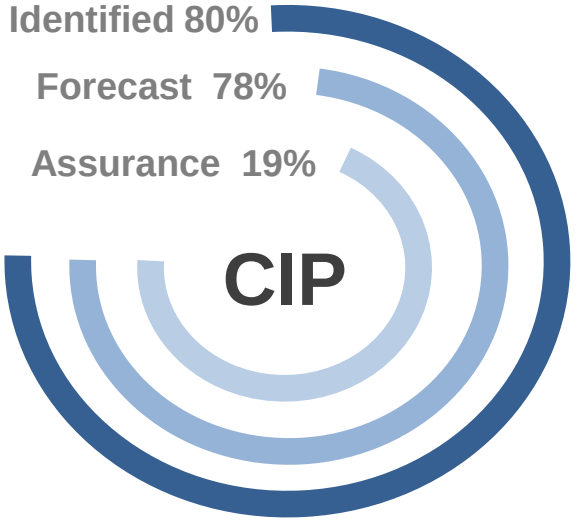
- The Trust's Plan is based on the closing position of the previous financial year 2015/16.
- The reduction in property, plant and equipment outturn is mainly due to a reduction in new additions (£3.2m non PFI and £3.5m PFI). Other movements are on; slippage of £2.9m in forecast indexation rate used from 7.39% to 6.23%, a £2.8m increase in impairments based on the calculation of the removal of PFI VAT from PFI valuation, and a £0.5m reduction in depreciation as a result of the slippage of new in-year additions.

Efficiency Delivery Programme – Reporting Month May 2016

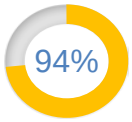
University Hospitals Coventry and Warwickshire NHS Trust

Overview

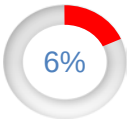
- The Trust, in its external plan to NHSI, submitted a CIP target of £21m; however an internal stretch target of £25.5m is required to support its financial delivery.
- To achieve the £0.6m surplus; the Trust is required to deliver a £24.6m internal CIP for 2016/17. £19m is expected to be achieved by cost reduction and/or income from new services from clinical and core groups whilst £5.6m is expected to be delivered from increased productivity, and continued improvement to counting and charging.
- As a driver for improving patient through-put across the organisation, the Trust has pledged a £0.9m investment and in-turn clinical groups have further agreed to an increased target of £0.9m. This will be allocated in July'16 (M4) increasing the Trust's CIP target to £25.5m for 2016/17.
- Groups have documented 227 schemes worth £19.7m (80%) against the internal target of £24.6m with an unidentified value of £4.9m as at Month 2.
- The Trust is reporting a £19.2m forecast delivery against the internal target of £24.6m giving a 78% forecast position as at Month 2.



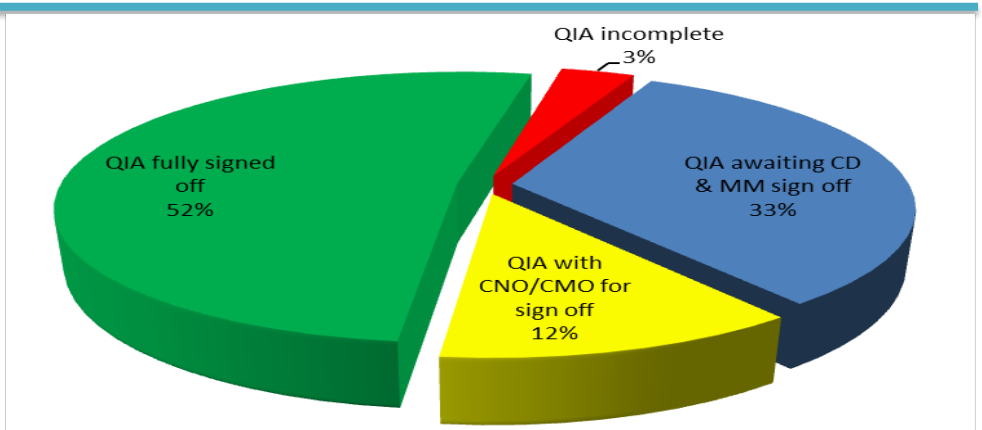
The **Financial Recovery Programme** is a further £15.7m target above the Trust CIP plan



£14.7m (94%) of the FRP has been transacted in Month 2. A high proportion (£5.6m) is reliant on agency expenditure reductions and additional CIP to core groups (£1m).



£1.0m (6%) of the FRP has yet to be transacted. Methods of delivery have been identified for instance the review of Outlier Team £1m. This will be transacted to groups over the forthcoming months



A **quality impact assessment (QIA)** is required for all CIP schemes regardless of the value. Each scheme require clinical approval from the Clinical Director (CD) and Modern Matron (MM); the Chief Nursing Officer (CNO) and Chief Medical Officer (CMO).

227 schemes have been documented to support the delivery of 2016/17 target. 52% of these schemes have had a full QIA review and are now signed-off

The **Value of Unapproved CIP schemes** as at Month 2 is £7.6m compared to £18.9m in Month 1.

Workforce Information | Headlines May 2016

(excluding bank and ad-hoc locums)

University Hospitals Coventry and Warwickshire NHS Trust

Workforce Summary

Staff in Post | Variation from Workforce Plan

	31st May 2016	TDA Plan	Variation from Plan	Last Month's Variation from Plan	ISS
WTE	6,696.84	6761.00	-64.16	-32.99	575.30
WTE including ISS	7272.14				
Headcount	*7622				749
Headcount including ISS	8371				

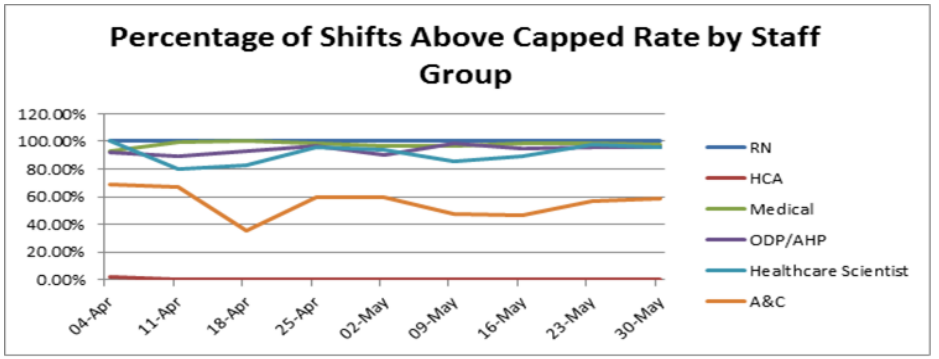
*The above figures do not include 1195 bank only staff who do not have contracted hours.

Staff in Post | Monthly Variation

Staff Group	Staff In Post WTE 30th Apr 2016	Staff In Post WTE 31st May 2016	Variance (WTE)	% Variance
Add Prof Scientific and Technic	214.55	214.28	-0.27	-0.12%
Additional Clinical Services	1531.84	1547.89	16.05	1.04%
Administrative and Clerical	1134.53	1141.23	6.70	0.59%
Allied Health Professionals	373.31	379.11	5.80	1.53%
Estates and Ancillary	5.00	5.00	0.00	0.00%
Healthcare Scientists	312.72	307.83	-4.89	-1.59%
Medical and Dental	936.99	938.27	1.28	0.14%
Nursing and Midwifery Registered	2121.86	2125.02	3.16	0.15%
Students	40.20	38.20	-2.00	-5.24%
Totals	**6671.01**	**6696.84**	**25.83**	**0.39%**
ISS	587.2	575.30	11.90	2.07%

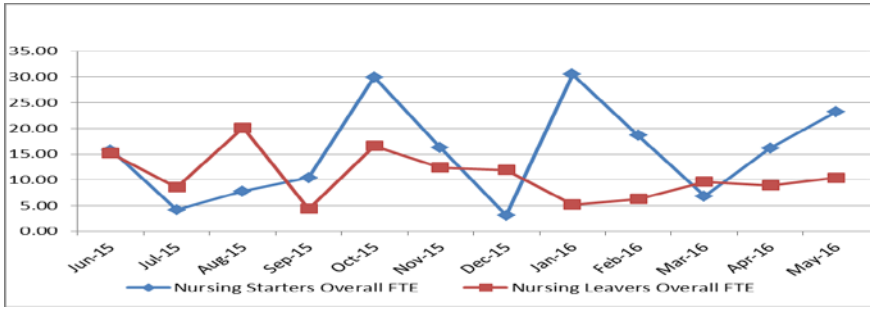
- The Trust's staff in post is 64.16 WTE behind the workforce plan of 6761.00 WTE.
- The Trust's monthly staff in post has increased by 25.83 WTE from April 2016 figures.
- The main increase in posts WTE is within the Additional Clinical services staff group (HCAs)

NHSI Rate Caps | Percentage of Shifts Booked Over Cap Rates



- The above graph outlines the information from the weekly submissions by the Trust to NHSI on usage of agency staff with charge rates above the current NHSI capped rates.
- Reduction in charge rates for nursing staff were agreed from 6th June onwards and initial indications are that the change has significantly reduced the proportion of nursing shifts above the capped rate.
- Work is being undertaken to standardise and reduce the rates for medical locums which will take effect from 18th July. Although this will not move them under the April cap, it will relate to a reduction in the total cost to the Trust.

Starters & Leavers | Nursing



- The starters results for Oct, Jan and Feb highlights the Newly Qualified Nurses intake.
- New starters equalled 23.25 WTE continuing the upward trend against leavers.
- The forecast Nursing starters for next month is twelve. There is some difficulty in forecasting figures currently as Resourcing are in the transitional period of migrating to the new TRAC recruitment management system which took effect on 6th June 2016.

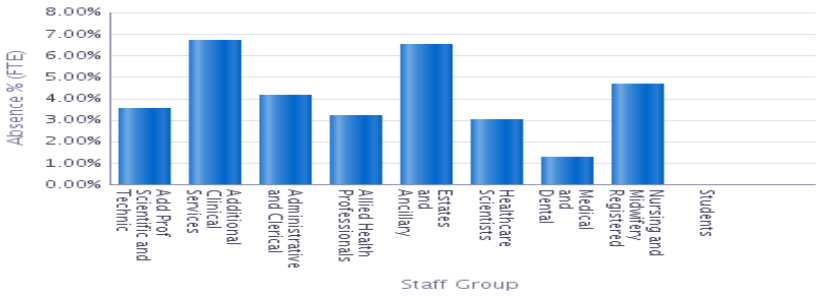
Workforce Information | Headlines

University Hospitals Coventry and Warwickshire NHS Trust

Absence | *Specialty Group*

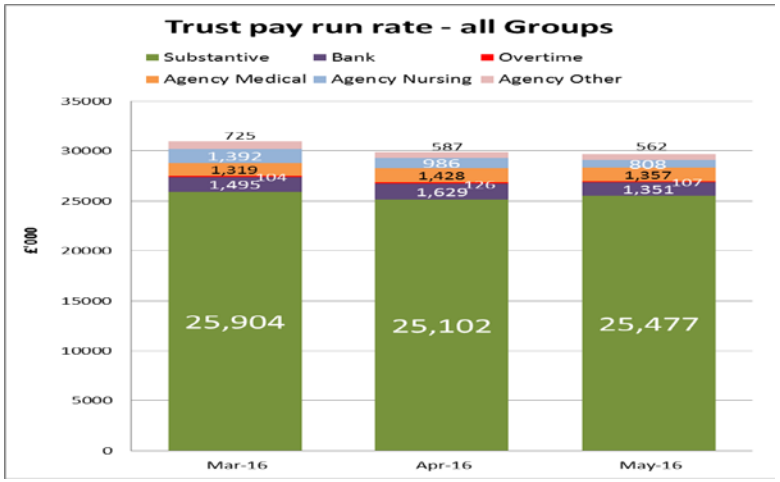
Specialty Group	% Abs Rate (WTE)
Cardiac & Respiratory	2.08%
Care of the Elderly	2.93%
Clinical Support Services Specialty Group	5.30%
Core Functions	2.92%
Delivery Unit	4.12%
Emergency Department Specialty Group	4.51%
Hospital of St Cross	2.97%
Imaging	2.46%
Neurosciences Specialty Group	2.88%
Oncology and Haematology	4.56%
Pathology Network Cov & Warwicks	6.12%
Renal Specialty Group	3.70%
Specialist Medicine & Ophthalmology	4.47%
Surgery Specialty Group	3.49%
Theatres and Anaesthetics Specialty Group	4.18%
Trauma & Orthopaedics Specialty Group	2.05%
Women & Children Specialty Group	4.88%
Totals	3.86%

Absence | *Staff Group* - 12 Months Rolling Period



- The Trust has achieved sickness absence rates below the 4% target for the second consecutive month.
- 8 specialty groups remain above the 4% target.
- In the past month there have been 33 long term sickness cases managed to either return to work (32) or exiting the organisation (1).

Pay Costs | *Provided by Finance*



- Temporary costs equate to 14.11% of the Trusts total pay bill (£29,661,613), this is a decrease of 1.82% from April 2016.
- Agency costs against total costs decreased from 10.05% to 9.19%
- There was reduction across the board in all agency usage with total spend reducing by £275k against April 2016.
- Bank and overtime usage decreased by £296,290 and decreased from 5.88% to 5.73% of the total spend.
- The substantive pay bill has increased by £374,690 from April to May.
- The overall pay bill for May 2016 is £196,554 below the April 2016 cost due to the reduction in Bank, overtime and agency spend.

Mandatory Training | *Topics*

- Mandatory Training compliance is currently 88.39% a decrease of 0.02% against April.
- 3 topics are above 95% (Hand Hygiene Non Clinical, Equality and Diversity & Thromboprophylaxis) with 15 topics between 85% and 95% and 16 topics below 85%.
- 3 topics are below 60% Moving & Handling Medical & Dental – 3 yearly 53.49%, Advanced Life Support 4 yearly 54.90%, Immediate Life Support 56.41% .
- The Moving and Handling Medical and Dental competency was created in April 2016 following changes to the frequency in refresher training required. Compliance has now increased from 45.41% in April to 53.49% in May 2016.
- Advanced Life Support Update Annual has the following compliance levels by group, Clinical Support Services, Hospital of St. Cross and Specialist Medicine and Ophthalmology 100%, Theatres and Anaesthetics 86.67%, Emergency Department 79.41%, Renal and Acute Medicine 78.57%, Core Functions 68.75%, Cardiac and Respiratory 63.93% and Care of the Elderly 60%.

University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD PAPER

Title	**Medical Education Report**
Author	**Dr Sailesh Sankar**
Responsible Chief Officer	**Professor Meghana Pandit, Chief Medical and Quality Officer**
Date	**30th June 2016**

1. Purpose

The Trust sees education, research and learning as central to improvement and it is our stated objective to be a Leading Training and Education Centre. We are the major undergraduate (UG) teaching partner to Warwick Medical School (WMS), and offer postgraduate (PG) training in almost all specialties. The Trust Board will be informed and updated on progress against this objective, and on substantial internal and external pressures that impinge upon Medical Education. We ask the support of the Board in maintaining the Trust's focus on, and excellence in, Medical Education and Training.

2. Background and Links to Previous Papers

- UHCW is one of the UK's largest and busiest NHS University Teaching Trusts.
- We have a mature and strengthened partnership with WMS, which allows us to combine excellence in teaching and research with high quality medical education. The Trust recognises that its association with Warwick has improved recruitment of high quality doctors at all levels.
- The delivery of postgraduate education and training is recognised as a Trust core activity. We have Foundation, Core and Specialty trainee doctors appointed by Health Education England West Midlands (HEEWM) undertake training, and patient care, within the Trust.
- Both areas must operate in line with the General Medical Council (GMC) document 'Promoting Excellence: Standards for Medical Education and Training' which took effect January 2016.
- Education impinges on many operational areas for the Trust; with regular reports to Patient Safety, Training, Education and Research, and Quality Governance Committees as well as Trust Board.
- Since the last report in March the Trust and WMS have made significant progress on the quality concerns noted in the last report both for medical student and doctors training.

3. Executive Summary

Medical Education has a Service Level Agreement with WMS and a Learning Development Agreement with HEEWM. These give us a clear framework for facilities, delivery, and in particular quality, of teaching and training, and of 'working conditions' for

our learners. We are subject to frequent inspection, particularly of the training we provide for trainee doctors (postgraduate - PG) Training.

Following Government recognition that more educational funds needed to be identified for nurse training and training of professions allied to medicine but a restriction in central funding there was a rebalancing of the education budget which has resulted in a considerable drop in funding for medical education in the past two years. This is likely to continue into the 2016-2017 budget with a further predicted drop of £800,000 for the UG income and on the PG side HEEWM now pays only 50% of trainees' basic salaries and no 'on call'; and the Trust must fund the remainder. Education income now explicitly follows the learner, and learners may only be assigned if teaching and training is at least satisfactory. While income has dropped the standards to be achieved for both medical students (undergraduate - UG) and PG training are becoming more explicit and demanding. Thus we are operating in a much tougher climate. We stand to lose income if we do not meet standards, and of course our aim is excellence, but against this we face a number of important service challenges which directly impact on our ability to provide excellent education.

From July 2016 all Teaching Leads & Supervisors are required to have attained full GMC Trainer Accreditation in order to be allowed to provide Educational supervision to trainees and students. The aim is that all trainers will be carefully selected, trained and supported by the Trust. Over the past two years we have made good progress against initial requirements for provisional registration by running a large number of tailored 'in house' courses, but full (and on-going) accreditation requires each trainer to maintain individual professional development in this area. We require increased emphasis on educational activity at appraisal and revalidation to support this. In the last three months we have run a further three 'Training the Trainer two day courses and 80 consultants have attended.

We now have 232 consultants registered as having attained full accreditation status and a few more are due their appraisal prior to July 2016, and we are in the process of updating the Intrepid database in submission of our final data to HEEWM. Therefore the Trust has successfully met this demanding target.

Specific Postgraduate Training Issues

There has been one Health Education England visit to inspect PG training since March 2016 to review Geriatrics at Rugby St Cross with a further revisit to Acute Medicine scheduled for July 2016. Such visits impose huge stress and workload upon the PG tutors and the senior clinicians within the specialties involved particularly in data gathering/analysis. The visit to Geriatrics at Rugby was a revisit 'level 3' inspection which means that the visit had been 'triggered' by significant criticisms or concerns. The visiting team found that the team led by Dr Suresh Gurijala had made 'exemplary' progress on the educational issues and they praised the support provided by Drs Holmes and Sankar. However, the visit identified three patient safety concerns linked to operational issues which the Trust have addressed and progress on these matters are to be formally discussed on July 7th 2016 when it is hoped that this service will be signed off and returned to Level 2 (routine) visiting status. The revisit to Acute Medicine in July is a Level 4 visit (triggered by concerns with GMC input). The operational issues in Acute medicine, are mainly linked to the high workload and the rota and consequently are proving very challenging to solve. However the Acute Medicine management team have

been working very hard to solve the complex issues and with the support both of the CMO and the Educational team believe that significant improvements have been made. This progress has been recognised by the trainees as evidenced by their feedback in their Junior Doctors Forum which is currently being led by Dr Holmes the Clinical Tutor to support the improvement process. HEE (WM) has recognised that the Trust is supportive of Education and Training and therefore it is hoped these positives will be noted in the July visit.

In summary our progress is being recognised by HEE (WM) and the number of 'high' level visits is reducing but major 'front door' pressures and associated patient safety issues, identified by trainees, continue to worry HEE (WM). The Non-Executive support and oversight of education by the Trust Board is very helpful, and favourably viewed by the GMC and HEE (WM). We are also in the process of recruiting clinical fellows in attractive posts that give them opportunity for clinical experience in Acute Medicine/ITU and dedicated time for Teaching with opportunity to take on qualifications in Medical education to make these posts more attractive and valuable for future career. Mrs Brenda Sheils, the Non-Executive Board member with the lead for Medical Education has been meeting with trainees to get a better understanding of the issues that confront them and plans to continue this initiative with further meetings planned for later in the summer and with the medical students in the Autumn. This additional connection between the Board and the shop floor helps to illustrate the Trust's genuine commitment to education. In addition the adoption of the target of reducing the level of HEE (WM) inspection visits to all specialties to Level 1 and 2 as one of the Trust's 7 strategic targets (in this case an innovation target) underpins the Trust's determination to address this area of concern.

Undergraduate

WMS introduced a 'refreshed' curriculum from September 2013. For the last three years we have run the original and refreshed curricula alongside each other. This caused a significant 'bulge' in UG teaching requirements and pressure on teachers and educational leads. They have stepped up to the mark to try to ensure neither original nor refreshed curriculum students were disadvantaged as the courses ran in parallel for three years. However, student dissatisfaction with their course was reflected in the results of the National Student Survey in 2015 and the extra pressure over the Christmas and New year was particularly challenging. Although, the strain caused by running the two curricula together is now behind us still some of the dissatisfaction caused by the two curricula rubbing against each other and teething problems with the refreshed curriculum is still showing up in the student satisfaction survey results. However, the strengthened administration and teaching team under the leadership of Dr Pijush Ray the Trust Lead for Undergraduate Education are getting to grips with the issues and students have reported (via the Student representatives and feedback meetings) that they have noticed the improvements that are being made. The administration teams from the three Trusts have begun to meet regularly to help enhance communication and Colin McDougall gave a recent presentation on the work of the Warwick Medical School at the Grand Round. The Medical Education team are committed to finding innovative ways to deliver excellent teaching and training opportunities to the medical students while ensuring that the service demands are also met.

The Surgical Training Centre

The Surgical Training Centre team have continued with their excellent, innovative work providing the Trust with a showcase of world class courses and world firsts in innovation. Currently the centre has a 3D HD Stereoscopic anatomy exhibition at the World Anatomy Exhibition. The technology used is a world class world first and the Vesalis Conference is on a Global Tour which started in the USA and is currently in Greece. The conference tour runs from 2015 – 2016.

In addition the centre is working in collaboration with the French company Aliscopy to promote world first technology i.e. a Glass less 3D Television – 3D that does not require the use of 3D glasses. The work is being exhibited in California and hopes to attract up to 20,000 visitors.

The Surgical Training centre is officially the busiest centre in the UK offering a diverse range of courses and this will get busier over the next 3 years whilst the Royal College of Surgeons close their facility for refurbishment. Over 1500 surgeons, many from overseas, have trained there. Teaching is in place for groups from local schoolchildren through to highly specialised consultants, with emphasis on our local UG and PG learners, including innovative multi-professional courses. This is now a substantially self-funding enterprise. However, it has reached a stage where it has optimised it's current facilities and the need to explore options for expansion are being explored.

Resuscitation, Clinical Skills and Simulation Centre

Our Clinical Skills and Simulation Centre are also well-equipped facilities, with Hi-Fidelity (i.e. near reality) simulation particularly suited to teaching on acute medical and surgical emergencies, non-technical skills under stress (e.g. team-working, leadership, communication skills, problem solving, situational awareness) applicable to all clinical disciplines, often as specialty multi-professional teams. Dr Carl Hillerman has taken on one of the two simulation lead roles, he has the remit to develop the scenarios and the training packages. Currently we are recruiting the second lead who will take on the role of marketing and business management. This is very timely; there is a HEE(WM) led drive to increase availability of simulation training and a national emphasis to develop the area. Catherine Baldock and her team have rolled out the new Zoll defibrillators and trained 5000 staff. In addition the team are currently managing the introduction and piloting of the DNA CPR Tab onto CRRS this involves a series of briefing sessions and the piloting of the system before full roll out.

4. Link to Trust Objectives and Corporate/Board Assurance Framework Risks

Medical education and training links to the Board Assurance Framework risk (9)

- **Clinical Risk.** If we lose trainees due to unsatisfactory standards of training we lose high standard clinical staff and will need to employ (at full cost) other clinical staff to fill the gaps. We may not have as much assurance on the standard of those replacement staff. Due to current workload pressures our highest current risk areas are our most pressurised. This continues to be a very real risk; we have had two middle grade Acute Medicine trainees taken away already and

adjoining Trusts have had trainees removed in other specialities. Difficulties with resolving the issues with the Acute Medicine rota are causing particular concern.

- **Financial;** as outlined above, funding now directly follows both medical students and PG trainees. Losing the 'contract' to teach and train will result in a reduction in income. Retaining that contract is dependent on maintaining high standards.
- **Business**; the success of our outward reaching educational ventures is in part built upon our general teaching and training reputation.
- **Reputation;** It is unthinkable that we should not maintain our status as a major teaching and training hospital. This has brought many advantages and improvements to the Trust and our local population and health care community
- **Performance;** as with clinical risk losing trainees will impact on performance in areas already under particular pressure

5. Governance

This paper links to the Trust's objective to become a Leading Training and Education Centre. It has been agreed that the Trust Board will receive quarterly progress reports.

6. Responsibility

Associate Medical Director for Education with UG and PG Education teams, reporting to Chief Medical Officer.

7. Recommendations

The Board is invited to **NOTE**:

1. The on-going work in respect of UG and PG training and education; and
2. Continue to provide oversight particularly in respect of HEEWM visits.

Dr Sailesh Sankar. Associate Medical Director for Education
Date**: 30th June 2016.**

PUBLIC TRUST BOARD PAPER

Title	**Safer Staffing Bi-Annual Report**
Author	**Elaine Clarke Associate Director of Nursing – Quality and Patient Safety**
Responsible Chief Officer	**Professor Mark Radford, Chief Nursing Officer**
Date	**30 June 2016**

1. Purpose

To provide an update to Board on the Trust's compliance with the standards relating to Safer Staffing following the full and comprehensive assessment that has been undertaken.

2. Background and Links to Previous Papers

A full and comprehensive assessment of nurse and midwifery staffing and gap analysis was undertaken and first presented to Trust Board in May 2014. Since then the Trust Board has received monthly data as part of the Integrated Performance Report and a more detailed six monthly staffing review. This report demonstrates a continued commitment at UHCW ensuring that we have the right staff in place with the right skills. It details the significant changes in the last six months predominately for nursing; however it also includes the results of a multi professional care contact time pilot on Trauma & Orthopedics.

3. Narrative

The Trust has a long term program in place for understanding and reporting against nursing and midwifery staffing levels. The systems in place are consistent with the national guidance received on safer staffing, including the Safer Nursing Care Tool (SNCT). This has consistently been reported through to Board and discussed in detail through sub-board governance systems and nursing hierarchy.

This paper sets out the work that is being undertaken across the Trust around staffing levels, the tools and initiatives that are in place to assess and understand how nursing time is spent and the output of the most recent twice-yearly assessment against standards.

4. Areas of Risk

If the Trust does not have in place systems and processes to monitor and ensure that wards are staffed in accordance with national guidance, best practice and patient acuity then patients may come to avoidable harm. These risks are mitigated by established reporting systems that have been in use within the Trust for some time and the use of the Safer Nursing Care Tool.

5. Governance

In line with the responsibility of the Trust Board for ensuring that services are safe, it is a national requirement that a staffing assessment is submitted twice a year, in order that the Board is aware of the Trust's position against national guidance and can take action where appropriate. This is in addition to the monthly staffing information that is provided within the Integrated Quality, Performance and Finance Report.

6. Responsibility

Mark Radford, Chief Nursing Officer
Elaine Clarke, Associate Director of Nursing – Quality and Patient Safety

7. Recommendations

The Board is invited to **NOTE** the results of the comprehensive assessment that has been undertaken to take ASSURANCE from the systems and the processes that are in place and to **RAISE** any queries or concerns.

Name and Title of Author:
Elaine Clarke, Associate Director of Nursing – Quality and Patient Safety

University Hospitals Coventry and Warwickshire NHS Trust

Safe Staffing Report June 2016

1. Introduction & Background

UHCW have taken a systematic approach to staffing wards and services safely over the past three years following the release of the National Quality Board standards in 2013 and 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.

This report demonstrates a continued commitment at UHCW to ensure that we have the right staff in place with the right skills. It details the significant changes in the last six months. The results of the pilot multi professional care contact time will be presented as will an update on the implementation of Care Hours Per Patient Day (CHPPD) as per Lord Carter's recommendations.

UHCW continues to use a strategic, tactical and operational approach ensuring a rounded view of staffing is undertaken. This ensures the best use of available resources to deliver quality care to our patients.

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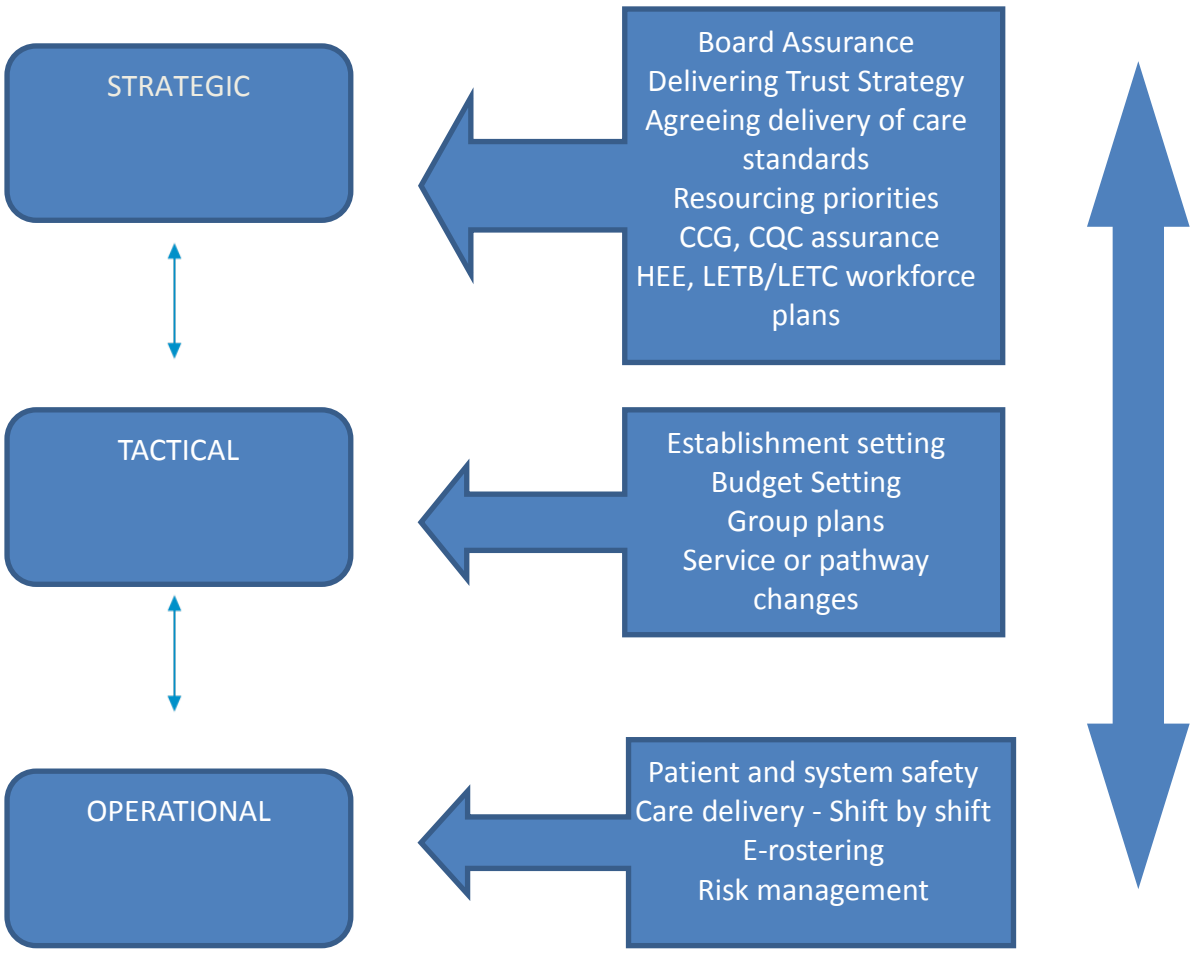


The following action points have taken place since the last report in November 2015 and will be explored in greater detail in this report;

- Acuity and Dependency scoring January 2016
- 'Safe Care' acuity and dependency module linked to E-roster pilot commences summer 2016.
- Care contact time multi professional pilot on Trauma & Orthopedics.
- Assessment of all wards staffing levels using the 'safer nursing care tool' and professional judgment incorporating CHPPD.

2. Acuity and Dependency Scoring

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 the National Institute for Health Care Excellence (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. Nurse Sensitive Indicators (NSIs) are also measured; 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. These are presented graphically to demonstrate the overall pattern of 'over' and 'under' established wards as whole time equivalents (wte) and percentages. Charts 1 (wte) and Chart 2 (%) demonstrate the difference between funded and suggested establishments using the 'SNCT' with the new care definitions and revised multipliers. It is, however, accepted that being within 10% of the SNCT multiplier suggested wte is within reasonable limits.

Using this as an indicator and according to the 'SNCT' in terms of wte (chart 1) there is one ward (22ECU) suggested to be 'over' established or above the agreed parameters. Ward 35 is suggested to be 'under' established or below the agreed parameters.

Conversely the position of the wards change (chart 2) when shown as a percentage difference between funded and suggested establishments.

There are now seven wards considered 'over' established or above 10% of the SNCT suggested wte compared to fourteen in June 2015.Those wards considered to be 'over' established or above 10% of the SNCT suggested wte are:

53ECU, 34, 22ECU, 22V, 33u, 33ss, 33gastro, there are some possible reasons for the increase in those above 10%;

Outcomes from 53MTECU demonstrate that over time there appears to be a seasonal pattern emerging. Over the winter period the number of level 1a and 1b patients increase with a consequent fall in level 0 patients. Over the summer period the level 0 patients appear to rise with a subsequent fall in level 1a patients.

Drilling further into the data there is an upward trend of level 1a and 1b patients with a downward trend of level 0 patients. The Modern Matron for Trauma and Orthopaedics throughout this episode of data collection has been monitoring the scoring on the ward. This is to ensure data collection was being undertaken correctly due to this suggested continual over establishment. Feedback from the Modern Matron would indicate that the scoring is accurate and reflects the levels of care of patients being nursed in this clinical area. As a result a review of the funded establishment will now be undertaken.

Ward 22ECU has a suggested 'over' establishments of 32%. A review of the scoring was undertaken during this data collection period with particular reference to level 1a and level 2 patients. The scoring criteria were revisited with the Ward Manager, Lead Nurse Critical Care Outreach and Lead Nurse Quality and Safety to ensure it was accurate and reflected the care provided on the ward.

The data would indicate that the patient's acuity in this area appears to be rising especially level 1a patients.

More patients are being nursed in this unit which require:

- Vasoactive drugs which need more intensive monitoring.
- There is a greater use of intrathecal analgesia

Renal transplant patients are now being nursed in the unit which also require a higher level of care post procedure.

Ward 34 has a suggested 'over' establishment of 15%. The number of Level 1a patients (acutely ill with the potential to deteriorate) have decreased from 32% in June 2015 to 21% with a subsequence rise in Level 1b patients (stable but have a higher dependency on nursing support) to 79% from 68%% June 2015. On average from January 2014 to January 2016 65% of patients are level 1b and 34% are level 1a. This clearly demonstrates the level of acuity and dependency of this particular group of patients. In addition

- The SNCT tool does not take into account patients being nursed in single side rooms and all the difficulties that brings.
- Patients and their families within this speciality require a significant amount of time, in terms of psychological support from the nursing team especially those with newly diagnosed haematological conditions.
- A larger proportion of patients on the ward are now receiving IV bolus medication. This would include chemotherapy drugs which require Registered Nurses to remain with patients for at least 60 minutes whilst they are being administered

This is only the second time surgery has scored since it reconfigured its service in February 2015. Ward 33 gastro, 33ss and 33u are now suggested to be over established by 13%,

26% and 14% respectively. As this is only the second time the wards have undertaken the acuity and dependency scoring since their reconfiguration, time is required for the pattern of activity to develop in order that the acuity and dependency of the wards can be assessed.

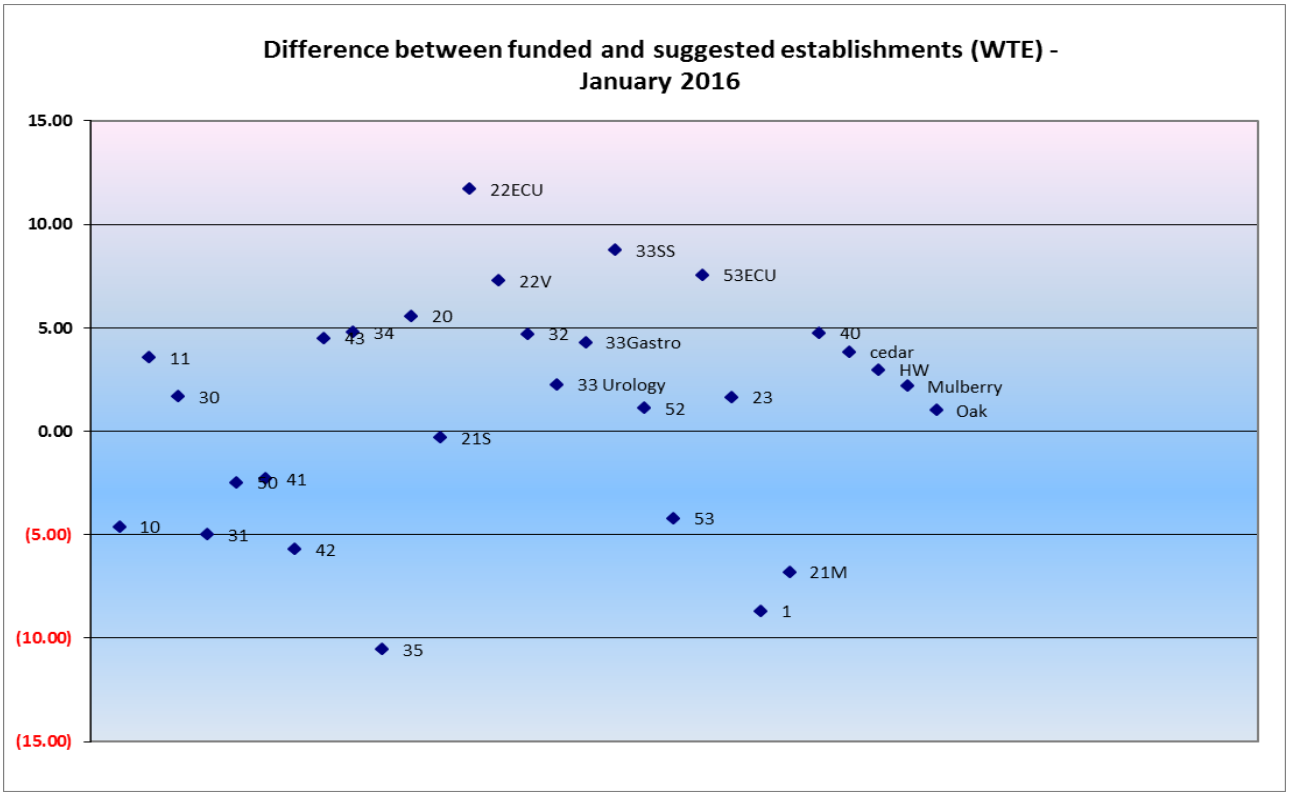


Chart 1 Position of the wards using the new care definitions and revised multipliers in the SNCT

There are five wards 42, 35, 21M, 10, and ward 1 which are considered to be 'under' established or below 10% of the SNCT suggested wte.

Ward 1 data commencing June 2011 to January 2016 shows this clinical area is sitting below the agreed parameters. This suggested 'under' establishment has increased from -18% in June 2015 to -20% in January 2016 following a rise in the number of level 1a and 1b patients with a subsequent fall in level 0 patients.

On average since June 2011 74% of patients on the ward were scored as level 1b (stable but have a higher dependency on nursing support) which indicates the level of dependency of patients nursed on ward 1.

Utilising information from the daily staffing tool the ward recorded 76 patients which required enhanced observation during January 2016 (this number would exclude weekends). All of these patients would have been scored as level 1b.

This level of dependency would impact on the ward's outcomes which will have contributed to the ward's current position.

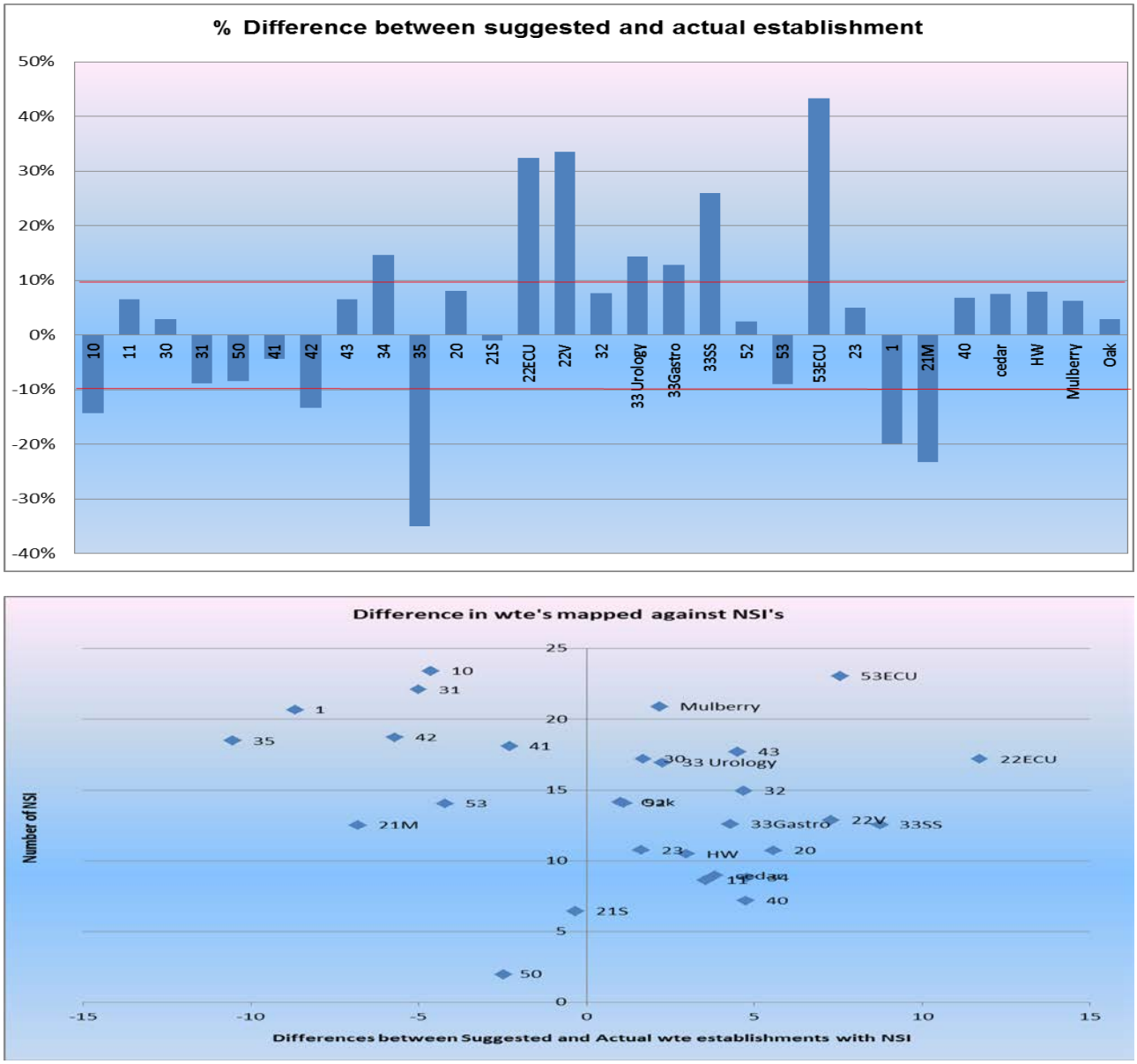
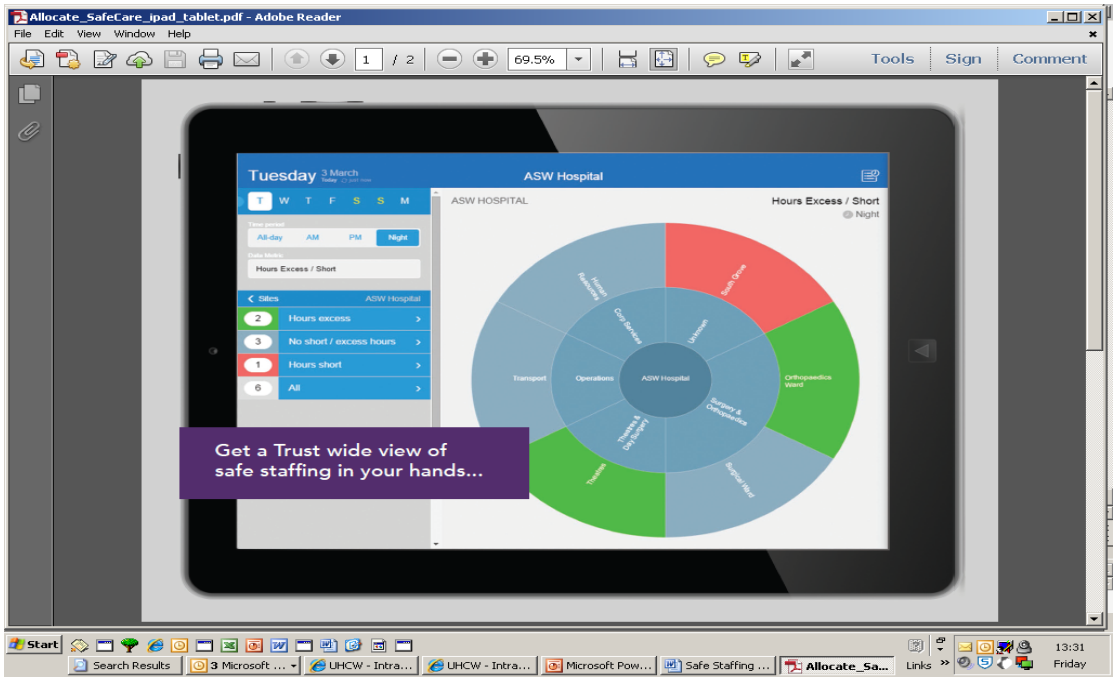


Chart 3 - the relationship between NSIs and the difference between suggested and a

The NSIs (nurse sensitive indicators) should be viewed in conjunction with the differences between funded and SNCT multiplier suggested establishments. This indicates for some wards the NSI rate is high despite funded establishments being above the agreed parameters. However, there are also examples of wards which are below the agreed parameters with a lower number of NSIs. It is, therefore, difficult to determine any specific relationship between staffing and nurse sensitive indicators. Chart 3 demonstrates the relationship between NSIs and the difference between suggested and actual wte's using the SNCT (NB not percentage difference).

'SafeCare' is acuity and dependency module that works in conjunction with the electronic roster. Introducing this tool has involved a deep dive and an evaluation of templates used on each ward/department for electronic rosters. Nurses will input a patient census three times

daily, this will then give us a more accurate picture of exactly what staff and skills mix are on each ward at any given time and how this relates to the patient needs.



A screen shot of what 'Safe Care' will look like form a trust view

A pilot on four wards was planned to commence at the end of 2015 however there were some technical difficulties with software that prevented this from happening. These have since been resolved and the pilot has just commenced in May 2016.

Acuity and dependency is an important element to take into consideration when analysing safe staffing however what is also of great importance is the amount of time staff spend delivering direct patient care.

3. Care Contact Time

'A Guide To Care Contact Time' was published by NHS England in November 2014. This is a method to determine the percentage of time nurses spend delivering direct patient care. This is about taking safer staffing beyond numbers, and looking in depth at the actual care being delivered to our patients, based on the activity of our nursing staff.

The guidance recommended that organisations should undertake a care contact time baseline assessment by summer 2015 and repeat this every six months.

The initial assessment of care contact time commenced in April 2015 at UHCW and took five months to complete in forty five inpatient areas, ending in August 2015. The findings of this report were presented in the staffing report to Trust Board in Nov 2015.

Reflecting on the initial roll out and working with ICT a care contact time APP has been designed and built. This has created an electronic solution to data collection and provides live reports, making the process more rigorous and timely.

Working together nursing, therapy and medicine have revisited the codes. This has resulted in a multi-disciplinary approach, to recording care contact time, which will better reflect the reality of care delivered in wards and departments.

Consequently this has resulted in number of unique developments nationally around this service improvement programme.

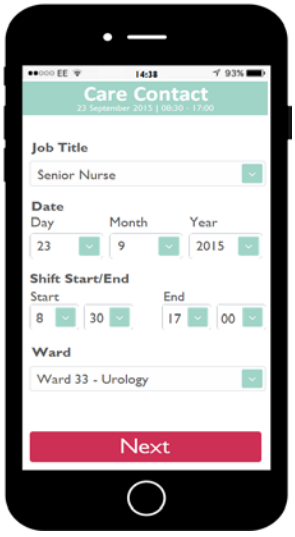
Category	Hours	Percent
Direct Care (ANP)	10.67	1.96 %
Direct Care (Medicine)	17	3.12 %
Direct Care (Nursing)	245.59	44.92 %
Direct Care (Process)	41.58	7.60 %
Direct Care (Therapy)	31.16	5.70 %
Indirect Care (ANP)	14.92	2.73 %
Indirect Care (Medicine)	7.5	1.38 %
Indirect Care (Nursing)	59.67	10.91 %
Indirect Care (Therapy)	21.92	4.00 %

To test the new tools and reporting system the care contact team decided it was important to undertake a pilot. This would ensure any problems with the APP and electronic reporting system could be addressed prior to rolling out these changes Trust wide

Trauma and Orthopaedics were approached and agreed to be the pilot ward. This speciality was chosen because

- The junior doctors had developed the codes for medicine
- Therapy services from Trauma and Orthopaedics were keen to participate.

The date for the pilot was agreed, commencing at 07:30hrs on the 24th February and ending at 08:00hrs on the 25th February and included the following wards and clinical teams Ward 52, Ward 53, Ward 53MTECU, Nursing, Medicine, Therapy & Advanced Nurse Practitioners.



The data in the table demonstrates for the first time nationally, a multi professional contact time.

Non-patient Activities	96.75	17.69 %
	546.76	**100.00 %**

The data shows the amount of time spent in direct and indirect care and non-patient activities in Trauma and Orthopaedics.

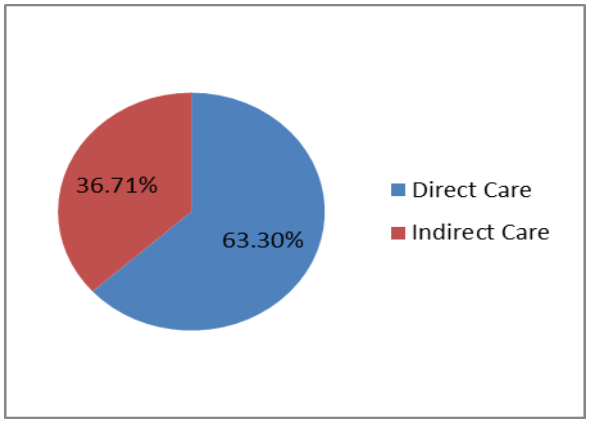


Chart 1 Care contact time for Trauma & Orthopaedics

Chart 1 shows the first overall multi-professional care contact time. This is a better reflection of how care is delivered in wards and department through teams working together in partnership.

Drilling further into the data the new reporting system now makes it possible to show how each member of the multidisciplinary team is spending their time. Charts three to seven demonstrate the top five jobs tasks undertaken by each of the professional groups

Breakdown of Care contact time for each profession

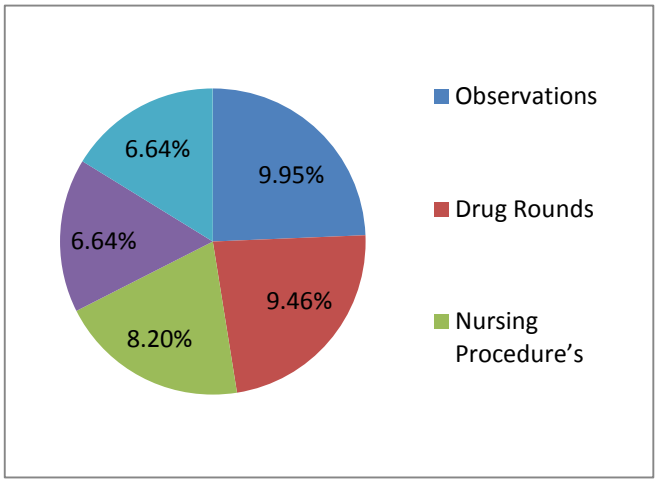


Chart 2 Registered Nurses top five job tasks

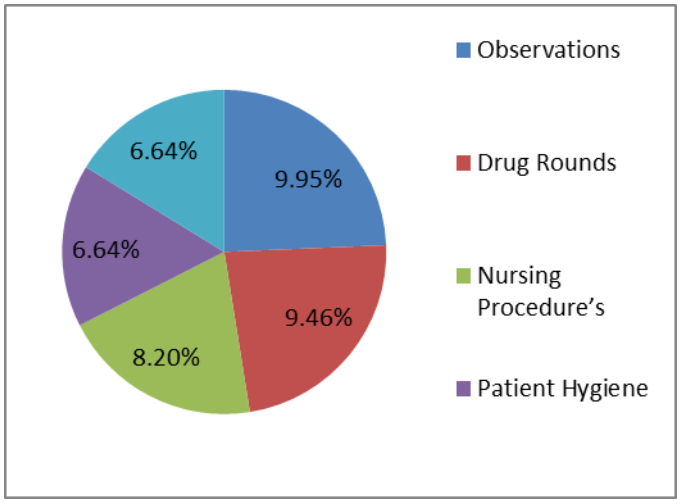


Chart 3 Health Care Support Worker top five job tasks

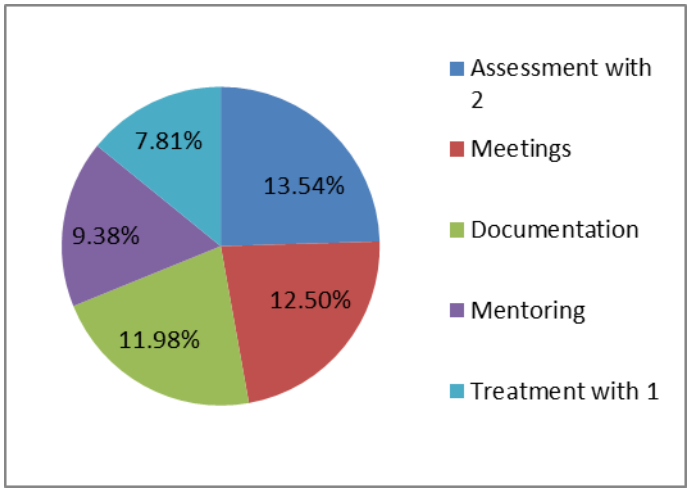


Chart 4 Occupational Therapy top five job tasks

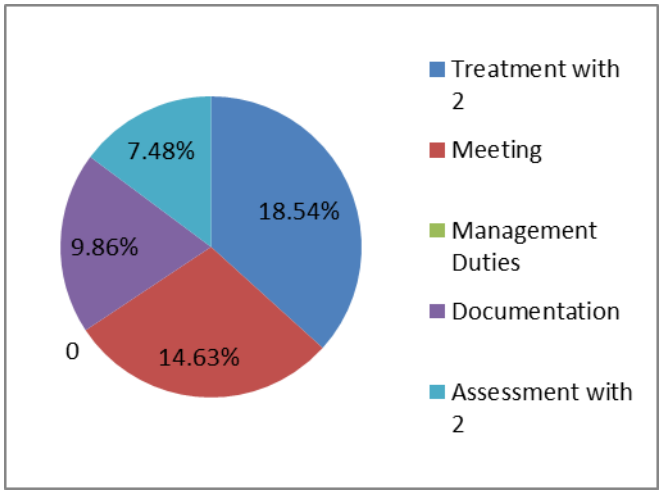


Chart 5 Physiotherapy top five job tasks

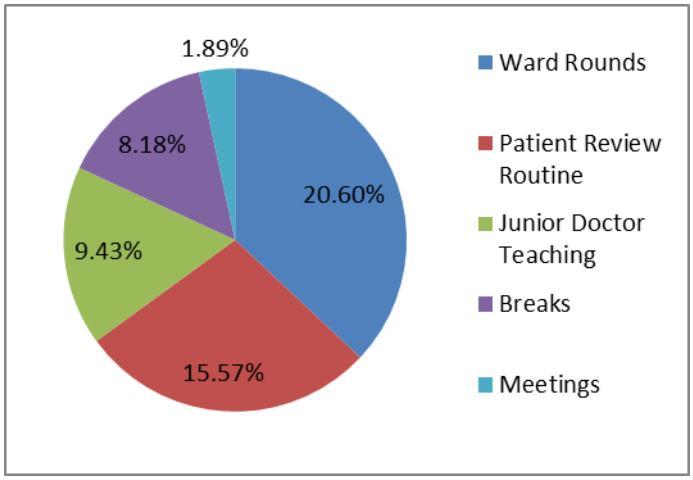


Chart 6 Junior Doctors top five job tasks

The new reporting system will also show how individual members of the team spend their time throughout the shift. This information could be used to support individual staff with their revalidation process.

Overall feedback from the staff was really positive and they were keen to see the outcomes of the pilot. All the staff in Trauma and Orthopaedics felt the APP was simple and easy to use.

This data will provide the clinical teams in Trauma and Orthopaedics with the first opportunity nationally to work together using shared outcomes, to improve and streamline systems and processes to increase care contact time for the benefit of our patients.

Recommendations from the pilot

- Develop a multi professional care contact time action plan with the team from Trauma and Orthopaedics
- Review and streamline the codes
- Develop an e-learning package
- June 2016 launch the APP Trust wide with training sessions and the e learning package
- Include clinical areas not previously included in the data collection for example the Emergency Department
- Roll out across the Trust between July and August 2016 by speciality
- Identify senior leads for each professional group to ensure outcomes are fed back in a timely manner and used to improve care contact time
- Organise a second Trust wide care contact time event which will be multi professional following its roll out in July and August

4. Care Hours Per Patient Day (CHPPD)

Care Hours Per Patient Day is a way of representing staffing data that puts the nursing hours in the context of the patient activity, in a easy to understand figure. It is calculated by dividing the number of actual nursing hours by the number of patients. It therefore

represents the number of nursing hours that are available to each patient. It is widely used as a nursing outcome indicator in South Africa, America, New Zealand and Australia.

During October 2015 (1st to 30th) 32 NHS Trusts including UHCW undertook a full month nurse staffing data collection to measure CHPPD across all wards. This data was submitted to Lord Carter's team at the Department of Health (DH). From June 2016 this data will be submitted monthly via the Unify system to DH.

The Model Hospital, using the CHPPD methodology allows a localised, efficiency-oriented approach to productivity: it situates the measurement of staffing contact with patients and clinical outputs in the broader context of cost efficiency and the quality of care, and it does so using measures that are meaningful to decision-makers at ward and board levels. The use of Care Hours Per Patient Day will allow Trusts to see how their CHPPD relates to other Trusts within a specialty and will encourage them to review variation. CHPPD would be one part of the wider nursing productivity dashboard including quality measures – from a productivity perspective ensuring the optimal allocation of workforce resources to maximise outputs and outcomes.

The intention of CHPPD is to:

- Reflect an estimate of the amount of time nurses available to patients each day
- Provide a measurement that enables wards and units and patient groups to be benchmarked on an intra-hospital and inter-hospital level, regardless of unit size.
- Allow the cost of delivering efficient care to be monitored in a timely manner
- Monitor the trends in CHPPD over time within the Trust and correlate with other key KPI data
- Assess the utilisation of nursing resources on a monthly basis, identifying areas for further scrutiny
- Allow work practices affecting data integrity to be monitored
- Aid the review of nursing establishments and skill mix.

As this is a new concept for staffing wards/departments workshops are planned for the nursing teams.

5. Ward staffing review

The following assessments (page 13-17) of all wards at UHCW are undertaken twice yearly and have utilised the SNCT, NICE guidance (looking at nurse patient ratios), CHPPD and professional judgment. The parameters for assessment are;

- SNCT +/- 10% from WTE establishment
- NICE ratio greater than 1:8 (subsequent guidance states this should not be unthinkably adhered to without looking at other parameters)
- Skill mix ratio – professional review
- CHPPD – we do not as yet have a national benchmark for comparisons for the UK however there is guidance from Western Australia for reference purposes.

The nurse to patient ratios has improved since the last assessment in November following review of rotas and E-roster templates on wards 11, 31, and AMU 3.

Ward 34 and 35 have just completed a proposal following a review of their combined establishments and the geography of the wards. The proposal will improve the acuity and dependency and nurse to patient ratio on ward 35.

Similarly wards 30 and 31 have completed a paper to reconfigure their wards; this is currently on hold until a decision is made on a medical enhanced care unit.

The National Maternity Review was released in February 2016. The focus of the report is to provide a personalised service to every woman involving safe and effective care and at the same time a good experience. All staff must be supported to deliver such care, promoting multi-professional working with any existing barriers being broken down.

Each maternity service must take into consideration the needs of the women who will be using the service taking, into account the pathways of care and the local geography. The staffing levels must be adequate to provide a safe high quality service to the women and their families. It is important that we ensure that we have the right staff, in the right place, at the right time.

Birthrate plus is a midwifery specific tool that is recognised nationally and endorsed by the Royal College of Midwives. It provides information regarding activity, demographics and case mix in addition to skill mix. It will calculate the ratio of clinical midwives to births. A Birthrate plus review will be undertaken in the maternity department in the coming months.

Please note ‘Other’ in the following tables refers to activity coordinators on all wards apart from the Paediatric wards where it refers to play specialists.

Ward (No of Beds)	Spec	WTE RN/HCSW	Other	Acuity	RN to Pt (Early)	RN to Pt (Late)	RN to Pt (Night)	SMR %	CHPPD
1 (34)	Spec Med	23.45/19.96		-8.69/-20%	1:7	1:8	1:11	54/46	5.7
Observation Ward (19)	ED	16 /11.84		+1.64/-6%	1:6	1:6	1:6	60/40	8.7
10 (28)	Cardiology	22.54 /9.72		-4.63/-14%	1:6	1:6	1:7	69/31	5.9
11 (22) 11SDU (14)	CT Surg	40.59/13.92		+3.57/+7 %	1:4 1:3	1:5 1:4	1:7 1:5	75/25	7.4 7.7
CCU (10)	Cardiology	17.69/3.12			1:3	1:3	1:3	85/15	12.6
20 (42)	Gerontology	39.7/31.62	1.99	+5.56/+8 %	1:7 1:6	1:8 1:6	1:11 1:7	55/45	8.1
21M (24)	Gerontology	17.25/11.98	0.55	-6.80/-23%	1:6	1:8	1:12	43/57	7
40 (42)	Gerontology	39.1/31.62	1.36	+4.76/+7 %	1:7 1:6	1:7 1:6	1:8 1:7	55/45	8.4
AMU 1	Acute med	45.07 /22.95		+17.61/+24%	1:5	1:4	1:5	66/44	10.5
AMU 2 (12)	Acute med	13.69/7.75		+2.52/+7 %	1:4	1:4	1:6	61/39	6.7
AMU 3 (26)	Acute med	21.83 /17.96		-7.11/-19%	1:6	1:6	1:9	53/47	7.1

Ward (No of Beds)	Spec	WTE RN/HCSW	Other	Acuity	RN to Pt (Early)	RN to Pt (Late)	RN to Pt (Night)	SMR %	CHPPD
21 surg (24)	Surgery	22.86 /13.66		-0.31/-15	1:6	1:6	1:8	56/44	6.5
22 Vas (12)	Surgery	12.37/9.37		+7.28/+33%	1:6	1:6	1:6	54/44	7.9
22 ECU (18)	Surgery	24.59 /11.97		+11.72/+43%	1:5	1:5	1:5	66/34	10.4
22 SAU (22)	Surgery	21.75/9.34		+1.96/+6%	1:6	1:6	1:7	72/28	8.1
33 gastro (24)	Surgery	21.74/11.97		+4.3/+13%	1:6	1:6	1:8	64/36	6.6
33 URL (12)	Surgery	12.37/3.39		+2.66/+14%	1:6	1:6	1:6	75/25	6.6
33 SS (24)	Surgery	21.74/11.97		+8.75/+26%	1:6	1:6	1:8	68/32	6.6
32 (34)	ENT	37.99/23.94		+4.7/+8%	1:6	1:6	1:7	60/40	9
34 (17)	Haem	27.67 /5.52		+4.79/+15%	1:4	1:4	1:4	81/19	9
35 (30)	Onc	28.24/9.40		-10.54/-35%	1:5	1:5	1:10	74/24	5.7
23 (28)	Gynae	21.02/11.95		-8.69/+5%	1:7	1:7	1:9	66/34	5.7

Ward (No of Beds)	Spec	WTE RN/HCSW	Other	Acuity	RN to Pt (Early)	RN to Pt (Late)	RN to Pt (Night)	SMR %	CHPPD
30 (40) incl NIV 4	Resp	35.67 /21.5		+1.68/+3%	1:7 1:2	1:9 1:2	1:9 1:2	62/38	6.7
31 (48)	Resp	29.59/26.66		-5.00/-9%	1:8	1:8	1:10	52/48	5.5
41 (24)	Stroke	33.22/19	0.51	-2.30/-4%	1:8	1:8	1:12	63/27	6
41 Ha (12)					1:4	1:6	1:6		
42 (36)	Neurology	25.14/17.68		-5.72/-13%	1:6	1:9	1:12	58/42	5.5
43 (34)	Neuro Surg	44.23/24.32		+4.49/=15%	1:6	1:7	1:12	64/36	6.9
43 SDU (12)	Neuro Surg				1:4	1:4	1:4		7.5
52 (36)	T & O	23.3 /17.37		+1.11/+2%	1:5	1:6	1:12	57/43	7.1
53 (36)	T & O	25.66/21		-4.21/-9%	1:6	1:6	1:12	54/46	6.5
53 ECU (7)	T & O	12.37/5.06		+7.55/+43%	1:4	1:4	1:4	70/30	11.8

Ward (No of Beds)	Spec	WTE RN/HCSW	Other	Acuity	RN to Pt (Early)	RN to Pt (Late)	RN to Pt (Night)	SMR %	CHPPD
14 (12)	Paeds	14.4 /3.68	5.88		1:4	1:4	1:6	70/30	7.7
15 (19)	Paeds	28.42			1:4	1:4	1:4		11.7
15 HDU (4)	Paeds	12.4			1:2	1:2	1:2		18.7
16 (24)	Paeds	31.2/6.52			1:4	1:4	1:4 1:5 Sat/Sun	83/17	10.3
Cedar (41)	T & O	34.31 /17.05		+3.84/+7 %	1:7	1:7	1:8	66/34	7.4
Hoskyn (25)	Rehab	22.14/15.35		+2.99/+8 %	1:6	1:6	1:8	60/40	7.4
Oak (22)	Med	18.6/15.39		+1.01/+3 %	1:7	1:7	1:7	53/47	7.4
Mulberry (22)	Med	18.9/16.4		+2.19/+6 %	1:7	1:7	1:7	54/46	7.5
50 (22)	Renal	19.54/10		-2.47/-8%	1:6	1:8	1:8 1:11Sat/Sun	67/33	5.6

Ward (No of Beds)	Spec	WTE RN/HCSW	Other	Acuity	RN to Pt (Early)	RN to Pt (Late)	RN to Pt (Night)	SMR %	CHPPD
24 (20)	W & C	15.53/5.87		1:7	1:7	1:10		71/29	6.6
25 (34)	W & C	21.71/15.14		1:8	1:8	1:11		56.44	8.8

6. Conclusion

The challenge is to get the balance right by neither under staffing nor over –spending and by having the right complement of clinical staff to meet patient needs and circumstances. It is also important to look at staffing in a flexible way which is focused on quality of care, patient safety and efficiency rather than just numbers.
We will continue with developments outlined in this report and await further guidance from NHS Improvement which is expected later this year.

University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD PAPER

Title	**You Said, We Did Update Report: November 2015- March 2016**
Author	**Anita Kane, Associate Director of Quality** **Laura Boyd, Patient Experience Facilitator**
Responsible Chief Officer	**Meghana Pandit, Chief Medical and Quality Officer**
Date	**30 June 2016**

1. Purpose

To present the bi-annual 'You Said, We Did' paper that details recent actions the Trust has taken after listening to user feedback. The paper also details the activities the Patient Experience Team will co-ordinate as part of the refreshed 'We are Listening' campaign for our patients, carers and relatives.

2. Background and Links to Previous Papers

This is an update to the Trust Board as part of the Together Towards World Class Programme. This report follows on from the report submitted to the December's Trust Board meeting and provides assurance that the Trust continues to act upon feedback that is received and to make changes as a result.

3. Narrative

It is important that the Trust puts listening into action and this paper demonstrates those activities which the Patient Experience Team has been informed about. There will, undoubtedly be more. This demonstrates our commitment to acting on our users' feedback and changing or enhancing systems and processes or environments that will deliver a better patient experience. This aligns with our organisational vision of being a national and international leader in healthcare and delivering a world class patient experience.

4. Areas of Risk

If the Trust does not act on feedback that is provided the following risks may arise:

Quality risks; patients may not receive the quality of patient experience that they and the Trust would want, resulting in dissatisfaction and the possibility of patients choosing to be treated elsewhere.

Reputation risks; the Trust's reputation may be adversely affected if patients are dissatisfied with the experience that they receive which also may result in patients electing to be treated elsewhere.

5. Governance

NHS Constitution

Section 3b:

Please give feedback – both positive and negative – about your experiences and the treatment and care you have received, including any adverse reactions you may have had. You can often provide feedback anonymously and giving feedback will not affect adversely your care or how you are treated. If a family member or someone you are a carer for is a patient and unable to provide feedback, you are encouraged to give feedback about their experiences on their behalf. Feedback will help to improve NHS services for all.

Section 4b

- to contribute towards providing fair and equitable services for all and play your part, wherever possible, in helping to reduce inequalities in experience, access or outcomes between differing groups or sections of society requiring health care;

- to view the services you provide from the standpoint of a patient, and involve patients, their families and carers in the services you provide, working with them, their communities and other organisations, and making it clear who is responsible for their care;

6. Responsibility

Anita Kane, Associate Director of Quality
Meghana Pandit, Chief Medical and Quality Officer

7. Recommendations

[A] The Board is invited to **NOTE** the actions staff have taken as result of listening to user feedback.

Name and Title of Author: Anita Kane, Associate Director of Quality

UHCW NHS Trust

We Are Listening
Patients, Friends and Family.

Patient Experience
We Are Listening: You Said, We Did in 2015/2016

Between November 2015 and March 2016, the Trust continued to listen and act on the views of its patients, relatives and carers.

With all this wealth of information on patient, relative and carer experience, the Trust has worked hard during 2015/16 to bring about improvements in line with what is important to those who use its services. Based directly on feedback from patients, relatives and carers, areas and departments have carried out:

You Said	We Did	Source
Trust Wide		
"Staff don't always introduce themselves"	The #hellomynameis campaign was launched across the Trust and has been really well received by all staff. An additional question has also been added to the online Impressions Survey asking respondents whether staff introduced themselves.	FFT, Impressions, Complaints, PALS, NHS Choices
University Hospital Only		
"We drive around full car parks looking for a space"	Electronic signs indicating how many spaces there are have been installed at UH.	FFT/Impressions/PALS
"There is traffic congestion on site"	Improvements have been made to the bus pick up and drop off point so that they can easily move around. There has been reconfiguration of the roundabouts and zebra crossings which are hoped will help improve traffic congestion.	FFT/Impressions/PALS
"The disabled car park surface is inadequate for people with mobility issues"	The car park has been resurfaced.	PALS
"There was no privacy for inpatients that were waiting in the radiology department on the ground floor"	All patients who are not in-patients requiring a radiology appointment are now directed out into the main corridor and through the department entrance at	TMI, CQC, Impressions, FFT, PALS, Complaints

You Said	We Did	Source
	the back. This way all inpatients that are waiting are left in privacy.	
"not sure how to access a copy of my consultation letter"	Introduction of notices throughout clinics advising patients how they can acquire a copy of their consultation letter.	Complaint
The Hospital of St. Cross Only		
"Waiting times for blood taking is too long"	The blood taking department has been relocated and now provides a much more pleasant environment for patients. The new unit also has extra capacity and more staff are now available, with new processes to help speed things up and improve experience. The new system is designed to be more comfortable to patients and more efficient for blood-taking staff.	FFT, Impressions
"Being in hospital is often lonely and boring"	Every Monday a Pets As Therapy dog (and owner) visits the Hospital of St Cross to provide company and therapy for the patients.	FFT, Impressions
"Hot meals are not available for patients transferring back from UH or from theatres after the meal service has finished"	We have now introduced the 'Lightbite' menu which offers food outside of meal times for these patients.	Complaint
Maternity Department		
"Partners were upset at not being able to accompany partners to the post natal ward during the night"	Now offer Mum +1 option on the post natal ward to allow partners to stay with their partners and new babies.	FFT
"The lunchtime menu for diabetic patients is not suitable. There is too many carbohydrate based foods"	Labour Ward now offers all menu choices from 7am – 6pm to be ordered for diabetic patients. Snack box options are also available 24/7.	Birth Listening Service
"We wanted skin to skin contact with our babies in theatre following Lower Segment Caesarean Sections"	This has been introduced, and offered as routine	Supervisor of Midwives Birth Listening Service
Children's Emergency Department		
"The waiting area is always	The Modern Matron now	FFT, Impressions

You Said	We Did	Source
dirty"	has a weekly meeting with ISS about cleaning. A cleaning checklist has also been displayed so that the public can see how often the facilities are cleaned. Additional ISS time has been allocated to the department to facilitate an increase in cleaning during busy periods.	
Paediatrics		
Mismanagement of medication	Provided additional education on prescribing for children in Dr induction in addition to paediatric Dispensing training.	Complaint

University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD PAPER

Title	**Equality and Diversity Annual Update**
Author	**Barbara Hay, Head of Diversity**
Responsible Chief Officer	**Karen Martin, Chief Workforce and Information Officer**
Date	**30th June 2016**

1. Purpose

The purpose of this report is to provide assurance to the Trust Board in relation to the Equality Delivery System 2 (EDS2) and the new NHS Workforce Race Equality Standard (WRES). As part of the agreed governance and monitoring process, the Equality and Diversity (E&D) team provides the Trust Board with an annual report and/or updates on the Trust's EDS2 Action Plan. This is also an expectation of both the Equality and Human Rights Commission and NHS England.

2. Background and Links to Previous Papers

- Each year E&D is required to report to Trust Board on progress against the EDS2.
- Each year the Trust is required to complete the WRES reporting template as mandated by NHS England.
- A report was received by Trust Board on 17th December 2015 to approve the content of the WRES Action Plan.
- An annual report was received by Trust Board on 25th June 2015 highlighting key points and any points for escalation.

3. Executive Summary

The Equality and Diversity team with support from the Independent Advisory Group Equality and Diversity (IAG) has implemented and delivered a number of training programmes and activities to develop knowledge, skills and understanding. The team has worked in partnership with internal departments and external agencies supporting staff to better understand the needs of our patients specifically those identified through the Equality Act i.e. Protected Characteristic groups.

The E&D team has also implemented a number of training activities to further develop our workforce in understanding the need to make respect and dignity key elements in all that they do through recognising and embracing diversity.

The EDS2 and the WRES are requirements of NHS England.

EDS2

Each year we are required to Red, Amber or Green (RAG) rate our progress against the Trust's EDS2 Action Plan. A desktop RAG rating has been undertaken (Appendix 1) and the initial findings show the number of ratings as follows:

Red: 1
Amber: 3
Green: 19

These ratings will be validated on 15th July 2016 by the IAG which includes our community partners and internal stakeholders. This will be the final rating for the majority of the current Action Plan. The next phase of the plan will be further developed in consultation with the IAG and will be finalised at the September IAG meeting.

Excellent progress has been made with the current Action Plan which, we believe, will give us an overall rating of Green. Some examples of the work that has been undertaken to achieve this rating are:

- Produced a training video in partnership with the Voluntary Services department and Patient Experience team to enable staff to support Blind/visually impaired and Deaf/hearing impaired patients.
- Secured funding to provide all wards with a 'Toolbox' containing resources that will enable Blind/visually impaired and Deaf/hearing impaired patients to be more independent and access important information whilst staying in hospital.
- Presented the video and Toolbox at Trust Board and Grand Round.
- Delivered Dignity at Work training to over 300 staff, further developing their understanding of issues that can negatively impact on the working environment.
- Supported several departments in developing their own 'Team Charter' setting out how they will behave and treat each other in line with the Trust's values.
- Provided Equality and Diversity training as part of the Trust's mandatory training programme (96.22% compliance – April 2016) as well other bespoke training programmes, such as the mental health, mental capacity and restraint day.
- Bespoke training for Volunteers.
- Delivered Master Classes in support of the Trust's Leadership programme.
- Provided feedback regarding cultural menus for patients in partnership with ISS.
- Consulted with Coventry Refugee and Migrant Centre to identify specific needs/issues for refugees, migrants and asylum seekers.
- Held the Embrace Equality – Enhance the Experience open day with internal and external exhibitors. Over 200 people attended on the day. This was in celebration of the NHS Equality, Diversity and Human Rights week.

Changing Futures Together (Supported Internship programme)

This year the E&D team has lead on a major project which exemplifies the Trust's commitment to make meaningful changes to its practice and ensure true engagement and accessibility for members of our community from Protected Characteristic groups. This project not only supports our local agenda but also aligns with national aims to address gaps and issues as they relate to specific groups.

The E&D team has worked in partnership with The Employment Support Service (TESS), part of Coventry City Council's Employment Team, to develop a Supported Internship programme for young disabled people.

This initiative has provided seven young people with learning disabilities from Hereward College the opportunity to complete work placements in a variety of departments and settings at UHCW during a nine month programme.

The interns work alongside staff and are supported by dedicated Job Coaches/experienced Employment Advisors. All interns are treated in the same way as employees, receiving a full induction, occupational health checks and risk assessments. The aim of Supported Internship is to enable interns to gain work experience through on-the-job training and provide them with the skills and knowledge required for paid employment. They also work towards a nationally recognised qualification.

The interns take on various roles to support patient care either on the wards, administration or facilities. In striving Towards World Class People, this programme strengthens the social responsibility the Trust has as one of the largest employers in Coventry and Warwickshire.

Since the start of the programme, two interns have been successful in gaining permanent employment, one in a full time role and the other part time. There will be a new intake in September 2016 and there is now an extensive range of placements to offer the interns including ICT, catering, porter's duties, administration, reception and elements of a Health Care Assistant role.

A key success to report to the Board is that one intern has secured a fixed term contract with the Trust with the possibility of a permanent position in the future. Discussions are currently taking place with ISS exploring possibilities for two other interns.

Workforce Race Equality Standard (WRES)

Last year saw the introduction of the WRES and a supporting Action Plan was developed to fulfil the requirements of NHS England. The WRES is intended to identify issues, gaps and areas of concern relating to Black Minority Ethnic (BME) staff in the NHS.

A small working group (which includes ESR and Workforce Information Team, Staffside, Learning & Development, HR Business Partners and TTWC) has worked together to

ensure a joined up approach implementing the WRES plan to provide relevant and appropriate outcomes to meet the needs of our BME staff.

The actions identified are directly related to the WRES reporting template but also support the Trust's TTWC programme as well as the Trust's Objectives to be an Employer of Choice and to Deliver Excellent Patient Care and Experience. On 17th December 2015 the Trust Board approved the jointly developed WRES action plan.

- Good progress has been made in completing the majority of actions in the agreed time frames.
- NHS Equality and Diversity Council (EDC) has recently published the 2015 data analysis report identifying key findings and enabling Trust to understand how they compare to other like Trusts.
- New WRES guidance has recently been published stating the next report is expected to be shared with Trust Board and published by 1st August 2016.

It is not possible to provide any further information on this year's WRES report because although the EDC have provided the guidance, Trusts have been instructed to use information to be supplied by them for the necessary calculations. We have been advised that information will be made available 1st July 2016.

Therefore, it is recommended that Trust Board receive a full WRES report at the July meeting when the new template and plan can be presented for agreement prior to publication.

Translation and Interpretation

We have continued to use Language Line Solutions (LLS) as our service providers through the extension of the Health Trust Europe's (HTE) original framework whilst a new framework was developed. The new framework is now in place and LLS continues to be one of the preferred supplier of this service. It is envisaged that there will be a reduction in the hourly cost and that the Trust will continue to use LLS.

During the period January to December 2015, it has been identified that a possible £31,456 could have been saved if telephone interpreting had been utilised for short appointments.

Language Line Solutions (LLS) has kindly agreed to provide the Trust with as many dual handset phones as required free of charge. The only necessity is for the Trust to source adaptors to connect phones to current sockets and to agree to return phones that are not being used.

The Maternity Department, as one of the highest users of the interpreting service, is piloting the use of these phones for a six month period. LLS are providing training on how and when it is appropriate to use telephone interpreting and will be monitoring usage on a monthly basis.

The Trust's current British Sign Language (BSL) interpreting service providers, Coventry & Warwickshire Sign Language Interpreting Service, are not on the new HTE framework.

They have been made aware that it is unlikely that the contract will be extended after this date. However, the Trust will be honouring the contract until March 2017.

The E&D team has been in discussions with other BSL providers, who are on the framework, with a view to identifying the most appropriate service provider who could be awarded the contract in 2017 to ensure a smooth transition.

Equality Data

In line with legislation (Equality Act 2010), the Trust must publish its Equality data annually by 31st January and for the fourth year running the Trust has been compliant in meeting this deadline. The data is available on the Trust's website and provides comparisons for the last three years data collection. As required, the data covers all of the Protected Characteristic groups (dependent on employee disclosures) in terms of workforce and patient information.

4. Link to Trust Objectives and Corporate/Board Assurance Framework Risks

The work of the E&D team contributes to the Corporate Objectives implicitly in that it enables staff to develop skills and knowledge to support patient experience. Not only that, it is recognised that when staff are happy/satisfied with their work, there is a direct positive impact for patients.

The work that has taken place to provide patients with resources and staff with the knowledge to support different Protected Characteristic groups contributes to achieving the Corporate Objectives.

5. Governance

- The Trust is required, by the Equality Act 2010, to eliminate discrimination, victimisation and harassment, advance equality of opportunity and foster good relations between different groups. We are also required to publish Equality data annually.
- NHS England requires the Trust to have in place an EDS2, to be Red, Amber, Green (RAG) rated annually. It includes a core set of outcomes.
- Progress of the EDS2 is monitored by the Independent Advisory Group (Equality & Diversity) which reports to the Workforce and Engagement Committee.
- There is a requirement for WRES reporting template to be submitted to NHS England and published on the Trust's website in order to be compliant.

6. Responsibility

Author/Lead – Barbara Hay, Head of Diversity
Chief Officer – Karen Martin, Chief Workforce and Information Officer

7. Recommendations

The Board is invited to **note**:

1. Progress against the EDS2 Action Plan 2015-16 and provisional RAG rating.
2. The success of the Changing Futures Together Supported Internship programme.

and **agree**

1. To receive a full WRES report at the July Trust Board.

Name and Title of Author: Barbara Hay – Head of Diversity
Date**: June 2016**

UNIVERSITY HOSPITALS COVENTRY & WARWICKSHIRE NHS TRUST
Equality & Diversity Action Plan 2015 – 2016

1. Better health outcomes for all

World class services

The NHS should achieve improvements in patient health, public health and patient safety for all, based on comprehensive evidence of needs and results

Actions	Method	Lead(s)	Target date	Measures	Progress
Independent Advisory Group (IAG) to support the Trust in ensuring that service delivery is appropriate, accessible and equitable for all members of the community.	Bi-monthly IAG meetings. Invite guest speakers who are able to provide insight and intelligence regarding equality issues as they affect patients and/or staff. Devise a process that will enable staff, patients and other relevant stakeholders to raise equality and diversity issues at the IAG	Barbara Hay (Head of Diversity)	Ongoing	- Regular notes, updates and reports provided to HR Equality & Diversity (now known as Workforce and Engagement Committee (WEC) and Trust Board - Feedback issues raised and identified at IAG meetings to HRED and/or relevant individuals/departments - Evidence of responses to consultations, Equality Impact Assessment (EIA's), requests for information is identifiable Issues affecting patients/staff and other relevant stakeholders will be addressed through training, guidance material, change practices etc.	• Regular reports presented to:- - HRED - Trust Board - WEC • All policies and significant change supported by EIA and/or reviewed by Head of Diversity. • Clay Lane (satellite centre) • BSL Charter • WRES • Car parking • Easy read • Disability access • Human Metabolic Research • Care Quality Commission • Freedom of Information requests • Complaints • Accessibility video • Toolkit for blind/visually impaired and deaf/hearing impaired patients • Dignity at Work training • Departments/team charters • Induction training • Deprivation of Liberties and Mental Health training • Volunteers training • TTWC leadership master class **Achieved** ■■■■■

UNIVERSITY HOSPITALS COVENTRY & WARWICKSHIRE NHS TRUST
Equality & Diversity Action Plan 2015 – 2016

Actions	Method	Lead(s)	Target date	Measures	Progress
Ensure IAG continues to be relevant and is able to shape and influence the Trust's Equality, Diversity and Human Rights agenda	Review membership and Terms of Reference Training and development for IAG members	Barbara Hay Monica Mabbett (Equality & Diversity Assistant)	November 2015 Ongoing	- Updated Terms of Reference - Evidence of training and/or development activities for IAG members	- Terms of Reference reviewed and agreed – May 2016. - Guest speakers included: - Heart of England Coventry Carers re. LGBT - GP Assessment Unit - Estates & Facilities - Macmillan CAB - Human Metabolic Research Unit - Coventry Refugee and Migrant Centre - HR Business Partner and Employee Relations Specialist **Achieved** ■■■■■
IAG will support the Trust by monitoring progress against the actions identified in the Equality and Diversity action plan	Equality and Diversity action plan will be a standing agenda item for all meetings	IAG	Ongoing	- Evidence of regular updates from identified leads in the action plan - Updates to WEC and the Trust Board	• Bi-monthly meetings addresses E&D matters and key issues are reported to:- - HRED - Trust Board - WEC • Leads attend IAG meetings to update on progress. **Achieved** ■■■■■
IAG to take the lead in Red, Amber, Green (RAG) rating the Trust's Equality and Diversity Action plan.	To be determined by the IAG which may include a RAG rating event, questionnaire	IAG supported by Barbara Hay Monica Mabbett	September 2015	- RAG ratings activities will have taken place - Results of RAG rating events will be reported to Workforce and Engagement Committee (WEC) - RAG ratings published on the Trust's internet site.	IAG to review and validate the proposed RAG rating (July 2016). WEC to ratify RAG rating outcomes. (Likely to be) **Achieved** ■■■■■:

UNIVERSITY HOSPITALS COVENTRY & WARWICKSHIRE NHS TRUST
Equality & Diversity Action Plan 2015 – 2016

Actions	Method	Lead(s)	Target date	Measures	Progress
To provide patients and community with relevant advice and information relating to Equality, Diversity and Human Rights and acute care	Collate information regarding community events The Trust will have representation and/or support at relevant events	IAG Anita Kane (Associate Director of Governance) Julia Flay (Patient Involvement Facilitator)	Ongoing	- To have either, participated in, organised or had representation at least four events - Evidence of relevant accessible and targeted material e.g. leaflets, posters etc. - Article published in the In Touch magazine reporting on events	- Presentation given to Coventry Deaf Club in conjunction with the British Deaf Association (BDA) in March 2015. The BDA's British Sign Language (BSL) Charter was signed by the Trust in May 2015. - Annual update to Coventry Deaf Club - Engagement event at Coventry Resource Centre for the Blind - NHS Ambassador - Careers event for Foxford School. - Visit from South Downs College and University Hospital Birmingham to learn about our Supported Internship programme. - Provided advice, information and guidance Pennine Trust re: community engagement and development of EDS2. - Embrace Equality – Enhance the Experience event with 25 exhibitors (May 2016) - Fact sharing visit to Hereward College re: Apprenticeships **Achieved** ■■■■■
Raise frontline staff awareness of how to interact with patients with Learning Disability/ Difficulties	Learning Disability/Difficulties awareness training to be provided by people with Learning Disabilities/Difficulties	Debra Walton (Grapevine) Lucy Taylor (Learning and Development Manager)	Ongoing	- Staff who have face to face contact with patients will have completed Learning Disability/Difficulties awareness training	- Training regarding engaging with people with learning disabilities and mental health provided by Grapevine. - E&D session delivered as part of the Deprivation of Liberties and Mental Health training programme. - Securing placements for Supported Interns in departments raising their awareness of contribution people with disabilities can make to both the workforce and patient satisfaction. **Achieved** ■■■■■

UNIVERSITY HOSPITALS COVENTRY & WARWICKSHIRE NHS TRUST
Equality & Diversity Action Plan 2015 – 2016

Actions	Method	Lead(s)	Target date	Measures	Progress
Raise frontline staff awareness of how to interact with patients who have visual or hearing impairments	Power training including a short video to be delivered to the wards including the do's and don'ts of dealing with this specific group of patients.	Barbara Hay Sarah Brennan (Patient Experience Manager)	May 2015	- Staff who have face to face contact with patients will have received the power training	- In partnership with Patient Experience Manager and Head of Volunteers developed training video - Involved Trust's staff from relevant protected characteristic group (disability) in the development of the video and delivery of training - Offered 56 short training sessions to cover early shifts through to late shifts - Through funding provided by Rugby and UHCW Voluntary Services, put together a resource toolkit for all wards. **Achieved** ■■■■■

UNIVERSITY HOSPITALS COVENTRY & WARWICKSHIRE NHS TRUST
Equality & Diversity Action Plan 2015 – 2016

2. Improved patient access and experience — World class experience

The NHS should improve accessibility and information, and deliver the right services that are targeted, useful, useable and used in order to improve patient experience

Actions	Method	Lead(s)	Target date	Measures	Progress
Develop telephone and video interpreting guidance	Consultations with JNCC, group managers, finance, consultants, medical secretaries, ward clerks and patients.	Barbara Hay Monica Mabbett	September 2015	- Staff will have access to the telephone and video interpreting guidance	- Draft guidance prepared in readiness for roll out dependent on results of the pilot. - Now receiving monthly data highlighting where telephone could have been used. **Achieved** ■■■■■
Promote telephone interpreting	Pilot telephone interpreting in one speciality for six months.	Barbara Hay Monica Mabbett Simon Jones	June 2015	- More use of telephone interpreting where appropriate	- The Trust's interpreting and translation provider is working closely with Maternity to pilot telephone interpreting. - Dual handsets will be made available free of charge for areas identified as high users of the service and/or reception areas. - Have worked with service provider to identify where spend can be reduced through telephone interpreting, timely cancellations and reduction in provision of interpreters for patients who Do Not Attend (DNA's). **Achieved** ■■■■■
Provide patients with Learning Disabilities/ Difficulties with information in accessible formats relating to: - What to expect for stays in hospital, outpatient appointments etc.	Produce information in accessible formats for people with Learning Disabilities/Difficulties e.g. - Audio - Video - BSL - Easy read	Sarah Brennan Julia Flay Debra Walton Grapevine	Ongoing	- Patients with Learning Disabilities/Difficulties will have access to generic information, and the top ten conditions which affect people with Learning Disabilities/Difficulties in an accessible format	- The Trust's top five leaflets are now available in easy-read formats. - Top twelve leaflets available in audio format - Top twelve leaflets available in Polish (highest users of interpreting in the Trust) - Top twelve leaflets available in audio format on USB sticks included in the Accessibility toolkit resource. - Three leaflets have been translated in BSL, currently being proof checked.

UNIVERSITY HOSPITALS COVENTRY & WARWICKSHIRE NHS TRUST
Equality & Diversity Action Plan 2015 – 2016

Actions	Method	Lead(s)	Target date	Measures	Progress
- Information leaflets in top 10 conditions affecting patients with learning difficulties.					**Achieved** ■■■■■
Employ Communication Activities Co-ordinators to enable patients who having hearing/visually impairments and/or have Learning Difficulties/ Disabilities to access all aspects of their healthcare.	Recruit three Communication Activities Co-ordinators	Barbara Hay Monica Mabbett	October 2015	- Three Communication Activities Co-ordinators will have been recruited - Patients who are hearing/visually impaired and/or have Learning Difficulties/ Disabilities will have access to all aspects of their healthcare and information needs - Reduce length of stay.	- Business case currently being reviewed. - Still working on identifying a budget. **Developing** ■■■■■

UNIVERSITY HOSPITALS COVENTRY & WARWICKSHIRE NHS TRUST
Equality & Diversity Action Plan 2015 – 2016

3. Empowered, engaged and well-supported staff — World class people

The NHS should increase the diversity and quality of the working lives of the paid and non-paid workforce, supporting all staff to better respond to patients' and communities needs

Actions	Method	Lead(s)	Target date	Measures	Progress
Develop and implement a programme of training modules and guidance for staff and volunteers based around the Equality Act 2010 and the protected characteristic groups	Bi-monthly training sessions on particular protected characteristics Bi-monthly "An Audience with …." inviting relevant individuals to discuss their experience of the NHS as relating to their protected characteristic	Barbara Hay Lucy Taylor	January 2015	- Staff and volunteers will have knowledge and understanding of protected characteristics and the Equality Act 2010 legislation - Patients covered by the Equality Act 2010 will have improved hospital experiences (Friends and Family Test).	- Due to capacity issues and the introduction of the Together Towards World Class Leadership programme, it was no longer viable or appropriate to deliver this training in the original format. - Now been superseded by TTWC Leadership programme. - Leading and Valuing Diversity Master classes are mandatory and take place monthly. - Volunteers induction training sessions agreed for 2016 across both UHCW and Rugby. **Developing** ■■■■■
Communicate to all staff clear and concise information explaining who/what is covered under disability in the Equality Act 2010	A clear definition of who/what is covered under disability to be available on the intranet	Barbara Hay Monica Mabbett HR Business Partners	August 2014	- All staff will be able to access information to ensure the Trust is compliant with legislation for people who are disabled. - Evidence of information, guidance and/or communications to staff relating to disability issues as defined by the Equality Act.	- Training has been provided to all HR Business Partners and to Occupational Health Department regarding disability, reasonable adjustment and recent case law. - This will be disseminated as appropriate through HR Business Partners and Occupational Health. - Further training will be provided as required. **Achieved** ■■■■■
Continuation of dedicated staff Health and well being events	Attendance at Health & Well events for staff to engage with relevant agencies and services.	Andrew McMenemy HR Business Partners	Ongoing	- Staff aware of support available for informal advice and/or ability to access information	- Health and Wellbeing events continue to take place regularly. - As the Health & Wellbeing event is aimed at staff's fitness and health, it was decided to hold a separate event, aimed at raising

UNIVERSITY HOSPITALS COVENTRY & WARWICKSHIRE NHS TRUST
Equality & Diversity Action Plan 2015 – 2016

Actions	Method	Lead(s)	Target date	Measures	Progress
					awareness of community groups who support Protected Characteristics groups. The Embrace Equality – Enhance the Experience event was held in May 2016 and over 200 people attended. - Health and Wellbeing featured heavily at the Embrace Equality – Enhance the Experience may. **Achieved** ■■■■■
Continue to provide a provision for informal resolution and less formal people management issues where appropriate.	Working and consulting with managers and union representatives.	HR teams Speciality Management Teams	Ongoing	- Reduction in the number of formal grievances, disciplinaries and tribunal cases.	Clear reduction in formal proceedings: - April 2014 to March 2014 total 125 cases - April 2015 to March 2016 total 78 cases. **Achieved** ■■■■■
Offer Supported Internships for young people with complex needs to move towards paid employment.	Provide information days to enable staff to gain an understanding of supported internships. To provide interns with 3 x 9-10 weeks placements in different settings across the Trust.	Patrick Carey The Employment Support Services (TESS) Barbara Hay Monica Mabbett	Original date - September 2014 September 2015	- The Trust to have an embedded Supported Internship programme and recruit individuals with complex needs on an annual basis. - Young people with complex needs will be given the opportunity to have placements within the Trust.	- Programme commenced in September 2015 - 7 young people recruited to the programme. - 1 intern made an informed decision to leave the programme with an option to re-join at a later date - 2 interns have been successful in finding employment (one outside of the Trust and the other is evening work). - Currently 7 young people recruited for September 2016 cohort. **1 job offer confirmed in the Trust.** **Achieved** ■■■■■

UNIVERSITY HOSPITALS COVENTRY & WARWICKSHIRE NHS TRUST
Equality & Diversity Action Plan 2015 – 2016

4. Inclusive leadership at all levels — World class leadership

NHS organisations should ensure that equality is everyone's business, and everyone is expected to take an active part, supported by the work of specialist equality leaders and champions

Actions	Method	Lead(s)	Target date	Measures	Progress
The Trust will be compliant with Equality legislation (Equality Act 2010) in relation to its Specific Duties .	Publish Equality data relating to staff and patients in line with Specific Duties which are a legal requirement Ensure Equality Objectives are published Develop and publish Equality Action Plan.	Barbara Hay Monica Mabbett	Annually at the end of January	On the Trust's website, the following documents will be available:- - Up-to-date Equality data covering all protected characteristics including the previous two years for both patients and staff - Our Equality Objectives are available supported by an up-to-date Equality Action Plan (EDS)	- Equality data update completed and published in January 2016. Information available via the Trust's website. - IAG to meet and agree proposed Equality objectives and draft next Action Plan (July 2016) **Achieved** ■■■■■
Ensure the Trust Board (Public) and the QGC are kept up-to-date on progress on Equality and Diversity Action Plan and are made aware of any issues or challenges for the Trust	Provide annual report to Trust Board Provide annual report to QGC Ensure IAG notes are submitted to HRED	Barbara Hay	Twice a year (February and May)	- Evidence of annual reports provided to both Trust Board and QGC - Evidence of recommendations from IAG to HRED	- The Trust Board received reports in September and December 2015. - The HRED received a report in November 2015 and this meeting has been superseded by the WEC who received reports in January and May 2016. - It has been agreed that there is no longer requirement for reports to go to QGC. Any issues for escalation will go via WEC. **Achieved** ■■■■■
Ensure support and leadership is sustained around Equality and Diversity agenda	Invite members of the Chief Officer's team to participate in relevant IAG meetings and events	Barbara Hay Monica Mabbett	November 2014	- Chief Officers are involved in the formulation and decision making for Equality Action Plan	- The Chief Executive Officer attended and signed up to the BSL Charter in May 2015. - The Chairman and Chief Officers launched

UNIVERSITY HOSPITALS COVENTRY & WARWICKSHIRE NHS TRUST
Equality & Diversity Action Plan 2015 – 2016

Actions	Method	Lead(s)	Target date	Measures	Progress
			March 2015	(Dragons' Den) - Chief Officers participate in events to engage with patients and wider community	the Supported Internship programme. - Chief Officers have attended presentations given by the Supported Interns on a termly basis. - The Chief Workforce and Information Officer attended the IAG in November 2015. - The Chairman and Chief Officers attended the Embrace Equality – Enhance the Experience event. **Achieved** ■■■■■
Support Together Towards World Class programme (TTWC) in identifying and developing future leaders targeting BME (Black and Minority Ethnic) and female staff	Analysis of survey conducted for BME and female staff (up to band 6) Identify common themes regarding barriers to development and progression Identify and/or develop professional development opportunities for BME and female staff (up to band 6)	Barbara Hay Rajni Martin	February 2015	- Report detailing analysis of survey to be produced - Development activities addressing barriers to progression - Develop action learning sets for BME and female staff	- NHS England has mandated Trusts to have a Workforce Race Equality Standard (WRES) and this has superseded the survey. Data is being collected for the WRES template. This will identify if there is any action to be taken to ensure there are no barriers for BME to prevent their development and progression. - Work is in progress with ascertaining whether there are BME staff who wish to be part of a BME network. - Small working group has been formed to facilitate BME focus groups. - Relevant BME staff have been actively encouraged to engage with the Leadership programme **Achieved** ■■■■■
Develop a mentoring programme, paired with Senior Managers,	Link with TTWC programme to identify mentors and mentoring	Barbara Hay	March 2015	- Staff who mentor will share best practice and demonstrate the skills	- This has been superseded by the WRES and relevant action as identified by BME staff through focus groups and/or network will be

UNIVERSITY HOSPITALS COVENTRY & WARWICKSHIRE NHS TRUST
Equality & Diversity Action Plan 2015 – 2016

Actions	Method	Lead(s)	Target date	Measures	Progress
for both BME and female staff who are entering or already engaged in management training or programme	opportunities			required for senior roles - Staff who are mentored will understand the skills required and be able to make informed decisions about their future roles.	escalated and developed through WEC and TTWC programme. - Leadership programme includes the opportunity for coaching and participation in Action Learning Sets. **Developing** ■■■■■
Identify good practice from across the country which the Trust could remodel for its use for developing future leaders	Link up with other NHS Trusts to identify good practice	Barbara Hay Monica Mabbett	Ongoing	- Engaging in good practice will extend to creating equality of opportunity in career development and identify future leaders.	- BME Conference: developed thinking for BME network and attendees at the conference from the Trust form the working group which is developing internal BME forum and/or focus groups. - Head of Diversity qualified as a Coach and provides coaching sessions to a limited staff predominantly BME. - Relevant BME staff are actively encouraged to participate in the TTWC Leadership programme. - National Deaf organisations promoting the Trust as an exemplar of best practice, in particular, the training of a BSL interpreter. - Other Trusts worked in partnership with UHCW to develop easy-read leaflets. **Achieved** ■■■■■
Publish testimonials from past and current employees who can demonstrate the possibilities for BME and female staff to enter leadership roles	Identify employees who would be willing to publish testimonials to support the TTWC programme	Barbara Hay Sarah Brennan	March 2015	- To employ senior members of staff on their ability to fulfil the requirements of the job and not to take into account their background (race, gender, sexual orientation) - To employ senior members of staff from a	- This has been superseded by the TTWC Leadership programme and the WRES. - Once the BME network or focus groups have taken place, this action can be further developed.

UNIVERSITY HOSPITALS COVENTRY & WARWICKSHIRE NHS TRUST
Equality & Diversity Action Plan 2015 – 2016

Actions	Method	Lead(s)	Target date	Measures	Progress
				variety of backgrounds will ensure a richer mix of skill set and offer different perspectives.	**Underdeveloped** ■■■■■

University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD PAPER

Title	**Complaints & PALS Annual Report 2015-16**
Author	**Andrew Wilkins, Head of Patient Relations**
Responsible Chief Officer	**Meghana Pandit, Chief Medical and Quality Officer**
Date	**30th June 2016**

1. Purpose

To present the Complaints & PALS Annual Report 2015/16 for approval. The Complaints and PALS Annual Report presents complaints data and analysis, performance information, Parliamentary Health and Service Ombudsman (PHSO) information and it sets out the areas in which the Complaints Service aims to develop in 2016-17. Similar information is provided concerning the Patient Advice and Liaison Service (PALS).

2. Background and Links to Previous Papers

Much of the complaint and performance data is presented in the quarterly 'We Care Report' to the Trust Board. The more detailed complaints data and analysis contained within this report supplements the complaints data presented in the Annual Quality Account, fulfilling the regulatory requirements set out in The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009.

3. Narrative

In keeping with the Trust's vision of becoming a national and international leader in healthcare and its values, this report shares the complaints data and analysis, as this is one of the mechanisms to understand the patient experience.

The Complaints Service received 574 complaints in 2015-16, 95 more than in 2014-15. Of the complaints received in 2015-16, 40% were upheld, 33% partially upheld and 27% not upheld.

The PHSO considered and made judgment on fifteen complaints in 2015-16. None of the complaints decided were fully upheld, seven were partially upheld and eight were not upheld.

There has been a significant improvement in performance against the 25 working day response standard in 2015-16, with 83% of complaints being responded to within 25 working days compared to 54% in 2014-15.

Of the complaints received in 2015-16, 15% were referred back for further local resolution. Further reducing this is one of the objectives for 2016-17 detailed within the Quality Strategy.

The PALS received a higher number of contacts in 2015-16 and this may be partly due to the relocation of the service to the main foyer. Appointments, delays and cancellations regarding outpatient care has seen the most contacts in 2015-16.

PALS will continue in 2016-17 to improve performance against the five working day response timeframe and implement a greater analysis of data to help identify opportunities to improve patient care and experience.

4. Areas of Risk

The increase in the number of complaints received in 2015-16 could be interpreted to mean that patient care or experience has worsened. The report makes the point that there are a number of factors that can influence complaint figures, many of which are positive, such as their being more support for those wanting to raise a complaint.

The Complaints Service has set itself challenging objectives for 2016-17. Improving local resolution rates to ≥90% will require a significant combined commitment across the organisation and Complaints Service. There is also a potential risk with the Complaints Service's objective of increasing the transparency of its work through a more robust communications strategy; this could result in reputational damage as well as increasing the number of complaints received. The risks associated with this will be continually assessed and monitored and recorded on the Trust's Risk Management System.

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
Anita Kane, Associate Director of Quality

7. Recommendations

The Board is invited to **NOTE** and **APPROVE** Complaints & PALS Annual Report

Name and Title of Author: Andrew Wilkins, Head of Patient Relations

University Hospitals Coventry and Warwickshire NHS Trust

We Care. We Achieve. We Innovate.

Introduction

In the vast majority of cases patients, relatives and carers are satisfied with the care, treatment and service they receive. On the occasions where a patient, relative or carer is dissatisfied, it is important that they feel comfortable in raising their concerns so that the Trust can resolve any misunderstandings or, if failings have occurred, ensure that learning and improvements take place.

The Trust is committed to resolving any concerns at the earliest opportunity and this is often achieved through the patient, relative or carer discussing their concerns directly with the service. The Patient Advice and Liaison Service (PALS) is available to provide confidential advice and support to any patient, relative or carer who may not feel comfortable raising their concern with the service directly, or where they have done so but their concern remains unresolved. The PALS aim to resolve any concerns that are raised with them quickly and informally.

Should the patient or carer feel that their concern should be formally investigated they are able to make a formal complaint. The Trust operates a centralised complaints service, which ensures that a patient centred approach is taken to the management of complaints and that all complaints received are thoroughly investigated and responded to within a timely manner, usually within 25 working days of receipt.

In addition to the valuable learning and improvements that result from individual concerns or complaints, complaints and PALS data is analysed to identify any themes and the intelligence generated is shared across the organisation so that the necessary improvements can be made. Additional mechanisms to share intelligence include regular reporting to the Patient Engagement and Experience Committee and monthly reports to Chief Officers, such as the Chief Nursing Officer. The Chairman of the Trust Board reviews the Trust's handling of feedback and complaints on a monthly basis.

Complaints

Introduction to Complaints

In 2015-16 the Complaints Service received 574 complaints, which is an increase of 95 complaints from 2014-15. The service continues to improve its timeliness of response, going from 52% of complaints responded to within 25 working days in 2014-15 to 82% in 2015-16.

Complaints Activity

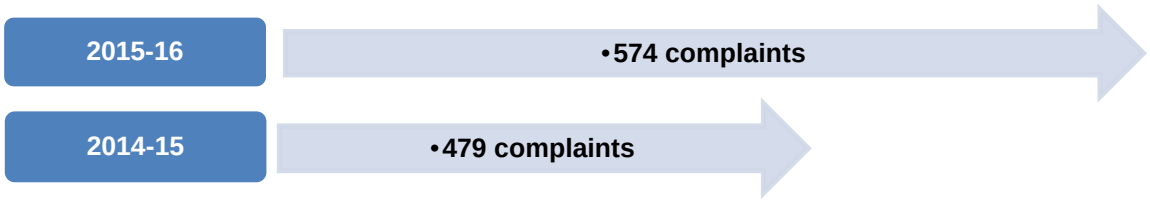


Figure 1: the number of complaints received in 2014-15 and 2015-16

An increase in the number of complaints could suggest that more patients are dissatisfied with the care, treatment or service they have received. However, other factors may influence the number of complaints received, such as patients and carers being more comfortable in making a complaint, the accessibility of the Complaints Service and the availability and level of support provided in raising a complaint. The reasoning behind an increase in complaints is therefore difficult to establish.

The graph below compares the number of complaints received by month for the 2015-16 and 2014-15 financial years. In 2015-16 the greatest numbers of complaints were received in October, whereas in 2014-15 the greatest numbers of complaints were received in July. However, in both years the fewest complaints were received in the months of December, January and February. It is however important to note that complaints are not always made in the same month that the issue of concern occurred, with some complaints being raised many months later.

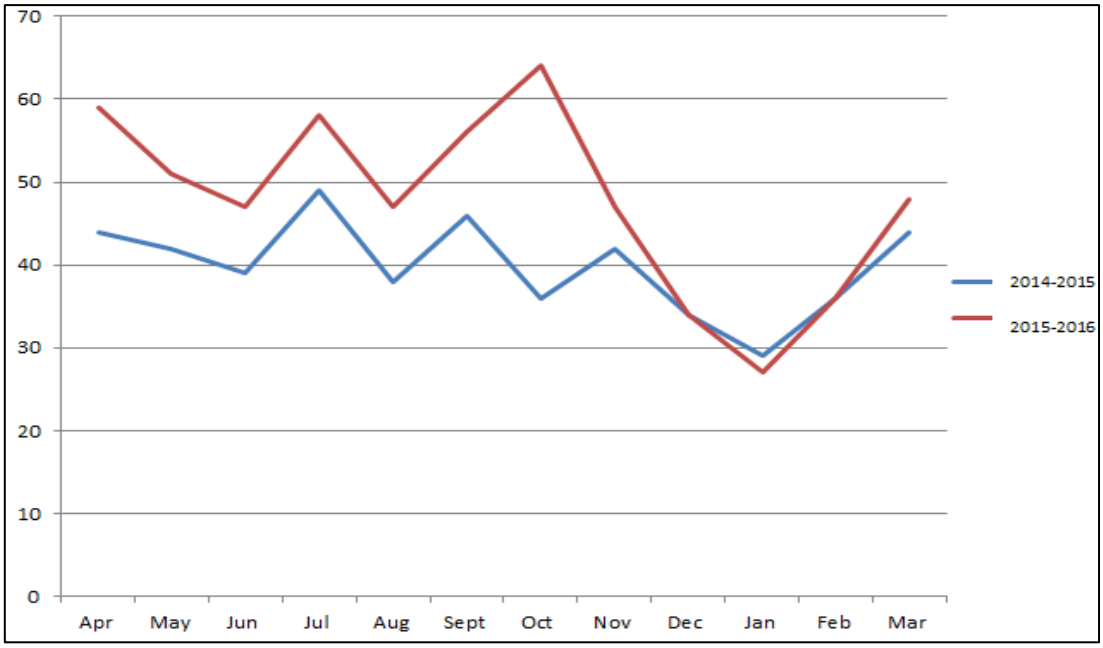


Figure 2: comparison of the number of complaints receiver per month in 2014-15 and 2015-16

Of the complaints received in 2015-16, 40% were upheld, 33% partially upheld and 27% not upheld. Partially upheld means that the complaint investigation identified areas for improvement, but the primary complaint was not upheld.

Complaint Activity by Specialty Group 2015-16

The chart below shows complaint activity by Specialty Group in 2015-16 and 2014-15. In 2015-16, the greatest numbers of complaints were about Surgery, followed by Women and Children's, which was followed by Trauma and Orthopaedics. Surgery and Women and Children's also had the greatest number of complaints in 2014-15. Trauma and Orthopaedics did not see a significant increase in any one area, with slight increases being seen across a range of subjects.

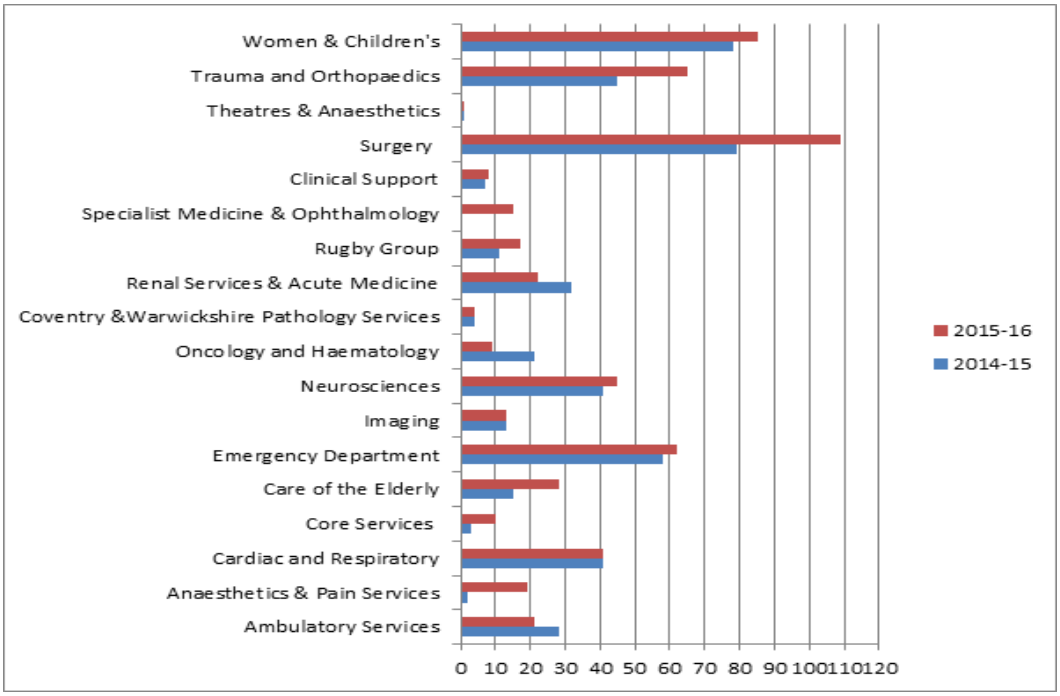


Figure 3: comparison of complaint activity per Specialty Group in 2014-15 and 2015-16

Trend Analysis

In both 2014-15 and 2015-16 the following subjects featured in the top 5 complaints received:

Subjects	2014-15	2015-16
All aspects of clinical treatment	242	313
Communication / information given to patients	75	79
Attitude of staff	46	36
Admissions, discharge and transfer arrangements	33	33
Failed to follow agreed procedure	36	5
Appointments, delay / cancellation (outpatient)	17	40
Appointments, delay / cancellation (inpatient)	23	33

Table 1: comparison of the most common subjects per complaints received in 2014-15 and 2015-16

Featured in the top 5 subject areas complained about in both 2014-15 and 2015-16

Featured in the top 5 subject areas complaint about in 2014-15 but not in 2015-16

Featured in the 2015-16 top 5 subject areas but not in 2014-15

Table 1 shows that there has been a significant reduction in complaints received about failure to follow agreed procedure but that there has been a significant increase in complaints about the delays and cancellations for both outpatient and inpatient appointments.

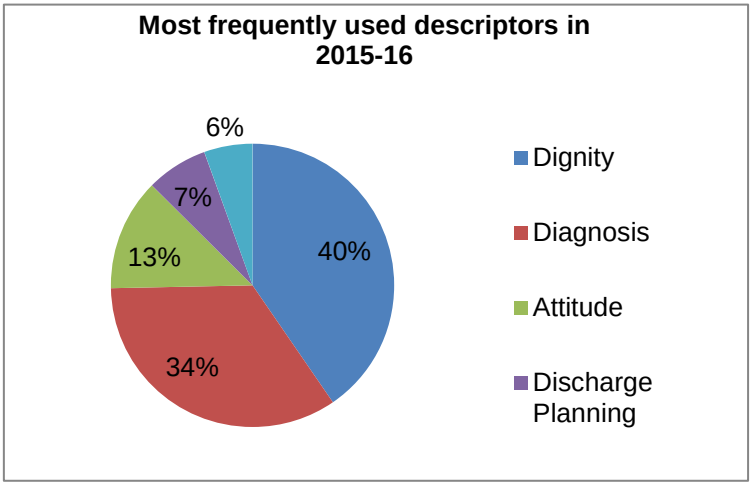


Figure 4: most frequently used descriptors 2015-16

In addition to the specific subject of the complaint, reported on above, the Trust also records the area the complaint would fall into, known as descriptors. As can be seen from Figure 4, there are two main areas that complaints fall within, namely dignity and diagnosis.

Parliamentary Health Service Ombudsman (PHSO)

The Trust recognises the value of having an independent body that patients, relatives and carers can refer their complaint to should the Trust not be able to resolve their concern to their satisfaction. In such instances and in accordance with the regulatory requirements, the Trust advises patients, relatives and carers of their option to refer their complaint to the PHSO. The Trust embraces the PHSO's scrutiny of its Complaint Handling and uses the PHSO's findings as an opportunity to learn and improve. In addition to the PHSO's case work, the Trust review and seek to learn from the reports that the PHSO produce throughout the year.

In the first three quarters of 2015-16 (quarter 4 figures have not yet been published), a total of 66 complaints were referred to the PHSO and they accepted 25 complaints for investigation in 2015-16. Eleven different Specialties featured in the complaints accepted for investigation.

The below table shows a summary of the primary subject matter of those complaints that were referred to the PHSO

Primary Subject Matter	Number of times featured in a referral
Clinical Judgment Query	1
Nursing Care	1
Consent to Treatment	1
Communication	5
Poor Medical Care	9
Clinical Judgment Query	5
All Aspects of Clinical Treatment	4

Table 2: primary subject matter of the complaints referred to the PHSO 2015-16

Table 2 shows that the majority of cases referred to the PHSO primarily concern clinical care and treatment or communication.

The PHSO considered and made judgement on fifteen complaints in 2015-16. None of the complaints decided were fully upheld, seven were partially upheld and eight were not upheld. In each case partially upheld the PHSO recommended an apology be given for the failings identified and recommended the creation of an action plan to reduce the likelihood of the same failings reoccurring. In three of these cases the PHSO also recommended that the Trust compensated the patient, relative or carer for the impact the failings had had on them.

The table below provides details of the seven cases that were partially upheld along with a summary of the decision of the PHSO and the actions taken to learn and improve from the failings identified.

Complaint	Decision	Recommendation	Actions
Complainant raised grievances relating to communication, the use of safeguarding barriers and delays in organisation and care	The PHSO were satisfied that the safeguarding order was used accurately, and records did not evidence that the patient was regularly repositioned	The Trust was advised to produce a letter of apology and an action plan to reduce the likelihood of the failings reoccurring	Several actions were implemented, including: • review of intentional documentation rounding procedures and work with the Tissue Viability Team at a Link Worker Study Day • continued education and teaching on pressure ulcer prevention (Trustwide) • sharing and learning promoted among ward staff • discussion of this case presented at Trust's Annual Record Keeping Training Day
Complainant raised grievances relating to	The PHSO found no failings in initial assessment but expect	The Trust was advised to apologise, produce	Several actions were implemented, including: • discussion and feedback on this case provided to the Cardiology team at the

Complaint	Decision	Recommendation	Actions
misdiagnosis of a stroke, failure to monitor the patient and communication	stroke to be identified sooner. The neurological examination was inadequate and the apology for communication failings was found to be insufficient. The PHSO could not confirm that the failures contributed to the patient's death.	an action plan and provide £500 in compensation	Quality Improvement and Patient Safety (QIPS) meeting • review of nursing handover procedures including provision of information to the family/next of kin • feedback to Junior Doctors regarding the importance of documentation • introduction of a complaints management plan to improve the timeliness of responses
Complainant raised grievances relating to withheld controlled medication, and poor communication	The PHSO found that medication was terminated without a conscious decision to do so. Trust communication should have been better. The Trust did acknowledge the failures in their response to the complaint but did not recognise the significance of the failures	The Trust was advised to produce an apology and an action plan to reduce the likelihood of failings reoccurring	Several actions were implemented, including: • a review of the ED business case to support NICE guidelines, and the Medicine Reconciliation Policy • reviews of patient medication to take place within Pharmacy, an e-handover for the Pharmacy team, Doctors training programme to include on-call Pharmacy services, and Pharmacy investment to comply with 24 hr NICE guidelines • Core Competency Training for Summary Care Records • Senior Clinical Review of medication charts and a named clinician for each outlier
Complainant raised grievances relating to continuity of care, poor communication, and lack of accurate drug documentation	The PHSO identified failures in consistency of care, but found no evidence of delayed treatment or diagnosis. The Trust was found to have caused additional distress to the family by failing to acknowledge the issues with discharge	An apology was given to the family for the distress caused, and the Trust was advised to produce an action plan and provide £250 in compensation	Several actions were implemented, including: • re-drafting of the Transfer Policy to include risk assessment and guidance on the appropriateness, frequency and monitoring of moves • review of and provision of discharge training continued but to include development for Discharge Link Nurses in all wards and departments • all complaints to be triaged by the Complaints Coordinator to assess and identify the relevant issues, and use of the Complaints Management Plan and a quality assurance tool to ensure the highest quality standards

Complaint	Decision	Recommendation	Actions
Complainant raised grievances relating to drug mismanagement and poor communication	The PHSO found that the Trust identified their failings and managed appropriately via internal mitigation to prevent a repeat of the event. The Trust was found to have communicated appropriately and shared this event with the wider NHS to promote learning with regard to the event.	The Trust was advised to produce an apology for the impact of the failings and provide £800 in compensation	Several actions were implemented, including: • discussion with the Junior Doctor to involved to reflect and learn from the incident • additional education on prescribing for children included in doctor induction in addition to paediatric dispensing training • reminder given to doctors regarding prescribing rules and emphasis on reference to the BNF and triple checking o calculated medications
Complainant raised grievances relating to the clinician's attitude during consultations, lack of information regarding diagnosis and poor communication	The PHSO found that there had been failings in communication relating to the patient's diagnosis	The staff involved made an apology to the complainant. An action plan was produced and the acknowledged failings were identified	Several actions were implemented, including: • introduction of notices throughout clinics advising patients that they can acquire a copy of their consultation letters • Junior Doctors are advised to question previous decisions, especially prior to surgery; the Junior Doctors are also encouraged to discuss significant departures from previous decisions with a senior clinician before performing the procedure • the department will emphasise the importance of clear communication and accurate note-keeping
Complainant raised grievances relating to the premature discharge of her son, and poor and inappropriate treatment when leaving the site which it is believed contributed to the patient's death	The PHSO found that the patient's condition was not suitably assessed and that he should not have been discharged. They also found that the Trust was unreasonable in its decision to forcefully remove the patient. There was insufficient evidence to confirm that this treatment contributed to the patient's death	The Trust was advised to produce a letter of apology, an action plan to reduce the likelihood of a repeat of the failings	Several actions were implemented, including: • a gap analysis of the NICE/Clinical Guidelines, discussion of the case at a QIPS meeting and presentation of the case anonymously at the Trust's Annual Record Keeping Training Day • inclusion of Alcohol Liaison Service induction training for ED Junior Doctors, training for Clinical Site Managers and Security Officers in the use of the Criminal Justice and Immigration Act 2018, and Registrar and Consultant Alcohol Liaison refresher training • discussion and sharing of the case at the Observation Ward's monthly meeting

Table 3: recommendations and actions taken as a result of complaints partially upheld by the PHSO

Performance Measures

The complaints service received 271 complaints by letter, 303 by email and none by telephone in 2015-16. In the interests of ensuring accessibility, the Complaints Service will be exploring why no complaints were received by telephone. To further increase the accessibility of the Complaints Service, Easy Read leaflets have been produced in conjunction with a local learning and development charity. These leaflets are available across the organisation on the wards and the PALS provide these to patients, relatives and carers when appropriate.

Overall Performance against the 25 Day Response Rate Standard

The Trust is committed to providing timely responses to any complaints received and the complaint management plan is designed to ensure complaints are responded to within 25 working days of receipt. The graph below shows the Trust's performance against the 25 working day response rate over the last three financial years.

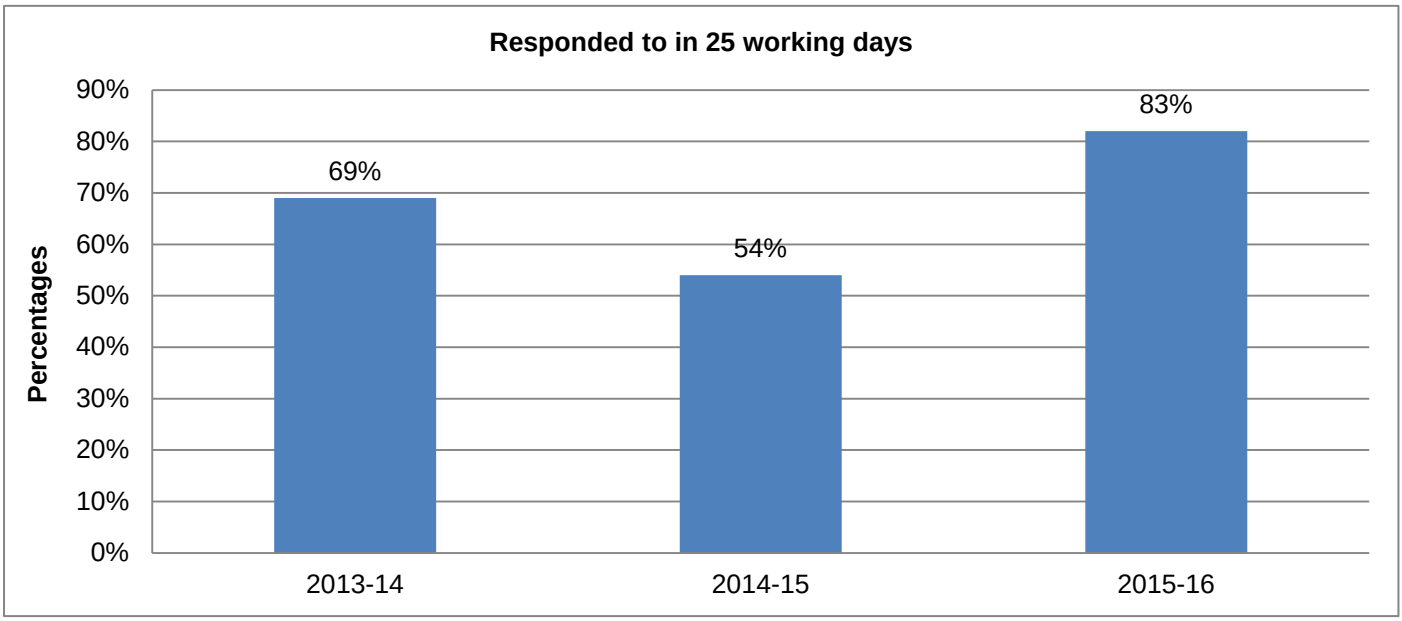


Figure 5: comparison of the Trust's performance against the 25 working day response standard from 2013-14 to 2015-16

As can be seen by Figure 5, the Trust responded to over 80% of complaints received in 2015-16 within 25 working days, which is a marked improvement on previous years. The improvement results from the implementation of a clear complaint management plan that ensures complaints are quickly actioned and progressed, with clear escalation points so that management support is provided as and when necessary. In addition, complaint response rates are now reviewed at Specialty Monthly Performance Reviews. Effective monitoring of performance against the 25 working day timeframe helps ensure that any operational issues impacting on the effective handling of complaints are identified and resolved.

Performance against the 25 working day response standard by Specialty Group for 2015-16

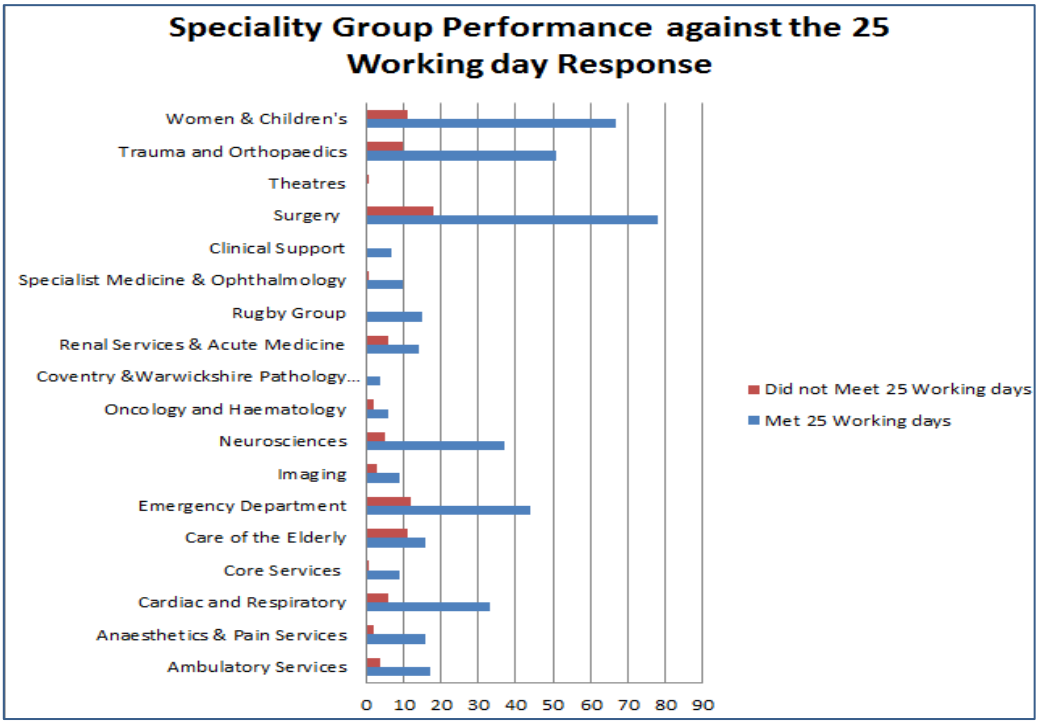


Figure 6: comparison of Specialty Group performance against the 25 day working day response standard

The graph shows that the Specialty of Surgery has more complaints responded to outside of the 25 day response standard than any other Specialty. However, in terms of percentage of complaints responded to within the 25 working day response standard, at 27% Care of the Elderly have the lowest percentage response rate.

Complaints returned for further local resolution

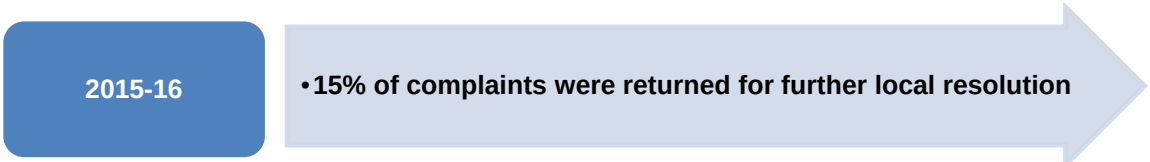


Figure 7: complaints returned for further local resolution in 2015-16

In 2015-16, 15% of complaints were referred back for further local resolution. The six months of data collected in 2014-15, if applied as an average across the year, would have produced a further local resolution rate of 25%. The number of complaints referred for further local resolution was therefore achieved in 2015-16. Further reducing the number of complaints referred for further local resolution will continue to be a priority in 2016-17. The chart below shows the number of complaints referred for further local resolution by Specialty.

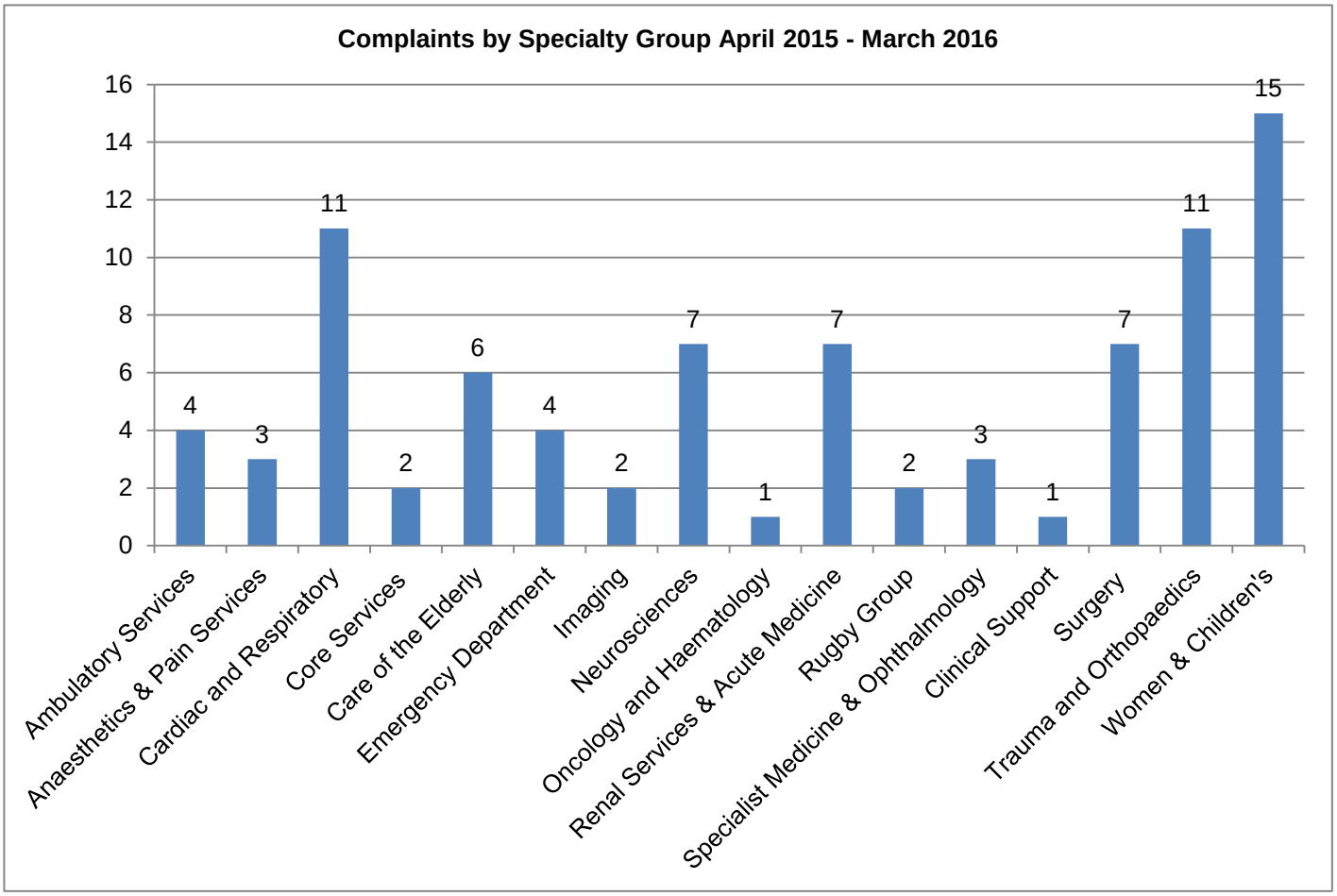


Figure 8: number of complaints returned by Speciality Group 2015-16

Member of Parliament (MP) Enquiries

In November 2015, the Complaints Service took over responsibility for managing concerns or enquiries raised by MPs on behalf of their constituents. The Complaints Service co-ordinates the investigation and response to MP enquiries, ensuring that they are fully investigated and a comprehensive and timely response is provided. Within the 5 months to the end of the financial year, the Complaints Service managed 36 enquiries. These enquiries are not reported in the complaint data unless they are registered as formal complaints, which in the vast majority of cases is not appropriate.

Examples of Complaints and Actions

Member of Parliament (MP) – Car parking An MP contacted us on behalf of their constituent who was unhappy with the lack of car parking spaces at University Hospital Coventry. They explained that they recently attended the hospital for an outpatient appointment and that they had encountered significant traffic congestion. They said that they had no option but to get out of the car and walk and they were concerned about the anxiety this situation causes patients and their carers.	The Trust responded to the MP apologising for the inconvenience caused. Assurance was given that the Trust was aware of the congestion issues at University Hospital, Coventry and the problems this causes for patients, staff and the operational effectiveness of the Hospital. The Trust explained to the MP the steps that University Hospital Coventry was taking to resolve this issue, which includes working with Coventry City Council and specialist designers to review the parking situation and traffic flows; obtaining planning permission for a further 250 car parking spaces and reassessing the viability of a Park and Ride Service.
Patient fall Mr H's family complained that when Mr H was transferred to the Hospital of St Cross, Rugby, he was not properly cared for allowing him to suffer a fall. They also complained that Mr H had to wait in the ambulance for a long period when being transferred from University Hospital Coventry to the Hospital of St Cross Rugby and they were unhappy with the level of communication the family received.	Mr H's fall was reported as a Clinical Adverse Event the same day as the fall. Mr H's family was informed that Mr H had fallen the same day and the incident was reviewed by the Serious Incident Group. This resulted in a full Root Cause Analysis investigation being undertaken. The family was invited to share the findings of the investigation and the resulting actions. The investigation found that the ward handover was inadequate which meant that the receiving ward did not properly understand Mr H's needs. A full review of the handover process was carried out as well as the assessments that are carried out when a patient is first received onto a ward.
Staff attitude Mr B complained about the manner of the Consultant that had reviewed him at an outpatient appointment. He complained that the Consultant had made no effort to welcome him or put him at ease, that they failed to explain the purpose of the appointment or explain any of the tests they were performing and that they abruptly ended the appointment without explaining what will happen next or giving him an opportunity to ask questions.	The Consultant concerned provided Mr B with all of the information he felt was not provided at the appointment. The Consultant explained that the clinic was not running to schedule on the day of Mr B's appointment and that they were also on call to provide emergency advice, which had meant they were bleeped during the appointment. However, this information was given as an explanation as to why they may not have conducted the appointment in the most appropriate manner rather than an as excuse. The Consultant apologised for Mr B's experience and assured him that they had reflected on this and that they would factor this learning into future practice.

Key Achievements of 2015-16

The Complaints Service committed to develop the service in five areas in 2015-16. These are set out below along with a summary of the work that has been undertaken to deliver on these commitments.

Increased Engagement with Internal Stakeholders

In order for a complaints service is to achieve its optimum value the service must have strong working relationships across the organisation. Working collaboratively with key internal stakeholders helps identify issues, promote best practice and disseminate learning and intelligence.

In 2015-16 the Complaints Service worked with the Risk Team with the implementation of the Duty of Candour process to ensure that this, combined with the Complaints Handling Process, remains patient centred. The Service works closely with the Lead Nurse for Patient Experience to ensure learning is appropriately disseminated and a joined up and patient centred approach is taken when managing complex complaints. The Complaints Service also delivers training on complaint handling and associated issues across the Trust on events such as the Bi-annual Nursing Summit.

Increased Engagement with External Stakeholders

The Complaints Service recognises the value of working with external stakeholders to share learning and identify ways in which the Complaints Service can improve. In 2015-16 the Complaints Service has had frequent contact with the Parliamentary and Health Service Ombudsman, ensuring that we fully engage with their investigations and maximise any learning opportunities. The service invited Healthwatch Coventry to present at its monthly meeting, where they explained their role in more detail. The Complaints Service also took over responsibility for responding to complaints or concerns received from MPs on behalf of their constituents, ensuring that timely and through responses are provided. In addition, key members of staff within the service attended a regional complaint managers group to share learning and ideas about how complaints may be better managed.

Greater Staff Awareness of the Role of the Complaints Service using the Market Place Induction Event

Ensuring all staff across the organisation are aware of the Complaints Process and how to support any patient or carer that is dissatisfied with the treatment, care or service they have received is crucial to delivering an accessible complaints service. To help raise awareness of the complaints process across the Trust the Complaints Service has attended the Market Place Induction Event with the aim of making any staff joining the Trust aware of the Complaints Service and the Complaints process.

Improved Local Resolution Response Rates

Responding to complaints within the 25 day response rate standard was a key objective for the Complaints Service in 2015-16. An ambitious target of 90% of complaints responded to within 25 working days was set. A Complaints Management Plan was implemented with clear timeframes and escalation points which

positively impacted response rates. In 2014-15 the Trust responded to 54% of complaints within 25 working days. In 2015-16 this increased to 82%. Improving response rates will continue to be a key objective in 2016-17.

Decreased Requests for Further Local Resolution

In 2014-15 13% of our complaints were returned for further local resolution and this increased to 15% in 2015-16; the six months of data collected in 2014-15, if applied as an average across the year, would have produced a further local resolution rate of 25%. In January 2016, the Complaints Service implemented an audit tool to help understand the reasons why people had returned their complaint for Further Local Resolution. The findings of this audit are shared with the Patient Experience and Engagement Committee and it will help inform the work being undertaken to increase satisfaction with the Complaint Handling Process and the initial response. This will continue to be a commitment in 2016-17.

Improved Communication Links with the Patient Advice and Liaison Service

Working closely with the Patient Advice and Liaison Service (PALS) is key to ensuring that patients, relatives or carer's complaints or concerns are effectively managed and responded to in the most appropriate manner. The PALS has appointed a substantive PALS Co-ordinator and a Head of Patient Relations has been appointed to oversee both the PALS and Complaints Service. These key appointments have improved communication between the services and helped ensure the services work collaboratively to improve the patient experience. PALS staff have reported that they feel communication has improved.

Further Developments for 2016-17

Improved Local Resolution Response Rates – Target ≥90% Responded to within 25 Working Days

The Complaints Service will continue its work on meeting the 25 working day response rate. This will involve further improving compliance with the Complaint Management Plan and delivering organisational wide training in areas such as statement writing.

Increased Use of the Case Management System to Produce and Share Quality Intelligence Across the Organisation

Through fully utilising the functions of the case management system, Datix, the Complaints Service will be able to better manage and report on workflow. The service will continue to review what information is captured on Datix and how this information is captured to maximise its ability to produce and disseminate intelligence organisation wide.

Training Delivered to Key Staff Groups

Working with the Lead Nurse for Patient Experience and the Patient Experience Team, the Complaints Service will develop a training plan with the objective of improving the organisation's ability to resolve dissatisfaction at an early stage and to conduct timely and effective investigations.

Action Planning and the Monitoring of Actions Resulting from Complaints

The Complaints Service will work with the organisation to ensure that clear actions result from complaints where failings are identified. The service will develop processes to monitor the completion of those actions through to completion.

Improving Internal and External Communications

In the interests of openness and transparency, the Complaints Service will review its communications strategy. The strategy will review how complaints data, performance data and intelligence is shared to maximise the value of complaints and to allow for increased scrutiny.

Reduced Further Local Resolution Rate – Target ≤10%

The Complaints Service will continue its work to analyse the results of the audit that has been put in place to capture the reasons for furthers being returned for further local resolution. The service will then explore ways in which the complaints processes can better suit the needs of the complainant and improve their satisfaction with the Trust's handing and response to their complaint.

Patient Advice and Liaison Service (PALS)

Introduction to PALS

The PALS is an independent and confidential advice and support service, helping resolve patients, relatives or carers concerns with the treatment, care or service being provided. The PALS liaise with the service to help resolve concerns quickly and informally to the satisfaction of the enquirer. Where necessary, the PALS will help patients, relatives or carers raise a complaint and provide the necessary support through that process.

In addition to the individual learning and improvements that result from individual enquiries, the PALS analyse enquiries data to identify and share learning opportunities across the organisation.

The PALS is appropriately located in the main foyer area, making it easily accessible to patients, relatives and carers. The enquiries the PALS received in 2015-16 range from questions about waiting times, appointments and cancellations and lost property through to supporting patients and families through a Root Cause Analysis Investigation. The PALS also received a number of requests for information covering a wide range of issues from general services available including how to access support and for assistance with aspects of present care. This also includes signposting requests from relatives and carers to

respective wards. The PALS is continuing to engage with staff at all levels to ensure that learning and improvements take place to improve the service for future patients.

PALS Activity

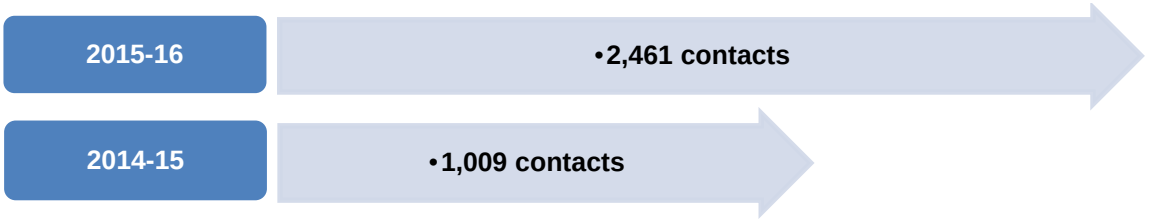


Figure 9: comparison of PALS contacts 2014-15 and 2015-16

Improvements to processes in 2015-16 have allowed enquiries to be more accurately categorised, recorded and reported. This data shows the number of enquiries received in 2015-16 compared to 2014-15, rather than the number of contacts made to PALS in these periods, which was the method of reporting in the 2014-15 report.

Contact Activity by Specialty Group

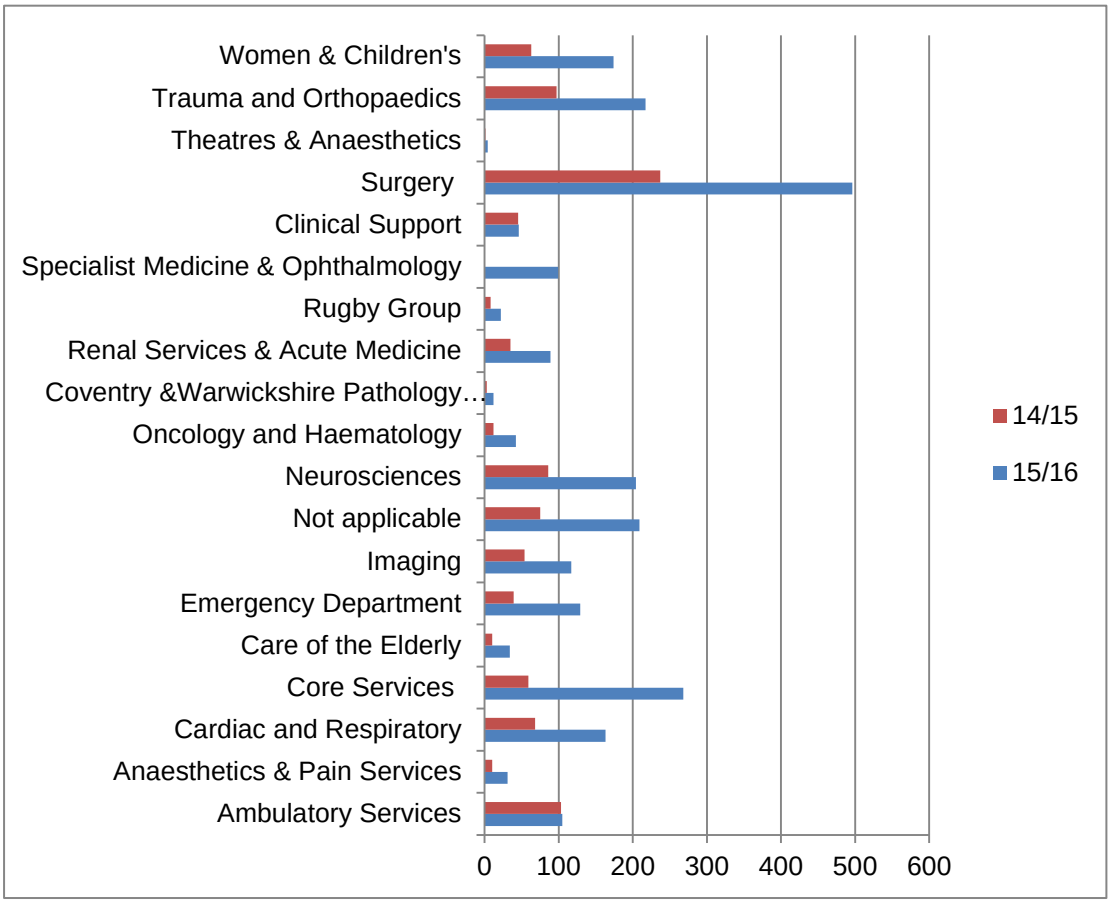


Figure 10: comparison PALS contacts by Specialty Group in 2014-15 and 2015-16

Figure 10 illustrates that Surgery received the most enquiries in 2015-16, which is consistent with 2014-15. Analysis of the enquiries received during 2015-16 concerning Surgery show that 49% relate to delay and cancellations for inpatients and outpatients appointments. Enquiries relating to car parking, how to access to health records and information on the complaints process has contributed to the increase of enquiries under Core Services.

Trend Analysis

PALS Contacts by Subject

Subjects	2015-16
Communication / information given to patients	267
Attitude of staff	81
Admissions, discharge and transfer arrangements	88
Appointments, delay / cancellation (outpatient)	499
Appointments, delay / cancellation (inpatient)	294

Table 4: most common subjects per PALS contacts in 2015-16

The largest number of concerns received in 2015-16 related to the outpatient appointment process. The level and quality of information provided to patients is also a common cause of enquiries. The number of enquiries concerning the attitude of staff has increased in 2015-16 and the PALS report that these enquiries usually arise from dissatisfaction with the way staff or the Trust handle their enquiry or concern.

PALS Contact by Method

Method	2015-16
Email	624
Letter	62
In person	449
Telephone	1320
Executive Office	6
Totals	2461

Table 5: comparison of method of receipt of PALS contacts in 2015-16.

To ensure that the PALS is accessible to all, they are contactable by a range of means. The above table shows that the majority of patients, relatives and carers contact the PALS by telephone. This is in line with the PALS objective of resolving enquiries with minimum formality and the PALS are able to resolve some enquiries in a single telephone conversation. The increase of in person contacts suggests that the repositioning of the PALS Office to the main entrance is of benefit and allowing more people to access the service in person.

Examples of PALS Contacts and Actions

Equality and Diversity – Translation Services Mrs H contacted the PALS and stated that her mother has been in hospital undergoing several tests for Dementia. The patient speaks only Punjabi and has had the use of translation services during her appointment. The relative alleges the translators have told her mother she is undergoing 'mad tests' or that 'she is mental' which she feels is a confusing and upsetting translation to the patient and would like this raised as a concern.	PALS liaised with Translation Services who reviewed the service provided and reiterated the important of accurate translation to the patient.
Signposting – Mental Health Services Mrs S contacted the PALS unhappy that she now longer has access to a mental health nurse. She explained she was feeling increasingly "depressed" and "some days felt suicidal"	The PALS contacted the PALS team responsible for the Mental Health Services (Under the Coventry and Warwickshire Partnership NHS Trust) and asked that they contact this lady. The following day the PALS spoke with Mrs S to ensure someone had contacted her. She advised she now had an appointment to meet with her new mental health nurse.
Reassurance – Clinical Processes Patient has been admitted twice to UHCW and on both occasions has contracted Norovirus, enquirer would like to know Trust's policy for dealing with this and how it protects is patients.	The PALS liaised with the Infection, Prevention and Control team asking them to contact this lady directly and talk through the process of events once Norovirus is confirmed within UHCW

Key Achievements of 2015-16

The PALS committed to develop the service in five areas in 2015-16. These are set out below along with a summary of the work that has been undertaken to deliver on these commitments.

Increased Engagement with Internal Stakeholders

To ensure the sustainable delivery of this commitment the appointment of a PALS Co-ordinator and Head of Patient Relations was prioritised and these appointments were made in December 2015 and January 2016 respectively. A review of the PALS internal engagement strategy is underway and through its work to resolve patient concerns, the PALS is building stronger relationship with key members of staff, such as the Lead Nurse for Patient Experience and the Specialty Group Leadership Teams. To increase the awareness of PALS the service attends the Market Place event on all new starter inductions.

Increased Engagement with External Stakeholders

Through their case work, the PALS have focussed on strengthening their relationships with PALS departments in other Trusts, identifying key points of contact and sharing learning in respect of the services offered and processes. In addition, the PALS have met with Healthwatch Coventry and discussed the performance of the PALS and their role within the complaints process.

Greater Staff Awareness of the Role of the PALS by Using the Market Place Induction Event

Ensuring all staff across the organisation are aware of the PALS and how to support any patient that is dissatisfied with the treatment, care or service they have received is crucial to delivering an accessible service. To help raise awareness of the PALS process and their availability, PALS staff have attended the Market Place Induction Event with the aim of making any staff joining the Trust aware of the service.

Improved Closure of the Enquiry within Five Working Days

The PALS have undertaken a review of their processes and operational approach to ensure that complaints are handled in the most effective manner. It was identified that improved use of the case management system, Datix, will allow for better performance management and significant work has been undertaken to improve the quality of the data captured and live reporting has been introduced to allow this data to be effectively analysed and reported on. In addition, a review of the initial triage process will allow the complaints to be categorised will the aim of improving their flow through the process.

The next stage of this work involves sharing the new processes with the wider organisation and developing an enquiry management plan setting out clear responsibilities and escalation points.

Improved Communication Links with the Complaints Department

The PALS have good links with the Complaints Department and they work collaboratively with the Complaints Service to ensure that those concerns that need to be investigated through the complaints procedure are quickly identified and actioned by the Complaints Service. The PALS Co-ordinator meets regularly with the Head of Patient Relations and this ensures that the PALS have a clear understanding of the wider department objectives and operational matters that are relevant to both the PALS and Complaints Service.

Further Developments for 2016-17

Service User Satisfaction Survey

As the PALS develops its procedures and operational approach in 2015-16 it is important to ensure that the experience of service users is received and factored into any measurements of improvements. The PALS will therefore design and introduce a service user survey, to better understand the service user experience. To meet the needs and expectations of service users will be able to complete this survey both

electronically, via post and in person. This feedback will be used to ensure that the PALS continue to provide a patient centred service.

Increased Accessibility

The PALS will review their opening hours with a view to extending them to better meet the needs and expectations of service users. A business case will be prepared to assess the viability of the PALS delivering a seven day service to service users. This will be a significant step for the PALS and ensuring that the organisation offers a truly patient centred service that is available at the time that they need it.

Increased Engagement with Internal and External Stakeholders

PALS will continue its focus on developing key stakeholder relationships. Internally, the PALS will focus on increasing the awareness and understanding of the PALS amongst key staff groups to ensure that the enquiries processes is clearly understood and adhered to. The PALS will also use their skills and experience to help develop staff's ability to resolve dissatisfaction at the earliest possible stage.

Externally the PALS will continue to work collaboratively with other PALS Officers, but it will seek to liaise more closely with other relevant services to ensure that they are aware of the support the PALS can provide so that they can signpost patients, relatives or carers accordingly.

Improved Performance Against the Five Working Day Response Timeframe

PALS will build upon the work undertaken in 2015-16 to complete the process improvement work, performance management and stakeholder engagement to improve and monitor the working day response rate. PALS will complete the implementation of the necessary performance monitoring tools required to regularly report on its performance against this response rate.

Greater Analysis of Data to Increase Intelligence Sharing Throughout the Organisation

The improved use of Datix, combined with quality insurance processes, will allow the PALS to perform greater data analysis. This will enable the PALS to produce and disseminate valuable intelligence across the organisation, helping the organisation identify opportunities to improve the patient treatment, care and experience.

University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD PAPER

Title	**Quarter 4 and 2015-16 Cancer Waiting Times Performance**
Author	**Danielle Taylor / Helen West, Deputy Associate Director of Cancer Services**
Responsible Chief Officer	**David Eltringham, Chief Operating Officer**
Date	**30th June 2016**

1. Purpose

This report demonstrates the Trust's analysis of cancer waiting times performance for Quarter 4 of 2015-16 and the full year 2015-16.

UHCW failed to meet the 62 day Cancer Waiting Times Standard for 2014-15 and 2015-16.

The Board is asked to acknowledge the content of this report and to endorse the aims for 2016-17 to improve performance in this area.

2. Background and Links to Previous Papers

Achievement of National Cancer Waiting Times standards has been challenging for the NHS to achieve over the last 18 months and specifically the 62-day standard from urgent GP referral to first definitive treatment for cancer.

- Monthly reports to Chief Officer's Group and to the Cancer Board have highlighted cancer performance and associated capacity constraints within the Trust, as well as the issue of late notice from referring organisations.
- This report was approved by Cancer Board on Wednesday 15th June, 2016
- This report is cognisant that delivery of the trajectory against the cancer 62 day target is expected to be one of the deliverables for payment of the sustainability and transformation funding that the Trust has been allocated in 2016/17

3. Executive Summary

Cancer Waiting Times are submitted monthly in line with national reporting requirements. This report includes site by site analysis of two week wait and 62 day performance with actions to be taken to improve performance; a comparison of UHCW performance against the national position; information regarding tertiary referrals; numbers of patients treated after day 100 and near misses (categorised as patients treated between days 57 and 62 of their pathway by tumour site.)

The percentage of two week wait (2WW) referrals continues to increase year on year (except for urology). Individual site increases are detailed in the report, but the overall increase in 2WW referrals for all sites combined is 11.4% (15,855 in 14/15 to 17,659 in 15/16).

It is not currently possible to receive an overview of current two week capacity, minus initiative clinics from the Performance & Programme Management Office (PPMO). Groups need to review their two week wait capacity in line with known numbers of patients and ensure 'upfront' clinic appointments are available.

Late tertiary referrals continue to impact on UHCW performance.

The percentage of patients receiving their first definitive treatment on day 57 – 62 has increased from 13% to 36%

82.7% of patients were treated within 62 days for 15/16 – this was below the national target of 85% but in line with UHCW's predicted target of 83%.Failure to achieve the 62 day target was influenced by the continuing work to treat the backlog of urology patients which were on a 62 day pathway.

The number of patients treated at greater than 100 days has increased throughout the year to a total of 67; a significant number of these are Urology patients.

The aims for 2016-17 are:

- Achieve all cancer waiting time targets with particular focus on achieving the 62 day target.
    - To achieve the 62 day target as an agreed element of the STF trajectory with the requirement for the 62 day target to be met to ensure that UHCW receives this funding stream.

- To aim to exceed the 62 day target with a 'safety margin' to ensure sustained performance in 16/17.

- Agree and implement shadow monitoring, utilising the new National Guidance regarding breach allocation.

- Work with Groups to ensure they are aware of 2WW capacity requirements for referrals – to ensure up-front capacity is available with reduced reliance on initiative clinics.

- Target work specifically with sites:

    - Urology - continue to work to decrease backlog
    - Ensure the revised prostate pathway is implemented, followed by bladder and kidney pathways
    - Colorectal and Head and Neck – proactive pathway tracking
    - Skin – further integration of 'GEH' pathways

- Work in conjunction with CCGs to achieve timely tertiary referrals to Multi-Disciplinary Teams (MDT).

- To reduce numbers of patients treated on day 100+ by 50% by September 2016, maintaining this decrease for 16/17 with zero patients treated at 100+ days by March 2017.

- Work in conjunction with Director of Operations to clarify theatre requirements for surgical services.

- Work in conjunction with Director of Operations to improve radiology and pathology services to ensure diagnostics are provided and reported in a timely manner.

- To include % conversion of cancers in Quarterly reports for 16/17.

The Board is asked to approve these aims

4. Link to Trust Objectives and Corporate/Board Assurance Framework Risks

This report links with most of the Trust's 2016-17annual objectives and specifically:

Increase substantive/flexible workforce in place of agency staff.
Several cancer multi-disciplinary teams have experienced manpower shortages over the last 12 months and ongoing vacancies within pathology and radiology continue to impact on the length of cancer pathways

Improve patient outcomes for mortality, infection control and hospital cleanliness.
Delays within cancer patient pathways could impact upon positive patient outcomes. A root cause analysis will be carried out for any patient waiting in excess of 100 days to receive first treatment

Align activity and capacity to achieve the 18 week referral, four hour A&E, and cancer waiting time standards.
Year on year increase in suspected cancer referrals and the significant diagnostic tests associated with these referrals needs to be met. Furthermore 18 week and A and E capacity issues also impact upon cancer pathways

Delivering sustainable services through the Sustainability and Transformation Plan and Together Towards World Class projects.
The Cancer Team has been pivotal in developing the Cancer STP for Coventry and Warwickshire

5. Governance

UHCW NHS Trust is required to achieve compliance with National Cancer Waiting Times standards for 2016-17. A range of capacity issues (theatres, imaging and pathology) are proving challenging.

Whilst performance against the cancer targets is reported in the Integrated Quality and Performance Report each month, the Trust is also required to produce an Annual Report to the Trust Board each year.

6. Responsibility

The Core Cancer Team is accountable to Emma Livesley Director of Operations; the responsible Chief Officer is David Eltringham.

7. Recommendations

The Board is invited to **NOTE**:

1. Quarter 4 and full year 2015-16 performance against Cancer Waiting Times standards

2. The cancer site performance across the range of specialties and the variation in performance

3. The numbers of patients treated after day 100 of a 62 day pathway

4. Trends in Two Week Wait referrals

And to **AGREE:**

1. Aims for 2016-17 to improve performance, in line with the STF trajectory agreement.

Name and Title of Author: **Danielle Taylor / Helen West Deputy Associate Director of Cancer**

University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD PAPER

Title	Together Towards World Class Programme Update
Author	Donna Griffiths, Associate Director of Workforce
Responsible Chief Officer	Andy Hardy, Chief Executive Officer
Date	30 June 2016

1. Purpose

To inform the Board of progress of the Together Towards World Class programme.

2. Background and Links to Previous Papers

The Together Towards World Class programme is the Trust's Organisational Development (OD) programme, and is focused on supporting our vision to be a national and international leader in healthcare.

The programme is broken down into five workstreams – World Class Experience, World Class Services, World Class Conversations, World Class Leadership and World Class People, and is led by the Chief Executive Officer with the Chairman sitting as a Non-Executive Director member of the board. Each workstream is overseen by a Chief Officer, with an identified workstream lead taking forward projects under their direction.

3. May 2016 Programme Board

In line with reporting arrangements, the Programme Board received assurance and information on progress against each workstream, alongside the identification of key milestones and risks.

A summary of the information received is outlined below.

3.1 World Class Experience

Health Information – As part of delivering our core outcome of being patient centered in our approach, work is on-going to expand the provision of health information for patients. At present, the PALS service has expanded opening hours once a week to coincide with visiting hours, with an impact assessment underway. The programme board was advised these service changes have encountered significant delays due to changes in staffing arrangements. Assurance was received that work will now be undertaken to fully scope the future requirements for health information provision in light of the need to provide services out of normal business hours and from the Hospital of St Cross site.

Health Information Prescription Service – The Board received an up-date that the pilot service for dementia commenced in May 2016, a delay from the original intended start date of March 2016. The pilot will proceed for a 3 month period, with an impact evaluation completed. If the pilot proves to be successful, consideration will be given to a full roll out across all major conditions.

Patient Experience Information and Reporting- This project is focused around maximizing the use of patient feedback data and information, to ensure key trends and issues are highlighted in a user friendly format for specialty teams to ensure patient experience information informs and drives service changes and improvements. The first newly developed patient impressions reports have been trialed with Gynaecology and Paediatrics, receiving positive feedback in regards to usability. Meanwhile, an intelligence profiling report is being trialed for Renal and will also be utilised for Hospital of St Cross. The roll-out plan for all specialties is currently being confirmed, subject to the trial reports being positively received.

Patient Experience and Customer Care Training – An audit of customer care training has highlighting that there are several disparate programmes currently in place, although none of these are linked to the Trust's values and behaviours. Through a multi-professional Customer Care Design Working Group (reporting to Patient Experience and Engagement Committee) a design event and listening workshops have been held to understand the requirements around a new bespoke programme. The intention is to develop a new bespoke programme which delivers a greater awareness and understanding for staff regarding patient expectation and experience, acting as a lever to embed the Trust values and behaviours.

3.2 <u>World Class Services</u>

Theatre Reconfiguration - This project is interlinked with a project around day case flow and is aimed at ensuring the most effective and efficient use of our resources to deliver the best possible care for our patients. A pilot proposal has been completed alongside a quality impact assessment for SODA (Surgery on the Day of Admission), with current focus around exploration of nurse led discharge.

Outpatients – The board was assured that that the outpatient self-check in system pilot within Ophthalmology is complete, with a full evaluation currently underway. Meanwhile a new approach to ensure visibility of physical room availability is being implemented within outpatients, with further roll-out planned for Hospital of St Cross in mid-May 2016. Further cultural changes have been identified as required across clinics 1-6, in order to ensure we continue to build on maximizing use of outpatient resources and therefore improving experience for patients.

Critical Care and Complex Surgical Pathways – This workstream is focused around ensuring the best utilisation of critical care facilities, ensuring elimination of waste in regards to unnecessary bookings and standardisation of admission criteria to improve experience for critically ill patients. The board received assurance that work has been completed in regards to booking processes and admission criteria, alongside capacity planning mapping.

Innovation Hub – This project is progressing at pace, with the new hub scheduled to launched on 1st July 2016. The board received assurance that the innovation vision had been set and a visitor guide developed, whilst work remains underway with external partner organisations around potential sponsorship for equipment and knowledge expertise.

Electronic Patient Record (EPR) – Following the development of an options paper, approval has been given to proceed to procurement phase and work is currently underway with potential suppliers. A full business case is to be completed for EPR based on procurement options identified.

3.3 World Class Conversations

Trust Intranet – The board was assured that the implementation programme remains on track with Ideagen, the selected Intranet provider. The wireframes (basic outlines) for key pages on the new system have been agreed, and work is underway on the home page design. Meanwhile local teams are reviewing content requirements, ahead of training scheduled for July 2016.

Staff Recognition Scheme – The Board received assurance that nominations continue to be received for the World Class Colleague programme, following successful launch in January 2016. The board noted that the OSCA nomination process has been underway, which has in turn impacted on the volume of World Class Colleague nominations received during April/ early May and agreed that clarification communications would be provided regarding the differences between the two recognition programmes. This communication will be sent following the completion of the OSCA's shortlisting process.

3.4 World Class Leadership

Leading Together – The Board received assurance the programme continues to be rolled out across the organisation with the first and second Service Leader cohorts having commenced the programme, alongside the first Team Leader cohorts. Initial evaluation from these cohorts remains extremely positive. Meanwhile leadership showcases are being delivered by Hospital Leaders cohorts to highlight lessons learnt and improvements made following completion of the programme.

Leading Together – Evaluation and Research - The board also received assurance that work with Warwick Business School to undertake an independent evaluation and research piece remains on track. Interviews for a dedicated research fellow were scheduled for 21st June 2016, with a view to commence in September / October 2016. This evaluation will take place over a 12-18 month period and will focus on reviewing the competent parts and overall programme design or the programme in line with best practice approaches to leadership development alongside considering the experiences of participants. The overarching aim is to evaluate the impact of the programme on improving overall organisational level improvement in leadership capability and to identify conditions which support the transfer of learning and barriers which prevent the transfer of learning into organisational improvements. The outcomes from this work will allow the programme format, design and/or approach to be amended as necessary.

Talent Management – This workstream focuses on implementing a systematic and structured approach to the identification and deployment of talent across the Trust. In the first instance this involves the inclusion of a 'talent conversation' as part of all appraisals, allowing for talent maps to be completed at local and Trust level, alongside the development of support systems for those identified as top talent. The board were assured that a pilot, involving all top leaders and Haemotology and Oncology, is underway with all staff in the pilot groups completing an appraisal between May – end of

September. Evaluation of this pilot will take place in October / November, with the proposed full roll-out scheduled for April 2017.

3.5 World Class People

Values Based Recruitment – The Board received assurance that a values based recruitment approach has now been launched for all roles, with briefing sessions taking place for recruiting managers on a rolling basis. This work will ensure all new starters to the Trust are aligned to our Trust values and behaviours, therefore helping to embed these into practice.

Values Based Induction – The Board received assurance a values-based approach is adopted for all corporate induction processes, with a full implementation plan for local induction currently under development. This work builds on work around values based recruitment and Trust induction, ensuring all new starters are aware of expected values and behaviours at the outset of their employment with the Trust.

Values Based Appraisal – This work ensures that appraisal discussions, a key opportunity to discuss performance, are focused on both what individuals are delivering and how they are delivering through the demonstration of Trust values and behaviours. The Board received assurance that a new approach for values based appraisal was launched for all non-medical staff in May 2016, with work continuing to ensure medical appraisal paperwork and systems (which is linked to medical revalidation) are adapted accordingly.

Staff Surveys – The Board received the results of Staff Impressions – the Trust local staff survey – which took place in March 2016. The Board agreed proposals regarding use of the results, with specialty groups and core services developing local action plans whilst results at a corporate level will inform 2016/2017 project plans for TTWC workstreams (please refer to below).

3.6 VMI Up-date

The board received assurance that two Rapid Process Improvement Workshops (RPIWs) relating to Ophthalmology Outpatients have been undertaken and outcomes continued to be measured in line with the Virginia Mason Production System (VMPS) framework. The board received assurance that the second value stream related to patient Safety Incidents would be taking place at the end of May 2016, the first national sharing and learning event for NHS organisations involved in the partnership would be taking place on 29th June 2016 and the first Lean for Leaders programme (40 staff) would commence during June.

3.7 VMI and TTWC Integration Proposals

The Board received a detailed paper regarding the future integration of the Virginia Mason Institute Programme and TTWC programme. The paper recognised that the programmes are interlinked, although at present are seen as distinctly separate due to different communications and governance systems in place. The board received proposals regarding future branding and communications that could be utilised to improve awareness and understanding of both programmes and activities across the organisation,

whilst also supporting the on-going integration of these important areas of work. The board approved the proposals in principle and agreed for Chief Officers to take these proposals forward.

3.8 Areas of Focus 2016/2017

The board approved proposals for all workstream areas to develop and submit project initiation documents to September TTWC board for discussion and approval. The board approved the utilisation of a standard template for this purpose, ensuring all projects identified are linked to core TTWC outcomes and supporting the continued journey to world class standards in the respective areas.

4. Areas of Risk

This paper links to our corporate objective 'to deliver excellent patient care and experience' and to Board Assurance Framework risk (3).

Risk assessments are completed within each workstream and reported to Programme Board.

Current areas of concern with regard to programme delivery and outcomes are:

(1) Key to the overall programme succeeding is wholescale adoption and demonstration of the Trust's Values and Behaviours, this requires changing hearts and minds and is not a quick process and requires continual focus. Work is currently underway to explore the implementation of a Leadership Compact.
(2) Capacity restraints within clinical and operational teams to participate in improvement work, whilst delivering against corporate objectives.
(3) Capacity restraints within the workstream leads will restrict the scope and scale of work that can be delivered.

5. Governance

The Together Towards World Class Programme is overseen by the dedicated programme board, which is chaired by the Chief Executive Officer and includes the Chairman as a Non-Executive Director representative, ensuring oversight through to Trust Board. The Trust Board receives a bi-monthly update report detailing the progress that is being made.

Whilst each workstream has its own local governance framework in place, the overall status and progress of the workstream are reported to each programme board meeting, alongside any overarching programme risks.

6. Responsibility

The Chief Executive Officer has overall ownership of the programme, reporting through the programme board to Trust Board.

6. Recommendations

This report has been submitted for noting and to provide reassurance on the current status of the programme.

Donna Griffiths
Associate Director of Workforce – Learning and Organisational Development

University Hospitals Coventry and Warwickshire NHS Trust

PUBLIC TRUST BOARD PAPER

Title	**Audit Committee and Auditor Panel Terms of Reference**
Author	**Rebecca Southall, Director of Corporate Affairs**
Responsible Chief Officer	**David Moon, Chief Finance & Strategy Officer**
Date	**30th June 2016**

1. Purpose

To present, for approval, the revised terms of reference for the Audit Committee and the terms of reference for the Trust's Auditor Panel.

2. Background and Links to Previous Papers

The Trust Board approved the terms of reference for the Audit Committee in March 2016 but a further amendment has been made to reflect the agreement that was reached at that same meeting, around establishing the Audit Committee as the Trust's Auditor Panel.

3. Executive Summary

The Trust Board is required to approve terms of reference for those Committees that it formally establishes. Whilst a review of the Audit Committee terms of reference was undertaken by the Audit Committee in February, and subsequently presented to the March Trust Board, reference was not made to the Audit Committee being appointed as the Trust's Auditor Panel as the decision had not been taken at that time. This amendment has now been made and specific reference to this additional responsibility is included under the purpose of the Committee.

At the March meeting, the Trust Board was advised that it is required to establish an Auditor Panel, which is charged with appointing the Trust's external auditor, in line with the requirements of the Local Audit and Accountability Act 2014. Given the requirement for the panel to comprise a majority of independent members, the proposal to utilise the current Audit Committee for this purpose was accepted and terms of reference have been drafted accordingly.

The terms of reference are clear that whilst the Auditor Panel is the Audit Committee, with the addition of the Chief Finance & Strategy Officer, when it meets, it is meeting in a different capacity and the terms of reference clearly set out its role and remit. The proposed membership and responsibilities of the Committee are compliant with the requirements of the legislation and following approval of the terms of reference; the Panel will convene and discuss how it will fulfil its responsibility in making a recommendation to the Trust Board around the appointment of an external auditor, in line with the deadline of 31st December 2016.

4. Link to Trust Objectives and Corporate/Board Assurance Framework Risks

The terms of reference do not specifically link to the Corporate Objectives or to any risk on the Board Assurance Framework but they are a key component of the Trust's corporate governance framework and also ensure that the Trust is meeting statutory and

regulatory requirements, thereby avoiding the risk and consequence of failure in this regard.

5. Governance

The Audit Committee will continue to report on its activity to the Trust Board and the Auditor Panel will report to the Trust Board periodically and will make a recommendation around the external auditor for 2017/18 before the end of the calendar year.

6. Responsibility

Rebecca Southall, Director of Corporate Affairs
David Moon, Chief Finance & Strategy Officer

7. Recommendations

The Trust Board is asked to **APPROVE** the terms of reference for the Audit Committee and for the Auditor Panel.

AUDIT COMMITTEE
TERMS OF REFERENCE

Constitution:

The Board of Directors ("the Board") hereby resolves to establish a standing committee of the Board to be known as the Audit Committee ("the Committee"). The Committee is a non-executive committee of the Board had has no executive powers other than those specifically delegated to it via these terms of reference. The Standing Orders adopted by the Trust Board are applicable to this Committee in as far as they are relevant.

Authority:

The Committee is authorised by the Board to investigate any activity within its terms of reference and is authorised to seek any information that it requires from any member of staff. All members of staff are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain legal or other independent professional advice and to secure the attendance of others from outside of the Trust with relevant experience and expertise if it considers this necessary.

Purpose of the Committee:

The purpose of the Committee is to focus upon establishing and ensuring the effectiveness of over-arching systems of integrated governance, risk management and internal control and to provide assurance to the Board thereon. The Committee will also act as the Auditor Panel for the Trust and operate under separate terms of reference.

Membership & Quorum:

Membership of the Committee will comprise 4 Non-Executive Directors who will be appointed as committee members by the Trust Board. A quorum shall be two of the four Non-Executive Directors. One of the members will be appointed as Chair of the Committee and another member will be appointed as Vice Chair by the Trust Board. The Chairman of the Trust Board shall not be a member of the Committee.

The Chairs of the Quality Governance Committee and Finance & Performance Committees shall be members of the Committee to reflect the assurance function that these committees provide to the Audit Committee.

Meeting dates will be agreed with committee members at the start of each calendar year. Members should make every effort to attend all meetings of the Committee but should maintain an 80% attendance level in order to ensure quoracy and consistency.

In attendance:

The following will be in regular attendance at Committee meetings unless the Chair of the Committee requests for them to be excluded.

- Chief Finance & Strategy Officer
- Director of Corporate Affairs
- Associate Director of Finance, Corporate Services
- Representatives from the Trust's external audit function
- Representatives from the Trust's internal audit function
- The Trust's Local Counter Fraud Specialist (required to attend at least 2 meetings per year)
- The Trust's Local Security Services Manager (required to attend at least 2 meetings per year)

The Chief Executive Officer shall attend on an annual basis to discuss the process that supports the Annual Governance Statement (AGS), the annual accounts and annual report.

Other Chief Officers and senior members of staff will be invited to attend at the request of the Chair to discuss matters relating to their portfolio.

Access:
The Head of Internal Audit, representatives of external audit and the Trust's Counter Fraud Specialist and Local Security Management Specialist shall have a right of direct access to the Chair of the Committee.

Members of the Committee will meet in private with the internal and external auditors at least once per year.

Frequency:
Five ordinary meetings of the Committee will be held per year and these will be scheduled in line with the business that the Committee is required to consider. One additional extraordinary meeting will take place to consider and approve the annual accounts and annual report each financial year.

The Trust's External Auditor or Head of Internal Audit may request a meeting if they consider this to be necessary.

Reporting to the Board:
The Chair of the Committee will report in writing to the Board at the Board meeting that follows the Committee meeting. This report will summarise the main issues of discussion and the Chair of the Committee will ensure that attention is drawn to any issues that require Board or Executive action or disclosure to the full Board.

The minutes of the meeting will be submitted to the private session of the Trust Board once approved by the Committee.

Responsibilities:
The Audit Committee will have responsibility for the following:

- Governance, risk management and internal control
- Internal Audit
- External Audit
- Other assurance functions
- Financial reporting.

Governance, Risk Management & Internal Control
The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the spectrum of the Trust's activities that supports the achievement of the Trust's corporate objectives. In particular, the Committee will review the adequacy of:

- all risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance with the requirements for Care Quality Commission registration), together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to submission to the Board;
- The Board Assurance Framework, ensuring that it identifies all key strategic risks that affect the Trust, that the controls in place are adequate and reasonable and that the Internal Audit Plan and Clinical Audit Plan remain appropriate in light of new and emerging risks.
- The underlying assurance processes that indicate the degree of the achievement of the corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications;
- The policies and procedures for all work related to counter fraud and security as required by NHS Protect, including approval and monitoring of the Counter Fraud Annual Work Plan.

The Committee will primarily utilise the work of internal and external audit and other assurance functions to carry out these duties but will not be limited to these. Reports and assurances will also be sought from Chief Officers and other managers as appropriate in relation to over-arching systems of integrated governance, risk management and internal control.

In addition, the Committee will review the work of other Board committees within the Trust, whose work provides assurance to the Committee's own scope of work. This will be achieved through the Chairs of the Quality Governance and

Finance & Performance Committees being members of the Committee and the provision of an annual committee report detailing the effectiveness of the committee's work.

Internal Audit
The Committee shall ensure that the Trust has an effective internal audit function that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive Officer and Board. This will be achieved by:

- Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal;
- Review and approval of the Internal Audit Annual Plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework;
- Approval of any proposed changes to the Internal Audit Annual Plan
- Consideration of the major findings of internal audit work (and management's response), and ensuring co-ordination between the Internal and External Auditors to optimise audit resources;
- Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation;
- Monitoring the effectiveness of internal audit and carrying out an annual review.

Counter Fraud
The Audit Committee shall satisfy itself that the Trust has adequate arrangements in place for counter fraud and security that meet the standards set by NHS Protect. This will be achieved by:

- Receiving reports and progress updates from the LCFS in relation to counter fraud
- Approval of the Fraud Policy drafted by the LCFS.
- Approval and monitoring of the LCFS Annual Plan and approval of the Annual Report

External Audit
The Committee shall review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the External Auditor and consider the implications and management's responses to their work. This will be achieved by:

- Consideration of the appointment and performance of the External Auditor, as far as the rules governing the appointment permit

- Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan.
- Discussion with External Auditors their evaluation of audit risks and assessment of the Trust and associated impact on the audit fee;
- Reviewing all External Audit reports, including agreement of the annual audit letter before submission to the Board and any work carried outside the annual audit plan, together with the appropriateness of management responses.
- Ensuring that there is in place a clear policy for the engagement of external auditors to supply non-audit services

Other Assurance Functions

The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the Trust, and consider the implications to the governance of the Trust.

- These will include, but will not be limited to, any reviews by Department of Health Arms-Length Bodies or Regulators/Inspectors (e.g. Care Quality Commission, NHS Litigation Authority, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.)
- In reviewing the work of the Quality Governance Committee the Audit Committee should satisfy itself on the assurance that can be gained from the Trust's clinical audit function. This will be achieved through bi-annual submission of the Clinical Audit Plan to the Audit Committee to ensure its adequacy and to monitor that audits are taking place in line with the plan.
- The Committee will also review the content of the Quality Account prior to submission to the Board to ensure that it is generally consistent with the Committee's knowledge and understanding
- The Audit Committee may request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

Financial Reporting

The Audit Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to its financial performance.

The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

The Committee shall review the annual report and financial statements before submission to the Board, particularly focusing on:

- The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee;
- Changes in, and compliance with, accounting policies and practices;
- Unadjusted mis-statements in the financial statements;
- Significant judgments in preparation of the financial statements
- Letters of representation
- Explanations for significant variances.

The Committee will review and approve all losses and special payments.

The Committee will review all instances where the Trust's Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation have been waived.

The Committee will review all proposed changes to the Trust's Standing Orders, Standing Financial Instructions and Scheme of Reservation and Delegation prior to submission to the Trust Board.

Raising Concerns (Whistleblowing)
The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently. This will be achieved through approval of the related Policies and monitoring of its usage.

Delegation
By approval of these terms of reference the Board delegates the following functions to the committee:

- Ratification of Trust Policies that fall within the remit of the committee and that are not reserved to the Trust Board.
- Approval of the Internal Audit Annual Plan and any changes thereto
- Approval of the Counter Fraud Annual Work Plan and Annual Report

Appraisal
The Committee will carry out an annual appraisal of its performance and will report this to the Trust Board via an Annual Report. The content of the Annual Report to the Trust Board will be in keeping with the requirements of the Audit Committee Handbook

Administration:
The Director of Corporate Affairs will act as Committee Secretary and will agree the agenda with the Chair of the Committee.

Review

These terms of reference will be reviewed in February 2017 unless there is a requirement to do so sooner.

Date of Audit Committee Approval	**24th February 2016**
Date of Trust Board Approval	

UNIVERSITY HOSPITALS COVENTRY & WARWICKSHIRE NHS TRUST

AUDITOR PANEL
TERMS OF REFERENCE

Constitution:
The Board of Directors ("the Board") hereby resolved to establish its audit committee to act as its auditor panel ("the Panel") pursuant to schedule 4 of the Local Audit and Accountability Act 2014 ("the Act"). The Panel is a non-executive committee of the Board and has no executive powers other than those specifically delegated to it via these terms of reference. The Standing Orders adopted by the Trust Board are applicable to this Committee in as far as they are relevant.

Authority:
The Panel is authorised by the Board to carry out the functions specified within these terms of reference and to seek any information it requires from any employees/relevant third parties to assist in discharging its duties. All employees are must co-operate with any request made by the auditor panel.

The Panel is authorised by the Board to obtain outside legal or other independent professional advice (for example, from procurement specialists) and to secure the attendance of outsiders with relevant experience and expertise, should it consider this necessary. Any such advice must be obtained in line with the Trust's existing rules.

Membership & Quorum:
Membership of the Panel shall comprise the entire membership[1] of the Trust's audit committee as it is constituted at the time that the Panel meets, together with the Chief Finance & Strategy Officer. The Chairman of the Board shall not be a member of the Panel.

The Chair of the Audit Committee shall be the Chair of the Panel and another member shall be appointed by the Panel as Vice Chair.

Only members of the Panel will count towards a quorum. At least 50% of the panel's total membership must be present for a quorum and independent members must be in the majority

In attendance:
The following officers of the Trust will be in attendance:

- Associate Director of Finance – Corporate Services
- Director of Corporate Affairs

Frequency:
The Panel shall consider the frequency and timing of meetings needed to allow it to discharge its responsibilities but as a general rule will meet on the same day as the audit committee.

Panel business shall be detailed on a separate agenda and Panel members will deal with these as Panel member and not as Audit Committee members. The Chair of the Panel

[1] The membership satisfies the requirement for an auditor panel to have a least 3 members with a majority who are independent, non-executive members of the Board.

shall formally state at the start of each meeting that the Panel is meeting in that capacity and not as the Audit Committee.

Conflicts of Interest:
Conflicts of interests must be declared and recorded at the start of each meeting of the auditor panel.

A register of Panel member interests must be maintained by the Director of Corporate Affairs and shall be submitted to the Trust Board in accordance with the Trust's Standing Orders.

If a conflict of interest arises during the meeting, the Chair may require the affected member to withdraw at the relevant discussion or voting point.

Reporting to the Board:
The Chair of the Panel will report in writing to the Board at the Board meeting that follows the Panel meeting on how the Panel has discharged its responsibilities and will highlight any issues that require full Board executive attention/action. Approved minutes of meetings of the Panel shall be submitted to the Board.

The minutes of the meeting will be submitted to the private session of the Trust Board once approved by the Panel.

Responsibilities:
The Panel will have responsibility for the following

- Advising the Board on the selection and appointment of the Trust's external auditor, including:
    - Agreeing and overseeing a robust process for selecting the external auditors in line with the Trust's normal procurement rules
    - Making a recommendation to the Board as to who should be appointed
    - Ensuring that any conflicts of interest are dealt with effectively

- Advising the Board on the maintenance of an independent relationship with the appointed external auditor
- Advising the Board on whether or not any proposal that may be received from the external auditor to enter into a liability limitation agreement as part of the procurement process is fair and reasonable
- Advising on, and approving, the Trust's Policy on the purchase of non-audit services from the appointed external auditor
- Advising the Board on any decision about the removal and resignation of the external auditor

Delegation
By approval of these terms of reference the Board delegates the following function to the Panel:

- Approval of the Trust's Policy on the purchase of non-audit services from the appointed external auditor

Administration:
The Director of Corporate Affairs will act as Committee Secretary and will agree the agenda with the Chair of the Panel.

Review
These terms of reference will be reviewed in July 2017 unless there is a requirement to do so sooner.

Date of Trust Board Approval	
Version	**1.0**

INTERIM QUALITY GOVERNANCE 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. The Board is asked to note the business discussed at the meeting and to raise any questions.
Committee Name: Quality Governance Committee
Committee Meeting Date: 20th June 2016
Quorate: Yes **Apologies:** Karen Martin
Chair: Ed Macalister-Smith
1. Violence and abuse of staff; following the results of the staff survey, an action plan was provided detailing the steps that are being taken to demonstrate the action that the Trust will take against perpetrators of violence and aggression towards staff, the communications plan around this and the support that is available to staff that have been subject to violence and aggression. A further update was requested and will be considered in September, alongside reviewed template letters.
2. Patient Story – following the patient story at the May Trust Board, and the related feedback from junior doctors at Rugby to HEWM, the Committee received an update of the actions that have been taken arising out of the root cause analysis that has been completed. Assurance was given that appropriate actions have been put into train. The number of patient falls at Rugby St Cross has reduced as a result, and transfer planning and handover arrangements have been improved.
3. Integrated Quality Report; the Committee received for the first time the new-style report, which details performance against the quality related KPIs in the performance management framework. This allows members to easily focus on key quality-related issues and seek further assurance where required, and in turn provide assurance to the Trust Board. This was welcomed and regarded as a helpful development.
4. Imaging Improvement Plan; a quarterly update against the plan that was put into place to address the concerns raised by the CQC was given. Good progress is being made in relation to the improvements to the physical environment. Work is still taking place in relation to cultural issues, which will take longer.
5. ISS 12 Month Action Plan; the Committee received a quarterly update which demonstrates continuing progress. Non-Executive Directors and the Trust Advisor indicated that the improvements that were being made were evident through Board Walk-Rounds that they were attending, through which staff were reporting a greater level of satisfaction with cleaning. A further update will follow in September.
6. Quality Department Annual Report; a comprehensive report was received detailing the work undertaken by the Quality Department during the year, which was welcomed by the Committee. The report is supplemental to the Quality Account and will be published on the Trust's website alongside it. The report contains 10 significant sub-section reports, including the annual Complaints Report.
7. Cervical Screening QA Visit; a succinct and helpful report was received detailing the findings of the external inspection visit that was undertaken by Public Health England on the 9th March. The key findings were extremely positive and a number of areas of good practice were noted. There were a small number of recommendations for improvement made and the team is in the process of implementing these, while responding to an upsurge in demand arising from the national HPV programme.
8. Sub-Committee reports; the overhaul of the work-plan resulted in fewer agenda items on the June agenda and allowed the Committee to focus on the work undertaken by the sub-committees in more detail than previously. This was a welcome development, and staff thanked for work on the Work Programme.

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: 22nd June 2016
Quoracy: Yes
Apologies: Karen Martin, Barbara Beal
Committee Chair: Ian Buckley
Report submitted by: Ian Buckley, Vice Chair
1. Minutes The minutes of the May meeting were **approved.**
2. Integrated Performance Report It was **noted** that meeting the A&E target continued to be a challenge in April with performance against the referral to treatment (RTT) incomplete standard remaining below target in April. The Committee **received assurance** that actions have been put in place to address this as part of the weekly Access Team Meeting discussions. In contrast, non-emergency care admissions have increased with activity in May demonstrating continued improvement. A broad discussion took place around A&E performance and early indications from a rapid review of the last three years activity data suggest that attendance through the adult emergency department has significantly increased over this period. The Committee **requested** a trend analysis of A&E activity data to be considered alongside changing patient profiles, capacity and decision making. The controls in place to reduce agency spend have demonstrated a positive impact in terms of nursing and the Committee sought assurance around what methods were being applied to hold the Groups to account in terms of reducing medical agency spend. The Committee proposed that further discussion around medical agency spend be escalated for whole Board discussion and **requested** that the Chief Workforce and Information Officer deliver a plan to the Trust Board in July demonstrating what innovations the Trust is exploring to solve the medical agency issue, including an in depth understanding of what medical locums are engaged and where within the trust and a plan to eliminate A&C agency spend.
3. Theatre Efficiency The Committee **received** an overview of key improvement schemes to illustrate the workstreams that will deliver theatre efficiency and maximise utilisation. The Committee **requested** that a further update be presented to the Committee in August in relation to progress with the key improvement schemes providing a cause and effect analysis, as well as demonstrating impact and next steps. The Committee **noted** that the Performance and Information Teams together are examining waiting list information to drive forensic discussions with the Groups to reduce delayed theatre start times. The Committee agreed to revisit the breakdown [by consultant] of delayed theatre start times previously presented to the Committee alongside a revised breakdown to seek assurance around progress made.

4. Integrated Finance Report

The Committee **approved** the proposal to receive a flash report of month 3 data to enhance discussions and demonstrate direction of travel against month 2 data.

The Committee **requested** that details of the rules to be applied around the provision of the Sustainability Transformation Fund be shared with the Committee within the Integrated Finance Report next month.

Discussion around the cash position took place and the Committee **requested** that further assurance around cash liquidity and the capital positon be presented to the Committee in July.

The Board is asked to note the business discussed at the meeting and to raise any questions in relation to the same.